patients prefer the quick and definitive answer of an operation, whereas others are unable to accept the necessary time off work, are afraid of surgical treatment, or prefer to avoid a scar for cosmetic reasons. Many are grateful to have the option of safe, pain free oral treatment in the form of bile acids.

While the authors point out that treatment to dissolve gall stones has a failure rate of 50%, they fail to indicate that the efficacy is much higher when appropriate patients are selected. Maton *et al* achieved a dissolution rate of 80% by limiting treatment to those with gall stones of <15 mm in diameter and by using a dose of chenodeoxycholic acid that results in desaturation of gall bladder bile (>13 mg/kg) for 12 months.² The dissolution rate is higher if computed tomography is used to exclude patients with small amounts of calcification not detectable by conventional radiology. The time when bile acids are given and the type of bile acids used are also important. Giving bile acids at bedtime is more effective than giving them at mealtimes.³ A combination of chenodeoxycholic acid and ursodeoxycholic acid is more effective than monotherapy.⁴

We agree that the rate of recurrence of gall stones can be as high as 50%, but, using an actuarial method based on life table analysis, we have shown that recurrence plateaus from the fifth year.⁵ We believe that giving bile acids intermittently is probably the best long term strategy for preventing recurrence.

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Rate of surgery for gall stones is increasing

EDITOR,—In their review on the treatment of gall stones N Tait and J M Little suggest that the selection of patients for cholecystectomy has not been changed by the introduction of laparoscopic surgery.¹ Our work² and studies by others,^{3,4} however, have shown that the total cholecystectomy rate has increased by an average of 25% since the introduction of laparoscopic cholecystectomy.

The causes for this increased rate have not been studied prospectively. The underlying reasons are probably multifactorial. Some patients with mild symptoms, who may be reluctant to have open surgery, may consent to laparoscopic surgery because it inflicts less postoperative pain and entails a shorter period of disability. This is the "enlarged patient pool factor." Secondly, a change in the surgeons' perception of the ratio of risk to benefit may result in a change in the indications for cholecystectomy. This is the "lower surgical threshold factor." Thirdly, gastroenterologists may increase referrals because the benefits offered by laparoscopic cholecystectomy outweigh those offered by other non-surgical management such as dissolution treatment or extracorporeal shock wave lithotripsy. This is the "increased referral factor."

On the other hand, whether this relative change

in the indications for cholecystectomy will benefit patients and society is unknown. For society, gross health care expenditure will increase with increasing numbers of cholecystectomies. The total expenditure on cholecystectomy has increased by 11.4% despite a 25.1% decrease in unit cost.³ Whether this increase in health care expenditure will be compensated for by the benefits obtained by the patients is, however, unknown. The possible benefits for the patients are immediate improvement or relief of symptoms and a reduction in the complications related to gall stones. While the risks of complications such as acute cholecystitis, ductal calculi, and cholangitis are easy to define, the risks of carcinomas of the gall bladder developing in patients with gall stones who do not have a cholecystectomy and of colorectal malignancies developing in those who have had a cholecystectomy are controversial. Therefore, prospective studies to investigate the indications for cholecystectomy in the era of laparoscopic surgery are needed. Furthermore, the cost effectiveness of laparoscopic cholecystectomy with the change of indications needs to be assessed.

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Qualitative thesis explored social dislocation and health

EDITOR,—Roland Petchey discusses J S Collings's report on general practice in England in 1950.¹ In 1939, a decade before Collings's survey, I wrote my MD thesis on the conditions of the lives of the working population in a new district in relation to health. It was a qualitative and in depth thesis that used statistics as only a supporting framework, and it criticised the lack of attention paid to medical social problems by primary care doctors.

I had started in practice in the middle of the 1930s, in a new dormitory suburb of Bristol that housed many previously unemployed tradesmen, recruited from all over Britain. The expanding Filton Aeroplane Works needed homes for the rapidly expanding workforce, and this forced builders to construct houses so quickly that they were often inhabited before they were properly finished: they were not properly insulated and were damp and leaking.

Most families moved to the district for purely financial reasons and had wrong expectations. They came from the slums of Bristol, rural west England, Welsh mining areas, Scotland, and Ireland. They found themselves isolated from family and friends in a swampy, poorly drained area with unfinished roads, inadequate street lighting, and no pavements. New neighbours had different backgrounds and religions and strange accents. There were no amenities such as public libraries or playgrounds for children, and there was no help from public agencies, organised health services, or trained individual helpers such as the

clergy or social workers. Home security had gone, nutrition was never taught, children were underdeveloped and anaemic, and the parents lacked education. Single men had to live unwanted with strangers, families needed advice on disturbances and marriage breakdowns, young men had no social facilities except the pub, and hooliganism was rife.

All these people came to the doctor they had learnt to trust, and emotional work overburdened me. I became a friend, supporter, and teacher; until then this had not been seen as a doctor's job, but it became more important than the traditional work I had been trained in. The desperate situation was not fully appreciated by the general community.

Since writing my thesis half a century ago I have come to believe that it is a doctor's job to take a much more active part in the education of the community. We can no longer sit on the sidelines and have little input into the new social and ethical problems that beset us. Commenting, criticising, and letting other people lead are not enough.

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I Petchey R. Collings report on general practice in England in 1950: unrecognised, pioneering piece of British social research? *BMJ* 1995;311:40-2. (1 July.)

Illness behaviour in the chronic fatigue syndrome and multiple sclerosis

Choice of multiple sclerosis as comparison condition was inappropriate

EDITOR,—Peter Trigwell and colleagues compared patients with the chronic fatigue syndrome with patients with multiple sclerosis and report similar responses on Pilowsky's illness behaviour questionnaire.¹ There is accumulating evidence that the chronic fatigue syndrome is a functional disorder, with psychological, social, and physical factors implicated in its cause, whereas in multiple sclerosis the primary cause is physical. Wood *et al* compared patients with the chronic fatigue syndrome with patients with various muscle diseases and found a threefold increase in psychiatric diagnoses in the group with the chronic fatigue syndrome.² Wessely *et al* describe an important prospective cohort study and conclude that common infections play little part in causing the chronic fatigue syndrome but that both previous psychological disorder and previous fatigue are associated with its development.³

We agree with Trigwell and colleagues that illness behaviour is highly relevant to the chronic fatigue syndrome, but we share their reservations about the particular method of assessing this. We also suggest that the choice of multiple sclerosis as a comparison condition was inappropriate. Multiple sclerosis, in contrast to muscle diseases, follows a relapsing and remitting course, often manifests sensory (subjective) rather than motor (objective) signs, and might therefore lead to illness behaviour that is abnormal, albeit for different reasons from those that might apply in the chronic fatigue syndrome.

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