One of the projects sponsored by the Trustees was the writing of a biography of Mackenzie. This work was undertaken by Professor Alex Mair. You, of course, know the biography and also the fact that royalties from it have been bequeathed to our College. In assembling the material for this biography Professor Mair collected several books and original correspondence. Since the task has been completed, and with the approval of the Trustees, Professor Mair has bequested this material to the Library of the University of Edinburgh.

It may be that some future research workers and students might wish to know of the existence of this material and the possibility of their gaining access to it by contacting the University Librarian. I am following up and supporting Professor Mair's suggestion that you might agree to inform readers of this possible source of " Mackenziana ".

RICHARD SCOTT

Livingstone House,
39 Cowgate,
Edinburgh, EH1 1JR

REFERENCES

Mair, A. (1973). *Sir James Mackenzie*, M.D., *1853–1925, General practitioner*. London: Churchill Livingstone.

McConaghey, R. M. S. (1974). *Journal of the Royal College of General Practitioners* (Book Review), **24**, 497–8.

COMMUNITY HOSPITALS

Sir,

We refer to your editorial (December *Journal*) on the Department of Health and Social Security paper on *Community Hospitals*. Your conclusion was that, in future, we may look back at this publication as an important milestone in the development of medical care.

The Lichfield doctors, however, have collectively studied this paper in detail and have reached the oppositite conclusion. The undersigned would not wish, however, to be branded as insular. Clearly, there exists the " have " and the " have not ". The former, such as we who have an active general-practitioner hospital with a high turnover of acute general medicine (much of it being among the younger age groups) and cold surgery, with consultant cover, are fortunate. We also have active x-ray, casualty, and physiotherapy departments. Those who do not have these excellent facilities no doubt would welcome the Department of Health and Social Security proposals, whereas we fear many of our facilities will be taken away.

Our experience is that a wide range of acute general medical patients, many of whom require in-patient investigation, can be adequately cared for in general-practitioner hospitals with mutual benefit to patients, relatives, and to doctors. This applies also to many minor and medium grade surgical cases whose operations are normally performed by consultants but who post-operatively are cared for by general practitioners and in many cases are anaesthetised by them. Normal obstetrics can be practised safely by properly qualified practitioners in a community-hospital setting. This, of course, is provided that the antenatal selection is sufficiently discriminating and rigorous.

We are in agreement with the stated general philosophy concerning the benefit of community hospitals to local communities. However, we disagree strongly with the unbalanced emphasis on geriatric care. This would apply particularly to the cases of dementia described in the Department of Health and Social Security publication. We shall resist energetically any erosion of our casualty, surgical, obstetric, and radiological freedom.

In our considered opinion good medicine depends upon care and concern for patients. This is not possible without effective communication between the patient, the family doctor, and the consultant. We feel that care that can properly and safely be given with good communications between the three levels should be revered.

J. R. DUNCAN BROWN
M. A. BROWN
B. R. COLLIER
P. DANDO
A. R. ELSAM
L. T. HARRINGTON
B. JONES
C. M. LOCKWOOD
E. SAUNSBURY
N. R. WHITING
J. D. W. WHITNEY

Victoria Hospital,
Friary Road,
Lichfield,
Staffs.

REFERENCES

Department of Health and Social Security (1974). *Community Hospitals: their role and development in the National Health Service*. London: H.M.S.O.

Journal of the Royal College of General Practitioners (1974). Editorial, **24**, 821–822.

DIPLOMA IN SEXUAL MEDICINE

Sir,

Much of the work of the general practitioner today is involved with relationship problems which are often presented as sexual difficulties.

This is a field of postgraduate education which has been largely ignored and is growing in importance. Handling such cases should stem from a broad base of knowledge and understanding. May I therefore make a plea that the College consider the implementation of a diploma in sexual medicine? This could include such topics as:

(1) How relationship problems commonly present to the doctor,

(2) Family behavioural patterns,
(3) Normal and abnormal sexual practices,
(4) Family planning,
(5) Stresses caused by children to the family.

Such a diploma would be very much more valuable and useful to general practitioners than many of the diplomas and courses that are available at present.

E. RONALD SEILER
University Health Service,
Richard Verney Health Centre,
Bristo Street,
Edinburgh EH8 9AL.

JAMES MACKENZIE LECTURE

Sir,

Professor McCormick in his James Mackenzie Lecture offers much food for thought, but surely he is totally out of touch with reality. In essence he seems to be suggesting that the family doctor should stop prescribing symptomatic treatment and should try instead to produce a state of mind in his patients that would enable them to face all the pains, discomforts, and other miseries of life with fortitude and resignation.

In my opinion this is dangerous nonsense and I suspect that Professor McCormick has been led to propound it by nostalgia engendered by a study of Mackenzie's work. I agree that the prescription of frank placebos, where discussion and acceptance of symptoms is the correct treatment, cannot be excused. It is another thing to suggest that we should not use those medicines which give comfort and relief to sufferers from maladies that are not properly understood.

It is just not possible to put the clock back in this way and it is inconceivable that the whole medical profession could be persuaded to adopt such an attitude even if every doctor were a model of patience and compassion. At its most mundane level, is it possible to imagine what would happen to a practitioner who tried to accept Professor McCormick's philosophy? It would not be very long before his practice melted away and he had to look elsewhere for a living.

I have noticed that each year the James Mackenzie lecture seems to get more and more sentimental; perhaps Mackenzie is becoming too much of a legend and it is time to get his work back into perspective before scientific medical progress becomes almost a dirty word in the College.

M. CURWEN
8, Eaton Road,
Margate,
CT9 1XE.

REFERENCE
McCormick, J. (1975). *Journal of the Royal College of General Practitioners*, **25**, 9–19.

RELATION OF ABNORMAL CYTOLOGICAL SMEARS AND CARCINOMA OF CERVIX UTERI TO HUSBANDS' OCCUPATION

An analysis of the cytological records of almost 300,000 women in the Manchester area shows that the rates of positive suspicious findings from population screening are highly correlated with the rates of mortality from cancer of the cervix, when both are distributed according to the occupation of the husband. The correlation holds for various occupational groupings and for all the individual occupation units in which there are more than 1,000 women. This evidence strengthens the case for believing that the condition revealed by a positive smear is a stage in the development of invasive cancer of the uterine cervix.

REFERENCE
Wakefield, J. *et al.* (1973). *British Medical Journal*, **2**, 142–143. (Authors' summary).

PROPRANOLOL IN THE TREATMENT OF MIGRAINE

Beta-blocking drugs that prevent cranial vasodilation are potentially valuable in the prophylaxis of migraine. Forty-nine patients with either classic or common migraine were treated with propranolol 160 mg/day for an average of six months.

The first 30 of the patients to respond well to this treatment then participated in the double-blind cross-over trial with a placebo and propranolol. None of the patients expressed a preference for placebo. Propranolol seems to be an effective prophylactic for common and classic migraine but the antimigraine properties of the various beta-blocking agents probably differ.

REFERENCE
Wideroe, Tor-Erik & Vigander, Tor. (1974). *British Medical Journal*, **2**, 699–701 (Authors' summary).