indirect support comes from Craig and Pitts (1968), who calculated the suicide rates of male and female physicians for the years May 1965 to May 1967, and found them approximately equal (males: 38·3/100,000, females: 40·5/100,000). This finding is in striking contrast to the suicide rates in the general population, which are much higher for males than females. Suicide rates, according to Craig and Pitts, can be used to give an indication of the prevalence of affective disorders, since a constant 15 per cent of deaths of individuals with affective disorders are due to suicide. However, 25 per cent of the deaths of males in the general population with affective disorders are due to suicide, as compared with only 10 per cent of deaths of females in the general population with affective disorders. As the female physicians' suicide rate calculated by Craig and Pitts is very significantly ($p < \cdot00001$) higher than the suicide rate of the general population of white U.S. females (11·4/100,000) over the same time period, they conclude, using this rate as an index of depression, that the incidence of affective disorders in female physicians is very high, certainly much higher than the incidence of affective disorder in male physicians. An equally probable alternative hypothesis from the socio-cultural perspective can be made. That is, social role may affect not only the prevalence of depressive disorders but also the behavioural expression of this depression, e.g. suicides. Thus similar suicide rates in male and female physicians may reflect either similar prevalence rates of depressive disorders within this sub-population or similar behavioural expressions within this sub-population.

No final conclusions can be drawn until epidemiological studies of the prevalence of depressive disorders can be carried out in various cultural segments of our society where the 'woman's role' has become similar to the man's, e.g. as in occupational categories. It is, however, probably premature to settle on any specific explanation, genetic or otherwise, for the apparent sex-related differences in diagnostic subcategories of affective disorders.

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ECONOMICS OF REHABILITATION

DEAR SIR,

Mr. Cheadle and Dr. Morgan (*Journal*, August, pp. 193–201), have made a most valuable contribution to the discussion of rehabilitation. At a time when the scrutiny of costs is becoming more and more rigorous throughout the public services it is at least equally important to examine and measure the benefits achieved. The meticulous research which is evident in this paper is an excellent example of the process of probing into the realities of health care which will be essential for the new Health Authorities in establishing their policies.

The paper is notable for its insistence upon hard facts; indeed it is most gratifying that the Department of Health and Social Security was able to be so helpful in providing information about National Insurance contributions, Sick Benefit and Unemployment Benefit. On the other hand, it was to be expected, and readily understood, that details of income tax could not be obtained. The authors, therefore, resorted to an estimate of earnings from which they calculated tax contributions.

All this is admirably done, but it is arguable that

too conservative a view has been taken of the benefits achieved. What emerges is a careful statement of the debits and credits in relation to the national exchequer, taking into account hospital and social security costs and tax, insurance and pension contributions. In the process, the earnings were discarded after calculating tax. If, however, the intention is to present the costs and benefits to the national economy, which is the term used in the paper, then it is proper to take credit for the output of the workers by way of contribution to production. It has been shown that the net direct costs are a little over £12 per patient per week, taking the cohort of 200 patients over ten years. It so happens that the notional weekly earnings, under-estimated by ignoring overtime, range during the decade from £7.74 to £12.92 for men and £6.83 to £11.50 for women. If these are accepted as a rough measure of output, then the contribution per working patient to the output of the economy goes a long way towards balancing the direct costs incurred on his or her behalf. Moreover, as the authors observe, every successful discharge carries benefits far beyond the limits of their ten year study.

The results of this research, and indeed of the work of the unique regional rehabilitation hospital at St. Wulstan's, can be placed in a wider perspective. Indications are given of various supportive measures in the community, and mention is made of Birmingham Industrial Therapy Association Ltd. This is a non-profit-making company which employs about 380 mental patients and has a record over some years of restoring workers to open employment at the rate of about two a week. This achievement, of course, owes a very great deal to the support of the Department of Employment, who second two Disablement Resettlement Officers to the factory, and also to health and local authorities. Nevertheless, the company operates on the principle that its objectives of rehabilitation are best achieved by accepting the normal commercial obligations of price, quality and service. On that basis the company accumulated funds which enabled it to add £17,000 to an interest-free loan of £53,000 made by the City of Birmingham, with repayment guaranteed by the Birmingham Regional Hospital Board, for the purpose of purchasing a factory. In other words, it is possible to claim that, within certain limitations, rehabilitation is consistent with good business performance.

The Department of Employment is now engaged in a radical review of the processes of rehabilitation, and the Department of Health and Social Security is, of course, closely concerned. The results revealed by Mr. Cheadle and Dr. Morgan in their research are an important addition to our knowledge of the facts and a stimulus to all those people, professional and lay, who have an interest in fostering the developments which must surely emerge from the new national initiatives.

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EFFECTS OF HYPNOTICS ON ANXIOUS PATIENTS

DEAR SIR,

We agree in substance with many of the comments made by Dr. Betts and his colleagues about our paper (*Journal*, September 1974, p. 329), including their suggestion that the actions of drugs on performance are likely to be more complex in anxious subjects than in normals. With regard to their two criticisms about methods, we would say, firstly, that although it is obviously difficult to eliminate carry-over effects completely the design of this study was calculated to minimize them; and secondly, that the controversy about how best to analyse data of the sort we have presented is too long to be gone into in these columns; but it has been discussed fully by one of us elsewhere (Malpas, 1972). We look forward to hearing the results of their new experiments in due course.

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A REQUEST FOR REFERENCES

DEAR SIR,

I should be grateful to receive details of any known references in the literature, or unpublished instances, in which the following triad may have appeared to be associated with an otherwise somewhat unexpected death or severity of illness:

1. Long-acting intramuscular antipsychotic medication.
2. Subnormality of intellect in child or adult.
3. Respiratory tract infection.

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