professional competition and bureaucracy on their return home. I agree that 'overseas doctors' are not a homogeneous group and generalisations cannot be drawn, but one cannot deny that higher qualifications are a must for professional survival anywhere.

What should be the common by-product of this symbiotic relationship which is ignored by all concerned parties? The answer lies in the betterment of mental health and its services in the developing world. Overseas trainees (irrespective of country) and the Royal College of Psychiatrists should both aim to achieve this common objective.

Overseas doctors should during their stay in the UK develop their initiative and creative instincts, and improve their theoretical education (which has too great a dependence on the retention of facts), by learning to assemble knowledge and use it. The College should strive to improve and standardise the quality of training imparted to overseas doctors (Mbwambo *et al*, 1992). The developing countries represent a unique social and human laboratory and a vast area of the 'universe' for renewed scientific consideration (Lambo, 1982).

'Achieving a balance' with a certain standard of quality and quantity of overseas trainees, and attaining the MRCPsych examinations for future survival, are but momentary phases of glory, both for the College and the trainees. Let us as professionals be honest in our long-term intentions and mutually assist in this novel approach to training by helping to make the ODTS a means to a nobler end: the alleviation of mental health suffering in the developing world.

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DEAR SIRS

Having recently spent time in an African country considering, among other things, postgraduate training in psychiatry, I read with interest the recent article on training psychiatrists for the developing world (*Psychiatric Bulletin*, June 1992, **16**, 352–354) and Dr Gandhi's letter on overseas doctors (*Psychiatric Bulletin*, July 1992, **16**, 446–447).

The ODTS offers a way for doctors from poorer countries to gain experience unavailable in their own countries and it also provides much needed manpower at a junior level for our own NHS. Both the article and the letter make the point that the training needs of the doctors on the scheme vary and that there should be greater flexibility in meeting individual requirements. There are, however, at least four elements each with its own agenda, namely the College, the NHS, the country of origin, and the trainees, so it is hardly surprising that criticism of the scheme should emerge and ways to balance and reorganise it should be sought.

If the scheme is truly to address the training needs of doctors from overseas then it would be advantageous for the trainers to have knowledge of services overseas, and while this is not immediately possible, some exchange of trainees might be explored. From my own experience in Zimbabwe I am convinced that valuable training opportunities exist, particularly at SR level, and the ODTS might develop a two way movement of trainees, forging links with particular centres in developing countries, perhaps having a list of approved centres that would be recognised for higher training purposes by the College.

There must be a role for a discipline such as psychiatry to foster understanding between cultures through an exchange of ideas and people, trying to overcome the boundaries that nations build between themselves.

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DEAR SIRS

I wish to comment on the article by Mbwambo and colleagues about the training of psychiatrists for the developing world (*Psychiatric Bulletin*, June 1992, **16**, 352–354) which opens a number of valid questions about the training of overseas doctors. I appreciate that countries from the developing world are very different in their needs and existing services. Egypt, with over 300 psychiatrists and a substantial number of religious and faith healers, would be very different from countries with a handful of psychiatrists and lacking an organised medical service.

The needs of individual trainees also differ. His long-term position in his home country may be in a teaching, research or clinical service. There is no possible way of improving the current training of doctors in a manner that would fulfil all the needs of different trainees from the developing world.

Rather than attempting to change the current training schemes in the UK, one should stress more the importance of communication between the UK training centre and local psychiatrists and health planners in the developing countries, to discuss the specific needs and expectations of individual trainees. The months preceding the trainee's arrival in the UK are usually spent sorting out GMC papers,

insurance, and accommodations plans. Very little communication is taking place with the home services discussing the needs of individuals.

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Primary care for people with mental handicaps

DEAR SIRS

Michael Kerr (*Psychiatric Bulletin*, June 1992, **16**, 364) reported on the needs of GPs in providing care for people with mental handicaps. His observations concur with the results of a postal questionnaire of GPs conducted in Greenwich. Approximately 30% of the questionnaires were returned. A number of these provided a response for the whole practice, and so reflect the thoughts of a larger percentage of GPs. Of those who did reply, 60% served a group home or hostel. While 60% of the respondents offered screening programmes (e.g. cervical cytology), only one GP offered screening specifically geared to those with learning disabilities (i.e. annual health check including thyroid function tests if appropriate). With regard to seeking specialist health advice and help, under 25% of the respondents had ever referred a patient to the Community Mental Handicap Team, and 47% had referred a patient to a psychiatrist (learning disability). Most (80%) wanted further information about the available services and some specifically requested information on the use of behavioural techniques and psychotropic medication in this group.

The result of this small survey indicated that there was a need for improved dissemination of information by the specialist services to the GPs and as a result a training evening was arranged to meet this need, where the structure of the service and various treatment strategies were discussed. This meeting was successful and it is planned that such educational sessions will continue regularly, and so hopefully improve the service to those with learning disabilities.

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'The madness of George III'

DEAR SIRS

Congratulations on your splendid review of 'The Madness of George III' (*Psychiatric Bulletin*, April 1992, **16**, 249–250): it was, I fully agree, an evening in the theatre of uncompromising delight.

May I presume, however, to add one or two footnotes?

Neither Richard Hunter nor his mother, Ida Macalpine, could have dreamed that their masterpiece of clinical and historical research into George III's periodic madness would be transformed into a smash-hit theatrical success. I can afford to be categorical on this point because of the evidence in my possession.

In 1965 I had written to Richard sending him a reprint of an early paper of mine in which I pointed out that the portrait of the "mongol" handed down uncritically through generations of textbooks was "sadly erroneous". As was his wont, Richard replied immediately in his own handwriting, on 8 December 1965. He adds a postscript which reads: "We have a paper coming out in the BMJ in the very next few weeks on George III in which we try to do the same for that maligned monarch whose psychiatric history seems to have been equally misunderstood." The first of the relevant Hunter/Macalpine papers, 'The "Insanity" of King George III: a Classic Case of Porphyria', was, in fact, published in the BMJ on 8 January 1966.

Again, it is more than passing interest, and also an illustration of their generosity, that, in 1974, Richard and his mother presented to HM The Queen for exhibition in Kew Palace, memorabilia of George III which they had collected during their investigations. The gift is acknowledged in the official catalogue, "enriched" being the adjective used to describe its value.

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The environment, health and the community

DEAR SIRS

The letter by E. S. Lister (*Psychiatric Bulletin*, June 1991, **15**, 373) identifies the increasing use by psychiatrists of motor vehicles in order to meet the demands created by community based services and rotation training schemes. Increased mobility for individual professionals is obviously essential to both these developments but results in additional problems. As we all spend more time driving our cars and waiting in traffic jams we also contribute to the deterioration in the atmosphere. In the aftermath of the United Nations conference in Rio de Janeiro on the environment, we may remind ourselves of the central role of the private motor vehicle in creating air pollution, traffic congestion, accidents, stress and noise. As psychiatrists we need to be mobile, but if the volume of traffic in Great Britain continues to increase at its present rate this will soon be impossible as gridlock becomes reality.