number of counselling styles that includes motivational interviewing. It is intended to be realistic within the time constraints of primary care; indeed the authors view short consultations over a long period as an advantage.

Each chapter covers one of the stages of change and suggests techniques to use with individuals at each stage. The authors acknowledge that this division is for convenience only and that in reality the approach will need to be somewhat more fluid. The book successfully describes the counselling model without using jargon. The text is interspersed with case studies and examples of dialogue that illustrate how the techniques can be applied. Although every attempt is made to be practical, I found that this dialogue made the text disjointed and was therefore tempted to skip it, which detracts from the whole point of the book. This is a difficult subject to address in a text, and I feel that there is really no replacement for acquiring these skills in a setting where there is an opportunity to practice. However, the book should provide new insight and ideas on how to improve the quality of lifestyle interventions. We know that the public want such help and regard doctors and nurses as credible sources of lifestyle information. This book should help practitioners review their practice and improve the quality of such interventions.

HELEN MOORE
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Narrative based medicine: dialogue and discourse in clinical practice. T Greenhagh, B Hurwitz (eds). (304 pages, £19.95.) BMJ Publishing Group, 1998. ISBN 0-7279-1223-2.

When we practice medicine, we should listen to the stories that our patients tell and offer our understanding. Or we should help our patients re-tell their stories in a way that both patient and doctor can agree to be useful in understanding what is happening. Or we should help distressed patients write down about themselves, so that they can feel some fulfilment in knowing that at least what they have written will live on after them. There are so many different ways of hearing and understanding the developing sagas that patients and their carers experience. The editors of this interesting book clearly feel that it is time to wrap some academic respectability around the activity that every true clinician enjoys more than any other—that of listening to patients and struggling to make sense of it all.

This book is published now in order to promote this old-fashioned stuff about essential listening skills in facing up to the current highly fashionable vogue for evidence-based medicine (EBM). Politicians and health economists are already looking to EBM to rationalize the use of scarce resources and to clinical guidelines to control clinicians' profligacy. We need this well-presented case, which argues for clinical freedom and idiosyncratic but highly personal professional caring.

Each of the many contributors to this volume approaches the task from a different point of view. Patients describe their experience. Physicians, surgeons, GPs and psychiatrists all have a turn and we get ethical, legal, electronic and anthropological angles in short succession. It is impossible not to find sections that are a joy to read as well as having plenty with which to argue. Ruth Richardson's wonderfully eerie envoi ends the main text in yet another totally different shift of gear.

It all makes for a stimulating, thought-provoking polemic, ending with important chapters by each of the editors and arguing for the prime place for narrative within clinical practice in a working relationship with epidemiology and scientific research. But I wish they had given more space to how you teach all this to young doctors trying to work under intolerable time pressure. The recommended reading lists of the classical literature are fun but a long way from where most exhausted youngsters are. I think that the next generation will need to re-invent something like a Balint group in which they can work out still newer solutions for themselves.

OLIVER SAMUEL
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Stories and their limits: narrative approaches to bioethics. Hilde Lindemann Nelson (ed.). (304 pages, £13.99.) Routledge, 1997. ISBN 0-415-91910-X.

'I want to tell you a story about . . . '. In traditional medicine, we discuss cases that we see and hear about down a corridor, over coffee, during breaks in medical meetings with our colleagues as well as more formal presentations. Hopefully, we learn from these and apply evidence-based medicine to our practice. How important are these stories in the current climate where randomized controlled trials and meta-analyses are the kings?

Bioethics is not a field littered with randomized controlled trials, but an opportunity to discuss and evaluate the role of narrative in changing and developing practice should not be overlooked in the heady rush to purer science. Many of the most important teachers in world history taught through stories. This has not been ignored in current medical education. Professor Kathryn Montgomery Hunter (an author of one of the chapters in this book) highlighted in her research almost 10 years ago the extent to which professionals learnt from stories.

Stories and their Limits is well constructed and referenced and has chapters written by many of the most

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eminent American leaders in the field of medical ethics. It starts with an introduction from the editor Hilde Lindemann Nelson, who provides a guide for the rest of the book. Narrative bioethics emerged only 10 years ago and is still in its infancy. This book describes its benefits, potential hazards and limitations. It appears to be comprehensive and provides a welcome balance of opinion and supporting evidence.

The book finishes with a chapter from James Childress posing the question "narrative or 'norm'—which is the best?" The conclusion is that both have value and importance in helping clinicians and the general public to be aware of and understand the importance of medical ethics in clinical practice. For example, does it matter whether it is the doctor, nurse, patient or relative who tells the story of an ethical dilemma? How do stories compare when told by different people? How do the stories of similar ethical dilemmas compare? Do they help in understanding and development for individual clinicians?

If you are looking for a beginner's guide to medical ethics for yourself or students, then please look elsewhere. However, if you want a book that indicates the relative values of stories and their manifold learning opportunities in medicine and especially bioethics, this may well be the book for you. It is well written, well referenced, well laid out and reasonably priced.

STEPHEN HOLMES
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Injury in the aging. MA Horan, RA Little (eds). (376 pages, £65.00.) Cambridge University Press, 1998. ISBN 0-521-62160-7.

This book was obviously written by a team of highly intelligent people who know a lot of detailed stuff about human physiology. I'm afraid it gave me the feeling that I had been sitting in the wrong lecture theatre. (What an admission from a "specialist family physician".) Proper science, to be sure, does not always provide handy answers to common problems. Scientific enquiry often generates more questions than answers and this is demonstrated by this book.

Putting my impatience to have clinically relevant facts aside, I found there were several concepts that help me with my daily practice. The idea of 'the wound' as a separate organ was an imaginative one. It made me more aware, in the elderly patient context, of the need to put down my antibiotic prescribing pen to consider what other processes are going on that might cause rubor, dolor and calor in a wound. I was reminded too of the relative cardiovascular robustness of the 'old elderly': those active elderly who make it into their 8th decade. This group would seem to benefit from intervention with regard to hypertension, and lipid and thrombolytic therapy, and withholding treatment on the basis of age alone would seem to be a great injustice.

The chapters on various aspects of clinical management of the injured captured my attention far more effectively than the preceding 16. I shan't say how long it took me to slog through the first part of the book, but, to be fair, the concepts of detailed physiology (general, of injury, related to the elderly), are perhaps now more familiar for having taken the trouble to do so.

I found the line diagram in Chapter 17 to be a useful 'mind map' for the concepts behind the additional measures which need to be considered when resuscitating or anaesthetizing the elderly. A picture can be worth a thousand words and never more so than here. The chapter 'Burns in the Elderly' was wonderfully short, yet left me with the feeling that I could roll up my sleeves and start dealing with incoming wounded with occasional references to the text.

The enduring impressions of this book are that the first two-thirds is extremely difficult to read and the remainder is written with more rounded, fluent language. The first part is left cerebral hemisphere stuff: analytical and critical, with a barrage of acronyms and physiological terms (half forgotten by this reader). The last half dozen chapters made me reflect on what I did, and what I could have done better during my time on the rehabilitation wards during my hospital jobs.

Quicker discharge dates and the concept of "hospital at home" seem to be gaining favourable outcomes, as well as social acceptability. As a GP in a small provincial city in New Zealand, I can see that rehabilitation of the elderly at home will become an increasing part of my workload.

TOM JAMES
GP in Gisborne, New Zealand

Injury prevention: an international perspective. P Barss, GS Smith, SP Barker, D Mohan. (390 pages, £42.50.) Oxford University Press, 1998. ISBN 0-19-511982-7.

Injury epidemiology: research and control strategies (second edition). LS Robertson. (275 pages, £35.00.) Oxford University Press, 1998. ISBN 0-19-512202-X.

These books produce an acute awareness in the reader that both intentional and unintentional injury are not 'assaults' or 'accidents' but phenomena with many similarities to infection. The aetiological agent for injury is energy which has a 'vehicle' (motor car or firearm) analogous to the carrier or vector of infection. There are also predisposing and protective factors in the 'victim' (host) and environment. Both books require the reader to change how he/she thinks about trauma. Injury does not 'just happen', but is amenable to study, understanding and intervention.

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