home visiting than some of our general practitioner colleagues.

Is it merely concidence that this reported fall in home visiting has coincided with the increasing influence of the College? If it is not, then it is surely high time that we reassembled our priorities with the accent on domiciliary family care. If we do not, then, as Dr Gray points out, the ensuing vacuum will be filled by others—to the detriment of general practice and our patients.

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OLFACTORY MIGRAINE

Sir,

The incidence of migraine is high and constitutes a potent cause of distress and absenteeism in industry and in schools. Critchley (1975) found that 6·3 per cent of the population suffered from chronic headaches and in general between five and ten per cent of the population are probably affected at some time in their lives, with a 60 to 70 per cent predominance in the female sex (Bickerstaff, 1974).

The origin of migraine is still mysterious, its effects devastating, and it is responsible for loss of more working hours than most of the major neurological or neurosurgical disorders for which curative treatment is available. Management is bedevilled by inaccuracy of diagnosis: migraine is considered a highly respectable disease, while tension headaches—the common differential error—may suggest some personality inadequacy (Bickerstaff, 1974). In practice, diagnosis is not always straightforward, which is not surprising considering the variants possible: classical migraine (unilateral headache, often preceded by sensory disturbance and commonly accompanied by nausea and vomiting), common migraine (less clear-cut and more often encountered), basilar artery, post-traumatic cervical, hemiplegic and ophthalmoplegic types, and periodic migrainous neuralgia. Of significant frequency are conditions sometimes associated with migraine, such as tension headaches, the periodic syndrome of bilious attacks in childhood, increased incidence linked with epilepsy, and some allergic disorders (Bickerstaff, 1974).

The sufferers may be misunderstood and develop secondary anxiety and possibly depression, fearing an underlying neoplasm, other organic con-

Sir,

I am in wholehearted agreement with almost all the sentiments and hopes expressed in the 1977 James Mackenzie Lecture.

I accept that during the past ten years home visiting has declined in both numbers of visits and in the time allocated to them. However, some published statistics indicating a drop in home visits to less than the equivalent of one home visit per doctor per day are far removed from the average number carried out by doctors north of the border.

Table 1 shows our visiting experience in this practice throughout 1977, and Table 2 shows our consultation rates.

We have three partners and a practice list of about 8,700 patients. The ancillary staff comprise an attached district nurse, one part-time health visitor, and a shared bath attendant. All home visits are carried out by the three partners without the aid of a locum or an emergency call service.

Assuming all three partners work 365 days in the year, the total number of visits (6,368) is equivalent to 17·4 visits per day; on a five-day week this is equivalent to 28·3 visits a day and, allowing 30 days' holiday per doctor, this would be 38 visits per day divided among the three.

I am not trying to extol the virtues of excessive home visiting. However, in reviewing our visiting lists we have discovered few visits which could have been eliminated.

As Dr Pereira Gray pointed out in the lecture, we have knowledge of the family environment and members of the family which I am sure can never be provided by snippets of information from various members of the team.

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Table 1. Home visits during 1977.

Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Totals	
N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R	N	R
214	281	229	322	304	416	290	284	220	256	243	296	211	230	240	275	216	301	228	265	211	351	204	281	2,810	3,558
495		551		720		574		476		539		441		515		517		493		562		485		6,368	

N = New visits.
R = Repeat visits.

Table 2. Surgery consultations during 1977.

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
1,721	2,230	2,076	1,884	2,074	1,643	1,621	2,187	2,202	1,886	1,747	1,798	23,069

dition, or a psychosis; not least, they might miss the opportunity of relief by prophylaxis and treatment where possible.

Awareness of precipitants is essential in prevention, with many patients benefitting from their own or anothers' experience, or from expert guidance, with reduction in attack frequency and/or severity. Such precipitants must be sought. Those described include psychological factors, allergies (foods such as chocolate and various wines and cheeses constituting about a third of cases), premenstrual tension, other endocrine changes (including contraceptive therapy, exacerbation in ten per cent of pregnancies and many menopausal sufferers), ill health, fatigue, fasting, drugs, cerebrovascular disease, hypertension, anaemia, arteriosclerosis, and trauma (cervical migraine).

As Bickerstaff (1974) rightly points out: "Other more bizarre causes may be described and such patients must be heeded, for it is, after all, their headache!" From this point of view I have recently noted a number of cases where olfactory stimuli appeared as valid precipitant and therefore potentially avoidable factors. In the Office of Health Economics publication *Migraine* (1972) there is reference to "intense odours or penetrating smells" acting as secondary trigger factors. Sacks (1973) describes an olfactory aura and distortion and intolerance of smells during migraine, often with feelings of *déjà vu* (reminiscent of those occurring in uncinate seizures). A Migraine Trust publication (1975) refers to "smells" under the heading of physical precipitating agents, and Wilkinson (1976) refers to "intense or penetrating smells" and, interestingly, smoking as precipitating environmental factors. Critchley (1975) mentions that for some individuals the atmosphere—humidity, lighting, and dusts—deserves consideration.

Apart from the olfactory aura, olfactory precipitation by noxious smells might be commoner than thought or noted. In the instances brought to my notice, the description "noxious" could be misleading and inappropriate. In fact, these cases were responses to the odour of heavy perfume (both expensive and cheap varieties), the fragrance of certain flowers (particularly freesias), and the smell of cigarette and other tobacco smoke. Repetition of exposure engendered further headaches, supporting the cause-effect hypothesis. Granted it is likely that individuals have a 'migraine diathesis' and odours act as secondary triggers or precipitants, I would be interested and grateful to know if any general practitioner or specialist colleagues have come across similar findings, for perhaps we and our patients are missing the chance of dealing with some of these incapacitating cases which cause such misery.

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A SYSTEM OF TRAINING FOR GENERAL PRACTICE

Sir,

Though less involved now in postgraduate education for general practice I am still actively interested and I therefore took up with keen anticipation *A System of Training for General Practice* by Dr D. J. Pereira Gray. On the first page I read with approbation a belief attributed to Bragg (1975) that among the great priorities now facing all British universities is to improve the critical thinking of all university students. I shall not dwell on the fact that, for me and all the universities I have worked in, this has *always* been an important aim; rather would I thank Dr Gray for the implied invitation, nay, the requirement, to exercise my critical capacities on his paper.

Though a little weary of reminders of the need to decide what I want students to learn before I proceed to teach—the first lesson I learned in my academic career—I commend Dr Gray's summary of relevant educational theory. However, his statement in section 4 of educational aims under Knowledge, Skills, and Attitudes, is marred by lack of definition; though he is reproducing aims contained in a document from the Working Party of the Second European Conference on the Teaching of General Practice held at Leeuwenhorst (1977). I should have expected him to comment first on the evident confusion between knowledge, skills, and attitudes— the meaning of these terms should be explicit—and secondly, on the absence of any quantification of these aims.

Surely it is beyond dispute that there are levels of 'understanding', for example, of what is called 'the basic method of research' and it must be equally obvious that unless the level to be acquired by a trainee is clearly specified, that aim can mean anything. I am therefore disappointed that the Exeter system does not appear to have stated at least minimum measurable levels of 'understanding'. Let me emphasize this by suggesting, for example, that before long, national minimum requirements should be spelled out in terms of factual knowledge so that an improved MCQ component can be introduced as the first part of the MRCGP examination.

At the beginning of the section on methods, we are told that "the Royal College of General Practitioners in promoting the Nuffield course has ensured that 75 course organizers from all over the British Isles have been trained as educators". Will Dr Gray please let us have the evidence for this remarkable claim? Along with others I am still awaiting the results of the evaluation of the Nuffield Course. On the same page we are given another impressive assertion, namely that organizers of vocational training programmes should be *real* general practitioners, real being apparently defined as at least five sessions per week in practice. I agree. So is a real university teacher one who spends at least five sessions per week on academic work? I do not care for the current dogmatic statements about how much time must be spent to be a 'real' service or a 'real' academic general practitioner, I much prefer to judge reality from what I see, hear, or read of actual work done.

On page 13 Dr Gray states that there is inevitable conflict between the educational needs of the trainee and the service requirements of the (hospital) unit. If I agreed with this I would want to ask whether such conflict may also arise in the training practice? Again and again I have heard good hospital consultants argue that this conflict is more apparent than real, indeed I have heard trainees themselves argue that self-learning while doing the job is very much part of a hospital post in a vocational training scheme.

Now I come to the most extraordinary assertion (page 13) that in medical school training the inferred educational message *was* "Your learning comes from famous people, big names, and experts". Either Dr Gray's medical school was very different from the three I have known well (both as a student and teacher) or he has not been in a modern undergraduate medical school recently enough to realize how much times have changed. His reminiscences on page 9 suggest the latter and would be comparable to isolated examples of bad doctor behaviour which I could (but would not) cite from my own early days