Little can be done to meet the first objection; the number of new patients which any consultant surgeon on the new basis will see will be smaller than that seen by contemporary surgeons; and he will have to undertake more of the less interesting minor items of medical care as well as the more interesting major procedures. Though changes of this kind will occur, they are unlikely to be gross (Table IV). To some extent this disadvantage could be offset by the introduction of a divisional system, within which an individual surgeon could develop a specialized interest, so that cross-referral from one orthopaedic surgeon to another would take place as a routine. The type of National Health Service practice visualized in the future would be more like contemporary private practice, in which a consultant surgeon undertakes all items of patient care, not just the major items. Future consultant surgeons would undertake as many items of patient care as do contemporary surgeons. Their work would be altered in that they would undertake more items of care for each of a smaller number of patients.

The physical difficulties would be met by a readjustment in contemporary working practices and by new building. Instead, for example, of a consultant doing an outpatient session with a registrar, two consultants might work together. Similarly a half-day's operating might be undertaken by two consultants working consecutively, rather than by a consultant doing the major half of the list and the registrar doing the minor half. It is again worth noting that this change would make National Health Service practice more like private practice. Many hospitals in the United Kingdom would have to be rebuilt in order to accommodate and attract a larger number of doctors. Indeed, an adequate hospital rebuilding programme is a prerequisite of the provision of satisfactory medical care and of an acceptable hospital medical staff structure in this country.

The problem of a fall in a surgeon's income from private practice seems to be a major objection to any expansion in the consultant grade. The Treasury is unlikely to increase the National Health Service income of consultants to offset this fall, but what are the implications of changing the method of calculating a consultant's salary to one based on a fee for an item of service? At a salary of £300 per annum per session the work-load described in the earlier part of this paper would be paid at about the following rates: first consultation 7s. 6d.; second consultation 6s. 6d.; an operation £2; night call to a hospital £6. Based on the fees at present charged in private practice in this country and on the fees charged in other countries with developed economies, the following scale of charges would not seem unreasonable: a first consultation £5, a second consultation £3, an operation (including the

inpatient care involved) on average £75, a night call to a hospital including the work (often an operation) required, £75. If this basis is used, the gross income for a consultant surgeon working as proposed earlier in this paper would be about £40,000 per annum, an income similar to that earned by orthopaedic surgeons in North America. If the country were to pay salaries of this order to consultant surgeons possibly the Department of Health and Social Security would find that not only was the work done but that it was done cheerfully. Furthermore, if consultants were paid on an item-of-service basis the market mechanism would be brought to bear on the distribution of doctors between specialties. This might be desirable, since if specialties such as orthopaedic and traumatic surgery (which are understaffed and hence overworked) were therefore highly paid they would be more attractive and hence would recruit additional doctors more easily than at present—when the more overworked and understaffed a specialty becomes the greater the difficulty it encounters recruiting doctors to its ranks.

It is unrealistic to suppose that salaries of this size would, or should, ever be paid in a Government service. On the other hand, were changes to be implemented which would result in a significant fall in average consultant income, the only consequence would be a higher emigration rate. Only one course remains: an increase in the amount of private practice commensurate with the increase in the number of consultant surgeons seeking that practice. Such an increase in the volume of private practice would have the further advantage of marginally reducing the number of patients presenting to the National Health Service for care. If private practice is to expand the present political and administrative attitude to private practice must change: private practice must not be attacked, it must be fostered.

Thus it would seem that if the consultant establishment is to be expanded as proposed there must be significant changes in the attitudes of existing consultants, in the political and administrative philosophy of those responsible for the provision of medical care in Britain, and in the funds allocated to medical care.

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NEW APPLIANCES

Aids to Surgery of Common Duct

Mr. C. PATRICK SAMES, Royal United Hospitals, Bath, writes: The common duct irrigator and suction spoon illustrated here

are complementary appliances. The irrigator is an adaptation of an ordinary Higginson syringe, one end of which is lengthened by

metal adapters and attached to a Eustachian catheter. It is essential that the catheter be of silver and therefore easily malleable, with a nicely rounded tip to prevent undue damage. The sucking-spoon rests naturally in Morison's pouch and its tip fits easily into the foramen of Winslow. It will usually stay in place without needing to be held by an assistant, irrespective of whether the incision is paramedian or Kocher. Stones and biliary sludge fall naturally into the spoon, and the protective cage filters them off, preventing blockage of the sucker.

These two pieces of apparatus have been in constant use by me for the last 15 years. The spoon is procurable through Down Bros. and Mayer & Phelps Ltd.