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.

A G LIM
Registrar in gastroenterology
R P JAZRAWI
Lecturer in biochemical medicine

Division of Biochemical Medicine,
St George's Hospital Medical School,
London SW17 0RE

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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.

CHI-MING LAM
Research fellow
ALFRED CUSCHIERI
Professor of surgery
FRANK E MURRAY
Consultant physician

Departments of Surgery and Clinical Pharmacology,
Ninewells Hospital and Medical School,
University of Dundee,
Dundee DD1 9SY

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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.

ERNST PHILIPP
Retired general practitioner

Eastbourne,
Wellington 6008,
New Zealand

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.

PETER D CAMPION
Senior lecturer
CHRISTOPHER F DOWRICK
Senior lecturer

Department of Primary Care,
University of Liverpool,
Liverpool L69 3BX

RICHARD H T EDWARDS
Professor

Department of Medicine,
University of Liverpool

- 1 Trigwell P, Hatcher S, Johnson M, Stanley P, House A. "Abnormal" illness behaviour in chronic fatigue syndrome and multiple sclerosis. *BMJ* 1995;311:15-8. (1 July.)
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Disentangling common characteristics is not so easy

EDITOR,—Over the past few years I have seen a growing number of patients with the chronic fatigue syndrome who have been told by psychiatrists and psychologists that abnormal illness behaviour and psychosocial factors are the main factors perpetuating their disability. Few patients have accepted or believed this explanation; neither have I. The ME Association now has evidence that the fashionable theory of abnormal illness behaviour linked to somatisation is being used by several agencies as a convenient excuse for turning down applications for financial benefits or for putting pressure on vulnerable patients to undergo speculative "rehabilitation" programmes, which they may be reluctant to participate in.

Although Peter Trigwell and colleagues conclude that patients with the chronic fatigue syndrome and multiple sclerosis have virtually identical patterns of illness behaviour without any form of shared aetiology, their study suggests that the two conditions may have more in common than just central fatigue and uncertainty about long term prognosis.¹ When DeLuca *et al* examined patients with the chronic fatigue syndrome, patients with multiple sclerosis, and healthy controls using a paced auditory serial addition test (a method of assessing processing of complex auditory information) they found that both groups of patients scored significantly below the controls, indicating similar difficulties with tasks that require simultaneous processing of cognitive information.²

I hope that Trigwell and colleagues' study will stimulate more objective, psychologically based research into the difficult task of disentangling the complexities of a syndrome in which (a) depression may be a natural reaction to both the distressing physical symptoms and the limitations imposed by the ensuing disability, (b) there may be pathology in the central nervous system leading to disturbances of neurotransmitters and mood,³ and (c) several key symptoms (for example, fatigue, cognitive dysfunction, and sleep disorder) are common to both the syndrome and several psychiatric disorders.

CHARLES SHEPHERD

Honorary medical adviser, ME Association

Chalford Hill,
Stroud,
Gloucestershire GL6 8EH

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Authors' reply

EDITOR,—Peter D Campion and colleagues suggest that it was inappropriate for us to use patients with multiple sclerosis as the comparison group in our study. We chose this comparison group precisely for the reasons that Campion and colleagues give for rejecting it. In other words, we chose multiple sclerosis because it often has a relapsing and remitting course and rather non-specific symptoms, as does the chronic fatigue syndrome. This was because one of the aims of our study was to examine the possibility that it is features of a

chronic illness and its treatment rather than its aetiology that determine scores obtained on an illness behaviour questionnaire.

As we indicated in our paper, the two groups of patients reached the same conclusions about their illnesses (as measured on the illness behaviour questionnaire), but these conclusions could have been reached in very different ways. Charles Shepherd is therefore incorrect in asserting that our study suggests that the two conditions share some aetiological factor. We agree, however, with Shepherd's assertion that more psychologically based research is needed. A better understanding of patients' "illness representation" is likely to be important in increasing our knowledge of the aetiology and maintenance of the chronic fatigue syndrome. A standardised measure to evaluate how patients form their attitudes about their illness is needed in order to investigate this further.

PETER TRIGWELL

Senior registrar in psychiatry

High Royds Hospital,
Menston, Leeds LS29 6AQ

University of Leeds,
Leeds LS2 9LT

St James's University Hospital,
Leeds LS9 7TF

Seacroft Hospital,
Leeds LS14 6UH

General Infirmary,
Leeds LS1 3EX

SIMON HATCHER
Lecturer in psychiatry

MICHAEL JOHNSON
Consultant neurologist

PHILIP STANLEY
Consultant in infectious diseases

ALLAN HOUSE
Consultant in liaison psychiatry

Medical firms should be retained

EDITOR,—Though I am sure that good reasons exist for changing the organisational structure of health care in Britain, I am disappointed by Fiona Moss and Martin McNicol's suggestion that the system of firms should be abandoned.¹ The organisation of consultant services in Britain seems to be undergoing "unbundling," and this is being accompanied by a reduction in the working hours of junior staff. What is important to continuity looks as if it may be lost.

The rapid adoption of the managed care model in the United States necessitates radical and immediate changes at academic health centres, many of which are the main source of health care staff for inner city (usually poor) populations. I advocate the concept of firms for American teaching hospitals because it offers considerable improvements over the current model of care. In the American system patients are often not cared for by the same attending physician regularly, or by the same house officer. This is aggravated by the educational requirements for residencies, which mean that residents are placed at remote hospitals or clinics, often in busy clinical services; this results in a suspension of the obligation to provide continuity of care to the patients in primary care.

Managed care plans have little tolerance for the needs of the teaching programme. For example, their basic requirement that a primary care physician should be available 50-60% of the time for direct patient care is impossible for many academic staff because of their diverse obligations and interests. Both academic staff and residents need to be organised into teams to ensure continuity. Care across the continuum under capitation necessitates that preventive, primary, and specialty care at every site be orchestrated by a care team that understands how to deliver cost effective, safe care. Thus in the United States we also need to restructure our subspecialty training programmes.

The successful introduction of firms in a few medical centres in the United States has been reported.^{2,4} Although initially introduced for research purposes, components of the firm system have also been implemented to improve the care

delivered to patients, including communication between doctors and patients and families. Despite the reported successes, progress has been slow.

I hope that the move in Britain to abandon firms is not going to make things worse for patients. In the United States, acceptance of this modified concept of firms could help to improve the way in which care is delivered in teaching hospitals, which still serve as the main source of role models for future physicians.

MICHAEL ELIASTAM
Associate partner

Andersen Consulting LLP,
Boston, MA 02110-2604,
USA

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Junior doctors' hours

Committee response was ignorant

EDITOR,—I could not have hoped for a better reply to my letter on junior doctors' hours than that from Keith Reid.¹ It sums up the ignorance of the Junior Doctors' Committee about the basic concept of training. Training in any profession requires exposure and practice: practice makes perfect. To gain experience in medicine one has to be exposed to clinical situations. It is a matter of numbers: the more you see and do the better you will be at making diagnoses, treatment, and operating, and this applies to all branches of medicine. One of the things that medical students are told is that interesting cases do not present only between 9 am and 5 pm on Mondays to Fridays. Somehow this simple message seems to have been forgotten by the Junior Doctors Committee.

Continuing medical education is important and provides structured learning without clinical pressures. It and clinical experience, however, are very different. They supplement each other but certainly do not replace one another.

We turn to our consultants for help, support, and guidance. This is not only because we work for them but also because of their years of experience. It is not enough just to know medical facts—if it was, any computer could be a consultant and we might as well give up. Clinical facts must be supported by clinical experience. In my opinion, an on call rota of 1 in 4 or 1 in 5 achieves the right balance of exposure without resulting in undue exhaustion. Partial shifts and full shifts may suit specialties such as accident and emergency departments, where continuity of care is not a priority. Implementing these rotas in specialties in which continuity of care is important has proved disastrous. Statements such as "reducing hours has no effect on training" and "shift systems are good for training" expose the committee's lack of comprehension of issues concerning training.

CHRISTOPHER WONG
Senior house officer

Department of Orthopaedic Surgery,
Cardiff Royal Infirmary, Cardiff CF1 1SZ

- 1 Reid K. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)

Long hours are needed

EDITOR,—Christopher Wong's letter about the Junior Doctors Committee¹ echoes the findings of our survey of the junior staff in training in Cardiff two years ago.² We found that only 9% of senior surgical trainees were in favour of a change in junior doctors' hours, and that was at a time when