Edsall and Collins reported that of 13,000 patients in New York City attending for routine follow-up in 1970 approximately 200 to 250 patients were considered to have reactivation of disease. Approximately 80 of these were identified by routine follow-up, the remainder by development of symptoms. All but three of these 80 had other problems for which medical supervision was indicated, though not necessarily in a chest clinic.

Bailey et al. found that in New Orleans in 1965–72, 63 (4%) of 1585 patients added to the register with active pulmonary tuberculosis had reactivated disease. Of these, six had had no previous chemotherapy, three had had streptomycin only, 47 had had combined chemotherapy self-interrupted or self-discontinued, and only seven had had two years’ combined chemotherapy. Adverse influences were present in 41 of the 47 non-co-operative patients—mental illness in six, drug addiction in two, “petty criminality” in two, alcoholism in 31. Of the relapses 60% were detected by the development of symptoms. Pearce and Horne reported on 825 patients treated during 1955–60 and followed up for periods up to 18 years. Most received “triple chemotherapy with PAS, isoniazid and streptomycin.” Thirty-three patients (4%) relapsed, with positive sputum cultures, and in 30 of these cases the relapse was attributable to inadequate treatment as a result of poor co-operation; 58% of relapses were detected at routine follow-up clinics. The relapse rate was lowest in the age group 0 to 24 years (1.1%) and highest in the age group 45 to 64 years (7.2%). The relapse rate in men was 4.9% and in women 2.5%. In these two series the relapse rate among patients who had taken appropriate chemotherapy was very low. In the series reported by Bailey et al. the relapse rate was only 7 out of 1585 (0.43%) and in Pearce and Horne’s series it was 3 out of 825 (0.36%). Of the three co-operative patients who relapsed one had been taking 10 mg of prednisolone for asthma for four years; another relapsed with resistant organisms, probably the result of the method used to desensitize her to the drugs given.

**Time of Relapse**

Reports show that relapse usually occurs within five years of the start of treatment. In Pearce and Horne’s series only eight of 33 relapses were detected more than five years from the start of treatment.

**Attitude of Patient to Prolonged Follow-up**

A leading article in *Tubercle* suggested that “long continued supervision could still be psychologically harmful for the patients. Many, after one and a half to two years of attending clinics, would be delighted to be told that they were no longer patients and need not attend again; that they were healthy people who need not be observed or their lives supervised.” This may not always be true. Patients accustomed to a yearly check do not always welcome the suggestion that they need not attend again. They feel relieved and happy if they are told all is well. However, patients now being treated and not conditioned to follow-up might well be glad to know they need not come again.

**Conclusion**

A third to a half of all relapses are detected by other means than routine follow-up. Except for patients with high-risk factors the follow-up of patients believed to have taken standard chemotherapy as defined for 18 to 24 months is no longer justified. But the discharged patient must be encouraged to return to the clinic if he develops symptoms that might indicate a relapse. It is therefore most important to keep the patient’s general practitioner fully informed and to refer treated tuberculous patients back to the clinic if he has any reason to suspect relapse or if the patient develops any of the conditions referred to under “high risk factors.”

**References**


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**Conversations with Consultants**

**Professional Satisfaction is Still Just Alive**

FROM A SPECIAL CORRESPONDENT

*British Medical Journal, 1975, 2, 29-30*

“My patients have rarely mentioned the dispute,” commented the plastic surgery consultant. “One father was a bit stroppy—I thought because of his son’s delayed operation. But it turned out his complaint was that doctors hadn’t acted militantly so as to end the dispute quickly.” “Some of my patients,” said another surgeon, “were most surprised to hear that I didn’t get paid extra for night work.” The patients of yet another seemed ignorant of the consultant’s row with the Government.

So it seemed unlikely, judged by this group of consultants drawn from a large English city, that public opinion was as yet a significant influence either way on the consultants’ dispute. Indeed, they were emphatic that the extra holidays for nurses (proposed by Lord Halsbury*) had closed more beds and lengthened waiting lists more effectively than their own work-to-contract. Empty beds there certainly were, and the consultants in the area had reduced their work load, with one wife observing how nice it was to see more of her husband in the evenings. Nevertheless, theirs seemed a gentlemanly response to recent events in the N.H.S.**

*No Illusions* They had no illusions, however, about the future. The air of resigned anger with which they criticized the N.H.S. was more devastating than any militant polemics. Four years previously, *B.M.J.* 28 September 1974, p. 762.
an anaesthetist said, all the planning procedures had been completed for a replacement hospital for the scattered E.M.S. buildings with their outcrops of post-war expedient architecture. But then nothing definitive had happened apart from the essential patching up and the occasional addition, and the present financial climate probably meant the end of the plans for the foreseeable future. So the anaesthetist still had his stool by the open corridor door, the 6-ft. 2-in. surgeon monotonously banged his head on the low-slung centre lamp, and spare ward furniture was stored outside.

Judgements on N.H.S. reorganization were by and large reserved on the grounds that it had not had time to prove itself. However, no one saw any real benefits coming to patients as a result of it. One consultant’s experience on an A.H.A. had, however, persuaded him that the area authorities were a superfluous level in the administration. He was almost nostalgic about the loss of the personal contacts he had built up pre-1974 which had enabled him to cut corners and get things done. “Now,” he declared, “responsibility is so diffused through so many committees that you can never pin down who takes decisions.” Resentment against decisions handed down from London was strong. The nurses’ holidays was a case in point. They felt that no administrator at the centre could have had any idea of the effect on hospitals of insisting that the extra allowance had to be taken by a certain date.

No-one was at all enamoured of the results of the Salmon reforms. “Those proposals,” observed the university surgeon, “were supposed to improve the sharp end of nursing: in fact, they blunted the point.” Too many good clinical nurses had been sucked into the administration. Apparently ward sisters were now unable to deal directly with ward cleaners—any instruction had to go via the administration. It was too early to judge, replied one surgeon, whether Lord Halsbury’s improved pay scales to ward sisters and staff nurses would reverse the drain into administration. They all thought that more part-time nurses should be used so as to tap the large reservoir of nursing skills in the community.

Language No Barrier

What about the brain drain of doctors? Surprising unanimity existed about the attraction of the E.E.C. The language barrier was brushed aside: “Any doctor wanting to go will soon learn the language.” “Senior registrars will emigrate unless the Government pays consultants realistic salaries,” warned one young radiologist. The younger brother, himself a consultant, of one specialist was tempting him to Australia with tales of £25 000 a year plus. Yet another of the consultants had just turned down a tempting offer from a continental clinic. He agreed Europe was a magnet—one recent anaesthetic post in Holland had attracted nearly a score of applicants from N.H.S. consultants—but he preferred to work in Britain “Even if Mrs. Castle introduces a whole-time salaried service I shall continue to practise privately in my own time. There is no law against it.”

Neither the whole time radiologist present nor the university employed surgeon were against the part-time contract. Like the others, they saw it as a protection against a whole-time salaried service—and a useful cushion against inflation. There had been no friction with local trade unions over private beds—in fact personal relations with the local shop stewards seemed reasonable. Several of the consultants saw a good many private patients: there were some local non-N.H.S. surgical facilities but the specialist surgeons realized that the scope for their work was limited outside the N.H.S.

Less than a Senior Registrar

A recently appointed consultant who had opted for a maximum part-time contract was disappointed at the slow build up of his private practice. His colleagues estimated that in their part of the world it took about four years to make up for the salary differential with the whole-time post. He had been shaken to discover his monthly take home pay was £100 less than when he had been a senior registrar. His successor was now earning (with extra duty payments) around £7000 a year.

“Of course,” said one, “it was the extra duty scheme for juniors which undermined the consultants financial position.” In his view the powers-that-be saw the juniors’ and seniors’ pay together as career earnings, and if one group had a large increase that meant proportionately less extra for the others. Furthermore, consultants were now called on to do more out-of-hours work than had been the case a few years ago. Present day junior staff were described as more intelligent but less dedicated than their predecessors, and there was some unhappiness about the quality of overseas doctors. A permanent on-call liability was the lot of one specialist as there was no other consultant in his specialty in the area, with little chance of such an appointment because of the budget squeeze. Add the increasing amount of “acting down” duties to falling living standards and a poor working environment and their disillusionment was understandable.

Pay Rise of 100%?

The country’s economic ills were well understood but with the radiologist suggesting that a 100% pay increase was needed to bring them into line with their European counterparts what should be done? This group of consultants were uncertain about what action they would support to improve their lot. Most of them were behind their negotiators, understanding the difficulties faced by those representing them. They realized, too, the possible public reaction to a 40%, rise for doctors and suggested that it might be wise to have some of the overdue improvement channelled into such items as better pension benefits instead of a straight pay rise. The present dispute was degenerating into an undignified semantic struggle typical of an industrial trade union, according to one or two of them. Not one was at all confident that a closed contract would cure their ills. Proper pricing of the existing contracts (with extra pay for some of the “out-of-hours” work) would in their view probably assuage much of the consultants’ discontent.

They acknowledged their 24-hour professional—as opposed to contractual—responsibility to patients, particularly now that junior staff were having more time off. Despite all the frustrations professional satisfaction is still just alive. Their parting shot can best be summed up as: “The Government must recognize how much our good will has held the Service together. It would be foolish of Mrs. Castle to throw this asset away.”