I note that in 1881 more than 61,000 persons were vaccinated in New South Wales. The presence within a community of smallpox is very good propaganda for vaccination.

If, of course, the supply of vaccine became restricted or facilities for its distribution to medical practitioners were curtailed, then I think we might fairly say that sooner or later an epidemic *was* probable. The fact that very few cases of classical or, as some say, African smallpox have come to notice in this country for many years may mean, perhaps *must* mean, that the virus has changed its type and fulfilled Sydenham's saying that epidemic diseases like empires rise, decline, and fall, giving place to others. But the history of scarlet fever warns us to be cautious in prophecy. We had better not boast that deadly smallpox is as extinct as bubonic plague in England.

THE ROLE OF THE PART-TIME CONSULTANT

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This paper seeks to set out the present position of part-time consultants and to discuss the advantages and disadvantages of their present position, with a view to deciding what part, if any, they should play in the medical service of the future.

Some definition of a "consultant" (this word being used in this discussion as synonymous with the term "specialist") is required. Three requisites of consultant status are apparent: (1) specialist experience in the department concerned; (2) postgraduate qualification of recognized standard in the specialty concerned; (3) recognition by other practitioners as being a specialist: a hospital appointment in his branch of medicine will usually be implied. All three criteria should ordinarily be fulfilled, though in certain cases the possession of a postgraduate specialist qualification might be waived. Satisfaction of all three criteria is not inconsistent with the work of a general practitioner.

Outside the largest centres the widespread development of specialization, carried out by full-time consultants, is of very recent development. Even in some large cities it is still found that some hospital consultants practise also as G.P.s; fifteen years ago the custom was more widespread. A large number of medical men with specialist experience and qualifications are at present employed in general practice, the great majority holding hospital appointments and carrying out a consultant or specialist function in the neighbourhood. The bulk of the work they do is very considerable. Their specialist experience is invaluable, and any satisfactory medical service must utilize them fully. This can be done (a) by maintaining their status as part-time consultants, with an assured "place in the sun," or (b) by employing them only as full-time specialists, the use of part-time consultants being stopped. The pros and cons of each alternative are discussed below.

Reasons for Entering General Practice

Why do young specialists (or young men with unusual postgraduate experience) enter general practice? Some of

the reasons, which are many, can be set out as follows: (1) Financial. The doctor, aged 26-30, wishes to marry, and requires a larger income than he can obtain while waiting for a highly paid full-time post or for the development of a remunerative consulting practice. (2) Personal. Not every doctor anxious to do specializing in medicine wishes to devote his life to a city centre, nor does his position as a family man always allow him to do so. (3) The area in which he wishes to practise, or the hospital to which he is appointed, may not be large enough to support a full-time consultant. The specialist experience may be adequate, but the financial returns will not support him unless he undertakes other medical work. This applies particularly to anaesthetists, but to a lesser degree also to physicians and surgeons.

Scope of the Work of a Part-time Consultant

This varies considerably in different centres throughout the country. In surgical practice, in the smaller centres, adequately experienced emergency surgeons may confine themselves to acute abdominal emergencies and a restricted list of routine (set) operations. At the other end of the scale, in the largest centres, part-time consulting surgeons undertake all set operations, with the exception of such special departments as cranial and thoracic surgery. These surgeons devote a diminishing portion of their time to general practice, and many of them as they reach seniority in their hospitals ultimately relinquish general practice for full-time consulting work. But, however much or however little surgery any part-time surgeon may undertake, it will be readily agreed that the total volume of work undertaken by a specialist of this type is very considerable, and also that the qualities he requires for successful practice (i.e., professional excellence, based on training and experience, and a high standard of professional honour limiting him to those procedures within his ability to perform) are precisely those necessary for his full-time colleague.

As the volume of work carried out by part-time consultants is too great for it to be done elsewhere than at present arranged, the next highest medical centres being already worked to capacity, only two alternative futures can be envisaged for them: (1) that they continue to function in their present appointments; or (2) that they enter full-time hospital or consultant practice, replacing hospital consultants of part-time basis.

Supply of Further Full-time Consultants

There is an acknowledged shortage of specialists in all departments of medicine, though this shortage is often masked by bad distribution and shortage of hospital accommodation. Junior consultants waiting for vacancies on the staffs of teaching and non-teaching hospitals throng the large centres. Few hospitals can afford to maintain adequate medical staffs owing to deficient bed and out-patient accommodation. If they expanded sufficiently to deal with their long waiting lists an increase in staff appointments by as much as 30% might be required. The real shortage would then at once become apparent. The medical schools cannot be expected to correct this shortage for at least ten years, and it would seem that the main source of further full-time consultants would be the ranks of their part-time colleagues. If the consultant service is to be widened, as it must be, then either greater use must be made of the part-time consultant or, if part-time specialization is to be discouraged, present-day specialists in part-time practice must be induced to enter the consultant service in a full-time capacity.

Seen from the point of view of patients in rural areas centred on smaller hospitals, three alternative forms of

hospital consultant service are possible: (1) a part-time system, the consultants undertaking general medical work; (2) hospitals with medical staffs headed by full-time salaried specialists; (3) a visiting staff of whole-time junior consultants from larger hospital centres. It is doubtful if the last innovation would give better service than that at present rendered by part-time consultant staffs. Probably full-time salaried posts at smaller hospitals would carry lower salaries and would be regarded by younger consultants as stepping-stones to more important and higher-paid appointments. Such (comparatively) temporary appointments of less-experienced men would be unlikely to be acceptable to the local population, and the service would probably be less satisfactory than that already given by part-time consultants. The probable disadvantages of such a change-over may be listed as follows:

I. Effects on General Medical Standards

(a) With the withdrawal from general practice of part-time consultants a general lowering of the standards among G.P.s consequent upon the loss of the stimulating influence of the more highly qualified men can be expected. Subsequent entrants into general practice will be of a lower average quality, as the entry of men with higher qualifications will practically cease.

(b) *Uneconomic Use of Hospitals.*—With lowering of the standards of general practice fewer cases will be investigated outside out-patient departments. Increasing reference to hospital will lead to overcrowding of out-patient accommodation and longer waiting-lists for admission. Hospitals will thus tend to be used uneconomically.

(c) *Effect on Full-time Consultants.*—As the full effect of the consultant's opinion depends, in fine, on the way his recommendations are carried out, any lowering of the standards of general practice will have an adverse effect on his work. Most consultants will agree that a high level of general practice is very stimulating to the keenness of the consultant and greatly aids him in his work.

II. Effect on Patients

When the doctor-patient relationship is satisfactory at the general practice level the bulk of patients prefer to undergo hospital treatment under their own doctor (or at least under his supervision) or by a consultant of their doctor's choice, especially if the consultant is already known to them. The impersonal atmosphere of a hospital where their own doctor is excluded from practice, and where his place is not taken by a well-known substitute (the old-type private consultant), is a great barrier to persuading patients to accept hospital treatment, especially of surgical type. Introduction of the paid hospital surgeon may easily lead to a failure of the doctor-patient relationship at the hospital level, with disastrous results. Only practitioners who have fought against old-standing prejudices arising from failure of this relationship in days long past realize how strong and malignant in their effects such prejudices can be. One unsatisfactory surgeon in sole charge of a surgical side of a hospital for as long as six months will prejudice the hospital for several years.

The part played by the part-time consultant, especially if he is the patient's own doctor, is of inestimable value here; if he does not perform the operation he may supervise post-operative care. His presence helps to dispel the fear of the unknown and the terrors of an unfamiliar atmosphere, and completely banishes the unreasonable fear of "experimentation" that some patients hold. From the patient's point of view the principle of continuity of treatment is of the utmost value. Where the present system of part-time consultants is working efficiently (especially where they are engaged in group practice around a small hospital) it is possible for a patient to be diagnosed in his own home, fully investigated and treated in hospital, and his after-care and convalescence all supervised by his own medical group, working as a team. The advantages of this contrast markedly with the situation where his hospital care is under-

taken by hospital consultants with no extra-hospital interests, whose concern with patients ends the moment they leave the hospital walls.

III. Effects on Doctors Themselves

All good doctors, whatever their form of practice, feel a very real sense of responsibility for their patients. This, however, varies enormously in different varieties of medical work. In hospital practice it is probably felt most acutely by the part-time consultant in general practice who lives in close touch with his patients, whose lives are intimately his concern. The whole-time consultant who operates feels that the life of a man is in his hands; the G.P. consultant realizes, as well as this, his responsibility for the well-being of that man's whole family. His sense of responsibility is therefore so much the stronger. The full-time salaried hospital surgeon, from his diminished contact with the patient's surroundings, cannot feel the same sense of responsibility.

This sense of responsibility is necessary not only to humanize the doctor's work but to maintain his standards of efficiency. A consultant paid an adequate salary for full-time work will not be stimulated to the utmost effort in the same way as a consultant doing private practice, whose reputation and income depend in large part on his abilities and his willingness to oblige and satisfy the doctors who send him cases.

The adverse effects of stripping general practice of its part-time consultants will not be felt fully until the present generation have retired from medical practice, to be replaced by full-time surgeons and physicians who have had no experience of general practice.

Criticisms of Part-time Consultants

Consultants, whether fully or only partly employed in consultant work, are liable to criticism in the same way as any other practitioner. Part-timers are, however, liable to a special form of criticism from full-time specialists, who look with suspicion on part-time colleagues, who, they feel, may lower consultant status if they are allowed to "creep or intrude or climb into the fold." These criticisms may at times be tainted with professional jealousy, but are nevertheless worth examining. They fall into four main groups.

1. *Unevenness of Standard and Unsoundness of Credentials.*—If the prerequisites of consultant status, set out earlier in this paper, are fulfilled, this criticism will be partly met. Unevenness of professional standard is not a monopoly of the part-time consultant, but is shared by all practitioners, general or specialist. The part-time consultant has, however, in addition to a high standard of professional honour which he should share with all members of the profession (and which should prevent him from undertaking work for which he is not the best man available) the additional constraint of having to live at close quarters with his cases—his successes and the results of his failures alike. All good G.P.s, and probably most G.P. consultants, will agree that this is the greatest and most effective check on any specialist embarking on an undertaking which is too high for him. The full-time consultant and the hospital surgeon, who often know little of their patients and sometimes nothing of the practitioner who referred the case, are not subject to this restraint.

2. *The G.P. Consultant (especially the Surgeon) tackles more than he should, and Consequently makes Serious Mistakes.*—This may be so in certain cases, but the criticism can be levelled equally well at full-time consultants and hospital surgeons, who equally may attempt procedures which are beyond their scope and which should be left to more highly specialized technicians. Once again the part-timer has his two restraining influences: professional honour—not allowing him to undertake more than he can manage—and having to live in close touch with his patient afterwards. The careful selection of part-time consultants who fulfil the prerequisites will go some way towards meeting this criticism, while a closer relation between part-time and full-time consultants (referred to in greater detail below) will add to its abolition.

3. *The Part-time Consultant is swayed by personal Gain (i.e., he Operates for Fees).*—This criticism has been levelled

at all medical practitioners since earliest times, the section of the profession most often so criticized being the full-time consultant. It is of course quite untrue of the full-time consultant, and at least as much can be said of his part-time colleague. The part-timer has, in fact, to be more careful of his reputation for professional skill than his full-time colleague, in view of the vigorous competition which the latter makes. In his own area the part-time consultant has to be doubly careful of his reputation, because if everything does not go well patients are more ready to attach blame to the local man than to the specialist who comes from a distance. This fact is an added inducement to the part-time consultant not to attempt anything beyond his scope.

4. *The Part-time Consultant is Overburdened with Other Work and has Little Time for Reading and Keeping Abreast in his Specialty.*—Unfortunately this is largely true at the present time. His contributions to the specialist service can be so great, however, that steps should be taken to remedy this, possibly by stipulating that his consulting type of work should occupy a fixed minimum number of hours a week, his general work being limited accordingly. In a State medical service the latter could be ensured by limiting the list of State patients of a part-time consultant to a level well below the maximum permitted to a G.P. In certain cases the attachment of part-time consultants to staffs of smaller hospitals as out-patient or in-patient clinical assistants at hospitals on the next highest level will effect the necessary liaison and maintain a level of medical treatment.

The Part-time Consultant and the G.P. Surgeon

None of the remarks above refer to the G.P. surgeon without pretence to being a consultant or specialist who after a moderate surgical experience at his teaching hospital continued operating, mainly on acute abdominal emergencies, throughout his professional career. Valuable as much of the work was, the standard was very uncertain, and it is doubtful if there is a place for surgery of this nature in a State medical service. The occasional surgeon, like the occasional anaesthetist, can be a menace, and it is in the public interest that work of such a responsible nature should be undertaken only by men who have the necessary credentials and experience. It is for this reason that such stress has been laid on the prerequisites for classification of a specialist, however much or however little of his time may be devoted to major consulting work.

Increasing Complexity of Medical Administration

The British Isles, a land with a small surface area, has nevertheless a great variety of local conditions so far as medical administration is concerned. No scheme which fails to take this local variation into account is likely to be completely successful. The most satisfactory scheme will be the one that is fluid enough to allow the preservation of arrangements which have been found well suited to the locality. Thus side by side in any one region we shall be able to find: (1) A full-time salaried medical service (in the Scottish Highlands and Islands Scheme); (2) G.P.s working in health centres; (3) part-time consultants working in group practice around smaller hospitals; (4) individual practitioners working towards the city centre, with its large teaching and non-teaching hospitals. It is possible that in many areas the present medical arrangements are not satisfactory and that certain places served by part-time specialists would do better with full-time consultants, while other scattered areas, poorly served by larger hospitals, would do better with part-time consultants working in group practice rather than calling, as at present, on specialists living 40 miles away. The point to be stressed is fluidity in administration, instead of setting up of hard-and-fast arrangements for universal application irrespective of local needs.

Summary and Recommendations

This paper is the outcome of the experience of a group of five part-time consultants working together in group medical practice, as set out in a former paper. Reference to this previous paper may amplify some of the points discussed herein. The points to be stressed are:

1. The strict fulfilment of prerequisites of consultant status, and the consideration of the part-timer as a consultant who does part-time work rather than as a G.P. who dabbles in the field of the specialist.
2. The encouragement of liaison between part-time consultants and hospitals on the next level. Facilities should be given for their appointment to junior posts of the clinical assistant type (to out-patient or in-patient departments).
3. The realization that if a part-time consultant is to do his best work he must be given every opportunity of keeping in touch with most recent work.
4. The recognition of the principle of fluid administration to meet varying local needs.
5. The fostering of the principle of group medical practice in areas for which it is suitable. Men of high professional attainments with postgraduate qualifications and experience who are willing to undertake general practice should be encouraged to enter these groups and to practise as consultants on the local hospital staffs, working in co-operation with the next largest hospital, as recommended above.
6. It is important that the full-time consultant should have opportunities for private consulting practice. He would thus retain a more personal link with his patients' surroundings than is normally possible from an interview in the out-patient department. This would help to ensure the maintenance of a satisfactory doctor-patient relationship at the hospital level.
7. Finally, the dangers of the full-time hospital surgeon, out of touch with conditions of general medical practice outside hospitals, are stressed.

Medical Memoranda

Rupture of Corpus Luteum of Pregnancy during Coitus causing Acute Abdomen followed by Abortion

The following case report is interesting enough to merit publication.

CASE REPORT

The patient, a nurse aged 33, married 3 years, had had one child, a male 9 lb. (4.08 kg.) at birth, who was delivered by lower uterine segment caesarean section on March 20, 1946, and is alive and well. The menarche occurred at 14. The menstrual cycle was 4 to 5 days every 28 to 35 days, and the last menstrual period was June 10, 1947.

She was first seen at 11 a.m. on July 20, 1947. At 3 a.m., during marital intercourse, she had been seized with sudden severe lower abdominal pain. She felt sick but did not vomit. She was promptly seen by her doctor, who administered 1/6 gr. (11 mg.) of heroin hypodermically without relief. A further 1/12 gr. (5.4 mg.) was given at about 5 a.m. Her menstrual period was 7 to 12 days overdue, but as that was not unusual it had excited no comment. She did not think she was pregnant, as she had had no subjective sensations to suggest that. On being pressed as to any earlier discomfort she admitted occasional vague uneasiness in the region of the left groin during the previous week or so.

On examination the patient was observed to be of light build and short stature. She was pale and restless and complained of cramp-like pains in the abdomen. The pulse rate was 80; the blood pressure was not recorded. The temperature was 96° F. (35.6° C.). The abdomen moved slightly with respiration but was diffusely and acutely tender over the lower segment. This appeared to be rather worse on the right side. There was no definite area of hyperaesthesia or any evidence of psoas irritation. Vaginal examination was difficult owing to severe generalized vault tenderness. Movement of the cervix, which was not noticeably soft, caused severe excitation pain. No palpable swelling was detected.

Twisted ovarian cyst was first considered, but vaginal examination, although inconclusive, seemed to exclude this and pointed either to an ectopic pregnancy or to a ruptured Graafian follicle. The latter was deemed the more probable diagnosis as there had been no vaginal bleeding, and the patient, an experienced nurse, could not