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.

DAVID H. RYDE

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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.

The study will not seek to influence management in any way and strict confidentiality will, of course, be observed at all times.

We are hoping that as many Members and Fellows of the College as possible will take part, as the whole study depends on recruiting enough general practitioners and, on completion, the study will be the first proper prospective study of epilepsy carried out in this country, and will give a lot of information on the natural history of epilepsy which surprisingly is still not known.

Please contact either of us if you are interested in participating.

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## Irish College of General Practitioners

Sir,

I know it will be of interest to your readers and particularly to those who have supported and helped us in so many different ways not least by joining as overseas members, to learn that the new Irish College of General Practitioners has got off to a promising start. Since our official launch on 29 May this year more than 700 general practitioners have applied to join and 600 of these applications have been processed and approved. Our goal of recruiting a majority of the 1800 general practitioners in the Republic of Ireland now seems achievable before our first Annual General Meeting in May 1985. Our confidence that we could overcome the stumbling block of small numbers inherent in launching an independent College in so small a country now seems to have been justified. We acknowledge the part played by the Royal College and its officers in giving us that confidence and contributing to our success.

MICHAEL BOLAND
*Chairman of Council*

Irish College of General Practitioners
10 Fitzwilliam Place
Dublin 2

## Displeased as punch

Sir,

My attention has been brought to your editorial (September *Journal,* p.473) in which you make specific reference to *Punch Digest for Doctors,* one of our medical titles.

I would wish to reply to your comment it is harder to find justification for a special edition of *Punch* as follows.

Over 22,000 UK general practitioners have actively requested future issues of this title and whilst you believe that general practitioners get the press they deserve, we believe that they should get the press they want and request.

Secondly, according to independent readership data (JICMARS), *Punch Digest for Doctors* is better read than any clinical title (including your own) simply because general practitioners receive up to 13 clinical titles which inevitably duplicate each other to an extent but at any rate fragment the time and effort doctors are prepared to invest in keeping up to date and digesting clinical information.

Thirdly, you imply criticism of those titles dependent on drug manufacturer advertising in order to produce this editorial text. Are you aware that *Punch Digest for Doctors* is the only title that allocates a part of its monthly advertising income (£1,000 per issue) to helping those in need as identified by our doctor readers and that we purchase medical equipment, education aids, and help the aged, physically handicapped, mentally infirm and other such deprived members of our society on a charitable basis directly as a result of the press support we receive?

These facts are, we believe, the justification for *Punch Digest for Doctors* and the reasons behind the journal's success. In addition we appreciate that today's general practitioner is being asked to perform a very rigorous job, and a very demanding role. The provision of a little light relief and humour will at least help to counter these pressures or do you believe that there is no place for humour in medicine? If so, perhaps we should instruct doctors not to joke with patients, ban drug representatives from the odd joke with the doctor and exclude all humour from the operating theatre.

I find your attitude somewhat surprising in that your editorial piece seeks to determine the type of medical publication that you believe doctors should receive. I think that our 30,000 or so general practitioner population are quite able to make up their own minds and have consistently been telling all publishers that they would prefer fewer journals and receive only those they want and are going to read.

M.G. HOLLINGSWORTH
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