distance of not less than 15 ft (4·6 m) from the eye, which gives some indication of the velocity of these flying particles and the danger of watching such work in progress.—I am, etc.,

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An Integrated Child Health Service

SIR,—I hope that many have read and approved the article by Drs. F. N. Bamford and J. A. Davis (*Supplement*, 20 January, p. 20). The need for a modified, expanded, and integrated service to meet the changed pattern of child health and to provide an effective medical contribution to those who at present receive only token attention, or even none at all, has been recognized by some of us for several years. If professional attitudes had been more favourable, comprehensive child health services would have evolved before now. The current spate of reorganization stimulates hope that the time is ripe for such integration. Administrative changes alone, however, will not be sufficient. Attitudes must change. In particular there must be wider appreciation of the value of the promotion of optimum health and development for all children, recognition of the value of developmental stimulation and guidance, and acknowledgement that the paediatrician grappling with the multifaceted problem of a disabled child in the community requires skills just as complex and demanding as those required of a hospital-based paediatrician focusing upon a problem in depth.

Many things can and should be done. The more important are as follows: (*a*) Increase undergraduate teaching of child health and development. The introduction of child development and behavioural sciences into the preclinical years is praiseworthy, but must be matched by practical demonstrations of developmental paediatrics in the clinical years. (*b*) Accept that the promotion of child health is a basic part of medical practice and not just another item to be added on a fee-for-service basis. (*c*) Plan and make available vocational training programmes for the many paediatricians required by the community child health services. (*d*) Create a journal of child health and development as a focal point of the multidisciplinary activities in this field. It is truly amazing that no journal which really meets the requirements exists in this country.

Obviously some of these are long-term aims, but there are many items on which we can begin this very day if we so wish. If we want our children to have the best prospects for health and development, we must work for these changes ourselves. We cannot sit back and hope that they will suddenly appear as if by an administrative sleight of hand.—I am, etc.,

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P.B.I./E.T.R. for Routine Screening of Thyroid Function

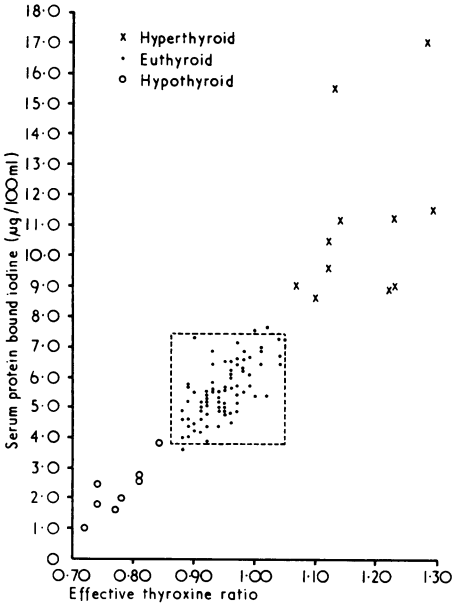
SIR,—As members of an endocrine unit with heavy clinical commitments we require a reliable screening test of thyroid function. During 1972 2,000 patients were screened for thyroid disease with an automated serum protein-bound iodine (P.B.I.) estimation (normal range 3·8-7·4 μg/100 ml, batch-to-batch variation 3%), and the effective thyroxine ratio (E.T.R.)[1] determined with a kit supplied by Mallinckrodt Nuclear (U.K.) Ltd., (normal range 0·86-1·05, batch-to-batch variation 3%). One thousand of these patients were seen in this unit.

Cause	Raised P.B.I. Normal E.T.R.				Normal P.B.I. Raised E.T.R.				Normal P.B.I. Lowered E.T.R.				Lowered P.B.I. Normal E.T.R.			
	A	B	C	D	A	B	C	D	A	B	C	D	A	B	C	D
Pill ..	13	–	–	1	–	–	–	–	–	–	–	–	–	–	–	–
Pregnant	5	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Iodine contaminants	14	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–
Antithyroid drugs ..	4	–	2	–	–	–	1	–	1	–	–	–	2	–	–	–
Non-thyroid drugs ..	4	–	2	–	3	–	–	1	3	–	–	1	1	–	–	–
Radioiodine-treated	4	–	–	1	–	–	–	–	–	–	–	–	–	1	–	1
No apparent cause ..	5	–	–	1	3	–	–	–	1	1	–	–	1	–	–	3

Final clinical diagnosis: A = euthyroid; B = hypothyroid; C = hyperthyroid; D = still awaited.

The relation between these two parameters in a consecutive series of 100 unit patients is shown in the figure. Patients undergoing treatment with thyroid hormones or antithyroid drugs and those known to have thyroxine-binding globulin abnormalities or iodine contaminants have been excluded. The correlation between E.T.R. and P.B.I. is high, as might be expected on theoretical grounds.

The findings in the 81 patients out of the whole series of 1,000 in whom the P.B.I. put the patient into one clinical category while the E.T.R. put the patient into a different category are shown in the table. For the purpose of this analysis the normal ranges have been strictly applied; no allowance has been made for the error on each result.



It will be seen that the E.T.R. fits the clinical diagnosis in all patients with quantitative changes in thyroxine-binding globulin capacity or with known iodine contamination. In the remainder, who form only 5% of all patients seen in this unit in one year, neither test has a clear diagnostic advantage.

The cost of a single P.B.I. determination is approximately 10p, and that of a single E.T.R. determination is approximately 110p. One must ask, therefore, whether the additional information obtained from the E.T.R. justifies its routine use for all patients suspected of having thyroid abnormalities.—We are, etc.,

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1 Thorson, S. C., Mincey, E. K., McIntosh, H. W., and Morrison, R. T., *British Medical Journal*, 1972, 2, 67.

Non-pharmacological Influences on Therapeutic Efficacy

SIR,—Interactions between doctor and patient and the nature of the treatment environment are non-pharmacological variables which may influence the objectivity of drug evaluations and affect the results of clinical trials.[1] The drug treatment of essential hypertension seemed to us a suitable medium for studying the effect on therapeutic efficacy of the doctor's attitude, and we therefore decided to carry out the study reported here. It was designed only to discover whether misleading information to the patient on the progress of treatment could affect the well-known hypotensive action of certain established hypotensive drugs.

Twenty-one hospital inpatients suffering from essential hypertension were studied. Antihypertensive treatment was not started until five to seven days after admission, when the patients had settled down and basic blood-pressure levels were established. They were then randomly divided into two groups, 10 in group A and 11 in group B. They were told that they would be given a new, effective drug against high blood pressure. No patient was given a drug which he or she had had previously and might recognize. Treatment was continued for from six to eight days and the drug dosage was not altered throughout. Each day between 8-9 a.m. the patients' blood pressures were measured by one of us (K.S.), always with the same sphygmomanometer. Patients in group A were told that their blood pressure had not changed and the drug was not yet effective. This was noted on the chart hanging at the end of the bed and accessible to the patient, while the true blood pressure values were recorded elsewhere. Similar information on progress was conveyed to each patient by the consultant on his round later in the day. An identical procedure was car-

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