coronary care. This means that individuals trained in coronary care and conversant with the use and limitations of antiarrhythmic agents should reach the patient as soon as possible after the onset of symptoms, relieve pain, stabilize the rhythm, and monitor the patient continuously during his transport to the coronary care unit. It also means that the patient must be admitted directly to the hospital coronary care unit, since delay and disturbance in the casualty department may aggravate the early dysrhythmias and lead to extension of the area of infarction.[2]—We are, etc.,

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1 Adgey, A. A. J. *et al.*, *Lancet*, 1969, **1**, 1169.
2 Pantridge, J. F., *Quarterly Journal of Medicine*, 1970, **39**, 621.
3 Fulton, M., Julian, D. G., Oliver M. F., *Circulation*, 1969, **40** (Supplement 4), 182.
4 Bainton, C. R., Peterson, D. R., *New England Journal of Medicine*, 1963, **268**, 569.

Transatlantic Debate on Addiction

SIR,—In your leading article "Transatlantic Debate on Addiction" (7 August, p. 321) you state, regarding the incidence of drug addiction in this country from 1913 onwards, "surprisingly, no one seems ever to have attempted the task of historical reconstruction which would be involved in providing an estimate of the United Kingdom's prevalence at the comparable period." May I state that I recently published the results of an investigation into this subject in a biography[1] of my father (see also *B.M.J.*, 20 March, p. 677), who was interested in and knowledgeable of this subject, a member of the Rolleston Committee, and medical adviser to the Home Office at that time. In 1923[2] he considered that hard drug addiction was rare in this country, though no statistics were obtainable. Again, the same conclusion was reached in 1926 by the Rolleston Committee which had met on 23 occasions, at 17 of which oral evidence was taken from many authoritative sources. The committee concluded that drug addiction had become rarer "in recent years" as a result of the D.D.A. regulations of 1920 and that heroin was less rare than morphine addiction.[3] In his evidence, which was not quoted in the report, Sir Archibald Bodkin stated that only 26 cases were known to the Home Office at that time.

The comparative rarity of addiction was again alluded to by Willcox in 1934.[4] Later, at the Royal College of Physicians Committee on Drug Addiction in 1937, during the presidency of Lord Dawson of Penn, himself a member, under the chairmanship of Dr. Bernard Hart, the only available statistics were provided by Major W. H. Coles of the Home Office. Mainly as a result of a successful system of voluntary notifications by practitioners to the Home Office he was able to quote (1938) 630 cases, 325 of women and 305 of men, compared with 616 cases for the previous year. Of the 630 cases 135 men and 10 women were members of the medical profession. In his evidence Coles stated that these figures represented approximately all the drug addicts that there were in Britain at that time. It was his firm belief that there was very little illicit traffic in drugs and the amount coming from such sources was negligible.—I am, etc.,

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1 Willcox, P. H. A., *The Detective-Physician, The Life and Work of Sir William Willcox*. London. Heinemann. 1970.
2 Willcox, W., *British Journal of Inebriety*, 1923/24, **21**, 75.
3 Ministry of Health, The Departmental Committee on Morphine and Heroin Addiction, (Rolleston Report), H.M.S.O., 1926.
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Research into Psoriasis

SIR,—A reader of Dr. Harvey Baker's excellent description (24 July, p. 231) of the protean manifestations and forms of psoriasis may surely wonder whether they are really all one and the same disease.

Medicine abounds in example of "diseases" which have been later recognized to be no more than symptoms or signs which may result from various pathogeneses. This has been the path to progress in the understanding and control of many dermatoses.

It is disappointing, therefore, that Professor Sam Shuster (p. 236) should repeatedly write "psoriasis is a disease," as if all cases were of the same essential nature. This assumption seems to be made throughout and is surely unjustified and may be holding up progress. One may yet hope to achieve a better understanding of psoriasis by the recognition of, not one, but perhaps several syndromes or pathways which lead to the eventual skin manifestation. This is what has already been done with the eczemas and the urticarias and, of course, with innumerable other disorders.—I am, etc.,

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SIR,—While being entertained by Professor Sam Shuster's racy style (24 July, p. 236), we were disturbed by serious inaccuracies and defective logic in his appraisal of our theory[1 2] of psoriasis. In direct opposition to Professor Shuster's report of our work, we concluded that psoriasis is *not* a "lymphocyte-borne immunological disease." Rather, it appears to be representative of another general class of disease in which, to quote from our paper,[1] the "primary pathogen should be a humoral as opposed to a cell-bound agent." We argued that the humoral agent is not an immunoglobulin autoantibody, but is more likely to be found in the α_2-globulin fraction of the serum proteins.[1]

Neither does the age-specific onset-rate of promotion to professor in British Universities fit any one of our stochastic equations—as one of us demonstrated to Professor Shuster during a visit to Newcastle. But even if it did, the coincidence would still have no bearing on the validity of our unified theory of disease. This states that, with certain provisos, the age-distribution of an autoaggressive disease should conform to simple, well-defined biological laws.[2] We have pointed out that ". . . the converse, of course, does not necessarily follow."[2] "Proof" of autoaggressive aetiology requires additional evidence.[2] Nevertheless, it remains true that the age-patterns of many, and seemingly diverse, diseases—malignant and non-malignant, infectious and non-infectious, chronic and acute, of early and late onset—agree remarkably well with these simple biological laws. And in many instances additional evidence indicates that we are dealing with autoaggressive diseases. Unlike Professor Shuster we do not regard this extensive agreement between observation and theory as a drawback: indeed, we take the opposite view and subscribe to the philosophy of Albert Einstein:[3] "A theory is the more impressive the greater the simplicity of its premisses is, the more different kinds of things it relates, and the more extended is its area of applicability."

That Professor Shuster's final assessment should closely resemble ours[1]—even though he fails to acknowledge this—reassures us. We deduced that psoriasis and other autoaggressive disorders arise from specific errors in the central part of the homoeostatic system that normally regulates the growth and size of target tissues.[1-2] This antedates Professor Shuster's suggestion ". . . that psoriasis is a disease of faulty epidermopoiesis possibly due to impaired autocontrol mechanisms."—We are, etc.,

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1 Burch, P. R. J., and Rowell, N. R., *Acta Dermatovenereologica*, 1965, **45**, 366.
2 Burch, P. R. J., *An Inquiry Concerning Growth, Disease and Ageing*. Edinburgh, Oliver and Boyd, 1968.
3 Einstein, A., Autobiographical Notes, in *Albert Einstein: Philosopher Scientist*, ed. P. A. Schilpp, Library of Living Philosophers, Evanston, Ill., 1949.

Mental Deficiency Nursing

SIR,—We welcome the publication of the report on staffing of mental deficiency hospitals[1] as a document that highlights many areas of need in the care of the mental defective. We are, however, greatly concerned by the content of paragraph 51, which states that the committee was "unable to identify any techniques of nursing which are peculiar to this field of work." In our opinion, this statement indicates that the committee has taken a very narrow view of the skills implicit in mental deficiency nursing, confining these specialist nurses to care only, and our concern is that an undue significance may be attached to this point concerning techniques. Basic techniques of care are, of course, not peculiar to any one branch of nursing.

We suggest that techniques in which the nurse in mental deficiency requires special skills are found in the following:

A caring function. This is common to all nursing disciplines but because of age and intellectual ability of patients in mental deficiency hospitals it is important that this caring aspect is highly developed in such a way that the appropriate therapeutic level of care is administered.

A training function. The mental defective remains much longer than the normal person in the sensory-motor stage of intellectual development (work of Piaget and others). Social training of the mental defective in-