treatment and management of patients with an increase in staff at all levels. When Dr Comerford died, Hugh took his place as Deputy, and when Dr Cook retired in 1958, Hugh became Medical Superintendent. He enjoyed his new position, but due to his sometimes brutal frankness and his exacting disposition he became, on occasion a controversial figure.

Many clinical psychiatrists at this time had become dissatisfied with the existing management structure and there was much discussion about the possibility of changing the way mental hospitals were administered. There was a proposal that a Medical Advisory Committee be set up to advise the Hospital Management Committee. A transition of this nature did begin to take place about 1960 and it affected the position of the Medical Superintendent. Hugh was not pleased, but accepted the change, uttering gloomy prognostications about the future of clinical freedom. No doubt, in later years, he did have the satisfaction of being able to say "I told you so!". He continued to pursue the goals he had set himself and was responsible for planning and organising the opening of Castlewood Day Hospital and re-instate, an industrial unit for patients. Both these projects are alive and active to this day.

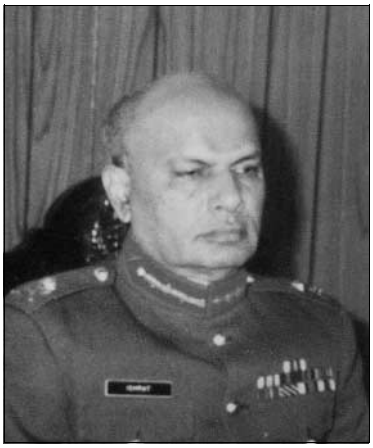
He decided to exercise the option to retire from his post at Bexley Hospital in 1968 and then held various locum posts as well as jobs with local authorities with the emphasis on children's care. He was also appointed for two consecutive terms of three years each to be a member of the Mental Health Review Tribunal, South-East Metropolitan Region, expiring October 1975. This work satisfied him immensely. Above all, he loved to have family and friends around him and would discuss and give advice on all manner of things. He was, in fact, very knowledgeable on many matters besides medicine.

He enjoyed good health and was able to follow his hobbies and pursuits fully until about 1982 when health problems arose. But with considerable ingenuity and resourcefulness he overcame most of his difficulties and was still able to enjoy motoring, watching car racing and holiday travel. It was only in the last year or two of his life that he became more housebound. He leaves a wife, two daughters, a son, nine grandchildren and six great-grandchildren.

Harbans Capoore

Major General Ishrat Husain

Formerly Consultant Psychiatrist, Karachi, Pakistan



Major General Ishrat Husain was born on 25 December 1928 in Gwalior, India and graduated in medicine from the King Edward Medical College, Punjab University in 1951. He entered the Armed Forces of Pakistan in 1952 and in 1957 specialised in Psychiatry.

He gained the DPM (Lon) in 1965 and became a Founder Member of the Royal College of Psychiatrists in 1971 and was elected to the Fellowship in 1984.

He was a major force in developing psychiatry in Pakistan and an eminent and leading psychiatrist in the Pakistan Armed Forces. The Pakistan Armed Forces recognised him as a true veteran by awarding him the *Sitara-e-Imtiaz* (Military) in 1978 and *Hilal-e-Imtiaz* (the highest award for meritorious services) in 1984. He was the Commandant, Armed Forces Medical College Rawalpindi, Pakistan from 1982–1986. As Commandant he arranged the first regional meeting outside the UK of the Royal College of Psychiatrists in Rawalpindi. He was also the Adviser in Psychiatry to the Armed Forces of Pakistan.

His influence in education was enormous, eventually becoming Dean of the Faculty of Medicine at the Quad-e-Azam University, Islamabad and Chairman of the Board of Studies for the MHSc (Medical Administration) in 1985. He took an active part in teaching psychiatry to medical students, junior doctors and postgraduate students. He was an inspiration and a role model to a number of his students who are now practising as consultants in psychiatry. Some of the key appointments he held were Chief Instructor in Psychiatry at Armed Forces Medical College, Professor in Psychiatry and Honorary Consultant at Agha Khan University.

His key research was into the psychological factors in military aviation and the use of psychotherapy. He was involved in the rehabilitation and psychological well-being of prisoners of war in 1971 on their return to Pakistan. He was instrumental in ensuring that the prisoners of war were allowed to continue their armed forces careers and, in addition, he conducted a study of their psychological and mental state.

In recent years he had been involved in developing Pakistan Institute of Learning and Living, an institution created with the object of promoting the state of mental well being with special emphasis on people with low income. This work reflects Ishrat Husain's qualities as a person and his passionate, enthusiastic approach. He was a deeply religious person who found great solace and wisdom in all religions.

On a personal level, he was noted for his gentle demeanour and his soft-spoken manner. He was a guide, a mentor and a great physical and emotional support to his children and grandchildren.

I. B. Chaudhry

book reviews

A Beautiful Mind: The Life of John Nash

By Sylvia Nasar. London: Faber & Faber. 1998. 459 pp. £17.99 (hb). ISBN 0-571-17794-8

The story of John Nash offers interest and encouragement to patients, relatives and psychiatrists. He is a highly respected mathematician who as a young man published from Princeton an analysis that is relevant to economic bargaining, to governments, nuclear strategy, interpersonal relations and animal behaviour. Subsequently he developed schizophrenia and was disabled by his illness. His slow and impressive improvement enabled him to travel to Stockholm in 1994 to receive, in honour of his youthful work, the Nobel Prize for Economics. Some readers may recall that later he addressed a plenary session at the World Congress of Psychiatry in Madrid.

Nash derives from a stable American home with no history of schizophrenia. Yet at the age of 30 years he told colleagues that he was receiving encoded messages through newspapers. He noticed that men wearing red ties were signalling to him. Nash complained that his career was threatened by aliens from

https://doi.org/10.1192/pb.24.2.77-a Published online by Cambridge University Press

columns

outer space. His recollection of this period is of mental exhaustion with an increasingly powerful understanding of a secret world unknown to others.

Twelve years ensued with involuntary admissions to psychiatric hospitals. Guilt, the need for penitence and dread became more prominent; voices argued within his head. Insulin coma and tranquillisers were given. Drug treatment conferred major benefits, renewing creativity, but he discontinued medication for a reason not usually proffered to psychiatrists: "If I take the drugs I stop hearing voices." Eventually he was accepted home by his wife and allowed to attend Princeton informally.

During his 40s and 50s Nash and others noticed a gradual weakening of his psychosis. He still experiences abnormal thoughts and voices, though with minimal intensity. He now recognises their unnaturalness and rejects them, or wards them off by avoiding reflection on subjects, such as politics, that have provided a focus for psychotic beliefs.

What trick of genes or environment cruelly ensured that a son of Nash developed schizophrenia when 13 years younger than his father had been? Or determined that an illegitimate son, who spent his early years in a succession of foster homes, escaped the illness? More hopeful is the reminder that schizophrenia can substantially and spontaneously improve, even while untreated. Also reassuring is the success of medication, while it was taken, in dispelling both positive and negative symptoms and restoring talent. Credit should be given to his wife and to Princeton. Their tolerance and understanding are patently the opposite of strong expressions of emotion.

The biographer portrays mathematicians as usually remote or odd, citing examples that include the mental illnesses of Newton and Gödel. Yet her case is not proven; indeed she describes several practical and well balanced colleagues of Nash. With this minor reservation I recommend her sensitive account for professional and lay readers alike.

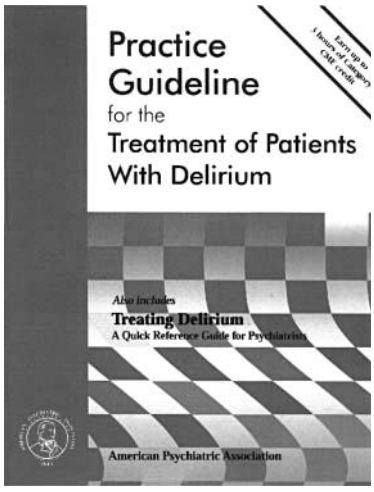
Spencer Madden, Emeritus Consultant Psychiatrist, Countess of Chester Hospital, Chester CH2 1UL

Practice Guideline for the Treatment of Patients with Delirium. Also includes Treating Delirium: A Quick Reference for Psychiatrists

By the American Psychiatric Association. Washington, DC: American Psychiatric Association. 1999. 64 pp. $22.50 ISBN 0-89042-313-X

This is the tenth in a series of practice guidelines published by the American Psychiatric Association and has been produced by consensus forming among experts in the field of delirium. I think the guidelines are excellent, providing a useable and welcome review of the management of delirium, as well as showing the direction developments in the management of this condition are likely to take us. They are well written, as well as up to date with the latest trends in our understanding of the outcome of delirium.

The guidelines discuss and outline the causes, investigation and management of delirium from the medical, psychiatric and environmental perspective. They are backed up by a quality review of the evidence base in the literature. The guidelines cover almost all the key areas of importance in delirium and give advice on the choice of therapeutic agents and other interventions. My only disappointment is that they do not really mention the differentiation of delirium from dementia, which is an important problem in the management of both conditions (Macdonald & Treloar, 1996). Topics even included a discussion of electroconvulsive therapy and delirium (only possibly indicated in the neuroleptic malignant syndrome). In addition, as is so often the case the guidelines highlight some of the differences between US and European psychiatry. Here is discussion of the use of restraints; interestingly, they are considered particularly safe for elderly people because of the lack of drug interactions, but it is admitted that fractures are a special risk in this group. More importantly, even though a solid evidence base for newer drugs is awaited, the guidelines show that we are now moving towards the use of physostigmine and other cholinesterase inhibitors in the acute management of delirium. In many ways the management of delirium has always been one of passively containing the problem until it either goes away or progresses to dementia. Now, we can see the beginnings of the active management of delirium with, hopefully, improved outcomes as a result.



I think this work is the best review I have seen of delirium and would recommend it for all libraries that postgraduate psychiatrists and physicians use. It would be a very useful standard resource for old age psychiatrists as well. As ever, we will need to help our medical colleagues find out more about delirium, and this book may well be helpful in this respect.

Finally, there is a useful *Patient and Family Guide for Delirium* included. I know of many families who would like to have such a document while they watch their relatives struggle through a delirious process.

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MACDONALD, A. J. D. & TRELOAR, A. (1996) Delirium and dementia: Are they distinct? *Journal of the American Geriatric Society*, **44**, 1001–1002.

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Clinical Research in Psychiatry. A Practical Guide

Edited by Stephan Curran & Christopher Williams. Oxford: Butterworth-Heinemann. 1999. 156 pp. £17.99 (pb). ISBN 0-7506-4073-1

Less than a third of specialist registrars make full use of the research time allocated to them during the four years of their higher training, and this book could have been dedicated to the other two-thirds who do not. A sentiment of 'no excuse will really do' weaves its way persuasively through the text. Each contributor works hard to promote the benefits and personal rewards of research on the one hand, while tackling head-on those commonly encountered obstacles which can transform the most enthusiastic, even euphoric researcher gripped with inspiration to answer a question which really interests them, into a frustrated and weary one disillusioned by the inevitable problems and pitfalls which will befall even the most carefully conceived projects.

Practical, task-focused and concise chapters describe many of the separate components of a research project from its conception to conclusion, including designing and undertaking a literature search, planning and writing a study protocol, identifying collaborators, assembling a project team, obtaining grants and disseminating results. The reader will understand that these authors are just as familiar with the challenges of research work as they are with its pleasures. One message comes across loud and clear: challenges are there, and will

https://doi.org/10.1192/pb.24.2.77-a Published online by Cambridge University Press