nephrectomy versus £660 (three days) for laparoscopic nephrectomy. More specific, itemised analysis shows a different picture. Open nephrectomy cost £1665.64 while laparoscopic nephrectomy cost £3446.58. This is due to the increased use of theatre time reported for the laparoscopic technique—355 minutes compared with 107 minutes for the open technique. In addition, the capital costs of the laparoscopic equipment and disposable items (which can be up to £450 for a laparoscopic operation for hernia[4]) need to be considered.

Theatre time is a costly and limited resource whose availability often determines surgical throughput and the length of a waiting list. Patients' satisfaction and recovery remain subjective and difficult to assess. Unless unequivocal clinical benefit can be shown, on the basis of hospital costs and throughput, many laparoscopic procedures seem hard to justify in today's NHS.

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1 Banta HD. Implications for hospitals, health workers, and patients. *BMJ* 1993;307:1546-9. (11 December.)
2 Cuckow PM. Cost of urology: financial audit in a clinical department. *BMJ* 1992;305:743-6.
3 Kerbl K, Clayman RV, McDougal EM, Kavoussi LR. Laparoscopic nephrectomy. *BMJ* 1993;307:1488-9. (4 December.)
4 Goodall RJR. Early experience with laparoscopic herniorrhaphy: results after the first 60 procedures. *Ann R Coll Surg Eng* 1994;76:47-9.

Decreasing hospital stay is nothing new

EDITOR,—H David Banta warns of the lack of proper evaluation of minimally invasive surgery and the need for this to be properly funded.[1] He seems to imply, however, that earlier discharge from hospital is largely due to changes in surgical technique. Far more important is the change in the attitudes of staff and patients that has taken place gradually over the past 25 years. The inpatient stay after repair of a hernia has been reduced from 10 days to 24 hours, or less, without the surgical technique changing at all. Incisions for cholecystectomy had already been getting smaller before laparoscopic operations were introduced,[2] and controlled trials show little difference in the stay in hospital between procedures requiring a small incision and laparoscopic procedures,[3,4] partly because both require general anaesthesia.

The other important factors affecting early discharge are the age, general medical state, and social conditions of the patient. An elderly person living alone in a high rise flat presents very different problems from a young adult who is taken to a family home in a comfortable car. For elderly patients, staying in hospital for an extra day or two may be both safer and, ultimately, more cost effective.

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1 Banta HD. Implications for hospitals, health workers, and patients. *BMJ* 1993;307:1546-9. (11 December.)
2 Dubois F, Burthelot B. Cholecystectomie par mini-laparotomie. *Nouvelle Presse Medicale* 1982;11:1139-41.
3 McMahon AJ, Russell IT, Baxter JN, O'Dwyer PJ. Comparison of the cost of laparoscopic and mini-cholecystectomy: a randomised trial. *Gut* 1993;34(suppl 1):F269(S69).
4 Tate JJT, Dawson JW, Chung SCS, Lau WY, Li AKC. Laparoscopic versus open appendicectomy: prospective randomised trial. *Lancet* 1993;342:633-7.

Day surgery developing rapidly

EDITOR,—H David Banta describes his vision of the impact of minimally invasive surgery on hospitals, health workers, and patients in the near future and states that it "brings many more possibilities for short stay surgery or day surgery, although this has not been recognised by doctors or policy makers in Europe."[1] This is not true.

Day surgery has been developing rapidly in Britain, and a recent report offered a "reasonable target" of half of all elective surgery being performed as day surgery by 2000.[2] The importance of day surgery and minimally invasive surgery was noted at a series of international scientific meetings last year. These meetings included the second European congress on ambulatory surgery (Brussels, 19-20 March), the founding congress of the European Society of Anaesthesiologists (Brussels, 11-16 May), and the third European congress of surgery (London, 14-17 September). New day surgery units are being constructed throughout Europe and are able to cope with a rapid turnover of patients as well as the implementation of minimally invasive surgery. The need for extensive community audit of minimally invasive surgery and day surgery has been emphasised by the Audit Commission.[3]

Banta refers to the importance of minimally invasive surgery and day surgery on economic grounds. Those who perform day surgery would argue that this is of secondary importance: the most important advantage of both it and minimally invasive surgery is the quality care that can be provided.

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1 Banta HD. Implications for hospitals, health workers, and patients. *BMJ* 1993;307:1546-9. (11 December.)
2 NHS Management Executive. *Day surgery—report of task force.* Heywood: British Association of Day Surgery Health Publications Unit, 1993.
3 Audit Commission. *Measuring quality: the patients view of day surgery.* London: HMSO, 1991.

Genetic markers in alcoholic liver disease

EDITOR,—D I N Sherman and colleagues suggest that variation in the alcohol dehydrogenase 2 gene may contribute to alcoholic liver disease.[1] Their study, however, has several shortcomings and their conclusions may be unjustified.

The initial hypothesis is unclear. The authors confuse genetic susceptibility to misuse of alcohol and genetic susceptibility to alcoholic liver disease; it is unlikely that the same genes contribute to these different disorders. If the authors intend to search for a marker for alcoholic liver disease the control group should be a population that has not developed liver disease (cirrhosis) despite prolonged and excessive alcohol intake. The control group causes particular concern because the only matching seems to have been on the basis of skin colour. This is unsatisfactory because large differences in frequencies of restriction fragment length polymorphism alleles may occur even among white populations. We have also observed different frequencies of restriction fragment length polymorphism alleles in white subjects collected from different social groups in London. Research and laboratory staff at King's College School of Medicine and Dentistry are of a higher socioeconomic class than alcohol misusers.

The authors do not discuss the problems of population association studies (better termed case-control studies), which are fraught with pitfalls and commonly result in false positive associations.[2] In this study the number of both patients and controls is small. Significance hinges on the genotypes of fewer than 10 subjects. In diabetes, studies of under 150 subjects are now rarely published. One group initially reported a positive association between a glucose transporter restriction fragment length polymorphism and non-insulin dependent diabetes,[3] but this proved erroneous once study numbers were increased.[4] Similarly, comparison of subgroups, as occurs in table III, is considered to be unacceptable.

Alcoholic fatty liver occurs in almost all long term misusers of alcohol, but cirrhosis occurs in only a minority. This suggests that genes encoding proteins involved in the regulation of hepatic fibrosis are far better candidates for conferring an inherited susceptibility to cirrhosis than is alcohol dehydrogenase, which is responsible only for the initial metabolism of alcohol.

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1 Sherman DIN, Ward RJ, Warren-Perry M, Williams R, Peters TJ. Association of restriction fragment length polymorphism in alcohol dehydrogenase 2 gene with alcohol induced liver damage. *BMJ* 1993;307:1388-90. (27 November.)
2 Cox NJ, Bell GI. Disease associations: chance, artefact or susceptibility genes? *Diabetes* 1989;38:947-50.
3 Li SR, Baroni MG, Oelbaum RS, Stock J, Galton DJ. Association of genetic variant of the glucose transporter with non-insulin dependent diabetes mellitus. *Lancet* 1988;ii:368-70.
4 Li SR, Oelbaum RS, Bouloux PMG, Stocks J, Baroni MG, Galton DJ. Restriction site polymorphisms at the human HepG2 glucose transporter gene locus in Caucasian and West Indian subjects with non-insulin dependent diabetes mellitus. *Human Heredity* 1990;40:38-44.

Covert video surveillance in Munchausen's syndrome by proxy

EDITOR,—The measures proposed by D M Foreman and C Farsides to promote the interests of all concerned in the use of covert video surveillance to detect Munchausen's syndrome by proxy are to be applauded.[1] It is therefore worrying that those interests have not been better protected when a surveillance programme has been implemented. The fact that the services of the local research ethics committees have not been used highlights loopholes in the process of ethical review. The doctors concerned have chosen to regard their procedures as clinical practice, thus avoiding the scrutiny of the committee.[2]

Such surveillance does not constitute clinical practice. No treatment is offered to the child, save in the event of the expected physical assault. The investigation is entirely forensic in character, which stretches the notion of medical diagnosis beyond normal parameters. No underlying pathophysiological condition or disease process in the child is sought, simply the incidence of violent assault on him or her. Increasing the likelihood of such assault to obtain forensic evidence exposes the child to harm—and this not in the course of treatment.[3] Though forensic investigation is important, it ought always to be separated from the provision of medical care to the patient.

Covert surveillance is largely a research exercise on human subjects in the NHS. The hypothesis that there is a significant correlation between multichannel tape recordings of physiological variables during episodes of asphyxia and those observed in other apnoeic episodes and that this makes certain patterns of data pathognomonic of imposed apnoea has been tested against the results of attempts at suffocation observed covertly by video.[3] This is a research activity. Many uncertainties surround Munchausen's syndrome by proxy. Any investigation of the syndrome therefore carries important overtones of research. To proceed as though the categories were clear and to assume that there is only one patient is to risk ignoring the clinical needs of one of the parties concerned.

These observations are intended to raise the question of the proper role of the doctor. While doctors have the responsibility to protect the health of their patients, they do not have a monopoly of such responsibility. Their duty is