and therefore they do not counter the arguments of previous research. Finally, using patients as their own self-controls is not really the best method of controlling. With such methodological differences, the only paper with which theirs is comparable is that of Kennedy *et al* (1983). The only remaining argument to support their claims of superior methodology is that a good instrument (the LEDS) was used. Unfortunately, good tools are never a substitute for correct selection, critical judgment, and a fair design which risks erring on the side of caution rather than drive to a pre-selected outcome.

However, the publication in its current form raises an even more important issue. The paper was presented at a College meeting, and from the floor I had a chance to point out to the presenter how he was consistently misrepresenting my work and what I considered the faults in sampling to be. It obviously made no difference. It is a sad state of affairs when publishability is allowed to over-ride what one might call etiquette if nothing else, and it becomes even sadder when our academic teachers undersign the deed.

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SIR: Our study was essentially a methodological one. Only one previous paper (Chung *et al* 1986) had used the LEDS to collect events and had carefully dated the onset of illness. These authors also failed to find an increased rate of severe events before the onset of mania.

Notwithstanding the above information, Ambelas' study (*Journal*, February 1987, **150**, 235–240) remains a case-note study. He relied on patients' hospital records to elicit life events and to date the onset of mania. We have previously pointed out the drawbacks in this method (*Journal*, June 1987, **150**, 875).

From past studies we had expected to find a relationship between life events and the onset of mania. However, our results indicated that illness episodes in a group of patients with established bipolar disorder did not appear to be preceded by events. Further research using the LEDS in first manic episodes is indicated.

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Racism, diagnosis and treatment

SIR: In their not unuseful analysis of black and white patients admitted to hospital under Section 136 (*Journal*, March 1990, **156**, 373–378), Dunn & Fahy make the surprising statement that it "challenges the findings of Littlewood & Lipsedge (1981), who suggest that treatment is independent of diagnosis in this [black] group". If they are talking about the paper I think they are (for they have got the title wrong in their references), I should point out that not only did Lipsedge and I not make the statement they claim but the study itself is not concerned with psychiatric treatment at all. More importantly, they are somewhat cavalier about dismissing the possibility of racism in their own data. Selective discrimination on the grounds of perceived ethnic status, whether in medicine or in other institutions, or in everyday encounters, is not something best seen as located in individual attitudes, but in the whole way social action in a society may operate. In the review which they cite (Littlewood, 1986), I was at pains to point out that racial bias in psychiatry is hardly likely to be a conscious and overt penalisation of certain patients. The alternative, however, is not to associate differences in diagnosis and treatment simply with differences located in the patients themselves. We need, painstakingly, to reconstruct how certain assumptions, behaviours and actions of individuals, both the putative patients and the professionals, interact in certain contexts. Such studies require surveys of theoretical assumptions, attitudes to the other, and perceived dangerousness: studies using video material of actual instances, besides an examination of the political economy of psychiatry itself.

To take an instance. One possibility is that doctors, whether through their training or through

sharing certain white middle-class professional values, have a tendency to perceive black patients as 'more psychotic' than analogous white patients, and hence are more likely to diagnose them as schizophrenic. We shall find it difficult to examine this in any sort of simple 'double-blind' study, for an extended video film of doctor–patient encounters cannot keep ethnicity as the single dependent variable.

If there is no ideal approach, we can nevertheless look at certain aspects. Do psychiatrists, for instance, carry around with them some sort of schema in which certain behaviours and experiences in one ethnic group are accorded a greater or lesser 'pathological weighting' than in another? To start examining this, admittedly restricted, hypothesis, I wrote a brief clinical vignette prepared in two versions, identical in all respects except that Afro-Caribbean origin was specified in one version but not in the other. The vignette was piloted and modified to offer a picture of what appeared to a group of colleagues could equally well be rated as one of six diagnoses (manic depressive psychosis, major depressive disorder, neurotic/stress reaction, paranoid psychosis, personality disorder, schizophrenia). One or other version of the vignette was randomly given to 338 health professionals: 103 doctors (61 of them psychiatrists), 32 social workers and psychologists, 39 nurses, 48 medical students before they had studied any psychiatry, and 116 medical students after their psychiatry teaching. They were invited to select one diagnosis alone as the most likely. There were three refusals/spoiled returns. The results suggested at this level no trends or significant effects of race on diagnosis, either taken as the separate categories or when collapsed into broader groups such as 'psychosis' or 'depression'. Neither training nor profession affected selection of diagnosis except that the 'medics' (doctors and medical students) were more likely to diagnose schizophrenia in both ethnic groups (taken together, $P<0.025$).

We cannot, however, now claim that there is no pre-existing mental set whereby qualified psychiatrists or others preferentially associate one or other pattern of psychopathology with a particular ethnic group. While a different vignette may have demonstrated an association, there are more serious problems. The 'neutral' components of a case history may already have an ethnic bias. My own example included repeated unemployment: as this is a more common experience for the black community in general, it will have a greater diagnostic salience for the whites where psychopathology may be presumed to have a greater effect on determining unemployment. Similar objections can be raised in relation to family constellation and so on. In other words, significant distress may be rated as 'normal' in black patients.

While I am thus not claiming any unique advantage for simulated clinical situations, it does seem important to attempt to use vignettes, both written and video, to examine the perception of patients by psychiatrists in more detail. Certainly the perception of 'dangerousness' is amenable to a similar study, inelegant and partial as it may be. The wider issues of the role of psychiatry as one among a number of social control procedures are not so amenable to such an experimental design and could more usefully be examined through an 'interpretative' approach.

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SIR: We are able to support some of the conclusions made by Lloyd & Moodley (*Journal*, June 1990, **156**, 907). We have also examined differences in neuroleptic dosage given to white patients of Caribbean origin and patients of Asian origin (Milner & Hayes, 1990). Data concerning 210 consecutive admissions to the All Saints Hospital in inner-city Birmingham were recorded. The sample comprised 138 (60%) British, 30 (14%) Asian, 34 (16%) Afro-Caribbean and 8 (4%) other subjects.

Of those admitted under section were 14% (19) of the British group, 33% (10) of the Asian group, and 41% (14) of the Afro-Caribbean group. It was found that 85% (32) of the Afro-Caribbean group, 57% (17) of the Asian group and 33% (60) of the British group were diagnosed as suffering from a psychosis (mainly schizophrenia). When each group was matched for diagnosis, there was no difference in mean oral chlorpromazine equivalents given in the first three days (all neuroleptic medication was included in the calculation). Each patient was rated on the Krawiecka scale (Krawiecka *et al*, 1977) in order to obtain a 'psychotic' rating. Those who were diagnosed as suffering from schizophrenia (and other psychoses) received a higher rating irrespective of ethnic group.

This confirms the suggestion made that black inpatients are more likely to receive antipsychotics