treatment of abscesses of different aetiology, with which we dealt in our second report.³ We regard this omission as dangerous.

Your preoccupation with a single chemotherapeutic agent, effective only against strict anaerobes, is misleading, since we have demonstrated that aerobic and microaerophilic organisms predominate in cerebral abscesses. Of the patients in our study, 76% were infected only with microbes that were demonstrably resistant to metronidazole. Further, we remind you that lincomycin and chloramphenicol are effective against anaerobic bacteria and that they were used in the treatment of some abscesses in both series of cases discussed in the leading article. Carbenicillin, not used in either series, and fusidic acid also have some activity against anaerobic bacteria.

The treatment of cerebral abscesses is primarily surgical and it remains so. Rapid and accurate location of the lesion followed by prompt evacuation of the pus and internal decompression continues to save lives. Factors other than the choice of antibiotics, such as measures taken against cerebral oedema, should be taken into account in any discussion of mortality.

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¹ de Louvois, J, Gortvai, P, and Hurley, R, *British Medical Journal*, 1977, 2, 981.

² Ingham, H R, Selkon, J B, and Roxby, C M, *British Medical Journal*, 1977, 2, 991.

³ de Louvois, J, Gortvai, P, and Hurley, R, *British Medical Journal*, 1977, 2, 985.

Polio immunisation in pregnancy

SIR,—To your expert (Any Questions?, 23 July, p 244) it is clearly sensible to use the opportunity of antenatal contact to immunise non-immune mothers against poliomyelitis. As recently as March of this year, however, the Joint Committee on Vaccination and Immunisation¹ stated that "live vaccines should not be administered to pregnant women, particularly early in pregnancy, because of possible harm to the fetus. However, where there is a significant risk of exposure to such serious conditions as poliomyelitis or yellow fever the importance of vaccination may outweigh the possible risk to the fetus." Attention to this general contra-indication is drawn again in the section of the same report specifically dealing with poliomyelitis.

Many doctors will instinctively feel that the more cautious approach of the joint committee is the wiser policy. It has been said that the best obstetrician is the one who keeps his hands longest in his pockets.

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¹ Note by Joint Committee on Vaccination and Immunisation. Appendix to CMO(77)7/CNO (77)3. London, DHSS, March 1977.

* * * Our expert replies: "My answer was to a question from Iraq, which was not made clear in the printed question but should have been. The Joint Committee on Vaccination and Immunisation provides national and not

international guidelines, although they do say, as Dr Twomey quotes, that vaccination during pregnancy may be justified 'where there is a significant risk of exposure to . . . poliomyelitis.' I therefore stand firmly by my view in the Iraqi context." We regret our omission to indicate the place of origin of the question and apologise to our expert and to readers for any misunderstanding that this may have caused.—Ed, *BMJ*.

Plight of Maltese medical students

SIR,—With reference to the comments by Scrutator on the position of Maltese medical students (15 October, p 1036) I must point out that the impasse the final-year medical students found themselves in when they were left with their examinations not completed was precipitated by the Medical Association of Malta when it decided to take industrial action fully aware that the examinations would have been completed had their action been delayed by just two more days and also fully aware at the time of the repercussions that would result therefrom.

The Government was in no way responsible for that situation, as, in the interest of the patients, it could not discriminate between consultants who refused to give an emergency service as required from them by the Government from those same consultants who, as examiners, insisted that they be admitted to hospital to select patients for clinical examinations. In this connection it is also to be borne in mind that at the time only emergency cases were being treated in Government hospitals and the Government was not therefore in a position to allow patients to be used for clinical examination purposes when their care and treatment were its primary consideration.

Besides, the examiners did not even have the decency to give advance notice when they would be using the hospital. They just appeared at the hospital doors and demanded admittance. Such arrogance could not be tolerated and was moreover interpreted as being intended to place the authorities in a position where they could not accede to the examiners' request.

The students, other than those in their final year, who chose to leave Malta did so despite the Government's promise that the medical school would be reopened, as it did on Monday, 17 October.

The fact that "Britain is still a democracy" does not give the right to any group of Britishers to interfere in the internal affairs of any other Commonwealth country. It is high time for these Colonels Blimp to accept the fact that Malta is no longer a British colony.

Lastly, it is more deplorable and it betrays a large measure of bias for Scrutator to conclude that the present dispute "seems bound to affect the standard of medical services." Not only have the previous standards been maintained but also the medical services being provided at present have been extended to include operations which before were never performed in Malta.

TONI PELLEGRINI
Director of Information

Office of the Prime Minister,
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* * * The Secretary writes: "Information reaching the BMA conflicts strongly with several of Mr Pellegrini's statements and sheds a very different light on the state of affairs in Malta as described by him.

"(1) None of the Malta doctors have refused to treat emergencies. The MAM has published advertisements in the press telling the people of Malta that they stand ready to treat emergencies in any hospital, public or private. This has been the position from the start. Unfortunately the Government reacted by locking doctors out of the hospitals, and those who attempted to remain were ejected by the police.

"(2) Dates when examinations are to be held are arranged a long time in advance and the Government therefore had plenty of notice of these dates. Nevertheless the examiners, including external examiners who had travelled from Britain, were refused admission to the hospital for purposes of conducting the examination.

"(3) As nearly all the clinical teaching staff have been dismissed by the Government it is impossible to see how clinical training can be conducted properly. The Maltese Minister of Health met the students on the evening of 15 October in order to tell them that the medical school would be reopened on 17 October. The students asked for the names of those who would teach them and they were not given a single name.

"(4) It is stated that the imported doctors staffing the hospitals at the time of the examinations were dealing only with emergencies. In fact they were dealing with 'cold' cases as well as with emergencies."—Ed, *BMJ*.

Dispute in Malta

SIR,—May I add my voice in support of Mr L J German, of the Medical Association of Malta (22 October, p 1082)? The struggle of our colleagues on that island is now against what is probably the ultimate threat to professional independence, a government that regards judgment of competence to practise as made better on political than on professional grounds. The Maltese Government has not only sought to dominate the profession by withdrawing their legal right to practise but has even added a quite monstrous denial of hard-earned pension rights. There are lessons in this, sir, for all of us. The independence of our profession must be fought for wherever it is challenged and I am happy to support Dr J A Cameron's appeal for funds (10 September, p 708).

Publicity is essential. We should be warning our patients personally, through the press and through travel agents, that a medical emergency to a tourist in Malta will no longer be managed by the local men for whose competence we in Britain have so often been able to vouch. Instead they will be in the care of doctors chosen on political grounds from Libya, Czechoslovakia, the Palestine Liberation Organisation, and Pakistan. Few if any of these will have reached professional standards of which we have knowledge or can approve. We should also surely be re-examining the arrangements for the treatment of selected Maltese patients under the NHS here so long as this duress continues.

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Vitamin B₁₂ deficiency in a child

SIR,—I think it is up to me to respond to Dr R Ferguson's criticism (22 October, p 1086) of our paper (24 September, p 807), since the question of jejunal biopsy was dis-

cussed in great detail when the child was my clinical responsibility. Vitamin B₁₂ deficiency occurs in severe adult coeliac disease, when the enteropathy presumably affects both proximal and distal small intestine, causing malabsorption of many nutrients¹; megaloblastic anaemia due to B₁₂ deficiency has not been described in childhood coeliac disease.²

I agree wholeheartedly that the only screening test for coeliac disease is jejunal biopsy, which is safe and easy by the method Dr Ferguson describes. I too advocate it as the initial investigation of suspected gluten-induced or other enteropathies. In this particular case, however, I find it difficult to believe that coeliac disease could have caused profound depression of a single function of the distal ileum without a hint of proximal intestinal dysfunction. There was no clinical indication for jejunal biopsy.

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¹ Hoffbrand, A V, *Clinics in Gastroenterology*, 1974, 3, 71.

² Dormandy, K M, Waters, A H, and Mollin, D L, *Lancet*, 1963, 1, 632.

³ Rossiter, M A, Wharton, B A, and Walker-Smith, J A. In preparation.

Science, race, and intelligence

SIR,—In your leading article "Science, race, and intelligence" (22 October, p 1040) you appeal to scientists to agree with the classical positivist belief that pure research into the variations of human capabilities is independent of the uses to which such theories might be put. This optimistic view of "pure research" in the human sciences seems naive at a time when race is once again an overt political issue.

Doctors have in the past offered a variety of ideas concerning the personalities and innate abilities of non-Whites. A large part of the theoretical underpinning of the work of Gobineau and Chamberlain was provided by nineteenth-century anthropologists and anatomists who, like Broca, associated skull type with particular social characteristics. Statistical and quasianatomical techniques have been used. The examination of the cerebral cortex apparently demonstrated that the Negro has the brain of a seven-year-old child.¹ The African has been described as a lobotomised European,² and kinkiness of hair is apparently inversely related to the frequency of depressive episodes.³ The psychologist McDougall stated that the inherited trait of submissiveness was particularly developed in Blacks.⁴

Specific patterns of mental illness have been related to skin pigmentation. In nineteenth-century America, in an attempt to provide an explanation for the tendency of slaves to escape from their plantations, doctors discovered a new disease—drapetomania, an irresistible desire to run away. In a similar way rascality was attributed to dysaesthesiae aethiopica.⁴ Blacks had apparently been spared one of the dangers of civilisation, depression: "Naturally most of the race are care-free, live in the 'here and now' with a limited capacity to recall or profit by experiences of the past. Sadness and depression have little part in his psychological makeup."⁵ Even now some veteran Southern psychiatrists who have had extensive experience in treating Negro patients consider a serious suicidal attempt to be *prima facie* evidence of white ancestry.⁶

Psychoanalytical and related theories also suggested that non-Whites were similar to children. G Stanley Hall called them an adolescent race. Jung believed they lacked a whole "historical layer."⁴ Laubscher suggested that the tendency of South African Blacks to raid White ranches was due to their overwhelming oral needs.⁷ Bleuler

observed that "West Indian Negroes in whom a white streak is easily noticed are a tribe so capable of enjoying life and so unburdened with any sense of responsibility that one may very well ask whether it is not we who constitute the unsuccessful variety of humanity."⁸ Jung wondered if the bad effects of "living together with the barbaric races exerts a suggestive effect on the laboriously tamed instinct of the white race and tends to pull it down."⁹

A theory which concluded that another race was incapable of responsibility and hence needed control had obvious practical consequences. That Negroes were spared psychological difficulties was "entirely due to the healthful restraints that surround them from childhood through life. They were taught from infancy obedience. . . ."¹⁰ None of the workers we have cited considered themselves prejudiced. It seems unlikely, however, that we can totally dissociate their theories from subsequent political events.

A recent point of concern is the overrepresentation of Black children in schools for the educationally subnormal. One reason that children of West Indian origin have scored badly in IQ tests is the ethnocentric assumption that linguistic competence is synonymous with the use of standard English.¹¹ It has also been established that the expectations of teachers are related to the future performance of schoolchildren.¹²

As scientists we can pretend neither that our measurements are culture-free nor that our theories are independent of underlying social and political considerations. The distinction between fact and value is less easily made than you comfortably assume.

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¹ Vint, F W, *East African Medical Journal*, 1932, 9, 30.

² Carothers, J C, *The African Mind in Health and Disease*, WHO Monograph Series, No 17. Geneva, WHO, 1953.

³ Fischer, S, *Journal of Nervous and Mental Disease*, 1943, 97, 409.

⁴ Thomas, A, and Sillens, S, *Racism and Psychiatry*. New York, Brunner/Mazel, 1972.

⁵ Bevis, W M, *American Journal of Psychiatry*, 1921, 1, 69.

⁶ Prange, A J, and Vitols, M M, *International Journal of Social Psychiatry*, 1962, 8, 104.

⁷ Laubscher, B J F, *Sex, Custom and Psychopathology—A Study of South African Pagan Natives*. London, Routledge, 1937.

⁸ Bleuler, E, *Textbook of Psychiatry*. New York, Macmillan, 1924.

⁹ Jung, C G, in *The Basic Writings of Sigmund Freud*, trans A A Brill. New York, Basic Books, 1938.

¹⁰ Babcock, J W, *Alienist and Neurologist*, 1893, 16, 423.

¹¹ Coard, B, *How the West Indian Child is made Educationally Subnormal in the British School System*. London, New Beacon Books, 1971.

¹² Rosenthal, P, and Jacob, L, *Pygmalion in the Classroom*. New York, Holt, Rhinehart, and Winston, 1968.

SIR,—“Science, race, and intelligence” (22 October, p 1040) was a model example of a leading article written with “scientific” sincerity. Your reference to the US policy of “affirmative action” and the anomaly of Alan Bakke and the Davis Medical School was so apt. However, before we “build into our system compensatory advantages for groups who might otherwise feel excluded from a fair share of well-rewarded and respected occupations” it would indeed be important to research into the role of genetic factors in education performance.

Britain does not as yet have an “affirmative policy.” Nevertheless, some Blacks have received higher education and some have entered and reached the top of “well-respected occupations” (except for politics and the

police). It is not known whether these successful ones are in proportion to their numbers in society. A most fruitful area of research would be into the attainment of such success by Blacks and an evaluation of the causes listed in your leading article “ranging from racial prejudice through deprivation and social inheritance to genetic factors.”

“Surely no scientist would disagree.”

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Painful shoulders and painful arcs

SIR,—We feel that your leading article on painful shoulders (8 October, p 913) gives a somewhat misleading impression of the value of local steroid injections. It has been shown^{1 2} that repeated small doses of intra-articular steroids will relieve pain in about 90% of patients and improve the range of active shoulder movement in about 85%. A local anaesthetic injection alone does not have any lasting effect.² Pain at rest is one of the most disabling features of the painful shoulder syndromes, and is relieved neither by analgesic drugs nor by any other method of treatment. The dose of steroid used is relatively low and quite consistent with the amount injected intra-articularly at other sites. We use a total of 20 mg of methyl prednisolone acetate and 40 mg of lignocaine per injection, half this amount being injected at each of two sites, the subacromial bursa and the glenohumeral joint, and we have found it unusual for any particular patient to need more than three injections at 5-6-day intervals.

We would suggest that the term “frozen shoulder” is misleading and inaccurate and should be abandoned and perhaps replaced by “stiff painful” or “stiff painless” shoulder. Much confusion has resulted from the general use of the term “frozen shoulder”—for instance, to describe painful arc syndrome, where prognosis is usually very much better. True progress in the management of painful shoulders will be made only when all those responsible for treating patients with this problem understand the types of lesions involved.

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¹ Steinbrocker, O, and Argyros, T G, *Archives of Physical Medicine and Rehabilitation*, 1974, 55, 209.

² Roy, S, and Oldham, R, *Lancet*, 1976, 1, 1322.

SIR,—I should like to make a plea for the abandonment of the term “painful arc syndrome.” A painful arc is a sign, not a syndrome; it shows that a tender area lies in a pinchable position between the acromion and humeral tuberosities. As well as occurring in lesions of the rotator cuff, a painful arc has been described¹ in subdeltoid bursitis, bicipital tendinitis, sprain of the inferior acromioclavicular ligament, metastases in the acromion, laxity of the shoulder joint capsule, and in cervical disc lesions.

Your leading article (8 October, p 913) recognises that supraspinatus tendinitis is responsible for only a third of rotator cuff lesions. Which part of the cuff is at fault is shown by eliciting the accessory signs—determining which resisted movement hurts. In supraspinatus tendinitis resisted abduction