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.

DENIS PEREIRA GRAY
General Practitioner, Exeter; Professor of General Practice, Postgraduate Medical School, Exeter

References

1. Balint M. *The doctor, his patient and the illness.* 2nd edition. London: Pitman, 1964.
2. Anonymous. Is counselling the key? *J R Coll Gen Pract* 1980; **30:** 643-644.
3. Marsh GN, Barr J. Marriage guidance counselling in a group practice. *J R Coll Gen Pract* 1975; **25:** 73-75.
4. Anderson S, Hasler J. Counselling in general practice. *J R Coll Gen Pract* 1979; **29:** 352-356.
5. Waydenfeld D, Waydenfeld S. Counselling in general practice. *J R Coll Gen Pract* 1980; **30:** 671-677.
6. Royal College of General Practitioners. *The front line of the health service. College response to 'Primary health care: an agenda for discussion'. Report from general practice 25.* London: RCGP, 1987.
7. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health. The Government's programme for improving primary health care (Cm 249).* London: HMSO, 1987.
8. Graham H, Sher M. Social worker and general practice. *J R Coll Gen Pract* 1976; **26:** 95-105.

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-

plications and for patients requiring specific advice such as suitability for surgery.[3-5]

Much still needs to be learnt about epilepsy in the community. More information is needed about the phenomenology of newly diagnosed epilepsy, the temporal patterns of seizure recurrence, the social and psychological impact of epilepsy, and the adequacy of health care provision. A nationwide community based investigation of epilepsy — the National General Practice Study of Epilepsy — was initiated several years ago to address these questions. A network of about 250 general practitioners throughout the UK is currently gathering medical and social information on 1200 patients with newly diagnosed epileptic seizures, followed prospectively from the time of diagnosis. This is the biggest cohort study of epilepsy yet carried out. With such research data, it is hoped to provide a detailed description of the clinical features, management and course of newly diagnosed epilepsy in the community, and to identify patterns of seizure recurrence and prognostic indices. It is only with this sort of data that health care provision can be rationally planned.

J.W.A.S. SANDER

Research Registrar, Institute of Neurology, London and Chalfont Centre for Epilepsy, Chalfont St Peter

S.D. SHORVON

Senior Lecturer in Neurology, Institute of Neurology, London and Chalfont Centre for Epilepsy, Chalfont St Peter

References

1. Sander JWAS, Shorvon SD. Incidence and prevalence studies in epilepsy and their methodological problems: a review. *J Neurol Neurosurg Psychiatry* 1987; **50**: 829-839.
2. Kurtze JF, Bennett DR, Berg BO, *et al.* On national needs for neurologist in the United States. *Neurology* 1986; **36**: 383-388.
3. Shorvon SD. Medical services. In: Laidlaw J, Richens A, Oxley J (eds). *A textbook of epilepsy*. Edinburgh: Churchill Livingstone, 1988: 611-630.
4. Oxley J, Espir M, Shorvon SD, *et al.* The framework of medical care of epilepsy. *Health Trends* 1988; **19**: 13-17.
5. DHSS Working Group. *A report of the working group on services for people with epilepsy. A report to the Department of Health and Social Security, Department of Education and Science and the Welsh Office.* London: HMSO, 1986.

INFECTIOUS DISEASES UPDATE: AIDS

In 1982 the Communicable Disease Surveillance Centre of the Public Health Laboratory Service for England and Wales and the Communicable Diseases (Scotland) Unit set up a national surveillance system for the acquired immune deficiency syndrome (AIDS). Since then these units have received reports, provided voluntarily by clinicians, on all AIDS cases in the United Kingdom. The definition of each case is based on the criteria of the Centers for Disease Control, US Public Health Service and the World Health Organization for the diagnosis of AIDS.

By the end of November 1987 a total of 1170 cases of AIDS had been reported in the UK of which 665 were known to have died. Males accounted for 96.5% of cases and this is attributable to the majority (986) belonging to the category of homosexual/bisexual transmission. There have been 68 haemophiliac patients and 24 blood-recipient cases, of whom eight received infected blood from abroad. Forty-three cases (3.7%) have been identified as having become infected through the heterosexual route, though 34 of this group were possibly infected outside the UK. Only 34 (2.9%) have been directly associated with intravenous drug misuse and half of these were also homosexual. Thirteen children of a human immunodeficiency virus (HIV)-antibody positive or high-risk parent have been identified as having AIDS.

By comparison, the USA had reported 47 298 cases of AIDS; more than any other country in the world. In addition to having a far greater number of cases, there are trans-atlantic differences in distribution of cases within individual transmission categories. For example, 11 371 (24%) have been directly associated with intravenous drug misuse and consequently the proportion of homosexual and bisexual cases is less compared with that in the UK. It is interesting that the proportion of heterosexual cases in the USA (3.9%) is similar to that in the UK and likewise, many of these cases might have been infected in other countries.

These Centers for Disease Control figures from the USA give us guidance as to where we might be heading over the next few years. AIDS in intravenous drug misusers in the UK generally is not a major problem at present but since at 30 September 1987 16% of our 7537 known seropositives were intravenous drug misusers, with the majority from Scotland, it is likely that by the beginning of the next decade we will see a similar trend to that seen in North America. Secondary spread of HIV infection into the heterosexual community in the USA is gaining momentum but this has not yet led to a proportional increase in the number of AIDS cases in this transmission category. In the UK therefore, we are unlikely to see the effect of HIV infection on the heterosexual population for some time. Indeed, there is still the opportunity to minimize such spread by concentrating our efforts on methods of risk reduction for intravenous drug misusers. This should be considered a major priority.

For further information contact: Dr D. Goldberg, AIDS Surveillance Programme Scotland, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB.