psychologist or counsellor. Psychologists do not belong to a profession which is registered by statute. There is no equivalent to the General Medical Council for psychology and therefore there is no definition in law as to what constitutes a 'properly qualified psychologist'; in theory anyone can put up a plate and claim to offer services as a psychologist. However, for many years the Department of Health has accepted that the British Psychological Society is the relevant professional body, incorporated by Royal Charter, to advise the Whitley Council on the qualifications necessary for clinical psychologists to be eligible for employment within the NHS. The society is also listed in the annex to the recent European Commission directive (98/48/EEC) concerned with the mutual recognition of professional qualifications between member states of the European Community as the 'designate competent authority' to determine use of the professional title 'chartered psychologist' by migrants to the United Kingdom.

This title 'chartered psychologist' has come into usage following amendments to the royal charter of the British Psychological Society in 1987 which authorized the society to maintain a register of chartered psychologists. Entry on the register is dependent on the applicant having the relevant qualifications (at least six years of undergraduate and postgraduate education, training and supervised experience in psychology) and agreement to adhere to a code of conduct. Allegations of professional misconduct involving chartered psychologists are considered by a disciplinary committee on which the majority of members are distinguished non-psychologist lay members of the public. A chartered psychologist who is found to have been guilty of professional misconduct may be struck off this register following a hearing of a disciplinary committee. Clause 2.2 in the society's code of conduct requires all chartered psychologists to 'recognize the boundaries of their own competence and not to attempt any form of psychology for which they do not have an appropriate preparation or, where applicable, specialist qualification'.

Regulations for the operation of the register of chartered psychologists permit the use of certain specialist titles, for instance chartered clinical psychologist and chartered educational psychologist. Therefore if a general practice is considering appointing a clinical psychologist we would strongly recommend that only chartered clinical psychologists should be appointed.

The position of psychologists expert in counselling is rather more complicated. Counselling is a service (again not regulated by statute) offered by practitioners from a wide variety of backgrounds including some psychology graduates. Among psychology graduates working in the counselling field, the society makes a distinction between counsellors who (a) specifically apply their expertise in psychology to counselling and (b) those who, though they may be psychology graduates, operate as counsellors without any specific application of psychology. Where psychology graduates in the former category have satisfied this society that they have the necessary postgraduate qualifications and expertise to offer a genuine specialized psychological service as counsellors, they are eligible for registration as chartered psychologists. (Some of these practitioners are adopting the title counselling psychologist, as used widely in the USA, but as yet, within the UK, use of the title chartered counselling psychologist has not been authorized.) Therefore, if a general practice wishes to appoint a counselling psychologist who has specific competence in the psychology of counselling, again we recommend that only chartered psychologists with appropriate experience of counselling should be appointed.

Thank you for this opportunity to pass on this information and advice to readers of the *Journal*.

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An unusual side effect of omeprazole: case report

Sir,

A 73 year old woman who is a known sufferer from chronic obstructive airways disease complained of severe and distressing heartburn. Treatment with antacids and ranitidine gave only a marginal response. She had a barium meal which showed a hiatus hernia associated with severe gastro-oesophageal reflux. She was referred to a consultant physician who started her on a daily dose of 20 mg omeprazole.

She showed improvement in her heartburn and was continued on the same treatment for three months. A home visit was requested because of numbness and paraesthesiae in her lower limbs which had lasted for two weeks. She was a teetotaller and not diabetic. She was on regular treatment with sustained-release aminophylline and nebulized beclomethasone and salbutamol for her airways disease. On examination she was found to be fairly fit and had slight exertional dyspnoea. Her peak flow rate was 200 l min^{-1} per minute (predicted normal 400 l min^{-1}). Sensitivity to light touch in the lower limbs was decreased. The knee reflexes were present but the ankle jerks were absent. Urine analysis by dipstick for sugar and albumen was negative and the liver function tests were within normal limits.

It was thought that omeprazole could be the cause of her symptoms and the drug was discontinued. The patient was reviewed at home after 10 days, when it was found that the symptoms had disappeared. The sensitivity to touch had returned to normal as had the ankle jerks. Since the symptoms had improved on discontinuation of omeprazole, it was considered to be the most likely cause and a report was accordingly made to the Committee on Safety of Medicines.

Omeprazole inhibits adenosine triphosphatase, the enzyme responsible for the exchange of H^+ and K^+ in the final steps of the acid secretory process within the gastric parietal cell. The usefulness of omeprazole in duodenal ulcer, gastric ulcer, reflux oesophagitis and Zollinger-Ellison syndrome has been well established. It is assumed to be a safe drug for short term treatment, and on evaluation of long term therapy has been shown to be without adverse side effects, as when used in the treatment of Zollinger-Ellison syndrome.[1]

Short term studies have shown that omeprazole has no major side effects and causes little or no haematological or biochemical damage.[2] It is likely that the peripheral neuropathy was due to omeprazole therapy which may cause subtle biochemical changes at subcellular level. The causal relationship between the use of specific drugs and their adverse effects is hard to establish. As omeprazole is a relatively new drug every adverse effect should be reported and a cautious approach exercised.[3]

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References

1. Maton PN, Vinayek R, Frucht H, *et al.* Long term efficacy and safety of omeprazole in patients with Zollinger syndrome. *Gastroenterology* 1989; 97: 827-836.
2. Loof L, Adami H, Gustavsson S, *et al.* Omeprazole. No evidence for frequent hepatic reactions. *Lancet* 1984; 1: 1347-1348.
3. Nelis GF. Safety profile of omeprazole. *Digestion* 1989; 44 (suppl): 68-76.