My suggestion is that when a doctor diagnoses a standard complaint, such as hypertension or diabetes, he should give the patient an information-sheet setting out the basic facts about the complaint and also giving advice and guidance on how he can best adjust his mode of living with a view to improving his condition and where this is not possible, how best to live with it. These information-sheets could be prepared under the auspices of the National Health by experts in the various fields of medicine and would thus be both up to date and authorative, and would not only be beneficial to the patient, but also I believe helpful to the doctor.

It is unreasonable to expect a doctor to repeat umpteen times a day the same story to umpteen patients all with the same complaint. These information-sheets would take this chore off his shoulders and as an extra bonus keep him up to date with the latest developments in medical science.

Summing up, is it not nonsensical that so much of the information on sickness existing inside the medical profession never gets through to the people who need it most—the patients?

R. M. HELSDON
Chartered Mechanical Engineer
Retired College Lecturer

27 Twemlow Avenue,
Parkstone,
Poole, Dorset.

REPRESENTATION OF COMMUNITY HEALTH COUNCILS IN HEALTH-CENTRE MANAGEMENT

Sir,

On 22 October 1974, health workers at Glyncorrwg Health Centre met members of the District and Divisional Health teams, at the latter's invitation, to form an advisory committee to help in managing the centre; this was a most welcome development.

In discussing composition of this committee it was suggested, with unanimous support of all local health workers, that the local Community Health Council be represented. This was opposed by representatives of the district team, as setting a precedent requiring a decision from higher bodies; we were unconvinced by this argument, as we thought it was up to all of us to define the content of the 1974 reorganisation in terms of our local experience and instincts. Where no guide lines were already laid down, we felt their definition should be by local opinion. In spite of this a week later we received a letter advising that in the District Administrator's opinion representation of the Community Health Council would be inappropriate, " as the meetings are intended to discuss matters of interest to the professional users of the health centre."

Who actually runs health centres? Who decides what is of interest to professional users and why should they not be intersted in consumer opinion? If those doctors who oppose consumer participation in the running of local health services have the right not only to refuse representation, but even a right of entry to their premises to the Community Health Councils (as they have been reassured by the Department of Health) is there not also a right for those doctors who think otherwise to invite such participation?

We can hardly believe that we have gone so far along the road to a corporate State that our experience could be universal, and we think it is time that more of us with either positive or negative experiences of attempts to involve patients or their representatives in some degree of control of local health services should pool their experience, and begin to build a progressive body of case law.

J. TUDOR HART
ANDREW HAINES

Glyncorrwg Health Centre,
Nr. Port Talbot,
Glamorgan.

VOCATIONAL TRAINEES

Sir,

It is interesting to compare the choice of practice of the first eight trainees from the Airedale vocational training scheme with that of Ipswich (Barley, 1972).

At Airedale three trainees have chosen practices within the immediate area of the scheme, three have moved out of the area, and two have dropped out in favour of hospital careers.

This contrasts with Ipswich's figures of one, five and one respectively.

I note that Dr Barley moved from Ipswich to Sheffield whereas I am reversing the flow from Yorkshire to Suffolk.

P. G. RAMSDEN
Vocational trainee,
Airedale, Yorkshire

25 Thornhill Road,
Steeton,
Keighley,
Yorkshire.

REFERENCE

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MYOCARDIAL INFARCTION

Sir,

In his excellent James McKenzie Lecture (January *Journal*) Professor James McCormick, appears to suggest that myocardial infarction was as common in the early years of this century as it is now and that it was only belief in the efficacy of anticoagulants in 1949 which induced general practitioners to send their cases into hospital.

The historical evidence of the occurrence of

coronary thrombosis and infarction does not support this suggestion.

In his review of the history of coronary heart disease from Graeco-Roman times onwards Michaels (Michaels, 1966) concludes that angina pectoris made its appearance late in the eighteenth century and that the unheralded single attack, " lasting several hours and neither preceded nor followed by angina " was first described in America by Herrich in 1912.

In Edinburgh the first case of infarction in the Royal Infirmary was described by Gilchrist in 1928. Those of us who began our clinical work before the last war can confirm Henderson's statement that to undergraduates of those pre-war years myocardial infarction was a very rare disease.

In the years 1938–1941 I was taught about angina of effort and its relief by sub-lingual glyceryl trinitrate, but the unheralded attack occurring may be at rest was mentioned as a rarity. It is quite inconceivable that cases of infarction were occurring at that time (as Professor McCormick suggests) outside hospital and that general practitioners were keeping them all at home.

For many people living near the large hospitals, in cases of emergency the outpatient department was (and still is) the first port of call.

From the records of hospital admissions, of death certificates, of the post-mortem room, and in the failure of physicians of the stature of McKenzie to record the classical unheralded attack, there is, in my opinion, no doubt at all that myocardial infarction is a new disease of the twentieth century.

In this respect its epidemiology is shared by duodenal ulcer and by diverticular disease. All three were preceded, before the turn of the century, by the appearance of another new disease, appendicitis.

Thanks to the work of T. L. Cleave, we can now understand the very simple cause for these diseases of civilisation and if some of us do get a bit emotional about their appalling toll of death and disability, it is because we believe that their prevention, so supremely simple, has to date been woefully neglected by our profession.

How interesting to note that in your same January issue, in his review of the latest edition of Cleave's book, *The Saccharine Disease* R. J. F. H. Pinsent, gives belated recognition of this great author's unique contribution to medical thought and to prevention. Would that more of our College members, having studied this book, may join Pinsent in believing that, in the words of his review, " the case now made for the impeachment of a refined carbohydrate diet has passed the threshold of credibility."

We might yet see the incidence of coronary thrombosis dwindle to its former obscurity.

W. W. YELLOWLEES

Inzievar,
Aberfeldy,
Perthshire, PH15 2BN.

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Sir,

After reading " Guidelines for admitting patients with myocardial infarction to hospital " I could not help wondering whether it was a Christmas joke. Somehow, an article apparently from the council of another of the Royal Colleges had found its way into our journal.

No attention was paid by the authors to the opinion of the patient or his relatives. Surely in an area of decision so grey as this the patient's and relatives' wishes should weigh heavily in the decision as to where the patient should be treated. Many patients have clear ideas about where they would like to be treated as a result of their own previous experience of the illness or as a result of what they have experienced through their relatives and friends, through their particular culture and through the media. It is important that the patient feel secure, whether it be at home or in hospital.

Another factor not touched upon was the standard of care that the patient would receive at home. Are the doctor and his team, who are to look after the patient at home, prepared to give the necessary standard of care? Are the communications good between the patient and the doctor? Will the doctor be able and ready to see him quickly at home at any time?

While in other respects this is an excellent article helping us to make a rational approach to what is always a difficult decision, we must avoid professional arrogance.

M. M. TELLIS

Measham Medical Unit,
Measham,
Burton-on-Trent,
Staffs.

REFERENCE

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COMMUNITY HOSPITALS

Sir,

Your editorial (December *Journal*) on *The Community Hospital* describes the development behind the recent memorandum issued by the DHSS and the Welsh Office. Whilst this memorandum should be welcomed for the fact that it officially recognises the need for hospitals staffed