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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

SIMON HATCHER
Lecturer in psychiatry
University of Leeds,
Leeds LS2 9LT

MICHAEL JOHNSON
Consultant neurologist
St James's University Hospital,
Leeds LS9 7TF

PHILIP STANLEY
Consultant in infectious diseases
Seacroft Hospital,
Leeds LS14 6UH

ALLAN HOUSE
Consultant in liaison psychiatry
General Infirmary,
Leeds LS1 3EX

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