informative journey. He sees many advantages in the old type of psychiatric care but does describe the blacker side of the coin and acknowledges that many asylums in the British Isles were not pleasant places. He says the conventional things about asylums being oases of peace and places where the abnormal and disabled could live safely within their own limitations and be treated with tolerance and understanding. He also comes up with the old chestnut about padded cells, claiming that most patients in padded cells were placed there at their own request because that is where they wanted to be.

My own experiences do not confirm this story and my memories of padded cells is of patients often screaming to be let out and exhibiting serious signs of fear and distress. In many hospitals in which I worked tolerance was also in very short supply.

There is little discussion of present day practice and the advantages and disadvantages of care in the community. Dr Blockey certainly regrets the disappearance of the old asylums and I think this is rather sad. They were not good places and community care with all its warts still offers a much better deal to the mentally ill and distressed. It would offer an even better deal if it had not been poisoned by political dictate and dogma, coupled with a delusional belief that providing care in the community is cheaper than keeping open large psychiatric hospitals. Our political masters should know that the old asylums were extremely cost effective while remaining destructive of the individual.

I enjoyed reading *Asylum Days* and I would recommend it as a book for the holidays.

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The Nature of General Medical Practice. Report from General Practice 27. 1996. £8.80. Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU

This report is the outcome of a working party, set up in 1995, which aimed to clarify the essential content of general medical practice in light of recent changes which many regard as threatening its continued existence as a separate discipline.

Concerns have been expressed that the public health role demanded by the 1990 contract which links remuneration to achieving immunisation, cervical cytology, and health promotion targets, clashes with the personal doctoring role which aims to help individuals to make informed choices, including the option of declining preventive interventions. Fundholding and involvement in commissioning secondary care services has involved GPs in deciding, in a cash-limited NHS, who should receive expensive services and who should not, a rationing role which clashes with the role of advocate for each and every patient in helping them obtain the care they need. Meanwhile, the development of practice nursing, nurse-prescribing, and the increasing tendency for other health professionals to be found working from general practice premises, threaten to make inroads into work which has previously been the preserve of the GP.

The report states that general practice has begun to be portrayed as a place of work or a venue for a team rather than as a clinical discipline. It claims that the strengths and values of the individual disciplines that make up the primary health care team are being overlooked, deliberately blurred, or made insufficiently explicit.

Sections include an overview of the history of health and illness, to provide a context and educational framework, the need for a clinical generalist in first-contact care, the issues listed above which have placed stresses on general practice in the 1990s, the range of clinical competencies required, and the results of a consultation process designed to move the definition of the essential content of general practice forward.

The report highlights the need for a clinical generalist trained in diagnosis in primary care, where the predictive significance of symptoms is different from specialist practice. A generalist must have high levels of competence in areas of high usage or high risk and adequate competence across the full range of clinical skills. (Thus from the psychiatric perspective, GPs should be competent in managing the minor depressive and anxiety disorders common in primary care, and be able to recognise when someone is seriously ill enough to require specialist psychiatric services.)

The report cites the available evidence suggesting that it is cost-effective to keep patients away from expensive specialists unless secondary care is appropriate. (This implies for example that, while community mental health teams should be welcomed onto general practice premises in order to facilitate consultation and liaison, they should remain secondary care services accessed via GP referral rather than by direct self-referral in most cases.) Psychiatric nurses, counsellors, social workers, and community medical specialists, are all classified as separate from the "generalist care team" of doctor, nurse, and practice manager.

The report has been criticised for stopping short of making specific recommendations on whether GPs should involve themselves in population medicine, management, and purchasing,

or stick to providing services to individual patients. It also fails to define how far delegation to nurses and other professionals should be permitted. However, it does state that rationing decisions should come from a politically accountable group who share the ground rules openly and review them regularly. It serves mainly to underline the need for accredited clinical generalist clinicians in primary care – obviously a prime consideration for the Royal College.

It concludes with a plea that those who see only an organisation in general practice should look again for the health of the clinical disciplines that give it its life and primary purpose, whilst those who see only clinical disciplines should appreciate that health promoting organisations need good management. Some of the issues with which GPs are struggling will resonate with psychiatrists working in multidisciplinary community mental health teams.

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Psychiatric Emergencies. By S. MERSON & D. BALDWIN. 1995. Oxford University Press. Pp. 122. Hb: ISBN 019 262 4784; pb: ISBN 019 262 4776.

Liaison between Accident & Emergency staff and psychiatrists is often poor and fraught with misunderstanding and frustration. Casualty staff often appear to lack understanding of the medical approach to psychological and behavioural disturbances and the role, limitations and constraints of psychiatric services. Psychiatrists may appear to offer little in the way of practical help or advice to a beleaguered casualty department.

This is one of a series of handbooks in emergency medicine whose target readership is the staff of Accident & Emergency Departments. It will also interest general practitioners and junior psychiatrists. The juxtaposition of the words concise, practical and psychiatry may come as a surprise to non-psychiatrists and medical students but this book combines all three most successfully, providing a clear practical approach to a wide range of problem symptoms and behaviours. Reading it evoked memories of nights spent as SHO on call for psychiatry wishing that I had such a book to hand.

The book is laid out in three sections covering general principles of psychiatric history taking and examination, clinical problems and practical procedures in psychiatry. The chapters are short and self-contained and where possible information is presented in lists or flow diagrams.

The first section reminds non-psychiatrists of the basis of clinical psychiatry and provides guidelines for making adequate referrals to specialist mental health services. The final chapters provide clear, if limited, accounts of common drugs used in psychiatric practice and use of the Mental Health Act. Both sections provide useful summary information and a good basis for teaching.

The middle section approaches clinical problems in psychiatry as symptoms rather than diagnoses. It is comprehensive and does not avoid difficult areas such as 'manipulative' behaviour, Munchhausen's and social crises. The argument for including this last as a psychiatric emergency is well made and illustrates the essentially helpful and practical approach evident throughout. The importance of the therapeutic relationship, transference and counter transference issues are discussed in an easily accessible way. The thought and work which went into discussion of these difficult topics are belied by the clarity and brevity of the prose.

The layout of the chapter on drug withdrawal and intoxication was a little disappointing. Although careful reading reveals much useful clinical information, it is well hidden and makes no mention of commonly used synthetic drugs such as Ecstasy (MDMA). I would have welcomed lists of common drugs of abuse with the corresponding symptoms and signs of acute intoxication and withdrawal. The chapter on psychotropic medication will be, I imagine, frustrating for non-psychiatrists, as it gives no examples of antidepressants or neuroleptics other than clozapine. A few key references as a guide to further reading would increase the appeal of the book for junior psychiatrists.

This book will be of interest to psychiatrists involved in teaching junior psychiatrists, medical students and casualty staff. As a background to tutorials and local protocols it should improve the management of psychiatric problems in casualty and the quality and appropriateness of referrals.

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The Facts About Alcohol, Aggression and Adolescence. By N. COGGANS & S. MCKELLAR. 1995. London: Cassell. Pp. 126. £10.99 (pb), £35.00 (hb).

There is a growing world-wide concern about the health, welfare and economic productivity of adolescents and youth. In the UK, the problems of young people are appearing increasingly on the Government agenda and special areas targeted as health priorities include health promotion, health education and the identification and management of mental health problems. The tragic consequences of drug and alcohol misuse feature prominently in the media and the problems created