complete cross-referencing in the Committee on Safety of Medicines' records since 1980 means that several reports may relate to the same incident. Doctors too vary in their willingness or their appreciation of the need to report adverse reactions. In addition, to compare adverse reports for a particular drug the number of scripts issued for the drug in question needs to be known. At present this is based on a 5% sample of all prescriptions issued and does not take into account such factors as dosage, duration or patient's age.

There have been pleas from various sources for more rational prescribing of non-steroidal anti-inflammatory drugs in general practice.[12-15] While the Committee on Safety of Medicines feels that ibuprofen[1] may possibly be less toxic than other non-steroidal anti-inflammatory drugs there is little clear-cut evidence on safety and efficacy when making comparisons among these drugs.

We know that certain patients are placed at considerable risk when a non-steroidal anti-inflammatory drug is prescribed and there are several points which general practitioners should take into account before initiating or continuing non-steroidal anti-inflammatory therapy:

1. Try simple analgesics first.
2. Start at the lowest dose.
3. Think twice before prescribing to an elderly patient.
4. Explain possible side effects to patients and warn them to stop the drug if they occur.
5. Take into account the patient's weight when considering the dose.
6. Counsel the patient on smoking and alcohol and provide dietary advice.
7. Monitor closely renal function and electrolyte balance in patients with cirrhosis, congestive heart failure, renal disease and gout.
8. Monitor blood pressure in all patients, especially known hypertensives, to detect any increase caused by non-steroidal anti-inflammatory therapy.
9. Avoid if possible prescribing to patients with recent peptic ulceration and prescribe with caution to patients with a history of indigestion or peptic ulceration in the past.
10. Do not issue repeat prescriptions to patients without regular assessments.

Of course, concern about the safety of this group of drugs needs to be balanced by an appreciation of the benefits which they provide. It was possible to restrict the use of phenylbutazone only when other less toxic anti-inflammatory drugs became available. Careful surveillance of existing and new anti-inflammatory drugs is required to establish which are the safest to prescribe and general practitioners can contribute to this process by reporting all adverse reactions to the Committee on Safety of Medicines.

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Counsellors in general practice

IT is a characteristic of primary care that people seek help for problems that are physical, psychological and social, and often for a combination of two or three.

How much of general practice work is psychosocial is disputed, partly because of the problems of classification — what one doctor legitimately labels as dyspepsia another can code as depression. Nevertheless, it is clear that the minimum amount of work which is associated with emotional disturbance is about 7%, as this is recorded even by doctors who clearly tend to make organic diagnoses. Some practitioners believe that as many as 30% of the problems that they see are primarily emotional in origin.

Such problems include unhappy marriages, trouble at work, bereavement and unsatisfactory relationships. It was Balint[1] who first threw light on the nature of these problems and the need for general practitioners to be sensitive to them, and his work led to doctors looking more critically at their own skills and feelings and their ability to handle these feelings.

The Balint approach has greatly influenced the development of British general practice and it remains true that a vast number of patients can be substantially helped by general practitioners using skills that in the past were described as brief psychotherapy but which today are increasingly recognized as the skill of counselling. An editorial in the *Journal*[2] in 1980 suggested that counselling was an essential part of general practice and that the skills and techniques it required were specially suited to doctors working in the front line of medical care.

However, as doctors have become more aware of the need for counselling, so counsellors, often with origins as diverse as marriage guidance, psychiatry or social work, have been emerging as professionals in their own right with their own association, code of ethics and methods of work.

As early as 1975, Geoffrey Marsh, one of the most radical thinkers in British general practice, reported the work of a counsellor in his practice.[3] In 1979 Anderson and Hasler helped to define the scope of the job and its potential.[4] The following year, Waydenfeld and Waydenfeld[5] described a more evaluative approach and it was not long before counsellors were emerging in a variety of settings in a variety of practices.

Last year, the College's *Report from general practice 25*[6] welcomed the decision of some family practitioner committees to accept the work of counsellors under the ancillary staff reimbursement scheme (para 5.3) and this brought counsellors, at least in those areas, into the mainstream of general practice.

More recently still, the Government's white paper, *Promoting better health,*[7] signalled the need for general practice to accept a wider range of other professions working within it and there are clear indications that the Government might be prepared to make more money available to remunerate them. This means that counselling is likely to become more common in British general practice, particularly as it offers a non-drug approach to some of the more intractable problems confronting the team.

However, there are often difficulties in establishing a *modus vivendi* between general practitioners and colleagues with different traditions and styles of approach,[8] and practices need to prepare carefully if they are to absorb successfully another member of the primary care team. Each new member inevitably affects every other member and while this can be a substantial advantage in counselling and contribute to greater sensitivity and understanding between team members, it can also mean one more line of communication to maintain and one more person taking part in team meetings. There may also be a temptation for doctors and nurses to opt out of the care of a major group of their patients and this must be avoided at all costs. Another potential problem is that if cash limits do materialize, and if hard competitive choices have to be made between the different health professionals in the primary care team, then awkward conflicts may arise.

All this may make it difficult for counsellors to achieve satisfactory entry to general practice. However, the gains for practice are considerable and these are underlined in a new occasional paper — *The work of counsellors in general practice.* The author, Dr June McLeod, visited 14 practices, where she met and questioned 17 counsellors, and she found that although there were some problems involved in counselling attachments, there were also many advantages for doctors, patients and counsellors themselves.

It is clear that the research carried out so far, culminating in this occasional paper, is enough to justify optimism about the role of counsellors in general practice, and it will be interesting to follow the development of this new discipline in the primary health care team of the future.

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The work of counsellors in general practice, Occasional paper 37, is available from the Central Sales Office, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £3.50 including postage. Cheques should be made payable to RCGP Enterprises Ltd. Access and Visa are welcome.

Epilepsy in the community

THE epidemiology of epilepsy has been studied in many countries, but no marked or consistent regional, racial or social class differences in incidence or prevalence rates have been demonstrated, since different diagnostic and inclusion criteria and case ascertainment methods make comparisons difficult.[1] Most studies show that each year between 20 and 80 people per 100 000 become first-time sufferers of epilepsy, and it can be estimated that about 2–5% of the general population will have at least one non-febrile seizure at some time in their life. The prevalence of chronic epilepsy is between three and 10 cases per 1000 persons. Epilepsy is therefore the most common serious neurological disorder encountered in general practice.

In many developed countries the burden of care of epileptic patients lies with the specialist, either the neurologist or neuropaediatrician. The great strength of the system in the United Kingdom is that general practitioners have an important role and the specialist is seldom involved with the day to day care of epileptic patients or in routine follow-up. This is reflected in manpower statistics. In a typical health region in the UK of about four million people, there will be 12 neurologists and 44 general paediatricians. In contrast, in the United States of America about 125 neurologists will serve a similar population.[2] In this same region in the UK, there will be about 1800 general practitioners, 2000 new cases of epilepsy each year, the same number of febrile convulsions, 800 new cases of single seizures and about 20 000 people with active epilepsy. Extrapolating from these figures, an average practitioner with about 2000 patients may expect to see two new cases of non-febrile seizures a year, and may have 10 patients with active epilepsy and about 40 with a history of epilepsy on his list.[3]

The general practitioner should therefore have a basic understanding of the diagnosis and treatment of epilepsy. He is usually the first doctor a patient presenting with a seizure will see and is therefore likely to be the first to suspect epilepsy. In patients with established epilepsy the general practitioner is, in the majority of cases, responsible for continued medical supervision and prescribing the patient's regular medication. The general practitioner has overall charge of a patient's medical care over long periods and should be able to monitor treatment, side effects and compliance, and should be conversant with emergency treatment. Many patients with epilepsy require psychological support and general practitioners should be skilled in counselling these patients.

Specialist referral is advisable for all new cases of suspected epilepsy, for chronic patients whose seizures worsen or are unacceptable, for patients who develop medical or neurological com-