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.

MONTAGUE SEGAL
Halifax General Hospital
Halifax
W. Yorkshire.

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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

in practice 30 years ago. Such anecdotal material from Dr Gray contrasts strangely with his own insistence on page 14 that a stimulating atmosphere is ensured by the custom of challenging all statements with the question 'what evidence?' which promotes critical thinking.

Generalizing from very small samples is almost a national pastime, but it can be dangerous. On page 18 Dr Gray makes much of the comments of junior medical staff in the hospital (he does not say how many) of "*a* well-known British medical school". These young doctors are said to have had little time alone with their consultant and in the next sentence this is unfavourably compared with the trainee-trainer situation. I hope he is right but I would be happier with real evidence. Not all trainees have been wholly satisfied with their experience.

Finally, on page 21 we are told that a bank of multiple choice questions is being constructed to cover the syllabus, and an example is given in which the learner is asked to say whether the projected increase in the over-75 population by 1985 is: five per cent, ten per cent, 20 per cent, 25 per cent, or 30 per cent. As MCQ Co-ordinator for the MRCGP examination I have spent much time over several years constructing, recruiting, scrutinizing, testing (through a small panel of experienced general-practitioner examiners), and evaluating multiple choice questions by advanced computer analysis techniques; I feel justified therefore in challenging the validity and relevance of this Exeter question which I hope is atypical (of course if atypical it should hardly have been cited).

I have other criticisms of Dr Gray's paper but let me end by saying how stimulating I found both those parts I endorse and those I do not. I see the efforts of Dr Gray and his colleagues to develop a progressive training scheme as both admirable and impressive. Thus I would hypothesize that their declared belief in the value of criticism will *ensure* (all italics in this paper are mine) an educated and spirited response to my letter, while preserving what I can assure them from my side is a real personal regard. It is through such criticism that we can all hope to improve vocational training.

I. M. RICHARDSON
Professor
Department of General Practice
University of Aberdeen
Foresterhill
Aberdeen AB9 2ZD
Scotland.

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INFANTILE COLIC

Sir,

In recent months we have had many complaints of severe infantile colic not related to organic disease.

In a sample of 75 babies born between 1 January 1977 and January 1978 and still living within our practice area, 48 have been brought to a doctor for medical advice. Routine advice about feeding problems given by our health visitors and at the welfare baby clinic has not been included in this total though many of the mothers and babies have had extensive support. Thirty-three babies (25 bottle fed, five mixed breast and bottle, three purely breast fed) had symptoms sufficiently severe and/or prolonged to warrant a prescription of, most commonly, dicyclomine hydrochloride.

Is this problem widespread with the new infant formulae milks or have we been particularly unfortunate? Some of the babies required many weeks of treatment. Most, but not all of the mothers obtain their milk supplies through the local clinics at reduced prices, so most babies have been given the same commercial brand.

In the original sample of 75, I excluded only two babies from random selection. One child had been in hospital for gastrointestinal disease and one family did not speak English and did not adhere to European methods of infant feeding.

M. L. BOWEN
18 Blenheim Way
Horspath
Oxfordshire OX9 1SB.

RESEARCH FELLOWSHIP OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Sir,

The College has a declared commitment and an organization to initiate, finance, and co-ordinate research in general practice. However, at present, the limited amount of time that practising doctors are able to devote to research is an inevitable restriction on any research project.

With the increase in vocational training schemes there is now a large number of doctors who are familiar with general practice. Not all of these doctors feel ready to join a partnership immediately and many would welcome the opportunity to study various aspects of general practice in greater depth.

May we suggest that the College considers offering a number of research fellowships to its new members? If there was financial support for a year's fellowship with the option to submit an MD thesis, we feel sure that there would be many applicants. To have a number of such full-time researchers would help to consolidate the body of research that general practice needs so much.

SIMON STREET
Oxford Area Trainee Representative

RICHARD LLOYD
Oxfordshire Region Trainee Representative
East Oxford Health Centre
Cowley Road
Oxford OX4 1XD.

BOOK REVIEWS

MEMOIRS OF A SURGEON

Hedley Atkins

Springwood Books, London (1977)
259 pages. Price £3.95

This is a well written and extremely readable book which tells us a great deal about one of the outstanding surgical personalities of our days—Professor Sir Hedley Atkins, KBE, DM, M.CH, FRCS, FRCP.

In it the author discusses, in a humble and witty manner, his family background and early home life, his student days, and his early struggles. He recalls his 40-year association with Guy's Hospital, his 24 years with the Royal