of whom were men, the greatest source of conflict perceived by both partners was "lack of time for self, family, and fun."⁷ The men blamed time spent on work, which averaged 56 hours a week, while their wives were primarily concerned about lack of intimacy. The doctors blamed their spouses for lack of sexual interest or sympathy for their job while their partners felt they did not talk to them enough or provide emotional support. Ironically, both complained that their partners did not listen, and satisfaction in marriage was clearly related to the time a couple spent talking to each other. Nearly half had sought marital counselling and a further fifth had considered it; these tended to be the couples who talked less to each other. In contrast to the findings of other studies, these couples, who had chosen to attend a re-education programme together, expressed high marital satisfaction overall.

Neither dissatisfaction in marriage nor emotional distress in house officers can be directly related to the numbers of hours worked,^{5,7} yet the houseman's main complaint is overwork and the primary source of marital conflict perceived by both partners is lack of time. How is it that traditional notions about the adverse effects of long hours are not supported by research? Firstly, intense preoccupation with work may be more harmful to people and their marriages. Secondly, doctors' hours are always long early in their careers, and time alone does not reflect the strain of disrupted sleep, study for postgraduate examinations, difficult staff relationships, or the pressure and responsibilities of certain specialties. Finally, there is self selection in the choice of specialties and on call rotas: women doctors tend to choose specialties they consider more compatible with family life rather than their preferred specialty, while men put their career choice first.⁸ Both men and women doctors marry early in their careers, and most women doctors, particularly in hospital medicine, now work full time. Within 10 years of qualification 85% of married female graduates had children.⁹

Little is known about the quality of recent medical marriages other than that doctors are increasingly marrying each other. These doctors experience the complications of hours on call, job moves, house moves, sharing housework, and childcare while trying to find time for one another and some social life. Couples and their marriages can survive these early years, even when both work, if they respect each other's careers and are both prepared to make some sacrifices, provide mutual emotional support, and devote much of their precious free time to talking. Otherwise, maladaptive patterns may set in with one or both partners withdrawing for protection, gratifying many needs at work until they discover their needs for intimacy are unmet; men tend to express a wish for greater physical intimacy and women greater verbal intimacy.^{2,7} Timing of starting a family is important, particularly in doctor-doctor marriages, and delay may allow for the more stressful years to be over; housework and childcare can then be afforded, and the couple can devote maximum amounts of free time for each other and their family. Little is known about the effects of medical marriages on the children other than that they tend to become doctors themselves. Certainly, if childcare is of high quality and consistent they need not suffer.

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Spout or pouch? Alternatives for patients with ileostomies

Advances in technology and ready access to a stoma therapy adviser have made life almost normal for many people with ileostomies.¹ None the less, there is a psychological and social cost to be borne,² and not surprisingly when a surgical alternative to the conventional spouted ileostomy becomes available patients are prepared to risk the dangers of a new procedure.

Until recently the best operation for patients with ulcerative colitis requiring surgery would have been a proctocolectomy since it removes all the diseased colon and any risk of cancer in one operation and is usually uncomplicated. A few patients with little disease in the rectum may be suitable for an ileorectal anastomosis. Though this avoids a stoma, about a third of patients eventually have to have an ileostomy.³ It does, however, allow suitable younger patients to mature through adolescence without a stoma. The disadvantage is a risk of malignant change in 3-5%, and since tumours arising in the retained rectum may be difficult to recognise follow up must be scrupulous. The stepping stone on the way to a procedure that does not necessitate an ileostomy was the Kock continent ileostomy, in which a reservoir was constructed from the ileum.⁴ Patients had no appliance but still had to intubate the reservoir intermittently for emptying. This operation, though ingenious, has now been superseded by the pelvic ileal reservoir or pouch procedure.

Joining the ileum to the anus was not a new idea, but putting a reservoir in the pelvis was. Ten years ago Parks *et al* and others recognised that the anal sphincter could be preserved in patients with ulcerative colitis, provided that the diseased mucosa in the uppermost anal canal and lower rectum was removed.^{5,6} The ileal reservoir, now of various designs (fig 1), is sewn on to the sphincter inside the anus, and the anastomosis protected temporarily by a loop ileostomy that is closed about eight weeks later (fig 2).⁶⁻⁸ The exact level of the anastomosis is controversial,^{9,10} but the theoretical danger of leaving behind islands of diseased rectal mucosa is unfounded.¹¹

Although there are no reports of postoperative deaths, patients have suffered formidable upsets during development of the procedure. Obstruction by small bowel adhesions is common, but the most serious complication is pelvic sepsis, usually around the anastomosis. It may be difficult to eradicate since it cannot drain freely, and healing with fibrosis may spoil the eventual functional result. None the less, over three quarters of patients will not have a complication. When the protective ileostomy is closed between 5% and 15% of patients will have minor discharge or soiling, especially at night, which is probably caused by an injury to the internal sphincter.¹² Frank incontinence is unusual, and function improves over the first 12 months. A stool frequency of three to six times a day without urgency can be expected,

though some patients continue to require codeine phosphate or loperamide. Some retention occurs in most pouches, but all patients recently treated can evacuate spontaneously.¹² Outright failure is rare, and patients with imperfect continence prefer this to an ileostomy. In a recent survey 90% favoured the pouch on grounds of cleanliness, confidence, sexual self image, social and sports activity, and ease at work.¹³

The long term morphological and nutritional consequences of an ileoanal reservoir are not known. Similar histological changes to those seen in Kock pouches have been reported—including chronic inflammation and villous atrophy—and bacterial overgrowth is common.^{14 15} Neither the degree of colonisation nor the severity of histological changes correlate, however, with the clinical result or the efficiency of evacuation from the pouch. Intriguingly, inflammation of the pouch is seen more often in patients with colitis and only rarely in the smaller group of patients with polyposis who are offered the operation.^{16 17} Some poor clinical results may be caused by jejunal bacterial overgrowth, but this and inflammation of the pouch will respond to oral metronidazole.¹⁶ Fat absorption and serum folate concentrations are normal, but a mild microcytic anaemia, low serum iron concentrations and marginally reduced serum vitamin B₁₂ concentrations have been reported.^{15 16}

Which patients are suitable for this operation? Though age is no absolute bar, those under 50 have the best functional results, and a short interval between colectomy and pouch formation is preferable. Crohn's disease is a contraindication even if it appears to be limited to the colon. It is feasible to carry out the procedure at the same time as an elective total colectomy, but this would clearly be unwise in a patient with

FIG 2—An ileal reservoir sited within the pelvis. The loop ileostomy can be closed about eight weeks after the pouch operation. (Figures reproduced with the permission of Churchill Livingstone.)

toxic dilatation. Patients with early malignant change may be candidates but not those with advanced rectal cancer.¹³ In women pregnancy and labour seem to be straightforward without any deterioration in the function of the pouch, and, although successful vaginal deliveries have been described, a caesarean section will obviate the possibility of injury to the anal sphincter.

Operative and clinical results have improved so much that the pouch procedure should now be offered more widely.

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FIG 1—The four most widely used ileal reservoir designs.

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