

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

Commission for Racial Equality, London, CRE, 1992, 51 pages, £1.50.

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

Edited by Roslyn Corney and Rachel Jenkins, London, Routledge, 1993, 119 pages, £9.99.

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 psychological 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

interesting chapter in as much as it examines in detail ethical conflicts that might confront a counsellor in his or her practice. The discussion is based on the four principles of autonomy, beneficence, non-maleficence and justice. Although this chapter presents an in-depth examination of those ethical issues of which all those involved in counselling should be aware, it does not focus specifically on any particular issues that might be more relevant to a counsellor working in general practice. A discussion of the four principles with specific reference to a counsellor working as a member of a primary care team might have been useful in the context of the book's focus.

The final chapter looks to the future of counselling in general practice and at its funding, the involvement of Family Health Service Authorities, evaluation, standards and counsellors' training needs.

The message of the book is that counselling in general practice should be made more accessible to people in order that they may be appropriately enabled to deal with their problems and to live more resourcefully.

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Torture and its consequences: current treatment approaches

Edited by Metin Başoğlu,
Cambridge, Cambridge University
Press, 1992, 517 pages, £55.00.

Medical science has been slow to recognise the special needs of victims of torture but over the past decade or so there has been increasing awareness; papers have appeared and treatment and rehabilitation units have been set up round the world, some in countries which have experienced torture and some in countries which have accepted torture survivors as refugees. The effects of torture have often been equated with various other forms of trauma, such as those arising from war, natural or man-made disasters, and child or sexual abuse. While all of these conditions share many features, (for instance, child and sex abuse are deliberate acts degrading another and may be ongoing), each has its own

specificity, and it would be wrong to lump them all together.

Should there then be a new specialty, dealing only with the diagnosis and treatment of torture victims? This question is put by the editor in the introduction to this book, bringing in the unpleasant-sounding neologism 'torturology'. Much space is given to consideration of post-traumatic stress disorder and most contributors agree that, although it is a valuable diagnosis, since it is recognised in major international classifications, and rightly demonstrates that very diverse causes of stress produce similar limited symptom patterns, it does not adequately cover the findings in torture survivors.

Since the editor and most of the contributors are psychiatrists or psychologists, there is a strong psychiatric slant in the book, many of the authors rightly pointing to the need for future research. One useful chapter on physical after-effects and chapters on the psycho-social consequences of torture and on its psycho-biological effects redress the balance somewhat. There are useful chapters on survivors of the holocaust and on the long-term fate of ex-prisoners of war. The predominant flavour of the book is of western experts writing from the safe perspective of their own country. This is helpfully offset by chapters from experts working in some of the countries which have experienced torture, namely, Argentina, South Africa, Pakistan and the Philippines. These, because the authors are able to convey their personal involvement, are the most compelling contributions of all. One aspect which seems to have been given less than its fair share of space is the psychosomatic effects of torture, and there is no mention at all of some, notably stress ulcer or hyperventilation. The origin of these effects needs to be detected but is often missed by non-specialists such as general practitioners or hospital doctors.

When it comes to treatment of the psychological after-effects, there is no consensus. Some contributors consider that mentioning the traumas of the past will trigger uncontrollable emotional distress, while the behaviourists regard recounting of events as an essential part of the therapy.

Altogether, this is a valuable discussion of current research and management of torture victims, of most use to those working in the field. The subject seems not to have been dealt with

previously in so comprehensive a volume.

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Euthanasia and other medical decisions concerning the end of life

P J van der Maas, J J M van Delden,
L Pijnenborg, Amsterdam, Elsevier,
1992, 262 + xvii pages \$160.50.

This investigation was completed in 1991, and a variety of interpretations of its findings have been in circulation. So it is useful now to have the full account in English. This helps to temper some of the wilder claims and counter-claims about the practice of euthanasia in the Netherlands. The book is based on interviews with over 400 Dutch physicians, who also collaborated in a prospective study, and on data related to a sample of around 8,500 death certificates.

It found that in 1990, 2,300 or 1.8 per cent of all deaths in the Netherlands could be classified as euthanasia ('purposeful acting to terminate life by someone other than the person concerned upon the request of the latter') and 400 or 0.3 per cent as assisted suicide. The lives of 1,000 patients (0.8 per cent of all deaths) were terminated without explicit request; and in the case of 22,500 others (17.5 per cent) pain and/or symptoms were alleviated, taking into account a probable shortening of life. Very few patients in any of these groups were likely to have survived for more than a further six months, and many had only days or hours to live. Almost all significant shortening of life was in the further category of decisions to withhold or withdraw treatment, which could equally be described as decisions not to prolong life by disproportionate means.

On initial reports of this investigation, critics made much of the 1,000 'life terminating acts without request'. The book suggests that over half of the patients involved had earlier indicated that they would have wanted their lives ended in these circumstances. Almost all of those whose wishes were not known were terminally ill, suffer-