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.

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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.

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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

by general practitioners in urban areas, it contains several disquieting features.

First, the rural practitioner who already looks after his own patients in his local cottage hospital will view with misgiving the statement (paragraph 28) that " many existing hospital . . . will be surplus to the total hospital needs of the district." The opposition to the closure of cottage hospitals mentioned in your editorial was not *political*, but because threatened hospitals served, and were supported by, their local *communities*.

Secondly, there is rejection of surgery and maternity units anywhere other than in the district hospital. This appears to be a policy decision which ignores all the published evidence of the worth of these units for selected cases.

Thirdly, in our area at least, the estimated number of beds needed for the different categories of patient is sadly astray.

Fourthly, much of the thinking behind the memorandum appears to be muddled, and even political: for example, in paragraph 17 it is suggested that the development of health centres will prevent unnecessary admission to hospitals. With adequate support, is a single-handed general practitioner or a group practice less able to look after patients at home?

In discussions of this memorandum I think it will be accepted that urban community hospitals would fulfil a definite need. But the scheme as it applies to rural areas needs considerable more knowledge of *fact* before any discussions could properly be made either overall or locally.

It would be nice to think that general practitioners who already have access to hospital beds could be stimulated to analyse their use, so that when decisions are taken they could be taken on a factual basis rather than on general impressions.

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Sir,

I was somewhat surprised at the enthusiasm with which your editorial greeted The Department of Health and Social Security's document on the development of community hospitals (December *Journal*). Whilst it is easy to appreciate that this is a step forward in areas where general practitioners have not been able to use a cottage hospital, I think that it represents a step backwards for those of us who are able to use the facilities available at a good cottage hospital.

As you point out, with emphasis, the community hospital is a new concept and not simply cottage hospitals under a new name and they are to be ideally an extension of primary care rather than as at present containing a considerable amount of true hospital care. For the doctor who at some time has developed obstetric, anaesthetic, or surgical skills these will atrophy if he is unable to use them, and it may well be that his other commitments and geographical location will not allow him to pursue these interests at a more distant district hospital. I think that all the reports on the causes of emigration stress the lack of hospital facilities for general practitioners and these facilities are the type that are now enjoyed in cottage hospitals and not those that will be present in a community hospital. One other great advantage of a cottage hospital which has consultants visiting is the improved communication which occurs between the practitioners and the consultants.

The documents from the Department in its forword by the Secretary of State puts forward the reasons why cottage hospitals have always been, and are very popular with the patients. " The document states that cottage hospitals often seem less formal and forbidding than larger hospitals. They are also more convenient for patients, visitors, and staff. Wherever possible people prefer to be looked after in hospitals close to where they live."

However, after these statements the document appears to lose sight of the patient's wishes and in no way gives reasons why the facilities now enjoyed in cottage hospitals should be reduced and replaced by those restricted services which might be available in a community hospital. Already the difficulties of local transport in rural areas are considerable and there is no reason to suppose that these will improve in any way.

The waiting lists in the larger hospitals are usually much greater than those in the smaller hospitals and particularly with the radiological services there is often a considerable delay in the investigation of patients' problems. This radiological service which is now available in some cottage hospitals is to be removed.

I see no advantage in the replacement of cottage hospitals by communiy hospitals and the reading of the Department's documents and your editorial do nothing to make me think differently. I think that the *Journal* and the College should press for the development of local hospitals on the lines in which larger local hospitals, such as Evesham General Hospital, at present work to be the pattern for the future.

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