to differences in size, geography, resources, and political structure of each rotation.

From the points made above it becomes clear that the Teaching Hospital benefits from centralised regional resources and a thriving university department. A large field of applicants is attracted when posts are advertised and appointments committees can afford to be selective. The training provides opportunities for research, and academic work is encouraged, not least by a well motivated peer group. Such a rotation produces a well qualified candidate for higher training, and career prospects are good.

The District Hospital does not have on-site access to comparable facilities and, as a probable result, appointments committees do not enjoy so wide a choice. These factors could be seen to promote a two tier training structure which would be self perpetuating.

The central function of each training scheme is, however, concerned with training doctors for consultant careers in psychiatry. As has been pointed out, clinical training differs in style but resulting clinical competence is comparable. The Teaching Hospital rotation undoubtedly provides an excellent training for academic psychiatrists and for consultants closely linked with academic centres. These posts are, however, in the minority nationally, most consultants being based in District Hospitals. It could be argued that, as things stand, the clinical training acquired in the district rotation provides better preparation for consultants in District Hospitals who carry out the bulk of clinical psychiatry in the NHS. Those who have trained exclusively in academic units could find themselves disorientated on gaining a District consultant appointment.

It appears to us that all trainees would benefit from experience in both types of rotation. At present, many Teaching Hospital rotations do include posts which rotate through District Hospitals. There are, however, fewer District Hospital rotations with fixed posts in academic centres. It could well be that the training of future consultant psychiatrists would be improved by more overlap between different types of rotations and this would also effectively reduce the gap created by the present two tiered structure.

ACKNOWLEDGEMENTS

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New Appointments

Oxford Regional Health Authority

Dr J. S. Harding, Consultant Psychiatrist with Special Responsibility for the Psychiatry of Old Age, East Berkshire, 1 February 1987.

Dr J. B. P. Brockless, Consultant in Child and Adolescent Psychiatry, East Berkshire, 14 September 1987.

Dr H. Bullard, Consultant in Forensic Psychiatry, West Berkshire, 1 October 1987.

Dr E. M. Spalding, Consultant Psychiatrist with Responsibility in Mental Handicap, High Wycombe, 21 September 1987.

South Western Regional Health Authority

Dr T. F. Packer, Consultant Psychiatrist with a Commitment to Community Care, Exeter, 17 February 1987.

Dr M. Missen, Consultant in Mental Illness with a Special Interest in the Elderly, Cheltenham, 23 March 1987.

Dr A. K. Darwish, Consultant in Child and Adolescent Psychiatry, North Devon, 10 June 1987.

Yorkshire Regional Health Authority

Dr R. J. Williams, Consultant in Child and Adolescent Psychiatry, Scarborough, 28 May 1987.

Dr M. E. Jenkins, Consultant in Child and Adolescent Psychiatry, Northallerton, 25 June 1987.

Dr A. Wade, Consultant in Child and Adolescent Psychiatry, East Yorkshire and Hull, 25 June 1987.

Dr B. C. Chaparala, Consultant in General Psychiatry with Special Responsibility for Psychogeriatrics, Scunthorpe, 25 June 1987.

Dr B. T. Saleh, Consultant in Mental Illness, Scunthorpe, 25 June 1987.

Dr A. K. Chaudhary, Consultant in Mental Illness, with one year's secondment to Leeds University, Scunthorpe, 25 June 1987.

Dr C. J. Simpson, Consultant in Mental Illness, Northallerton, 25 June 1987.

The Editors would welcome information about recent consultant appointments from other Regional Health Authorities.