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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.

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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.

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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.

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- 1 Moss F, McNicol M. Alternative models of organisation are needed. *BMJ* 1995;310:925-8. (8 April.)
- 2 Neuhauser D. Progress on firms research. *International Journal of Technology Assessment in Health Care* 1992;8:321-4.
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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.

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- 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

the reduction was to only 83 hours a week. Furthermore, although we included some of the more benign comments of the trainees in our article, many of them, though entertaining, were unprintable.

We agree that the Junior Doctors Committee (which allegedly disbelieved our data) is out of touch with the wishes of many junior staff, particularly surgical trainees. Perish the thought that we should shorten our hours to the levels in Europe. For example, in Denmark (where they have a 37 hour week), on a urological unit a little bigger than ours there are eight senior registrars. The trainee who covers a weekend has to have the whole of the next week off. Surely even the Junior Doctors Committee cannot believe that this is compatible with an adequate training programme. One of the great advantages of consultant practice in Britain is personal autonomy (though this also is under threat). This requires a higher level of exposure and experience than is needed by our counterparts in Europe, who are more protected. If Keith Reid³ and his colleagues have their way there won't be any "fully trained specialists" to be "supported."

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- 1 Wong C. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)
- 2 West S, Weight S, Jenkins BJ, Stephenson TP. Junior doctors' hours: what do they really think? *J R Soc Med* 1994;87:331-3.
- 3 Reid K. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)

Committee lacks "shop floor" support

EDITOR,—Christopher Wong is wonderful: he has put into words exactly what thousands of doctors throughout Britain are thinking—that the Junior Doctors Committee does not have the support of all junior doctors.¹ I wish that the committee would stop and listen to what doctors on "the shop floor" think of the new working patterns. Instead it is forcing changes that many juniors do not consider to be an improvement, and this is leading to unhappiness in many workplaces. I accept that exceptionally long hours do not necessarily lead to better training, but partial and full shifts do not suit the essential continuity of care needed in many specialties and deprive doctors of daytime educational activities.

I find it interesting that Keith Reid believes that "appropriate pay for the intensity of work is a high priority." Does the Junior Doctors Committee think that an additional duty hour paid at 50% of the standard hourly rate for a full rota is appropriate? I believe—and I know many who agree—that if the Junior Committee had insisted on 100% of the standard hourly rate, or even more, for extra hours then the hours would have been reduced automatically. Unfortunately, the last BMA representative to attend this hospital told me that this is not current policy. The same amount of work (if not more) still has to be done, but because of the reduction in the official hours worked we are being paid less to do it. Has the committee asked enough people what they think is the best policy?

I was surprised to receive a letter addressed to me as the "mess president" at this hospital informing me that "all mess presidents in the region are automatically included as members of the regional Junior Doctors Committee." How wrong of the BMA to assume that it has everybody's support. The role of all doctors' messes should be to provide social activities for their members and to help bring unity to a workforce whose members often do not meet each other owing to the introduction of shift work.

Wong's letter is a breath of fresh air, and I hope that it will prompt new activity in a quiescent population.

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

Wong was right

EDITOR,—I endorse Christopher Wong's sentiments concerning the Junior Doctors Committee.¹ Like him, I wrote to many of my junior doctors' representatives during my time as a trainee, expressing dissatisfaction with the way in which junior doctors' hours were being reduced at the expense of my training. No attention seemed to be paid to this. I suspect that the vast and silent majority of doctors are prepared to work hard and for prolonged periods and that it is the vocal minority who are unhappiest.

In his reply to Wong's letter Keith Reid, the deputy chairman of the committee, says that many doctors confuse the two concepts of clinical experience and training,² but, unfortunately, these go hand in hand. While there is no doubt that improvements can be made in the British training structure, there is still no substitute for experience. Furthermore, I think that most juniors are more concerned that there is some guarantee that a job will be available at the end of their training programme. Until the exit arrangements from training programmes are sorted out no amount of window dressing in the form of changes to training will adequately address the problems and difficulties encountered by junior doctors.

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

Wong should join Junior Doctors' Committee

EDITOR,—The exchange of views between Christopher Wong¹ and Keith Reid² regarding junior doctors' hours has a depressingly familiar sound: on one side are the quietly moaning majority who are unhappy with recent changes in junior doctors' hours and conditions and on the other side is the complacently clever committee man who is still admiring the emperor's new clothes.

Wong makes some valid points in his letter about the views of many junior doctors. But the Junior Doctors Committee consists of his elected representatives. If he does not think that they are giving adequate representation he should join the committee and get something done about it. If more junior doctors who feel dissatisfied with the position that their representatives are taking had been more active earlier in the negotiating process we might not be in the present position.

Meanwhile, Reid continues to display the ostrich-like attitude of so many members of the executive of the Junior Doctors Committee, who seem unable or unwilling to listen to the views of many higher trainees in acute specialties. As Wong says, the days of 100 hours a week are gone, and this is important, particularly for doctors who are first on call in busy specialties. On the other hand, higher trainees in quieter specialties, who would expect to be on call from home and rarely called, could easily work busier rotas without these im-

pinging greatly on their family or leisure time. Reid says that the changes were endorsed by the royal colleges, the Joint Consultants Committee, the Central Consultants and Specialists Committee and the NHS Executive but ignores where the pressure for these changes came from and that many of the juniors who are supposed to be helped by the changes have been disappointed by the effect of their implementation.

Please will all members of the Junior Doctors Committee and the executive recognise that they are supposed to represent the views of all junior doctors, from preregistration house staff to experienced senior registrars. And please will all doctors in these grades recognise that it is up to them to use their democratic powers to ensure that they or their representatives on the Junior Doctors Committee work towards changing the system genuinely for the better.

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

Terms and conditions of service for new specialist registrar grade are not yet established

EDITOR,—It is now clear that the new grade of specialist registrar will be introduced on 1 December in the specialties of general surgery and radiology. The Junior Doctors Committee continues to believe that it is wrong to introduce the grade before its terms and conditions of service have been established.¹ In initial negotiations the Department of Health has made two unwelcome proposals: an all inclusive professional contract, which does away with the current system of payments for additional duty hours; and salary increments linked to educational progress, rather than the current system of automatic annual increments. The negotiators from the Junior Doctors Committee made their opposition to these proposals clear to the department at the meeting.

The negotiating process continues, with a further meeting to take place this month. There is no question of the committee pulling out of these negotiations, which are crucial to the future of medical training in Britain. In my view, agreement is unlikely to be reached by 1 December. Therefore, if the introduction of the specialist registrar grade in general surgery and radiology goes ahead on that date we shall insist that registrars and senior registrars who are included in the new training arrangements retain their current terms and conditions of service.

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- 1 Beecham L. Juniors will oppose all inclusive contract. *BMJ* 1995;311:954. (7 October.)

Correction

Differences in mortality after fracture of hip

An author's error occurred in the third letter in this cluster, by Alison Avenell (26 August, p 572). The lengths of stay in hospital given in the final sentence of the penultimate paragraph of this letter were transposed. The sentence should have read: "For example, patients receiving an oral supplement of 250 ml daily in one study had a median hospital stay of 24 days, compared with 40 days in a group not given the supplement."