subject of their research. Neither should they buy or sell shares in any other company whose share price might be affected by the results of their research from the time the research starts until results are made public. Clinical studies may last several years.

Proposed guidelines

Academic clinical investigators generally need to be more familiar with the issues concerned in owning and trading in pharmaceutical companies' shares. We offer the following guidelines and advice. Clinical investigators (and their immediate relatives) should not buy or sell shares in pharmaceutical companies whose share price might be affected by their work until this is completed and results have been made public. Clinical investigators should not disclose unpublished price sensitive results of studies in confidence to third parties. Anyone to whom such disclosures are made is subject to the same potential criminal liability under the Company Securities (Insider Dealing) Act 1985 as the person from whom they had the information.

Clinical investigators, ethics committees, and research institutions might feel more comfortable if clinical investigators were to make a voluntary declaration to study ethics committees and to sponsors of any shareholdings for which there might be a conflict of interest and undertake not to trade in the relevant company's securities until the studies are completed and the results made public.

The views expressed in this paper are not necessarily those of Wellcome.

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For Debate

Gall stones: the real issues

Alan G Johnson

Over the past two years there has been enormous interest in laparoscopic techniques and millions of pounds have been invested in the design and manufacture of more and more advanced instruments for performing an operation that surgeons have been doing for the past 100 years—that is, removing the gall bladder for gall stones. We welcome, and await with interest, the results of the few randomised controlled trials that have been set up to assess the advantages of the new technique as applied to unselected patients and the possible savings (if any) when all costs and safety are included. I am, however, less concerned by the lack of proper data on these matters than by the frightening way in which commercial and technical interest has diverted attention from the two really important questions in gall stone disease. Both are far more relevant to the health service than the question of which technique to use. Why do gall stones form at all and how may they be prevented? And how many of the 40 000–50 000 patients a year who undergo cholecystectomy actually need their operations or gain overall health benefits from them?

The wrong debate

It is a cliché that it is cheaper and safer to put a fence at the top of the cliff than to provide ambulances on the beach below to rescue those who fall over the edge. In this context the debate between laparoscopic and small incision cholecystectomy is like a discussion of whether it is more comfortable and quick to be picked up by a

Rolls-Royce or a Ford ambulance. It is far more relevant to ask how near we are to building a fence at the cliff edge and how many people on the beach are in fact happily playing in the sand, in no danger and not needing rescue! If the money that has been spent on new techniques with lithotripters and laparoscopes had been put into research on the cause and prevention of

Ultrasonic image of gall bladder containing stone and contracting (right hand side) after fatty meal

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gall stones the fence might have been more than half built by now.

The problem is that we surgeons enjoy rescuing people who fall over cliffs and are fairly well paid for it. When the fence is built and gall stones prevented, as they will be in the not too distant future, surgeons' attention will have to be diverted to other patients with other conditions. This is nothing new in the history of surgery—why else are many cardiac units situated in old tuberculosis hospitals? Thoracic surgeons adapted very quickly when thoracoplasties and phrenic crushes were no longer needed and took up cardiac surgery instead.

Who should have their gall bladders removed?

The important every day question for all clinicians is: Who needs treatment for gall stones? The question has become particularly acute over the past few years since ultrasonography can detect stones so easily. When asked to scan the pelvis ultrasonographers have the annoying habit of waving their ultrasound wands over the right hypochondrium. Many patients come to a clinic with a cheerful smile on their faces saying, "At last they have found the cause of the pain that I have been telling my general practitioner about for years. It is all due to my gall stones." When asked where the pain is they point to the suprapubic region or to the left iliac fossa and the smile fades when they are told that it probably has nothing to do with their gall stones. Removing the gall bladder, even through the smallest

incision, can provide no guarantee that these symptoms will be cured.

Jorgensen's prevalence study in Denmark on an unselected population found that there was no significant difference in pain characteristics and pain location between those with a normal gall bladder and those with gall stones (so long as the patients with gall stones were not aware they had them).¹ The prevalence of pain in patients who had undergone cholecystectomy was in fact significantly higher than in those who had not. But surely in practice we are all agreed about who should have their gall bladders removed.

Unfortunately, a recent study explodes this myth. Scott and Black showed the case histories of 252 patients who had undergone cholecystectomy to a panel of doctors of varying specialties and to a panel of surgeons.² The mixed panel agreed that the operations were appropriate in 41% of cases and inappropriate in 30%, whereas the surgeons agreed that 52% were appropriate and 2% inappropriate but could not agree on the remaining 46%.

If half the operations should not be done at all, whether by open or laparoscopic techniques, the discussions about one less day in hospital or half an hour longer in the operating theatre pale into insignificance.

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Helping people with dementia feel at home

Stuart Handysides

In December 1992 an NHS unit designed specifically for elderly people with dementia opened at 210 Knight's Hill in south London. It provides residential and day hospital care for elderly people with dementia, many of whom would previously have occupied a ward at Cane Hill Hospital, a Victorian asylum. The need for such a service is increasing for two reasons. The number of elderly people is rising: in 1974 people over 75 made up 5% of the population¹ but in 1989 they made up 7%.² Closure of mental hospitals began in the 1950s, but as psychiatric patients were discharged into

the community their places were taken by elderly people with dementia. This has delayed the closure of some hospitals; for those that are left, though, it is now imminent. Knight's Hill incorporates features and a philosophy that may become a benchmark for future homes.

The Knight's Hill project

Ten years ago in Camberwell, after assessment at the Maudsley or Dulwich Hospitals, demented patients who could not be looked after at home usually went to Cane Hill Hospital (fig), an old asylum several miles out of London with "loony bin" connotations for patients and their relatives. In preparation for Cane Hill's closure, Age Concern Southwark opened a nursing home for 30 people in association with the Maudsley Hospital. At the same time, the Knight's Hill project began.

Camberwell Health Authority had a former tuberculosis hostel in the Maudsley catchment area. On this site, with the prospect of monies arising from the sale of Cane Hill, they commissioned a building for the care of demented patients. Unlike the long wards of Cane Hill, it would provide residents with their own rooms. It would also offer respite care and day hospital care for people with dementia living in the community.

The project members met over two years, and Knight's Hill opened in December 1992. Michael Manser, the architect, designed the unit on a cruciform plan, with an enclosed courtyard in the centre which leads out to four houses. Twelve people live in each of three of the houses, and the fourth provides space for day care, administration, the kitchen, and laundry. This kind of design is known as a group home and

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Cane Hill Hospital was occupied until recently by elderly people with dementia