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Hirschsprung's Disease: Mr. G. C. Fraser and Mr. A. W. Wilkinson emphasize high mortality in the neonate and the necessity for relieving obstruction on diagnosis (p. 7).

Dyspnoea in Coal Miners: Study of aetiology, by Dr. C. Ogilvie and colleagues (p. 10).

Enigma of Ulcerative Colitis: Dr. Fred Feldman and colleagues, from Los Angeles, question whether this is a psychosomatic disease (p. 14). Leader this page.

Pernicious Anaemia in Asians: Dr. F. J. Jayaratnam and colleagues report this condition for the first time from Singapore (p. 18).

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Psychological Factors in Ulcerative Colitis

For many years it has been widely accepted that psychological factors are prominent in ulcerative colitis. Some physicians indeed go so far as to regard ulcerative colitis as a psychosomatic disease in the strict sense of this term—namely, as an illness in which the organic lesions are the consequence of emotional disturbances.

An extensive literature exists on the psychological aspects of the disease. Perhaps the outstanding pioneer was C. D. Murray,[1] who in 1930 investigated twelve patients from the psychological viewpoint. He found "a well-marked time-relationship between the outbreak of an emotional disturbance and the onset of the symptoms." Mental conflicts concerned with marriage were the most common source of anxiety, and he judged that the patients faced their problems in an inadequate and infantile manner. E. Wittkower[2] made personality studies of 40 unselected patients with ulcerative colitis and found that psychological abnormalities and disorders far beyond the range of individual differences in the normal population existed before the onset of the colitis in the majority. Furthermore, in 28 of the 40 patients "a clear-cut emotional trauma, serious enough to be regarded as a precipitating agent, immediately preceded the onset of the colitis."

The psychosomatic hypothesis was fully reviewed by G. L. Engel[3-5] in articles dealing with 39 of his own patients and the published reports on 700 others. He found that four factors emerged "with impressive consistency": defects in personality long preceding the colitis; dependent and restricted relationship with other people; psychopathology in the mothers; and failure to achieve full heterosexual development.

Some physicians[6 7] have been so impressed by the importance of psychological factors in ulcerative colitis that they have regarded psychotherapy as the mainstay of treatment. Some objective evidence that psychotherapy can be beneficial comes from W. J. Grace, R. H. Pinsky, and H. G. Wolff.[8] They compared two matched groups of 34 patients in the first of which the management was by one physician (W. J. G.) with the emphasis on superficial psychotherapy aimed at relieving stress, whereas the second group was managed by various physicians who relied on diet, medication, and antibiotics. The psychotherapeutic group fared better than the control group, but even so the results do not appear impressive.

While many of the psychiatric studies of ulcerative colitis have been on individuals or on small groups of patients and are thus necessarily subjective and anecdotal, some workers have attempted to provide objective evidence. For example, L. Krasner[9] made use of a battery of intelligence and personality tests, including the Guilford-Martin factor inventory, to compare two groups of patients suffering from "psychosomatic diseases" (duodenal ulcer and ulcerative colitis) with a control group

of patients who had never suffered from any of the diseases often considered to be psychosomatic. The group with ulcerative colitis did best in the intelligence test, but their results did not depart significantly from the normal distribution. Personality differences between the ulcerative colitis group and the control group were revealed by significant differences in scores on the Guilford–Martin factor inventory, the results tending to confirm previous descriptions of the ulcerative patients as being passive, insecure, shy, sensitive, and moody.

The article by Drs. F. Feldman, D. Cantor, S. Soll, and W. Bachrach which appears at page 14 of the *B.M.J.* this week must be one of the few psychiatric studies to discount the importance of psychological factors in the aetiology of ulcerative colitis. Its sharp disagreement with most of the conclusions reached by earlier authors is bound to excite controversy, which can hardly fail to be beneficial. The study consisted of a psychological evaluation of 34 patients with ulcerative colitis and a comparison with the general population and also with 74 patients admitted for other gastroenterological conditions. In essence, on the basis of scoring 65 variables, the subjects were placed in five categories of normality or abnormality. The great majority of the patients were classified as "normal" as regards personality and psychiatric illness. In only a small number was there an emotional precipitant closely preceding the first attack of ulcerative colitis. Seven of the patients had undergone extensive psychiatric treatment after the onset of ulcerative colitis. In three of these psychotherapy had helped the patient to adjust to his illness, but in none did it appear to have had any appreciable effect on the course of the disease.

Some support for the iconoclastic view of Feldman and his colleagues comes from the epidemiological study by E. D. Acheson and M. D. Nefzger[10] of ulcerative colitis in the United States Army. They were able to match each case with a control subject of the same rank, age, and sex, and it is interesting that they found no appreciable difference in intelligence, educational attainments, income before enlistment, or military conduct. M. Monk[11] made a study in Baltimore designed to uncover differences in social environment between patients with ulcerative colitis and the population from which they came. She found no differences in educational attainments, amount of life lived with parents or alone, degree of social contact with others before the onset of the illness, or the number of bereavements or marital disagreements in the month preceding the symptoms. However, she did show that the ulcerative colitis group were more likely to have fathers who had died during the patient's childhood. Does this positive finding support the view of J. W. Paulley[12] that "the disease is associated with a well-defined personality not uncommonly related to the unfortunate effect of overpossessive mothers"?

[1] Murray, C. D., *Amer. J. med. Sci.*, 1930, **180**, 239.
[2] Wittkower, E., *Brit. med. J.*, 1938, **2**, 1356.
[3] Engel, G. L., *Psychosomat. Med.*, 1954, **16**, 496.
[4] —— *Amer. J. Med.*, 1954, **16**, 416.
[5] —— ibid., 1955, **19**, 231.
[6] Groen, J., and Bastiaans, J., *Gastroenterology*, 1951, **17**, 344.
[7] Paulley, J. W., *Lancet*, 1956, **2**, 215.
[8] Grace, W. J., Pinsky, R. H., and Wolff, H. G., *Gastroenterology*, 1954, **26**, 462.
[9] Krasner, L., *J. abnorm. soc. Psych.*, 1953, **48**, 10.
[10] Acheson, E. D., and Nefzger, M. D., *Gastroenterology*, 1963, **44**, 7.
[11] Monk, M., Paper read at the First Internat. Congr. Soc. Psychiat., London, 1964.
[12] Paulley, J. W., *Gastroenterology*, 1963, **44**, 7.

Hospital Junior Staff

The wisdom of giving autonomous powers to sectional interests within the B.M.A., which exists to represent the medical profession as a whole, has often been questioned. The exercise of autonomy has on occasions seriously strained intraprofessional relations. Yet to those who possess it the advantages of autonomy have always seemed to outweigh its disadvantages, and under the new B.M.A. constitution, which the Annual Representative Meeting at Bristol next week is likely to approve, the autonomous powers of the committees representing the major branches of medical practice will be strengthened rather than weakened. It is therefore not surprising, nor unreasonable, that there should be renewed demands from hospital junior medical staff for the same rights of self-government as their seniors in established practice have.

However, the wish for autonomy is by no means universal among hospital junior doctors. Some think they would fare no better with it and perhaps less well. The Hospital Junior Staffs Group Council, which represents hospital junior doctors in the B.M.A., is against breaking away from the Central Consultants and Specialists Committee (or, as it will be named, the Committee for Hospital Medical Services), on which junior doctors will in future have twelve representatives instead of four. It is to be hoped, therefore, that the Junior Hospital Doctors' Association, the prime mover in the demand for autonomy, will not press the matter too hard. It would be a pity if this association went so far as to demand the right to negotiate separately on behalf of its members, as its chairman has stated[1] it will in the event of failing to get antonomous powers for hospital junior staff within the B.M.A. That would create an unfortunate division.

It is doubtful whether any organization could completely overcome the problems in representing the interests of a group of doctors so disparate as hospital junior staff. The personal and professional concerns of a middle-aged senior registrar experienced in a specialty and those of a newly fledged, provisionally registered houseman uncommitted for the future are far apart. But both rank as hospital junior staff—as do a British-born registrar intent on becoming a consultant and his colleague from the Commonwealth wanting postgraduate experience. It is difficult to make a convincing case for autonomy for what may be called the "junior" hospital junior staff, whose future may lie in any branch of medicine. Their membership of the hospital population is surely too transient to make it worth while for them to try to create the elaborate and expensive machinery needed for self-government. The more senior among the junior staff are in the main committed to a hospital career, and their interests are as much in what their terms of service are likely to be on promotion as in what they currently are. Their polarity must be towards the top of the ladder.

Last week the Council of the B.M.A. approved the Hospital Junior Staffs Group Council's proposals for reorganizing the constitution of the Group Council itself and of its constituent regional groups. The number of representatives from the regions on the Group Council are to be increased from 42 to 50. The total membership of the Group Council will be 60 instead of 48, and of the 60 only two will be appointed by the Central Consultants and Specialists Committee. Participation in the affairs of the Group is to be open to all hospital junior staff, whether members of the B.M.A. or not.

[1] Briggs, J. H., *World Medicine*, 1967, **2**, 15.
[2] *Brit. med. J. Suppl.*, 1967, **2**, 45.