recommended by the Secretary of State for research projects on the advice of the Health Services Research Committee would thus tend to show that research from general practice is principally funded by this rather than the Biomedical Research Committee.

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GENERAL PRACTICE IN NEW ZEALAND

Sir,
I must congratulate Dr Noble on his excellent article on general practice in New Zealand (April *Journal*, p.211). I too undertook a practice exchange last year from August until December with an Auckland general practitioner and found the experience exhilarating. I was also fortunate to visit the centre in Dunedin at which Dr Noble had been working and was very impressed with all I saw there.

My practice, which was single-handed, was about 15 miles from Auckland and because of this tended to refer fewer patients to hospital than my own practice. There was no practice nurse but fortunately my wife is an SRN. Not having done any minor surgery for many years I grew to like the feel of the scalpel again and I am now doing minor surgery at home here.

Large numbers of patients of all ages presented with sore throats; many of them appeared more or less normal but nearly all expected to be treated with antibiotics and were unhappy if these were not prescribed. I much preferred the New Zealand system of patients paying a fee each time they saw the doctor and gained the impression that emigrants from the UK also preferred the system to our NHS 'free for all'.

A feature of the area in which I was working was the Weekend Medical Centre, built by 30 doctors. Patients do not telephone their own doctor at weekends but contact the doctor on duty at the centre; a nurse is also in attendance. Doctors pay for the use of the centre and also for the nurse on duty, but the fees for the weekend may bring in several hundred pounds. I had two six-hour surgeries from Saturday morning until Sunday at 08.45 hours and saw 119 patients, including 12 visits often at considerable distances and in the hours of darkness, but it was fun!

Like Dr Noble, I would certainly recommend a practice exchange in the delightful country of New Zealand.

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BUTTERWORTH GOLD MEDAL ESSAY

Sir,
It was refreshing to read Dr Taylor's lucid discussion of the merits of better prescribing in his Butterworth Gold Medal Essay (May *Journal*, p. 263).

However, I am sure that the 'carrot' method would be the most successful way of altering poor prescribing habits. At present no general practitioner has any motivation to prescribe fewer drugs or cheaper, equally effective ones, the only control being his conscience and the latest information from the drug firms.

This motivation could be provided by giving general practitioners an annual allowance (say £1,000) if their average monthly prescribing costs were below a figure agreed between the profession and the DHSS. This information could be collected by the Pricing Authority as it is done routinely now.

For an annual outlay of thousands of pounds the government could save millions, but this simple remedy seems to have been missed.

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WHAT KIND OF COLLEGE?

Sir,
At one time it was taken for granted that a medical graduate could enter general practice and only if he wished to specialize did he need further formal training and examination. The explosion of medical knowledge has brought this concept into question, and I believe that in the future a postgraduate qualification will be necessary before a general practitioner can become a principal. If we look back at the birth problems of our sister Colleges, history suggests that our College should take its place as the examining body to ensure standards in general practice. This is what the MRCGP examination should be all about.

We are at present in the uncomfortable transitional period when the majority of practitioners are non-members with resulting voices of dissent both from without and within. Another 25 years will see the end of this problem if we concentrate our efforts in the right direction.

Our efforts must be directed at undergraduates in order to instil in them the ideas of the College from the earliest possible time; so the future rests heavily upon undergraduate tutors. I have heard one fellow say recently that we must attract principals already in practice as members through our activities. I applaud the idea but do not believe it will deliver the results.

Just as most busy consultant surgeons and physicians do not find enough time to attend many meetings, symposia, or undertake research, so the majority of general practitioners will never be highly active in these directions. Many of us, however, can be effective and useful to trainees as we have them with us and among our patients. This is where most postgraduate dissemination of ideas from the College will occur.

What then of the FRCGP? In time to come I hope that this will be given to members who have given long and good service in any aspect of college life including, say 10 to 15 years of active work as trainers in general practice. Fellowship will then be a recognition for services rendered towards ensuring the continued improvement of standards of practice.

Finally, while we are in this uncomfortable transitional period let us not antagonize our non-member colleagues by inferring that we hold the monopoly on integrity and continuing self-censorship and education.

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Sir,
I note with interest your series of articles on the future of the College (March *Journal*). On a recent visit to Britain, which included a stay at the College, I was impressed by the dissatisfaction expressed by individuals regarding the role of the College. All institutions have their fair share of critics, but the