

Irish persist long beyond the initial migration. The paper by Harding and Balarajan suggests that continuing socioeconomic disadvantage is not the full explanation. There seem to be other important elements of being Irish that influence their patterns of morbidity and mortality, although what these are and the mechanisms by which they contribute to the relatively poor health of Irish people in England and Wales remain unclear.

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## Does Britain need an academy of medicine?

### *It needs something*

"The doctor is different, the patient is different, and the medicine is different. In short, everything is different except the way you organise yourselves." This was what Maurice Shock, former rector of Lincoln College, Oxford, told British doctors in 1994 at their first "summit" meeting for over 30 years.<sup>1 2</sup> Because they lacked a body capable of analysing the environment and setting a strategy for the whole profession, doctors were overwhelmed by a "blitzkrieg from the right" at the end of the 80s. If doctors are to regain their influence, then they need a top body concerned primarily with strategic and high political matters. Otherwise, warned Sir Maurice, "the profession will never be able to punch its weight."

Although Sir Maurice's diagnosis and prescription were remarkable for their directness, and clarity, they were far from new. British doctors have for 50 years been debating the need for some sort of body that would bring doctors together and speak with a respected and well informed voice on the great matters of the day. Several attempts have been made to create such a body, but all have foundered. Meanwhile, the colleges have gone on splitting, and new committees with unmemorable acronyms have appeared to represent academic medicine. Medicine has many leaders but little leadership. "There is no kingdom," says John Green, chief executive of the Royal Society of Medicine, "too small for a doctor to be king of." More potentates means less influence.

Dr Green, a former mathematics don at Cambridge, is worth quoting because—unusually in medical affairs—he is a man who prefers action to talk and because he is the man behind further attempts to found an academy of medicine. Indeed, he is behind two attempts—because after 50 years of inaction Britain is now in danger of having two academies of medicine. The first is coming about because the Conference of Royal Medical Colleges has become an incorporated body and is applying to become the Academy of Medical Royal Colleges. Dr Green has supplied the conference with a home and a secretariat. The second academy may emerge from the activities of a working group on a possible academy of medicine set up by MERCC (Medical Education and Research Coordinating Committee), a body comprising representatives from the Conference of Royal Medical Colleges, the deans of medical schools, the postgraduate deans, and the Royal Society. The working party is chaired by Sir Michael Atiyah, immediate past president of the Royal Society, and is about as grand a working party as British medicine can currently muster. Dr Green is half of a two man secretariat. The working group has produced a consultation paper on the desirability and feasibility of establishing an academy of medicine (which is included in the copies of this BMJ being circulated to British doctors), and it wants responses by 21 June.

Few can dissent from the need for something. Current fragmentation must contribute to the declining influence of doctors. Many doctors feel that their misery is going unnoticed. The profession seems to have no way to solve complex problems—like the decline in clinical research or scientific fraud. The government and others have no single, authoritative medical body with which to consult. There is no place for all those who are important within health care—doctors, nurses, managers, and others—to meet together and develop policies. And—perhaps most important of all—the public has nobody that it can believe on subjects like the spread of bovine spongiform encephalopathy (BSE) to humans.

Could an academy of medicine meet all these needs? Probably not, but it might meet some. Sir Michael's working party envisages a body "that can speak for the whole of medicine, in the widest sense." It would include people other than doctors and would advise government, educate the public, provide a forum for discussion, collaborate with other bodies, "protect the status of medicine as learned profession," and provide "a framework in which medical education and research can be addressed." The working party imagines a body rather like the Royal Society or the Institute of Medicine in the United States: it might comprise 500 to 1000 people from around health care (perhaps 75% doctors) who would be there because of their "excellence." They would be supported by a generously funded secretariat that would be independent of government.

Effective organisations have a clear purpose and members or employees who are strongly motivated to achieve that purpose. Regaining or preserving the influence of doctors may not prove compatible with speaking for medicine in the widest sense (including those who are not doctors) and providing independent advice. Sir Maurice Shock seemed to be imagining a body that would regain doctors' influence, but the academy would surely do better to concentrate on speaking for all those involved in health care and providing independent advice. Although British doctors might be preoccupied with their own declining influence, a glance around the world shows that doctors everywhere are losing their influence. This may not be all bad. Doctors should forget the influence that comes from being the richest and strongest group in health care and concentrate on the influence that comes from having the best ideas.

The most obvious danger for the new academy is that it becomes yet another voice among a cacophony. It may find itself fighting other medical bodies rather than speaking for them, and following the route of excellence may make this more likely. Doctors are fiercely democratic and may be unim-

pressed by a group of 500— some of them managers, lawyers, non-medical academics, and (God forbid) journalists—who purport to speak for medicine. It would be tragic if an academy were to degenerate to yet another body for doling out honours.

We must applaud Sir Michaels' working party for wanting to consult with everybody interested over the future of an academy, and let us hope that the consultation produces a rich debate and good ideas on which to base the academy. There is

undoubtedly a job to be done, but there is also a good chance of producing yet another body that dines and processes and changes nothing.

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## Laparoscopic cholecystectomy: the other side of the coin

### *Choose between a larger scar or a slightly larger risk of bile duct injury*

The conventional view, supported by randomised trials, is that laparoscopic surgery is associated with less surgical trauma than surgery by laparotomy, resulting in less pain, quicker recovery, and earlier return to work.<sup>1-3</sup> Recently, however, another trial has cast doubt on these assumptions,<sup>4</sup> and an extensive review of laparoscopic cholecystectomy in Britain has urged surgeons to be cautious in adopting the procedure.<sup>5</sup>

Two of the three randomised trials comparing laparoscopic cholecystectomy with cholecystectomy by minilaparotomy found that the postoperative hospital stay was shortened by one to two days after laparoscopic cholecystectomy,<sup>1 2</sup> and all three studies found that convalescence was shortened by three to eight days.<sup>1-3</sup> Although the minilaparotomy differs substantially from a classic cholecystectomy, the alleged advantages of the laparoscopic approach seemed proved—until the study of Majeed *et al* was published last month.<sup>4</sup> Majeed *et al* found no differences in hospital stay, time back to work, and time to resume full activity between the patients who underwent a laparoscopic cholecystectomy and those who had a small incision cholecystectomy.<sup>4</sup> Why are their findings so different from the others?

The answer might lie in the unique design of their study: randomisation took place after induction of general anaesthesia, patients and carers were blinded in the immediate postoperative period because identical wound dressings were applied (including blood stains), great care was taken to relieve pain, and the time of hospital discharge was determined by the patients themselves. General practitioners were asked not to influence the time needed before the patient could resume full activities (since doctors vary widely in their opinion of how much time off is needed after surgery<sup>6</sup>). No advice was given about the time needed for convalescence. In this way the study group tried to circumvent any bias that might be introduced by the belief that recovery after "keyhole surgery" is quicker than after laparotomy.

If recovery after laparoscopic cholecystectomy is no quicker, or only marginally so, than after laparotomy, what other advantage does the technique have? The cosmetic results are better: three or four tiny scars instead of a 5-9 cm transverse incision in the right upper abdomen. In the trial by McMahon *et al* patients who underwent laparoscopic cholecystectomy were more often "very satisfied" with the appearance of the scar than those who underwent minilaparotomy.<sup>2</sup>

On some measures, however, laparoscopic cholecystectomy seems worse, notably length of operating time and the incidence of serious complications during or after surgery. In all four comparisons with minilaparotomy, laparoscopic cholecystectomy took 13-25 minutes longer to perform.<sup>1-4</sup> This was despite the fact that (with one exception) all surgeons were experienced in both methods, having performed at least 30 laparoscopic cholecystectomies before the study started.

In most studies the overall complication rates for laparoscopic cholecystectomy and cholecystectomy by mini-

laparotomy are similar. However, injury to the biliary tract is a particular cause for concern with the laparoscopic technique, varying from 0.2% to 0.9% in audit series.<sup>7</sup> There is probably slight underreporting when individual surgeons and centres are asked to report their outcomes. When a different approach was used, by asking how many bile duct injuries were repaired during one year, the incidence of injury to the bile duct from laparoscopic cholecystectomy was found to be 1%, twice the incidence found after conventional cholecystectomy.<sup>8</sup> Several reports indicate that most injuries to the bile duct occur during the first 30 laparoscopic cholecystectomies performed by an individual surgeon.<sup>9</sup> This suggests that the "learning curve" is responsible for the increased incidence and that proper training in laparoscopic surgery should decrease such injuries.<sup>7</sup> Epidemiologists in Ontario did indeed find a decrease in the incidence of bile duct injuries after laparoscopic cholecystectomy over the years 1989-94, but they also found a tripling in the overall incidence of bile duct injuries for all cholecystectomies.<sup>10</sup> Is the increased chance of injury to the bile duct inherent in the laparoscopic technique or in the surgeon performing it?

It was probably this concern that drove Britain's Department of Health to ask the epidemiology and audit unit of the Royal College of Surgeons to review the evidence on the effectiveness and safety of laparoscopic cholecystectomy. The report concludes that there is some evidence that patients undergoing laparoscopic cholecystectomy recover more quickly and return to normal activity earlier than those undergoing open cholecystectomy and minilaparotomy, though reported differences are likely to have been overestimated. It found "weak evidence" that the risk of bile duct injury is greater in laparoscopic cholecystectomy than in open cholecystectomy. The report's first recommendation is, however, of particular interest: "Surgeons should not be encouraged to replace mini-cholecystectomy with laparoscopic cholecystectomy." This recommendation comes a little late, at least for continental Europe, where laparoscopic cholecystectomy has become the procedure of choice for removing the gall bladder.

Surgeons are responsible for informing their patients as completely as possible about the risks and benefits of a procedure, and that must include the new scientific data now available. The patient may then make the choice between a larger scar or a slightly increased risk of bile duct injury.

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