

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

dissatisfaction I heard expressed went far beyond the usual grumbling.

By contrast, the Academy of Family Practice in this country has never been more popular. Many factors may be responsible for this contrast, but I wish to suggest one or two striking differences which may be at least partly responsible for the differences in attitudes.

1. The Academy does not examine candidates for the American 'Boards' in family practice. This is done by a totally separate group in parallel with other specialty groups. Incidentally, re-examination is required every seven years. I realize that the Royal Colleges have a long tradition as examiners and grantors of diplomas but the separation of this task on the American model must surely be worth considering!

2. The College appears to be a rather highly centralized organization. The Americans traditionally are organized at a State level and this federal structure places far more responsibility and initiative on the State chapters. Headquarters happens to be in Kansas City and the organization does not seem to suffer from the fact that it is not located at the national capital. Is the present British structure not too tightly centralized? Does the College headquarters have to be in London?

3. The State organizations play a very real role in continuing education and the annual state meetings are something of a social and scientific occasion to be enjoyed from time to time. The national meeting is a colossal organization, which I personally do not like, but it gives many individuals the chance to visit a new city. The standard of the speakers and the presentation of exhibits and papers are high indeed!

I hope these observations may be of interest to you and the readers of your *Journal*.

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Sir,

At a recent meeting of the South-West England Faculty Board there was discussion about the need to encourage the active participation of more College members. It was felt that this would be best achieved by organizing meetings for members living within a small

geographical area—perhaps a radius of 20 miles. In his recent paper on the future of the College Dr Irvine (*March Journal*, p. 146-153) suggested that more activities should devolve on the faculties, encouraging more local participation.

I have noticed what an administrative burden is carried by the faculty secretary, a fact noticed also by Dr Irvine, who recommends more secretarial help. I believe that the organization necessary to encourage local participation would be helped enormously if the College were to use a computer to register all members (and fellows!); doctors could be registered in categories according to where they lived. At the press of a button, for example, all those in the South-West England Faculty, County of Devon, or those living within a 20-mile radius of Exeter, could be identified. The focal point of each area would be determined by the faculties and would often, I suspect, be the local postgraduate centre.

Such a computer facility would clearly need regular updating, but this need not be difficult. I believe it would be of great administrative help to the faculties; it should prove cost effective, and it would make the organization of local participation much easier.

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## BALINT SOCIETY TRAINEE GROUP LEADERS' MEETING

Sir,

Following our meeting at Oxford last December, we have made some valuable contacts with trainee group leaders in various parts of the country. There have been several suggestions that we should have a further meeting in the autumn to share problems and ideas on trainee group leadership.

We hope to arrange another whole-day meeting at Oxford on Saturday, 4 November 1978. Any suggestions about the form that this meeting should take would be welcome. We propose an initial demonstration group, with trainees brought by their trainers to the meeting. In the afternoon we propose to spend rather more time in small group discussion, concerned with the aims and techniques of leading case discussion groups for trainee general practitioners.

I hope readers will note the date in their diaries and inform any colleagues who might be interested. Meanwhile I should be glad to hear any comments about the proposed meeting and to know who would be interested in attending such a meeting.

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## ANAPHYLAXIS AND THE COMMUNITY NURSE

Sir,

Your recent editorial, "Anaphylaxis and the community nurse" (*May Journal*, p. 261) advises doctors and nurses to renew ampoules of adrenaline "perhaps annually". There is nothing as vague on the box of ampoules that I bought today (30 May 1978). It states quite clearly that the product can be used until February 1980.

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## DIPHTHERIA: A REMINISCENCE

Sir,

When one looks back at diphtheria, it is difficult to recall the worry and anxiety provoked in doctor and patient alike by this dangerous disease.

In the winter of 1920, my brother aged six had a sore throat. The doctor diagnosed diphtheria and sent him to the Southampton Isolation Hospital. He was put on the danger list and we were not allowed to see him. Gifts had to be handed in at the porter's lodge and were either not returned or fumigated. He was given large doses of 20,000 units of diphtheria antitoxin and we were told there was a danger of reaction to the horse serum from which it was prepared. He recovered but was not allowed to come home until he had had three successive negative swabs, because of the danger of the carrier state. Six weeks after his admission, he was declared free from the disease and discharged.

I next encountered diphtheria in 1938, as a student. We were Schick tested and later shown a row of ill patients with swollen necks—the bull neck of diphtheria—who were forbidden to sit