Now the top place in the stress chart is occupied by ‘problem patients’. Hospital doctors, on the other hand are less stressed by patients; their fight-or-flight reaction is triggered by ugly confrontations with sarcastic colleagues. So what can we do about all this stress? Set goals, write lists, prioritize everything, handle papers only once and try to get rid of time wasters. (No, not you Mrs Smith, always a pleasure to see you, what is it this time?) Part Three takes us on to the key connection between behaviour and stress. I was amazed to discover that most of our stress is due to our aggression; we are short tempered, we don’t listen, we constantly interrupt people, we are over critical and are quick to blame others. Dear me. It seems that many of us are exhibiting ‘Type A coronary prone behaviour’. I don’t want to be confrontational, because that would up my stress level, but wasn’t that a 1970s concept, which was replaced as a major risk factor by low density lipoproteins?

Still, maybe there is something in it, and you will enjoy doing the self-administered test to see if you are Type A or Type B. Then, get the special person in your life to score you and see if you can spot the difference. Driven? Impatient? Perfectionist? Moi?

After the diagnosis comes the treatment. The bottom line is that you must subtly and assiduously try to change your personality. There is a 12-point plan (that sounds familiar) and plenty of useful strategies are recommended. You will not be surprised to hear that they include exercise, deep breathing, less coffee and alcohol, more social support, time with family and the assistance of a friendly counsellor.

Alternatively, you could buy a copy of Dr Tony Copperfield’s collection of his weekly columns in Doctor magazine and have a good laugh. Dr Copperfield’s journalistic persona is the weary down-trodden, hardworking, jobbing GP (or as he would say, sodding GP) who has a gift for venting his withering scorn on all the annoying people who make his stress level go ballistic. Dr Tony hates nurses, counsellors, pharmacists, hospital docs, BMA docs, College docs, warm empathic ‘cardie’ docs; the list is endless. But most of all he hates patients. Tony’s patients are all called Mrs Lard: they are fat, lazy, stupid, demanding, querulous and litigious. I’m sure you will recognize them and in the darker recesses of your soul you may hear yourself cheering the good doctor on as he mercilessly chastises them. Tony is aggressive, outrageous, vulgar and fearless. He is also extremely funny. In his fantasies he inflicts all sorts of punishments on the heartsinks who infest his Essex surgery. The thought of a meddlesome toddler getting his fat little arm stuck in the sharps container fills him with joy. He has the deepest loathing and contempt for all forms of health promotion and interference with the doctor’s autonomy. But can he really be so savage and uncaring? I suspect that the real Tony is a very sweet doctor who is adored by his patients. And by the three nurses, who in one of his fantasies, take down his trousers and spank him with a cricket bat. At least, I think it’s a fantasy, but you must judge for yourselves. I am prescribing this book as Step One in your de-stressing programme.

JOHN SALINSKY
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Doi: 10.1093/fampra/cmg625


This new book, which unashamedly focuses on the needs of GPs, will strike a chord with anyone who is involved in developing and supporting doctors. It boldly goes into those areas that are seen as ‘difficult’ by those undertaking the formal appraisal process currently being introduced into general practice in the UK.

Supervision is seen as the act of “looking after people rather than looking over their shoulders”. Somewhat less catchy, it is defined by the editors as “facilitated learning in relation to live practical issues” and is characterised by non-judgemental reflection. This activity is well-illustrated by a good practical example of how a narrative-based approach was used in a small group setting to enable the learners to gain a deeper understanding of the attitude of a 15 year old pregnant girl presenting herself for the first time, but seemingly more concerned about her clicky jaw than her pregnancy.

As you will already have gathered, this book is strong on educational theory and spans a whole range of relevant educational activities, from Balint groups, through mentoring and co-tutoring, to the application of supervision in vocational training and higher professional education. Perhaps it is this very broad span that left me with a slightly dissatisfied feeling of having visited the table and come away with less on my plate than I had hoped. The chapter on psychotherapy and counselling felt somewhat out of place, whilst there could have been more use made of the wide experience of clinical supervision in nursing. The focus on practice nurses, in the helpful chapter on nursing supervision in primary care, seemed unduly narrow and a greater exploration of the impact of clinical supervision in nursing more widely would have been useful.

Having said all that, I can’t help feeling that this book has missed a trick. The area that is crying out for this type of approach is ‘GP appraisal.’ Anyone who has ever sat with a colleague from general practice to discuss their development is acutely aware of the pastoral need such an encounter invariably uncovers. Supervision has the potential to fulfil that need. In that context, I found the few pages devoted to the relationship between supervision and appraisal the most disappointing part of this book. The suggestion that appraisers should
be trained in the techniques of supervision is a good one, but does not go far enough. For appraisal to meet the needs of the individual doctor, these techniques should be employed as part of every appraisal interview.

**GEOFF ROBERTS**

*GP Trainer, trained appraiser with several years experience in assisting doctors and other professionals in developing their own personal development plans; Clinical Lead at the Modernisation Agency and performance assessor for the GMC*

Doi: 10.1093/fampra/cmg626


This unpromising title covers an interesting book about counselling in primary care. The author is an experienced counsellor who works in a general practice and is schooled in the technique developed by Carl Rogers and here described as the person-centred approach (PCA)—the discipline in which at least a third of all primary care counsellors in the UK have been trained.

Counsellors have been generally welcomed as useful recruits to the primary care team even though, at first, many GPs had very little idea about what they actually did. It was just good to have someone around who might be willing to take on some of those distressed patients who seemed to want more than was otherwise on offer. Counselling has become a more regulated profession in recent times and even though this may increase the confidence that people have in the professionalism of counsellors, it can at times still be hard to understand what actually they do.

Counsellors have often found the high throughput and pressure of general practice inimical to the open time-consuming approach in which they are schooled, to allow the client enough time and space to work in depth with their problems. Many practices ask their counsellors to accept a limited time engagement with their referred patients—perhaps seeing them for not more than half a dozen sessions—to enable a greater number of referrals than might be possible if the counsellor were to work in greater depth but with only very small numbers. But there is good evidence to show that working with a time-limit may bring its own pressure on the client to achieve more in the few sessions that are available than might happen in a more leisurely setting.

So here we have a book that gives a lively account of what the experience of time-limited PCA counselling in primary care really feels like. After a short introduction to the background and theory, the text comprises of a detailed description of six sessions with one client, described from the viewpoint of the counsellor, and including some supervision sessions about the case, where the supervisor is also PCA trained.

The client is a stressed out young woman who has lost her energy and ability to cope at work. The counsellor gently helps her to explore her troubles, to express upset and to cry about her lot. Then without offering any advice or working towards specific goals, helps her work out what to do about her life. Inevitably as I read the story, I was itching to edge her into other areas, but the counsellor was extremely effective in allowing the client to set the agenda and make the pace in the limited number of sessions available—a topic that is discussed further. This is a book that illuminates the practise of counselling in a subtle and feeling way. It is a good read.

**OLIVER SAMUEL**

Retired GP in London

Doi: 10.1093/fampra/cmg627


Health care systems, whether private or national, face increasingly tough budget allocation choices. As such, physicians and policymakers who are charged with making these decisions will find Dr McCulloch’s work timely and useful. According to the preface, this book intends to introduce medical doctors to the spectrum of issues associated with health care valuation. If its mission is to provide an unbiased and complete explanation of approaches, this text fails. However, it does present a thorough, understandable exploration of one set of tools. The recurrent theme is that health care resources are limited, so choices must be made. The tools we have for valuing medical interventions are imperfect. However, according to Dr McCulloch, they are better than the inconsistent, nonsystematic approaches we currently use. Hence, he strongly advocates adopting such tools for public health policy.

The first chapter reviews several methods for valuing medical choices more effectively, with an expressed bias for cost-effectiveness analysis. The next three chapters cover the concept of quality-adjusted life years (QALYs) as a measure for the effectiveness of a health care intervention. After concluding that QALYs are a sound, if imperfect, approach to valuation, Dr McCulloch details measures of health care related quality of life, then reviews the construct validity of two such scales. Most of the remainder of this text presents examples of applications of the QALY measure in medical situations—specifically, a comparison of cardiac interventions, and a discussion of the cost-effectiveness of Alzheimer’s disease treatments.

Dr McCulloch is an economist, not a physician, and at times I felt that his analysis of health care decision-making