at the Serbsky Institute of Forensic Psychiatry—at which visiting Western psychiatrists were manipulated in an effort to whitewash Soviet psychiatry (see pp 303-320)—to gain an impression of the devious tactics resorted to by the core group. No informed Western psychiatrists could possibly be sympathetic to this group. We should, however, make every effort to support those of our colleagues—the majority of Soviet psychiatrists—who find the political misuse of their profession as abhorrent as we do, and particularly the courageous few who are being punished for exercising their professional conscience.

We are also puzzled by Dr Hare's comments on the dissenters. His suggestion that they seek martyrdom and obsessively persist in their campaigns demeans the whole human rights movement in the USSR. All the dissenters we have interviewed were more than aware of the risks they were taking, including, ironically, the possibility of internment in a mental hospital. Certainly none of them relished this possibility!

We would entirely agree with Dr Hare's final comment that there is a need for British psychiatrists to look into their own backyard. However, ethical issues in medicine transcend geographical boundaries and a concern about our own practices and those of our colleagues elsewhere are not mutually exclusive.

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Science, race, and intelligence

SIR,—The question of race and intelligence is not as simple as would appear from your leading article (22 October, p 1040). It would be better were we able to research and discuss the problem in an emotionally neutral scientific environment, but nowadays this is not possible even in the scientific press. There are too many people eager to distort the facts for their own political ends. May I draw your attention to the following facts, which you appear not to have considered?

(1) The Black man in a predominantly White society sees himself in an uncertain, even overtly hostile, environment. As intelligence is commonly equated with worth it is not surprising that he reacts to the suggestion that he and his children may be innately less intelligent than their White neighbours.

(2) When race and intelligence are discussed the assumption always seems to be that there is a clear distinction between Blacks and Whites. Blacks are people who are seen to be not White. The mixed-raced child is classified as Black and accepted by both ethnic groups as such; thus White is equated with purity and Black with impurity.

(3) Leaving aside this philosophical consideration, the prejudices of many researchers lead them to lump together all the non-White people into the Black group. It is a matter of history and common observation that the Blacks of the West Indies and America are ethnically heterogeneous people. The genetic mixture of the West Indian Blacks is mainly of African, European, and Indian. It is possible to find an average intelligence and draw a normal distribution curve of intelligence in these people, but the meaning and application are doubtful. Even were it provable that our

Black population are less intelligent than the White majority this fact would be meaningless when faced with a child who could be "95% White" and yet still look very black.

It may be that we shall one day answer the question, but it behoves researchers to take heed of the feelings of the people they are investigating. Until we have an unequivocal answer uninformed speculation in public is mischievous. Kite-flying is a fine occupation for the scientist, but it is dangerous in stormy weather.

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Incidence and mortality of acute pancreatitis

SIR,—Your leading article (22 October, p 1043) gave valuable emphasis to the growing weight of evidence linking acute pancreatitis with a wide variety of drugs. However, I feel that the quoted incidence of 2500 people a year in Britain (± 46 cases per million) with 500 deaths (20% mortality rate) may present a somewhat pessimistic impression of the disease.

The incidence of acute pancreatitis probably reflects the thoroughness with which the disease is sought as well as the criteria which are accepted to define its existence. Using conventionally acceptable criteria for diagnosis such as a consistent clinical presentation and course, a serum amylase level of at least 1000 Somogyi units, or characteristic findings at laparotomy or post-mortem examination, 35 cases of acute pancreatitis were treated in this hospital during 1976. This is an approximate incidence of 110 cases per million of population. As there is no evidence to suggest that the disease is more common in Leeds than elsewhere, this would indicate that some 6000 cases per year might be expected in Great Britain. The mortality rate in this hospital, in common with several other centres in Great Britain, is at present less than 10%.

A simple mathematical calculation might lead to the conclusion that we are doubling the incidence by uncovering many mild cases and thus apparently achieving a halved mortality. Although this may be true to some extent I believe that a thorough screening of all acute admissions enables many cases to be diagnosed and treated early enough in the course of the disease to achieve a real reduction in mortality.

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SIR,—The purpose of focusing attention on the problem of iatrogenic pancreatitis, in particular that associated with certain drugs, was admirably achieved by your recent leading article (22 October, p 1043). However, the figures quoted in the introductory section regarding the incidence and mortality of acute pancreatitis warrant comment. The total number of patients suffering from acute pancreatitis was quoted as about 2500 per annum in Britain. This figure was presumably reached by simple arithmetic reckoning, assuming the Bristol¹ and Nottingham² incidence of 50 per million of the population to be representative for the whole country. It is not justifiable to present these figures as national statistics without clearly stating that an extrapolation

from regional surveys has been performed. There are very few areas of the country in which even short-term prospective statistics are available, but in one area where almost six years of continuous prospective analysis has been performed the incidence is at least twice the suggested national average.^{3,4}

The quoted mortality rate of 20% takes little cognisance of more recent evidence from prospective studies of over 630 patients, indicating a much lower mortality from acute pancreatitis.³⁻⁵ A study of 213 patients reported two years ago revealed a mortality rate of 11%.³ and since that time the multi-centre MRC study has confirmed that figure with an identical mortality rate in 257 patients.⁵ One further study of 161 patients has reported an even lower mortality rate of under 9%.⁴ The time has now surely come to lay aside the concept of mortality rates in the region of 20% being part of acceptable clinical practice in this country.

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¹ Trapnell, J E, and Duncan, E H L, *British Medical Journal*, 1975, **1**, 179.

² Bourke, J B, *Lancet*, 1975, **2**, 967.

³ Imrie, C W, and Blumgart, L H, *Bulletin de la Société Internationale de Chirurgie*, 1975, **34**, 601.

⁴ Imrie, C W, et al, *British Society of Gastroenterology Meeting* (York), 1977.

⁵ Cox, A G, et al, *Lancet*, 1977, **2**, 632.

Role of the hospital in primary paediatric care

SIR,—Dr A J R Waterston (15 October, p 1021) has missed the main point of my lecture (24 September, p 787) when he suggests that I am "reverting to the 'disease palace' for the cure of all ills." This is the antithesis of my real concern to improve the standard of general practice in large urban areas with their declining living standards. I believe that in the immediate future this can be achieved only by the hospital going out into the community to give assistance and I have suggested a way by which this might be done. Dr Waterston has given undue emphasis to the "ill child presenting at the door," implying that this would be a new situation. As I emphasised, this already happens and is a considerable burden and responsibility for departments which have not the establishment to handle these problems. By creating a better relationship and communication with the general practitioners in these areas and with an intelligent use of child health visitors and liaison health visitors it will be easier and safer to return these children to their homes and also to implement a home nursing scheme, as mentioned in my lecture.

In no way did I propose that this would be a casualty-based service. It is clearly stated that the project would be based in the paediatric department and the children's section of the accident and emergency department of the hospital concerned, and I suggested that the pilot trial should be based on the three major children's units in Manchester (two of them being children's hospitals). Again, there is nothing to indicate that I am trying to get extra casualty sessions for general practitioners. I stated that "one or more of the practitioners on duty could be on call at the hospital, and this night and weekend duty could be shared by the general practitioners, child health practitioners who had agreed to