difficulties of reaching firm conclusions about the adaptive significance of traits; this is challenging science. However, most working biologists find little value in philosophical arguments about whole fields and generalisations about the study of adaptations. Using historical, comparative, and other evidence to assess hypotheses about past events poses challenges in geology and cosmology, as well as in evolutionary biology. Generalisations about the difficulties are not very helpful. Examples like the one provided do not undermine the enterprise, they illustrate how such hypotheses can be tested. We will come to better methods, not by disparaging whole areas of work, but by pursuing specific questions in depth with evidence.

The fields of animal behaviour, behavioural ecology, and evolutionary genetics offer well-developed frameworks for understanding phenomena of core importance to psychiatry, such as the origins and functions of the capacities for emotions, attachment, and social behaviour. Darwinian medicine offers explanations for why natural selection has left us vulnerable to diseases.[5] My argument is simple: basic knowledge from these fields is useful in psychiatry. Unfortunately, they are connected to psychiatry by only a few bridges.[6] I hope readers will explore and build more.

1 Nesse RM. Evolution at 150: time for truly biological psychiatry. *Br J Psychiatry* 2009; **195**: 471–2.

2 Zampieri F. Medicine, evolution and natural selection. An historical overview. *Q Rev Biol* 2009; **84**: 1–23.

3 Nesse RM. On the difficulty of defining disease: a Darwinian perspective. *Med Health Care Philos* 2001; **4**: 37–46.

4 Nesse RM, Jackson ED. Evolution: psychiatric nosology's missing biological foundation. *Clin Neuropsychiatry* 2006; **3**: 121–31.

5 Nesse RM, Bergstrom CT, Ellison PT, Flier JS, Gluckman P, Govindaraju DR, et al (2009) Making evolutionary biology a basic science for medicine. *Proc Natl Acad Sci*, published online before print November 16, 2009, doi: 10.1073/pnas.0906224106

6 Brüne M. *Textbook of Evolutionary Psychiatry: The Origins of Psychopathology*. Oxford University Press, 2008.

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Correction

Long-term mental health of Vietnamese refugees in the aftermath of trauma. *BJP*, **196**, 122–125. The second sentence of the Method (p. 122, col. 1) should read: An interview administered in the respondents' home (by A.B.V. and T.V.T.) included a self-report questionnaire available in Vietnamese and Norwegian, and a structured face-to-face interview in Vietnamese.

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extra

Bringing new life into psychiatry

Rebecca McKnight

I recently spent my elective doing psychiatry in a world-renowned hospital in the USA. I went hoping to confirm my interest in psychiatry as a career, but also as a way of avoiding the practical nature of most placements in low- and middle-income countries. I am not a 'hands-on' person, much preferring talking therapies to actually doing anything practical.

During my time on the in-patient unit, a patient with bulimia nervosa was admitted with hypokalaemia secondary to thrice-daily purging. This was not an unusual scenario, but this lady happened to be 34 weeks pregnant. One morning, having arrived on the ward at 6.40 am to prepare for the daily rounds, I was asked to review the patient as she was having abdominal pain. From the end of the bed I could see she was sweaty, pale, and looked to be in severe discomfort. I was concerned, and asked the nurse to contact an obstetrician urgently. Moving closer I saw there was bloody fluid on the bedclothes, and the patient starting yelling she could 'feel something coming out'. I took the plunge and asked for permission to examine her. After the usual psychiatric ward struggle to find some equipment, I performed a vaginal examination. I was alarmed to feel a head pushing down on my hand, and immediately went into the push . . . stop . . . .push mode I had learnt during obstetrics. A few moments later and I had delivered the baby, which thankfully started to breathe by itself. I put the baby onto the mother's chest, and then started to panic as to what to do next. I was saved by the arrival of a paediatrician, swiftly followed by someone with a pair of umbilical cord scissors. Now all I had to do was to sort out the fourth year resident – obstetrics was optional in her training, and witnessing her first delivery left her collapsed in a heap on the floor.

While I hated obstetrics as a student, and complained about most practical specialties, I am extremely glad the UK training system remains for the most part general and all-inclusive. I'm still heading for psychiatry, but perhaps will put a little more effort into honing my practical skills, and encouraging other psychiatrists to do the same.

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