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.

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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.

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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