seem that both general practitioners and receptionists were in agreement with regard to topics for inclusion on courses.

There are various training courses available throughout the country for medical receptionists working in the field. However, AMSPAR is the only body to provide nationally recognized standards to candidates who are successful in their examinations. Bain and Durno[1] indicated, using patient management questions, that standards achieved by receptionists are dependent on both attendance at formal courses and regular in-service training and review. In their report[2] the AMSPAR/RCGP Working Party suggested a model for part-time training, geared to local needs, which could lead to the award of the AMSPAR Certificate in Medical Reception.

In conclusion, it did seem from the questionnaires returned that general practitioners, while willing to send their staff on courses, were unaware of course content. I hope that this letter has gone some way towards clarifying the sort of subjects which are studied on courses and how they may prove useful to the receptionist in her work and hence to the general practitioner in his.

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References

1. Bain DJG, Durno D. Assessment of receptionists by questions on patient management. *Br Med J;* **284:** 1165-1167, 1982.
2. AMSPAR/RCGP Working Party Report. Receptionist training for general practice. AMSPAR, 1983.

Choice or chance? An audit of patients' complaints

Sir,
May I comment on a small audit I conducted in my practice in late July 1984. It was to ascertain roughly the extent people were accountable for their ills, that is, to decide if their sickness was providential, as formerly held, or related to their lifestyle. Thus an insect bite I attributed to 'chance' and alcoholism to 'choice', likewise a man suffering from Parkinson's disease can hardly be blamed for his predicament (boxers excluded) and a sunburnt lady cannot blame others for hers.

To what extent then did 'choice' and 'chance' account for the conditions seen in my general practice audit?

From 100 consecutive consultations I attributed 50 of the complaints to chance and 34 to choice. There were 16 equivocal assignations including four contraceptive Pill repeats and two new pregnancies. The use of the Pill may be considered as choice, but there is an element of risk or chance with sex which gives the patient little choice.

But however caused, the audit only represents that proportion of people who decide to complain. Of what significance then are the motives for consultation? It seems that frequently it was the anxiety the complaint engendered, rather than the suffering it caused. Not the condition then nor the suffering but the fear of its possible implication was the motive for consultation. Patients are often prepared to let an unpleasant condition pursue its natural course if assured of its eventual resolution, but will suffear much anguish from a milder condition if they fear its implications.

Hence some consult while others with the same condition do not, depending on their attitude, and the conditions consulted for in this survey included sore throats, a wart, a sprained ankle, a pulled neck muscle, common colds, an abrasion, a cough, a mild diarrhoea, mumps and insect bites. Yet, knowing the outcome of these conditions, do doctors ever contemplate treatment for themselves? But they often give medication to patients and medicalize an attitude, whereas explanation and description rather than prescription may suffice.

Other choice consultations included dyspepsia from dietary indiscretion, depression while living with a boyfriend because of parental disapproval, paronychia from household chores and a request to rewrite a lost hospital appointment letter, and further chance conditions included repeat consultations for epilepsy, schizophrenia, the Parkinsonism and maturity onset diabetes. But even here the diabetes was really an outcome of long term dietary excess, but let us not go to extremes.

The implications of all this are that whatever the origin, whatever his attitude, much of man's destiny lies in his own hands — he needs to stand on his own feet. The doctor's role is primarily educational (*doctum* = learned), and in fulfilling this he largely fulfills his therapeutic role.

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A nationwide prospective study of epilepsy in general practice

Sir,
A major nationwide prospective study of epilepsy in general practice was launched in May 1984. This is based at the Institute of Neurology, Queen's Square, London, and at the Chalfont Centre for Epilepsy.

Our aim is to study the clinical features and prognosis of patients with newly diagnosed epilepsy, identified at and followed from the time of diagnosis. The success of the study depends on the participation of general practitioners from various parts of the UK. An average practice, with a list size of 2,000, can expect to see about two patients per year with newly diagnosed epilepsy and the doctors taking part in the study will be asked to spend a little longer with these patients to fill in the necessary paperwork of three questionnaires per year for each patient. No other action will be required.