comment freely (including commenting on certain aspects of medical evidence) on issues where the professional boundaries are not particularly clear cut (e.g. diagnosis of early dementia) and where individual skill and experience is a key factor as opposed to what titles or labels one happens to have before or after one's name. Indeed, in some instances relating to brain function, I would have no hesitation in advising a solicitor or barrister to challenge a medical person's competence to offer an expert opinion in a Court of Law.

It seems ironical to non-medical professionals who have written papers or given lectures on specific topics (for doctors) then to be challenged, because they are not doctors, on their right to practice as experts within the legal framework. Hopefully, these are matters that will come right in time as courts become more and more familiar with the varying (and overlapping skills) of various professional groups.

One particularly difficult problem—as Mrs Brahams rightly reminds us—is that of bringing to court 'a whole constellation of expert witnesses' whenever there is 'a whisper of abnormality'. Although I would agree that there is certainly a danger of too many experts (or perhaps too many experts from too many fields) getting in 'on the act', there are almost certainly greater risks entailed when issues that are by no means clear cut are allowed to become the exclusive province of one discipline—as the ghosts of the Ripper trial will continue to remind us for some time to come.

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REFERENCE

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Planning registrar and senior registrar training in mental handicap

DEAR SIR

I wish to congratulate Dr Spencer for his outline of training activities for registrars and senior registrars in mental handicap (*Bulletin*, May 1982, **6**, 82). I would, however, like to state that the training *standards* of registrars and senior registrars in mental handicap should be similar to those of trainees in adult psychiatry. The sad fact is that this is not the case.

Most registrar and senior registrar posts are occupied by foreigners on an indefinite locum basis. There is very little exchange of knowledge between consultant and trainee, i.e., no teaching or very little. No admissions, no discharges, no journal clubs, no case presentations. Library facilities are inadequate, if not ancient. The work is basically that of a GP looking after the general health needs of his mentally-handicapped patients. In institutions which are 'progressive' the registrar/senior registrar attends case presentations at the postgraduate centre of a psychiatric complex.

Training in mental handicap must change and reach the standards of that in adult psychiatry.

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Trainees' views of approval visits

DEAR SIR

I think Philip Thomas (*Bulletin*, July 1982, **6**, 124-25) may have made some unwarranted assumptions as to why trainees from teaching hospitals were much less satisfied with the accuracy of the reports of Approval Panels compared with trainees from peripheral hospitals. It would be of interest to look at the relationship between the final result of the Approval visit (A, P or U) and the satisfaction or dissatisfaction expressed by the trainees. It would seem to me that there might be a 'halo effect' in that trainees would be more inclined to be satisfied with the approval team providing the highest grade of Approval and vice versa.

In this Region the peripheral hospitals in general have done rather better than several of the teaching hospitals with regard to their category of Approval. The reason for satisfaction amongst trainees in these peripheral hospitals may be their satisfaction with the outcome of the visit, or satisfaction with their hospital which has perhaps earned a high Approval category. To make the assumption that trainees in peripheral hospitals are demoralized and faced with inertia or lack of interest from their senior colleagues seems to be unwarranted if the true situation is as described above.

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