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.

IAN W B GRANT
Former consultant physician

Nether Balchandy,
By Pitlochry,
Perthshire PH16 5JT

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.

JOHN HARVEY
Consultant physician

Lung Function Unit,
Southmead Hospital,
Bristol BS10 5NB

ROBIN PRESCOTT
Senior lecturer in medical statistics

Department of Public Health Sciences,
Edinburgh University Medical School,
Edinburgh EH8 9AG

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.

J DAVID WATTS
Secretary

Ayrshire and Arran Local Medical Committee,
Dundonald,
Ayrshire KA2 9HE

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.

BRENDAN HARRINGTON
Lecturer in child health

St Mary's Hospital,
Manchester M13 0JH

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;

they will not make substantial inroads on their own.

Purchasing authorities have a major part to play in funding consultant posts. They should be working collaboratively with trusts to make the most of their local market, and this does not mean that the needs of the district's population have to be fulfilled in the atmosphere of a competitive marketplace. At the same time the move to increasing specialisation suggests that there will be fewer district general hospitals, although more central provision will not mean fewer consultants. In addition, as the shift to primary care occurs general practitioners will need to consult more closely with their colleagues so that consultant skills are directed at the most challenging problems that patients present.

Brearley's analysis of the problems is not wrong, but he is too pessimistic. The ability of influential people to increase numbers of consultants may require a degree of vision, but the increase will certainly not be achieved unless they cooperate locally.

JONATHAN HOWELL
Senior registrar in public health medicine
SAM RAMAIAH
Director of public health

Walsall Health Authority,
Walsall WS1 1TE

1 Brearley S. The failure of consultant expansion. *BMJ* 1994;309:1245-6. (12 November.)

Expansion depends on rigorous control of numbers in training and non-consultant career grades

EDITOR,—Stephen Brearley identifies the principal influences on the duration of training for junior doctors in Britain: the rate of entry to and exit from the training grades.¹ He does not, however, consider fully how those rates may be varied and regulated.

The rate of outflow from the training grades is influenced mainly by the number of consultant posts. If purchasers wish to buy more or better quality services they must finance more consultant posts—unless, that is, trusts employ other doctors at lower salaries. Staff grade posts are subject to a regional and national ceiling of 10% of the number of consultants. Some trusts have appointed career grade or training grade doctors to non-existent grades or to unauthorised staff grade posts.

Where trusts comply with national staffing agreements the rate of increase in the number of consultants has been much greater than average. In the old East Anglian region, during the 12 months to September 1994, a 7.8% increase in consultant posts occurred. In this region the regional manpower committee has continued to meet and to regulate staff grade posts. A representative of trust management is a full member of the committee, and clinicians, including junior doctors, vigorously vet all applications for new posts, rejecting those where a consultant post would be appropriate. In other regions manpower committees have been disbanded and trusts ignore national staffing agreements.

There can be no restriction on doctors from the European Union coming to Britain to work, so the number of posts available at the preregistration house officer and senior house officer grades is in fact the main regulator of inflow to the training grades. Regional task forces and postgraduate deans have been given the responsibility for regulating numbers of senior house officers, with any increases to be a last resort after all other mechanisms to achieve the targets for hours under the new deal have been exhausted. Information from junior representatives on regional task forces suggests that in some regions deans or chairpeople of task forces have authorised senior house officer

posts without consulting junior members of the task force and without insisting that all the targets under the new deal be met for the new posts. This has not been the case in East Anglia. Expansion in the number of consultants can be driven by a rigorous control on the number of posts in the training grades and non-consultant career grades. The proposed Advisory Group on Medical Education, Training, and Staffing must be matched by a subregional body with power to regulate numbers of non-consultant staff.

Hinchingbrooke Hospital,
Huntingdon PE18 8NT

ANDREW G HOBART
Senior house officer in surgery

1 Brearley S. The failure of consultant expansion. *BMJ* 1994;309:1245-6. (12 November.)

"Subconsultant" posts are increasing dramatically

EDITOR,—The declared intent of both the government and the medical profession is the expansion of the consultant grade^{1,2}; *Plan for Action* proposed the mechanisms for this.² The staff grade was a response to the need for a non-consultant or subconsultant career grade. Concern that this grade might develop was evident in the joint agreement that the number in the staff grade should not exceed 10% of the number of consultants. The table shows that the annual increase in consultant posts was the lowest on record in 1993-4; that in associate specialist posts has increased to the highest on record (from three a year in 1991-3 in the West Midlands to 18 in 1994), and staff grade posts rose by 48% in 1992-3 alone.

Percentage annual expansion in career grade doctors*

	Consultant	Associate specialist	Staff grade
1983-93	2.5	0.5	
1990-3	2.9	4.8	
1992-3	2.4	8.4	48.2
1993-4	1.8†	45 (West Midlands)	

*Department of Health figures.

†If task force consultants are included, 2.1%.

The source of these subconsultants does the profession no credit. They were "stuck doctors," with insufficient qualifications or lack of ambition, often manoeuvred into a career cul de sac, who have been flushed out by the reviews by the task forces—the first accurate assessment of staffing in the NHS since its inception. They were clinical assistants or "permanent locum" registrars or senior house officers, some "illegal" and some appointed without staffing approval since 1987—the West Midlands regional task force "discovered" 74 illegal senior house officers, about 5% of the total; most were simply used for unpopular tasks. In reality the profession wants a subconsultant grade, has had one for a long time, and in many cases cynically sets about creating one.

Many trusts (flouting national agreements) have attempted to make cheap but illegal appointments without staffing approval. Associate specialists have "appeared" for approval, having been variously employed for years. Doctors in staff grades and associate specialists are supervised to a degree by the task forces and manpower committees to ensure that they have suitable qualifications for permanent posts. There is no such control over clinical assistants, and any trust may appoint whomever it wishes with whatever qualifications it chooses. The standard of the only other unlimited grade, consultant, is controlled by the advisory appointments committee.

There is now a permanent career path in parallel: the clinical assistant, (permanent) staff grade, and (permanent) associate specialist exist

in parallel with the senior house officer, senior registrar, and consultant. The NHS has introduced the means whereby a potentially poorly trained body of medical staff can develop and frustrate the goal of increasing the number of consultants to the level required to give a high standard of service and a satisfactory career path for the captive graduates of our medical schools.

P E ROBIN
Regional manpower executive

City Hospital NHS Trust,
Birmingham B18 7QH

- 1 Department of Health and Social Security, Joint Consultants Committee, chairmen of regional health authorities. *Hospital medical staffing: achieving a balance*. London: DHSS, 1986.
- 2 United Kingdom Health Departments, Joint Consultants Committee, chairmen of regional health authorities. *Hospital medical staffing: achieving a balance: plan for action*. London: Department of Health and Social Security, 1987.
- 3 Working Group on Specialist Medical Training. *Hospital doctors: training for the future*. London: Department of Health, 1993.

Mortality and alcohol consumption

EDITOR,—In our prospective study of mortality in relation to use of alcohol 12 000 British male doctors who had been born in 1900-30 were asked in 1978 what they then drank, and over the next 13 years one third of them died of various causes.¹ After standardisation for age and smoking the mortality from ischaemic heart disease was about one third lower among those who had said that they usually had a few drinks a day than among those who had said that they did not drink at all ($P < 0.0001$).

The higher mortality from ischaemic heart disease among the self reported non-drinkers cannot be attributed to the inclusion of some heavy drinkers, or former heavy drinkers, among them because even the highest category of alcohol use was not associated with any material increase in cardiac mortality. Moreover, for the reasons discussed in our paper, among the "non-drinkers" the proportion thus misclassified is likely to be only a few per cent. David F Marks's suggestion that it might be about 50% is entirely unjustified (especially since the proportion of the deaths among non-drinkers that were attributed to liver disease or cancers of the mouth or throat was only 2% (10/486) and not the 53% (10/19) that Marks calculated),¹ and his redrawing of our graphs should be ignored.

A G Shaper suggests that the apparently protective effects of moderate drinking might be chiefly due to confounding by some factor other than alcohol consumption.² We showed, however, that it was not due to confounding by vascular ill health, smoking, age, or social class and cited evidence that it was unlikely to be due to confounding by diet. Differences between drinkers and non-drinkers in factors such as physical exercise or blood pressure would have to be implausibly extreme to account for a reduction of one third in cardiac mortality. In view of the known beneficial effects of alcohol on some haematological factors that may in turn affect the incidence of heart disease, confounding would seem to be a less likely explanation of our findings than a real protective effect of moderate alcohol use.

RICHARD DOLL
Emeritus professor of medicine

RICHARD PETO
Professor of medical statistics and epidemiology

ICRF Cancer Studies Unit,
Radcliffe Infirmary,
Oxford OX2 6HE

1 Doll R, Peto R, Wheatley K, Gray R. Mortality in relation to consumption of alcohol: 13 years' observations on male British doctors. *BMJ* 1994;309:911-8. (8 October.)

2 Shaper AG. Mortality and alcohol consumption [letters]. *BMJ* 1995;310:325-6. (4 February.)