number of women members. As late as 1991, 28 per cent of research ethics committees in the UK (who responded to the questionnaire sent out by the King's Fund Institute) had fewer than 20 per cent female membership and only seven per cent of the committees had equal numbers of women – or a female majority (3). It is in the institutions governing research, and in the way that decisions are made, that the problems lie – and the discrimination is not conscious.

Sherwin, Holmes and Purdy have produced excellent, thought-provoking volumes. What is lacking is a programme for action, but action is impossible without the analysis, which they and their colleagues have provided. We may not agree with everything. But there is enough material here for all of us to be brought up short, and think that a feminist analysis of medicine and medical training is long overdue.

References

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Choices in health care


This Dutch report ought to be required reading for anyone who is interested in health care rationing. It was produced by a committee chaired by Professor Dunning, a cardiologist, in response to a formal request from the government, and is intended as the start of a public discussion. The report, which is available in English, also provided the focus for a resolution of the Council of Ministers of the EEC, during the Netherlands presidency, calling for some collective co-operation within the community to enable national governments to make better choices. Quite where that European initiative will go must be uncertain until it becomes clear post-Maastricht what the content and limits of the European Union's health competence are to be.

The Dunning committee's approach is first to assert that choices are necessary, and will become more so, because scientific and technological advance will generate treatment possibilities faster than our capacity to pay for them. They suggest that there should be a basic package of care, financed collectively, which should comprise only services that meet four criteria. The committee presents these criteria as a series of sieves, each retaining some services that will therefore fail to qualify for the basic package. The four criteria are:

1. From a community viewpoint, is this service necessary in the sense, for example, that it guarantees normal function as a member of the community? Examples include continuing tender loving care for people for whom cure is out of the question, such as the elderly confused and (using Dutch terminology) people who are mentally handicapped.
2. Is this service effective, and is effectiveness confirmed and documented?
3. Is this service efficient, using cost-effectiveness and cost-utility analyses?
4. Is this something that cannot properly be left to individual responsibility?

The idea of the sieves is graphic and conceptually helpful. Personally, I find the first sieve the least clear conceptually. I can understand a sense in which immunisation is communally necessary, but not one in which (apparently) all nursing home care is equally necessary. On the other hand, I was encouraged to hear a member of the committee say that when care had to be rationed the Dutch would ration acute care but not humane care for people with chronic illness. Overall, however, the notion of communally necessary care seems much less clear in the committee's thinking than the other three criteria.

A problem that the Dutch (along with everyone else) will face is that general principles are one thing, specific exclusions are another. In New Zealand there is a national committee at work trying to define core services. Surprise, surprise, it looks as though the core may turn out to be roughly equivalent to the range of services currently financed by the state. Similarly in the UK, once people have proposed the exclusion of tattoo removals and cosmetic surgery, the going quickly becomes rough.

One of the strengths of the Dunning report, however, is that it does take a number of examples of specific services (IVF, homoeopathic medicines, dental care for adults, sports injuries, homes for the elderly) and discusses whether they qualify for inclusion in the core. In the committee's opinion, IVF, homoeopathic medicines and adult dental care do not qualify; sports injuries and homes for the elderly do. Whether or not one is convinced, the book deserves to be widely read. It provides an alternative to Oregon in the staple rationing diet.

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Talking with patients: a basic clinical skill


Students often regard talking with patients as 'commonsense' and may resent teaching which they perceive as belittling. Yet there is ample evidence that the communication skills of young doctors are often seriously deficient. This discrepancy between a student's opinion of his or her skills and reality poses a major obstacle to teaching. Overcoming this requires skill and tact. Talking with Patients falls at this obstacle for two reasons. It is very superficial, dealing with a huge range of subjects in 200 pages with only brief mention of important aspects of relating to patients such as non-verbal communication. More seriously, much of the book is devoted to the data-gathering of traditional history-taking, which is doctor and disease-oriented rather than concerned with the patient and his problem. In this respect the author appears as a new and sometimes reluctant convert to communication skills.

Talking with Patients: a basic clinical skill
The writer's assertion that not all doctors have time, inclination or aptitude to adopt models of patient-doctor interaction as expounded by psychologists such as Balint is counter to the recommendations of the General Medical Council quoted in the preface. There is scant reference to the many ethical problems generated by poor communication. While there is brief discussion of confidentiality and informed consent, difficult areas which so concern students such as breaking bad news, how to request a postmortem, the switching off of a respirator, how to deal with discussions on euthanasia, and 'not for resuscitation orders' receive little or no mention. AIDS, the greatest challenge to communication skills and one which is compounded by ethical problems, receives little more than a single page.

However, there are some gems; the sections on talking to the elderly, and to the dying and especially that on talking to adolescents, are a welcome addition to the literature.

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Race relations: code of practice in primary health care services


The principle of justice, however poorly understood, is generally accepted as an important ethical precept of health care staff. Why then is it necessary for the Commission for Racial Equality to publish a code of practice on race relations in primary health care services? This should, 18 years after the relevant legislation was enacted, in the form of the Race Relations Act, 1976, be part of the culture of the health care services and require little new writing.

The principles of equity and justice are not referred to in the code; the legislation is. It is a sad reflection on the current state of health care ethics if fear of legal consequences produces more action than the underlying ethical principles. The sad fact is that discrimination within the health service as an employer is commonplace with, for example, overseas doctors poorly represented amongst consultants (14 per cent in 1975 rising to 17 per cent in 1981), and discrimination in relation to the provision of care continues.

The cases quoted by the CRE are the tip of the iceberg. Most discrimination is institutionalised and results from a lack of understanding of the needs of ethnic minority patients, a lack of resources to deal with the inequities which arise and in some circumstances a lack of interest. The CRE discusses indirect discrimination in detail, and later provides examples where positive action can help. But it does not address the issue of resources. Who will pay for professional interpreters in primary care, and should they replace staff providing hands-on care at a time when money for staffing of primary care is increasingly squeezed?

The reader will first be horrified by the examples, mostly based on real cases, of discrimination and victimisation. But that is to miss the more important element – the requirement to act positively to prevent inequalities, to gather information on service needs, accessibility and provision, and to monitor health services on the basis of equity as well as cost/benefits. These are all, of course, requirements in addition to those of the NHS and Community Care Act, and to the raft of further work required by the Patient's Charter and the Health of the Nation. But action in primary care is possible: in particular, audit of service access to ethnic minority groups, training of staff on anti-discrimination measures, and a concerted move under the health promotion action to fund the training and employment of interpreters for the primary health care setting.

More fundamentally, the cases described by the CRE clearly demonstrate that the lack of teaching on ethics in many medical schools has practical consequences, and they provide more evidence of the need for formal required training at undergraduate level and within continuing medical education.

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Counselling in general practice


In this book Roslyn Corney, Senior Lecturer at the Institute of Psychiatry and in the Centre for Health Service Studies at the University of Kent, and Rachel Jenkins, Principal Medical Officer of the Mental Health, Elderly and Disability Unit at the Department of Health, present a series of papers on the subject of counselling in general practice. The book is aimed at a readership of general practitioners, counsellors and other members of the primary care team. At the same time a number of the issues examined in the various papers would be of interest to any reader wishing to gain greater insight into, and understanding of, counselling as a function, not just within general practice.

The ten papers by a wide range of contributors, collected together in this book, cover a comprehensive range of issues relevant to counselling in general practice. A clear and concise account is provided of the need for counselling in general practice in order to meet the requirements presented by the high level of psychosocial and psychiatric disorders diagnosed in primary care. In her paper, Nancy Rowland explains what, precisely, counselling is, who it is for and how it differs from a consultation with the GP or any other member of the primary care team. She establishes that counselling is an ethical task, rooted in a code of ethics and practice, which enables the counsellor to create a therapeutic alliance with the client in order to help the client to discover a way to work towards the resolution of problems and find a way of living more resourcefully. In other papers the book presents an analysis of the effectiveness of counselling in general practice and examines methods of evaluation of such counselling. The book presents illuminating papers on the practical issues regarding how to find a well qualified and experienced counsellor and how to go about setting up a counselling attachment. A range of associated issues are discussed in detail and two existing counselling attachments are presented.

Of particular interest is a paper by Rachel Jenkins and Raanan Gillon on the ethics of counselling. This is an