what out of touch with the methods she once used and know little of the principles or the details of newer practices.

I agree with Miss Mary Whittow (p. 369) that senior nursing administrators are "very concerned to provide the best possible patient care." But it is difficult to understand how they can "assist" the ward sisters in the nursing care except in its general aspects. One way to make nursing administrators able to assist ward sisters is to ensure that ward sisters know less by having only relatively junior nurses as sisters. I doubt if this would lead to "the best possible patient care."

Like doctors, nurses observe and decide. Doctors can become consultants and go on doing clinical work without loss of advance in status and income. Why do experienced nurses have to have administration nurses out of touch with clinical work "assisting" them, when doctors don't?—I am, etc.,

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SIR,—In recent correspondence Professor R. Y. Calne (3 July, p. 45) and Dr. J. W. Paulley (31 July, p. 304) and others have drawn our attention to the central importance of an experienced ward sister in maintaining the standard of care given to patients in hospital. They are concerned by the failure of Salmon¹ to provide adequate career prospects for those nurses whose vocation and gifts lie in this field of work.

Their comments raise important general issues, which are of relevance to all who work in the caring professions. There seems to be a growing tendency to establish organizations within these professions, in which advancement implies a withdrawal from direct involvement with patients or clients. It is to be seen as much in the reorganization of the social services, introduced by Seeborn,² as it is in Salmon.

None of us can have any quarrel with the argument that we need good administration, nor that we should make such a career attractive to experienced professionals, whether nurses or social workers, who wish to work in this way and have talent for the task. But to attract good professional workers away from their direct involvement with patients or clients on the pretext that their skills can be distributed more widely and more effectively at secondhand is a dishonest folly.

We must maintain an organization that encourages those who so wish to continue to work where their most valuable gifts may lie—in the use of a direct relationship with those who need their help. However, doctors themselves would be less than honest if they did not recognize that it is not just rank and money that has influenced the nursing and social work professions to adopt organizations where advancement is recognized by a carefully labelled hierarchy of rank. Both professions are well aware of the tendency of medicine to treat them as handmaidens. They doubt, perhaps, whether they would ever be accepted as equal partners in decision making unless they created a professional structure that gave them this power independent of doctors.

So perhaps if we really want our ward sisters and social workers to stay looking after our patients with us we must make sure that, as well as enough pay and prestige in their own professions, they enjoy a real professional equality with us in the working relationships we create.—I am, etc.,

IAN TAIT

Aldeburgh, Suffolk

- 1 Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*. London. H.M.S.O. 1965.
- 2 Local Authority and Allied Personal Services. *Report*. Cmd. 3703. London. H.M.S.O. 1968.

Violence in Hospitals

SIR,—In your leading article "Violence in Hospitals" (21 August, p. 443) you rightly point out that an act of violence in itself is frequently symptomatic of the facilities available.

Because of the more constant contact of nurses and patients, it is the nurses who will on most occasions be involved in handling violent episodes. This is no reason, however, for any other disciplines within the hospital to opt out of accepting a measure of responsibility for dealing with such situations.

A joint working party set up between the Royal College of Psychiatrists and the Royal College of Nursing, psychiatric section, earlier this year to consider matters of common concern is currently pursuing this subject to produce a code of conduct for all staff who may have to deal with violent situations.

Even when we are able to make recommendations, they will only be viable if adequate facilities, both in manpower and materials, are available to give the mentally disordered the standard of care to which they are rightly entitled.—I am, etc.,

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Royal College of Nursing

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SIR,—I am grateful to you for noticing, even in so patronizing a leader (21 August, p. 443), the fact that the National Association for Mental Health has issued a consultative document¹ aimed at promoting discussion of the best ways of preventing violent episodes in psychiatric hospitals, and the best way of dealing with them on the rare occasions when in the best conducted hospitals they occasionally arise.

The document was indeed prompted by the cry of pain which emanated from Farleigh Hospital before ever the Farleigh Hospital inquiry was held. It was a cry from nurses who, as we now know, were faced with containing an explosive patient population with small benefit of medical help and in conditions totally inimical to good practice. Our document was the work of a group of nurses and doctors experienced in hospital work, and was designed to promote discussion of problems recognized by this group as not uncommon.

Is it possible that the writer of your leader has not worked in a mental hospital, for his phrase "in a conventional hospital it is preposterous that this situation should ever

arise" betrays to the ears of anyone who has sat on the Farleigh inquiry so crass an ignorance as to make it extraordinary that the *British Medical Journal* should publish such a leader? I invite the writer to read Dr. Jack Bavin's address to the Annual Conference of the National Association for Mental Health in 1971² on the subject of violence in hospitals for the mentally handicapped. I should be glad to send him a copy.—I am, etc.,

MARY APPLEBEY

General Secretary,
National Association for Mental Health
London W.1

- 1 National Association for Mental Health. *Guidelines for the Care of Patients who Exhibit Violent Behaviour in Mental and Subnormality Hospitals*, A Consultative Document, London, 1971.
- 2 National Association for Mental Health. *Report of the Annual Conference*, London, 1971.

**Miss Applebey has taken the quoted phrase out of its context. It is followed by the words, "That it does is, of course, undeniable, and it reflects sadly on the present inadequacy of accommodation for the care of known dangerous patients. . . ."—ED., B.M.J.

Treatment of Myocardial Infarction

SIR,—We have awaited with interest the paper of Dr. H. G. Mather and others on acute myocardial infarction (7 August, p. 334). The results of the Bristol study were predictable. It has been indicated repeatedly^{1,2} that the admission of patients to hospital coronary care units would not influence significantly the overall community mortality from acute myocardial infarction. If, however, the paper of Dr. Mather and his colleagues is interpreted as questioning the value of intensive coronary care initiated immediately after the onset of symptoms, it will have the tragic effect of inhibiting the attack on the early high mortality from acute myocardial infarction.

The undisputed facts are that the community mortality from myocardial infarction is of the order of 40%,³ that the majority of deaths occur within the first hour,⁴ and that the majority of the early deaths occur from ventricular fibrillation which can either be prevented or corrected.

The irrelevance of the paper of Dr. Mather and colleagues is indicated by the authors' lack of appreciation of the time factor. While the group of patients treated at home are comparable to those hospitalized in relation to age, sex, history of previous cardiovascular disease, etc., there is no indication that any significant number of hospitalized patients came under intensive care early. It is true that in the appendix to the article Dr. Mather and colleagues indicate that among 117 patients the interval between the onset of symptoms and first contact with a doctor was less than one hour. Thirty of these 117 patients died (mortality 26%). Few are, therefore, likely to have had early intensive coronary care and no indication is given of the outcome among those who did.

It has been shown that the mortality among patients who come under intensive care within one hour of the onset of symptoms may be reduced to 8.6%.² The Bristol study may be considered unnecessary but it does emphasize the need for pre-hospital

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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Cardiac Departments,
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Royal Victoria Hospital,
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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 biography¹ 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 1923² 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.,

PHILIP H. WILCOX

Windsor, Berks

- 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.
- 4 Willcox, W., *British Journal of Inebriety*, 1933/34, **31**, 131.

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 auto-aggressive 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 ours¹—even though he fails to acknowledge this—reassures us. We deduced that psoriasis and other auto-aggressive disorders arise from specific errors in the central part of the homeostatic 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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N. R. ROWELL

The General Infirmary,
Leeds

- 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 hospitals¹ 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-