the Mental Health Act if the Responsible Medical Officer considers this as amounting to mental disorder.

I would like to suggest that the best way of dealing with delirium tremens is to admit the person in the first instance to a medical facility under common law, rather than to a psychiatric setup under compulsory order.

IQBAL SINGH

Leavesden Hospital
Abbots Langley
Watford, Hertfordshire

Medical détente with the USSR

DEAR SIRS

In relation to your correspondent's appeal on behalf of Dr Anatoly Koryagin, who was recently elected to Fellowship of the College (*Bulletin*, December 1985, **9**, 244), I should like to make two comments.

Your anonymous correspondent wants the Koryagin family's immediate emigration to be made 'an absolute condition of any cooperation with the health organisation of the USSR'. We, however, believe that cooperation with the Soviets in matters of health and medical exchange will also promote understanding in other aspects of humanitarian concern, including justice and peace. We consider that a medical *détente* will be of benefit to all concerned.

Your correspondent continues, 'these 'doctors'... couldn't even care less about the health of the 'free' citizen of this country, so is it likely they'll care about prisoners?' Any abuse of medicine is to be deplored, but such should not lead us to damn the whole Soviet medical profession. Although there is considerable disparity in the quality of health care throughout the USSR, and the Soviet doctors themselves admit this, a great effort is being made to achieve a uniformly high standard of health care. There remains much to be done, as indeed there does here in Britain, but, considering the constraints under which the Soviet doctors have been working, and not least that of the destruction and death toll of World War II, their achievements are considerable.

J. R. ROBINSON

UK–USSR Medical Exchange Programme
480 Banbury Road, Oxford

DEAR SIRS

The use in Dr Robinson's letter of such expressions as 'medical exchange' and 'medical détente' needs clarification.

These expressions have meaning only in the context of professional relations with the Soviet Union if there exists an equivalence in the professional status of doctors in the Soviet Union and the democracies. However, the concept of an independent profession simply does not exist in the Soviet Union. Doctors, and in particular psychiatrists, who are permitted to attend international congresses or meet foreign colleagues are specially selected representatives whose loyalty is not in doubt and who are frequently trained to present official views in terms acceptable to the West. Any discussion on the political misuse of psychiatry is invariably met with a bland denial in the face of firm and convincing evidence. The ordinary Soviet doctor is 'protected' from Western contacts and Soviet doctors know better than to approach Western doctors directly through any but the most secret channels.

Two instances illustrate this sad state of affairs. Some time ago, Dr Kazanets wrote a scholarly article on the application of the concept of schizophrenia in the USSR which was published in *The Archives of General Psychiatry*. Following this article, the College invited Dr Kazanets to lecture on this topic at a College meeting. Dr Kazanets enthusiastically accepted the invitation but did not attend because he was refused a visa by the Soviet authorities. Subsequently he lost the job he had at the Serbsky Institute.

The second incident involved the Scientific Attaché at the Soviet Embassy in London. He sought a meeting with a representative from the Royal College. Dr Sidney Levine and I met him at his Embassy on one occasion and at the College on another. At the first visit he enquired about the College's views on the political abuse of psychiatry in the Soviet Union. He refused to entertain even the possibility that such practices occurred in his country. At our second meeting, the problem of closer co-operation between Soviet and British psychiatrists was raised. He was very keen for the College to have a small conference here with Soviet psychiatrists, but insisted that these representatives would have to be arranged by the Soviet Embassy and not through our personal invitations.

PETER SAINSBURY
Chairman—Special Committee on the Political Abuse of Psychiatry

Note Dr Anatoly Koryagin's new address is:
SSSR 618801,
Permskaya abl.,
Chusovskey r–n,
St. Polovinka,
Uchr. VS 389/37,
USSR.

Mother and baby units

DEAR SIRS

I would like to make a few comments on the paper by Shawcross and McRae (*Bulletin*, March 1986, **10**, 50–51). The writers feel that for a catchment population of 190,000 a specialised unit would not be appropriate and were hoping to explore with neighbouring districts the possibility of providing a joint mother and baby unit. Whilst I agree that a specialised unit is perhaps appropriate for a large catchment area population e.g. 500,000, I do not agree with the rest of the conclusions, particularly that a satisfactory facility could not be provided in a general adult psychiatric ward.

I work in the East Surrey Health District with a catchment population of 186,600 and we have had a mother and

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baby facility in the acute psychiatric admission ward for over 10 years. We have facilities to admit up to three mothers and their babies at any one time and admit babies (up to 1 year of age). There is a nursery downstairs and a sleeping nursery upstairs where the babies sleep at night. The mothers have adjacent rooms. Over a two-year period from January 1984 to December 1985 we admitted 13 mothers with babies. Therefore, as can be seen, the facility is not always in use and the beds are used by general psychiatric patients at other times.

It is not difficult to provide this facility which does not entail special building requirements or additional staff. It was only rarely that we had three babies at the same time and needed additional nursing staff. Usually we have managed with the regular staff on duty. We have also not experienced any major problems having mothers with babies in an adult psychiatric unit from the other patients. It would have been extremely traumatic if these mothers had had to be admitted to a unit outside the catchment area miles away from their homes, both as regards visiting and later follow-up.

This facility has been well used by our catchment area population. All those admitted could not have been managed at home in spite of the fact that we have a very good community psychiatric nursing service with close liaison with the general practitioners. I would like to conclude therefore that, though the mother and baby facility is not in use all the time it serves a very important client group and should be available in all health districts in the country.

V. R. Pandita-Gunawardena

Netherne Hospital
Coulsdon, Surrey

Medicine for trainees?

Dear Sirs

The exam regulations permit one of the three premembership years to be spent in a recognised medical job, but is this a good idea? I believe so.

After house jobs I spent a year as a SHO in psychiatry, and after this brief introduction I returned to medicine, to a post involving six months in the 'specialties' (e.g. chest medicine, infectious diseases) and six months general medicine—thus providing broad experience.

It was worth while doing this medical job for several reasons: most obviously I simply learned more medicine—acute, emergencies, how to differentiate the significant from the insignificant, resuscitation. I gained experience in outpatient management—the 'fine adjustment' of treatment, and the art of continuous review.

Did all this relate to psychiatric practice? Yes: as a psychiatrist I feel I acquire a responsibility for the patient's physical as well as mental wellbeing, most significant in the care of long-stay and psychogeriatric patients; I also found it not unusual in a psychiatric clinic that a patient had 'saved up' a medical problem.

Psychiatric disorder may be the presenting feature of medical problems or may complicate primary medical problems. Psychopathology influences time and mode of presentation of medical disorder and vice versa. In such cases a reasonable medical knowledge *is* necessary—either to treat the medical aspect or simply to allow a better comprehension of all areas of the problem.

In medical practice I came across a wide variety of psychiatric symptomatology, ranging from the mild to the florid, and was frequently forced to ask myself whether formal therapy was justified—I certainly found myself considering 'caseness' much more critically as my year in medicine progressed. A year in medicine also provided an excellent opportunity for research into its psychiatric aspects as well as being a good source of ideas for later. Finally it added that 'something different' to improve my CV.

How about the *problems posed* by spending the extra time in medicine? There has been some concern expressed about the problems faced by applicants intending to pursue other career specialties in obtaining junior medical posts. I found no problem getting a medical SHO job for several reasons: I was not a stranger to the hospital, having been a houseman there. It is a district general in a (very arguably) 'less desirable' area of the country, but the training given was more than adequate (and College recognised). Similar DGH posts are certainly accessible to others.

The clinical methodology, required knowledge apart, was very different in medical and psychiatric jobs and as a result I spent some weeks acclimatising after moving between specialties—furthermore keeping up with psychiatry became more difficult during the 'year out'.

Those are my arguments for and against a year in a medical SHO post. To spend a year in an alternative specialty prior to complete and final involvement in one's career specialty can, I feel, only produce a more mature, capable, and better rounded clinician. If medicine does not appeal, then how about paediatrics, or neurosurgery?

No doubt there are other arguments for and against 'extra-psychiatric' experience and hopefully these will be debated but, whatever one's personal opinion, it is an option that at least should be considered.

K. A. Wood

The Bethlem Royal Hospital
Beckenham, Kent

NHS Central Register

Dear Sirs

Drs O'Connor and Daly, in their article 'The Problems of Tracing' (*Bulletin*, March 1986, **10**, 51–52) do not mention one important aid that is available to researchers in England and Wales. The National Health Service Central Register at Southport is able to provide the address of the Family Practitioner Committee with which a patient is registered. To obtain this information the most valuable lead is the NHS number. However, if this is not available, as it is extremely unlikely to have been recorded in the patient's notes in a hospital admission, the full name and exact date of birth would in most cases enable that patient to be

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