description by each team member as well as by the author, who was in charge of research and development. The headings under which the assessment procedure was carried out are listed in detail. Some problems could be quantified, as in the case of the lady who screamed a good deal (baseline: 102 screams in a 2-hour period); the lady who banged on the table; the lady whose knees were stiff; the lady who needed a hearing aid; the lady with untreated diabetes, and the lady with unrecognised parkinsonism associated with a recognised dementia. Examples are given to illustrate the success of care in such cases.

The principles involved in 'single case experiments' are well known. In general, it is difficult to standardise the procedures in order to make comparisons. The demonstrable results (as in the examples mentioned above) come from undoing past neglect. Maintaining improvement is just as important but less easy to measure.

The authors therefore had problems with quantifying their system and provide no scales or statistics. They do not provide references to quantitative research into similar projects from the 1950s to TAPS, nor mention clinical audit, perhaps because they do not seem to know the highly relevant psychiatric literature. They do, however, cite a few of the excellent social work studies (with which psychiatrists should be more familiar) and correctly point out that the creation of mental health information systems should make routine evaluation easier.

Apart from its heartening illustration of the resource and energy with which people can tackle difficult problems when starting, as they think, from scratch, the booklet illustrates two sadder facts. The real skills and real knowledge acquired during the early postwar reform period in the best mental hospitals has only rarely been handed on to the present generation of carers, whether in residential or in non-residential settings. And the ideological and administrative divide that opened between the health and social services after the Seebohm Report seems as difficult to bridge as ever, on the brink of transfer of responsibility for community care from one to the other.

JOHN WING

Research Director
Royal College of Psychiatrists

The Royal College of Physicians of Edinburgh: Continuing Medical Education for Trained Physicians. RCPE, 9 Queen Street, Edinburgh. 1992. Pp 14.

This is a very valuable succinct report on issues that will affect all practising doctors. Although directed at a non-psychiatric service, it is clearly of relevance to psychiatry and especially to those involved in the supervision of audit and postgraduate training.

The document neatly summarises the background and the reasons for continuing medical education (CME) becoming such a prominent issue. It is not surprising to find that this section overlaps considerably with the early sections of the report by the College working group on Continuing Medical Education (*Psychiatric Bulletin*, 1992, **15**, 711–715).

At first reading the document appears reassuring for current psychiatric practice. Many of the recommendations are already standard practice in psychiatric services, e.g. regular academic programmes including case conferences, journal clubs, audit meetings and regular College inspection visits. Repeat reading dissolves this cosy picture. It becomes increasingly clear that full implementation of the proposals could have profound effects on psychiatric practice.

The Physicians appear to be convinced of the need for mandatory rules on CME and propose tough penalties for failure to comply. These include loss of junior staff and imposing a temporary category of specialist accreditation until compliance was confirmed. Section 9 of their document cogently argues the case for this viewpoint and Section 13 acknowledges the resource implications. The College working group did not go so far in their recommendations but appear to have been thinking along similar lines. The systems proposed would require enormous additional manpower in order to free doctors to attend CME but also to run programmes, to conduct the individual assessments and to run the vetting and monitoring arrangements.

CME is clearly a good thing and will have an impact on all psychiatrists. It is now over a year since the report of the College working group was published and members of the College should make themselves aware of developments. The risk is clearly that mandatory rules will be introduced by default "within existing resources" and we all know what that means!

In summary, this report clearly demonstrates why CME is good for patients and doctors alike. Why then am I left with a clear picture of the big stick but without any sign of the carrot?

IAN DAVIDSON

Consultant Psychiatrist
Community Mental Health Resource Centre
Sefton General Hospital
Liverpool L15 2LF

Health Trends, Vol. 24, 2, 1992, Department of Health. HMSO. £2.80. (Annual subscription £10.80).

A review of health and social services for mentally disordered offenders and others requiring similar