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## Psychiatry in the Soviet Union

SIR,—Professor Georgi Morozov (6 July, p. 40) points to the fact that there is a good deal of difference in the way psychiatric diagnoses are made in different parts of the world and he is, of course, right. I suggested in my article (9 March, p. 433) that this explained in part why many British psychiatrists could not accept Soviet practice in respect of political dissenters who are regarded as insane. There were, however, other reasons. For example, few of the dissenters would be regarded in Britain as having committed any serious crime, so that the question of "responsibility" would not arise. Moreover, except in the case of gross abnormalities immediately obvious to a layman, when the accused person may be ruled "unfit to plead," in a British court it is only the *defence* that enters a plea of insanity. I mentioned a number of other apparent disadvantages of Soviet legal procedures in these cases.

However, Professor Morozov's main point was that I had not indicated the favourable outcome of the meeting between western and Soviet psychiatrists at the Serbsky Institute on 15 October 1973. In fact, of the 13 westerners who attended, 12 had first signed a statement containing two main principles: firstly, that the visit could not in itself be held to imply acceptance or rejection of any of the allegations and, secondly, that such difficult and complex problems could not be adequately evaluated in one day. We wished to begin what it was hoped would be continuing discussions. General statements are therefore out of order. Nevertheless, I have no doubt that many of my colleagues were not satisfied, as I myself was not, that all five political dissenters whose cases we heard were so seriously mentally ill during the time of their legal examination as to be unfit to

plead, to conduct their own defence, or to instruct defence lawyers.

In addition to these five cases we asked to discuss the case of Dr. Zhores A. Medvedev (who has given me permission to mention his name). We were told that his compulsory admission to hospital was an error. This frank statement was, for me, one of the most encouraging features of our visit to the Serbsky Institute, since it indicated a willingness to admit mistakes which, if it were matched by an equivalent attitude on the part of western psychiatrists, could lead to constructive discussions. I may have missed a public announcement about an inquiry into this matter. If such an inquiry has been held it seems important that its conclusions should be published together with an account of the action that has been taken to ensure that such an error will not be repeated.

Finally, I should like to endorse Professor Morozov's plea for impartial discussion of these issues. As I suggested in my paper at Yerevan, accusations have been levelled at psychiatrists in many countries and we ought to consider them attentively in order to decide whether, after the stridency and exaggeration have been removed, there does not remain a kernel of truth. The Royal College of Psychiatrists, the American Psychiatric Association, and many other professional psychiatric bodies throughout the world have agreed to set up a committee to examine such issues. A main aim is to discover how best to arrive at a just and humane legal procedure which will spare people suffering from severe mental disorders from being held responsible for actions undertaken under the compulsion of forces they cannot withstand, while at the same time ensuring that those who deliberately and rationally choose to break

what they regard as morally indefensible conventions or laws should not be treated as insane. It is much to be hoped that the All-Union Society will join this endeavour. —I am, etc.,

J. K. WING

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## Autonomic Neuropathy and Autovagotomy

SIR,—Your leading article on diabetic autonomic neuropathy (6 July, p. 2) ignored gastric secretion. Achlorhydria<sup>1,2</sup> and associated gastritis<sup>3,4</sup> after an augmented histamine test are abnormally frequent in diabetics, especially those with a high fasting blood sugar with severe complications.

Vagal function has been studied in diabetics by comparing the peak acid output (P.A.O.) after a chemical stimulus of histamine, Histalog (Hg) (ametazone hydrochloride) or pentagastrin (Pg), and a vagal stimulus, intravenous insulin (I). P.A.O.<sub>pg</sub> was normal in a group of 10 diabetics (seven with neuropathy) but the mean P.A.O.<sub>i</sub> of these diabetics (19.8 mEq/hr) was significantly lower than in control subjects (33.5 mEq/hr).<sup>5</sup> The ratio of acid output in response to insulin and to a maximum stimulus estimates the proportion of parietal cells which are vagally excitable.<sup>6</sup> This ratio was significantly lower in these diabetics (49%) than in controls (87%). One of the 10 diabetics secreted no acid after insulin,<sup>5</sup> just as if the patient had had a "complete" surgical vagotomy. In another group of 11 diabetics (eight with neuropathy) two failed to secrete acid after insulin.<sup>7</sup> Evidence of autonomic neuropathy was not sought specifically in these Swedish patients.<sup>5,6</sup>

In three diabetic patients with autonomic neuropathy (neurogenic bladder, negative Valsalva tests, and absent sweating) the