least some of the 28 patients with "complete collapse" of the lung might well have been shown to have a tension pneumothorax if intrapleural pressures had been measured. Unrecognised tension pneumothorax might therefore have been responsible for some of the seven failures of aspiration, and that figure could have been even higher if most patients (18/28) with complete lung collapse had not been treated by intercostal drainage.

Secondly, although the authors state that "28 out of 35 aspirations were successful," the corresponding figures for intercostal drainage are not provided. Why not?

Thirdly, it is methodologically unsound, and perhaps ethically questionable, to include in a clinical trial of this type patients with vastly different indications for therapeutic intervention. Those with only a "small rim" pneumothorax should not have been exposed to the chance of being submitted to the unnecessary trauma of intercostal drainage (as one of them was) when they probably required no active treatment at all. Conversely, it could have been dangerous not to resort immediately to intercostal drainage in patients with complete lung collapse when the aspiration of 3 litres of air without x ray evidence of re-expansion of the lung strongly suggested the persistence of a fistulous communication between the lung and pleura. The doctors concerned should also have considered the remote but lethal possibility of a pneumothorax developing on the opposite side.

Fourthly, two of the benefits attributed to aspiration—less pain than with intercostal drainage and a shorter stay in hospital—were surely too obvious to warrant statistical analysis. The observation that intercostal drainage increased the need for subsequent pleurectomy (now an obsolete procedure) would surprise most thoracic physicians and surgeons but could perhaps be explained by the higher frequency of complete lung collapse (18/38 v 10/35) in the intercostal drainage group.

The authors are right to advocate aspiration in suitable cases as a less uncomfortable alternative to intercostal drainage. They have not, however, provided convincing evidence that the results of a statistical comparison of two ill matched groups should usurp individual clinical decisions on whether the initial treatment of spontaneous pneumothorax should be aspiration or intercostal drainage.

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1 Harvey J, Prescott RJ. Simple aspiration versus intercostal tube drainage for spontaneous pneumothorax in patients with healthy lungs. *BMJ* 1994;309:1338-9. (19 November.)

Author's reply

EDITOR,—When the British Thoracic Society's research committee began the study in 1985 some doctors declined to take part because they thought that all pneumothoraces should be treated by simple aspiration. An equal number declined to take part because they thought that all pneumothoraces required intercostal tube drainage. It was because of these uncertainties that a well designed, randomly selected study was undertaken. Rather than "reinventing the wheel," we were testing which of the two commonly used wheels was the right one to use.

Since our aim was to test current clinical practice, patients with signs of tension pneumothorax were specifically excluded from the trial. Most doctors do not now measure intrapleural pressures and would not diagnose tension pneumothorax simply on the basis of complete collapse. Whatever the numbers might indicate, the distribution of patients between the two randomly

selected arms showed no greater variation than would be expected by chance, and the interpretation of our findings is not affected by the greater number of patients with complete collapse in the intercostal drainage group. Aspiration was successful in six of 10 patients with complete collapse, so that even in this group an initial attempt at aspiration would not be contraindicated. We do not agree, therefore, that routine thorascopic surgery is indicated as the initial treatment for all patients with spontaneous pneumothorax who present with complete collapse, as Anthony P C Yim proposes, although it may in future be more commonly used for recurrent episodes.

Whether intercostal drainage is successful depends on how success is defined. Two of the 38 patients treated by intercostal drainage required pleurectomy during the same admission and a further five within the next year because of recurrent pneumothorax, whereas none of the patients in whom aspiration either failed or was successful required pleurectomy during the subsequent year. The size of pneumothorax is not, therefore, an "alternative explanation for the higher rate of pleurectomy in the group treated by intercostal drainage."

We accept that minimal intervention thorascopic surgery is now rapidly replacing pleurectomy, but it was not in widespread use during the years of this study. We also agree that "small rim" pneumothoraces would not usually require any drainage procedure. Only four of the 73 patients in our study had small rim pneumothoraces, and they were judged by the doctors to merit a drainage procedure.

As we mentioned, the results of this study have been widely discussed with respiratory physicians and thoracic surgeons and form the basis of our guidelines.³ Given the successful outcome measures, a less painful and less traumatic procedure that requires a shorter stay in hospital seems to be the best initial management for all spontaneous pneumothoraces in patients with normal lungs.

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1 Bradley G. Simple aspiration for spontaneous pneumothorax. *BMJ* 1994;310:255-6. (28 January.)

2 Currie D. Simple aspiration for spontaneous pneumothorax. *BMJ* 1994;310:256. (28 January.)

3 Miller AC, Harvey J. Guidelines for the management of spontaneous pneumothorax. *BMJ* 1993;307:114-6.

Reform of GMSC not needed

EDITOR,—I believe that David Roberts is wrong in his assertion that morale in general practice is related to the method of election of the General Medical Services Committee and in his conclusion that the committee is undemocratic.¹ I have been a member of the GMSC since 1980 and have served on the agenda committee for the annual representative meeting for several years. I carried out the detailed work on the section of the agenda that included the motion about the method of election to the GMSC. My original decision was adopted after debate by the agenda committee, and my view of the motion's importance was upheld by the annual representative meeting, which decided not to suspend standing orders to debate it.

There were two main reasons for the decision not to raise the issue at the meeting. The first concerns the internal working of the constitution of the BMA² and the necessity of maintaining a united front to represent all doctors. This requires

that the GMSC is allowed to operate in a largely autonomous way and also that amendment of its constitution and electoral arrangements is carried out in a way acceptable to the conference of local medical committees. The second and much more important reason relates to democracy and the representation of ordinary general practitioners. Roberts fails to appreciate that the sovereign body in general practice affairs is the local medical committee, not the GMSC. All general practitioners have ample opportunity to seek to influence the decisions of their local medical committee; they have the opportunity to seek election to it and from there to seek election to the GMSC.

The role of the GMSC is to carry out the collective will of local medical committees. These committees raise the quota that maintains the General Medical Services Defence Fund Limited, which gives freedom of action to the GMSC while maintaining the local medical committees' control over it. As the NHS becomes more fragmented and local deals attain increasing importance, the prime need for every general practitioner is an effective local medical committee. I believe it is essential that the role of local medical committees is not sidelined by the adoption of a spurious argument about democracy.

Finally I believe that my office of secretary of a local medical committee requires me to vote against an extraordinary general meeting or referendum if Roberts puts such a resolution to the BMA's council.

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1 Roberts D. Reform of GMSC needed. *BMJ* 1994;309:1585. (10 December.)

2 Watts JD. Strains in the constitutional framework of the BMA? *BMJ* 1988;296:1549.

Doctors and management

EDITOR,—In describing how managers and doctors view each other Jenny Simpson makes no reference to the inherent suspicion among doctors that managers are not totally committed to health care.¹ Whatever changes occur in the health service, doctors will still be there caring for their patients in what they believe to be the best way; most doctors would never contemplate leaving the NHS, no matter how dire the situation. Managers, however, have a skill that is in demand throughout the economy. A better offer of remuneration could mean that they find themselves in the upper echelons of a trust one week and in the offices of a manufacturer of machine tools or a telecommunications company the next. Many health service managers are dedicated to the NHS, but they must communicate this to doctors in word and deed if they are to dispel this commonly held prejudice.

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1 Simpson J. Doctors and management—why bother? *BMJ* 1994;309:1505-8. (3 December.)

Failure of consultant expansion

Consultant expansion depends on local cooperation

EDITOR,—Surely Stephen Brearley's editorial on the failure of consultant expansion underestimates the importance of teamwork in producing changes in major issues at the local level.¹ If people wish to move towards a consultant led service then the consultants in individual hospitals will need to work closely with their purchasing authorities;