partments. Too much political and financial investment is now involved with vocational training and I cannot see the *status quo* altering.

In research, the College has some very fine departments and their work is well respected. However, as long as resources flow to these departments, they can only be diverted away from university departments, and it is only the latter that are going to train researchers of tomorrow. In my view the College should be solely a standard-setting and policing body (as are the other Royal Colleges), independent of both government and universities.

If we wish our subject to grow and expand, we must invest in and support academic departments and that means that existing institutions must sacrifice some of their empire to this end. I fear that if we continue along our present line of progress, we shall find that we have progressed up a blind alley.

D. W. GAU

The Simpson Centre
70 Gregories Road
Beaconsfield
Bucks HP9 1HL

Sir,

Your Editorial (October *Journal,* p.587) is literally of academic interest to those of us still not yet fortunate enough to have a university department. It prompts me to ask two questions and to suggest possible solutions.

How can the College help those of us without departments of general practice to exert effective pressure on a university which is hard-up and apathetic? What opportunities exist in the UK for those late developers amongst us who, after a period of becoming established in our practices, might then wish to become involved in more academic general practice, yet may lack temporarily the requisite skills and a local centre through which to acquire them?

There is a danger that the present common practice of recruiting junior lecturers mainly from recent vocational trainees may be building up a spurious base of experience for the future in academic departments. The present alternative of having to make huge financial and social sacrifices in order to move to an established department might be deterring a wealth of potential academic talent.

Two not necessarily mutually exclusive strategies might be considered. Already established departments might wish to consider extending their liaison with interested satellites elsewhere in the country, thereby not only broadening their own horizons but meeting others' needs. These departments, possibly co-ordinated through the College, might also consider running modular courses in the relevant academic disciplines for experienced principals who wish to become involved academically, without wanting to uproot themselves from their established practices. This would provide the ideal marriage between academic and real general practice.

RICHARD MAXWELL

'Quarry House'
Charlton Road
Westbury-on-Trym
Bristol BS10 6NP.

Lessons from a Home Visit

Sir,

The value of home visiting has been much debated. I visited a 58-year-old woman who recently had transferred onto the practice list, and who had already been seen five times in surgery with a headache. At that time her old notes had not reached the practice. At the house she was tended by her strained-looking husband and had a cold compress on her brow. She gave a 20-year history of headache following her hysterectomy, and dramatically described pain in the left side of her face and palate, which she said was not relieved by any medication she had ever had. She asked her husband to bring out the drugs she had tried recently.

There were 48 bottles and packets (see Table) containing 1,544½ tablets and three solutions. Apart from a Spanish preparation and two bottles labelled by outside chemists, all were dispensed by two hospital pharmacies and four local chemists. No labels showed the total number of tablets dispensed, but there were only two empty bottles. An estimate of the basic NHS cost of the unused medication (based on the midpoint of 1982 British National Formulary price ranges) was £44, an underestimate of the true cost.

While this home visit did not provide a solution to the patient's problem, it illuminated the patient's symptoms in the context of her family, and demonstrated her poor compliance with treatment. It also illustrated the difficulties in diagnosing and treating chronic headache, which often lead to polypharmacy and multiple referrals. When her notes arrived from the Family Practitioner Committee they revealed that she had attended at least 14 hospitals, and many more departments, with a 30-year history of similar symptoms.

I am grateful to my trainer, Dr S. M. Griffiths, for allowing me to describe a patient in her care.

ANNA LIVINGSTONE

61 Chesterton Road
Plaistow
London E13 8BD.

Drugs handed over by the patient on the home visit

Group of drugs	Number of varieties and doses of drugs	Number of tablets
Simple analgesics	1	1
Mixed preparations	3	40
Narcotic analgesics used in mild to moderate pain.	3	176
Non-steroidal anti-inflammatory analgesics	5	186
Migraine prophylactics	1	19
Barbiturates	1	0
Carbamazepine	2	159
Benzodiazepines:		
hypnotic	3	36
anxiolytic	6	272½
Major tranquillizers	2	62
Antidepressants	4	345
Combined antidepressant and tranquillizer	1	68
Antihistamine	1	28
Antiemetic	1	20
Antibacterials	4	22
Vitamins	2	109
Unidentified tablet	1	1
	41	
Drops for nose and eyes	3 bottles	
Totals	44	1,544½