Disgusted with myself, I gave up my office, wore polo-necked sweaters, and asked the 'consumers' to call me Vic. I felt compelled to beat myself with leather thongs every time I thought of the 'medical model'. Every night I chanted passages either from the Draft Code of Practice or our latest HAS report. I so much wanted to be liked by everyone, I was willing to give up everything.

But Marge, how can I escape? I am desperately unhappy. All they want me for now is to write prescriptions, and be on-call at night. They despise me. Can you please consult your multidisciplinary team, and ask the key worker to send me an individual care plan—soon!

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P.S. I've just remembered. I do hope I'm in *your* sector.

Part-time training in psychiatry

DEAR SIRS

I was interested to read a brief guide to the options available, prepared by a working party of the Collegiate Trainees' Committee, (*Bulletin*, April 1987, **11**, 137).

All my training in psychiatry has been carried out on a part-time basis, initially as a part-time supernumerary Registrar funded by the Welsh Office, and more recently as a Senior Registrar working part time in an established full-time post.

I am writing to draw your attention, and that of your readers, to this option which was described as available in Scotland but was not so described for England and Wales, that is the option of applying for a full-time post and then of requesting at interview to work on a part-time basis. I did this with the support of the Clinical Tutor at these hospitals and the support of the Consultant for whose post I was applying. I am now in post (part-time).

This seems a logical way of achieving part-time training. The Joint Committee for Higher Psychiatric Training holds the view that Senior Registrar training positions should not be used for routine provision of services. It seems appropriate therefore that such posts should be offered to the most suitable candidate even if this person is only able to work part-time.

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Asylum of Leros

DEAR SIRS

Lawrence Durrell's description of Leros as a gloomy, shut-in sort of place, with fjords full of lustreless water as cold as a polar bear's kiss[1] did this pretty Greek island an injustice. Some of these remarks, however, aptly describe the asylum of Leros, which for many years (and perhaps for centuries) has served as a depository for undesirable social misfits including convicts, political dissidents and, now, incurable psychiatric patients from the whole of Greece. The current asylum population of 1350 includes about 300 'children'. Many are mentally handicapped and some have multiple disabilities. Over 90% are poor and illiterate. They are looked after by one psychiatrist, one social worker, a few nurses and several hundred unqualified persons known as guards; there are no psychologists, no occupational therapists, physiotherapists, speech therapists, or teachers. The general policy is one of containment; the patients are fed, cleaned and kept quiet, and physical restraint is used. The classic features of institutionalism are evident throughout, and the patients exist in a socially impoverished, restricted environment, with no stimulation, occupation or other remedial activity. They seldom have any personal possessions and hardly any links with their areas of origin or with the outside island community.

In 1984, a project team headed by Professor Ivor Browne was appointed by the EEC. The team's report[2] made clear urgent recommendations for the assessment of the asylum's population, the initiation of programmes for training and rehabilitation, the transfer of some patients to hospitals near their families and the resettlement of others in suitable community accommodation, as well as for the development of trained staff teams. The report also stressed the importance of combining these programmes with plans for alternative economic developments for the islanders who are dependent on the asylum for their livelihood. During the last three years, there was very little uptake of the allocated EEC funds, and nothing has changed since the report's publication. There are powerful and complex political, cultural and economic reasons for this inactivity, and, meanwhile, hundreds of disabled people continue to live within "the most serious example of human misery and suffering in the Greek psychiatric problems".[2]

At the recent First European Meeting on De-institutionalisation and Vocational Rehabilitation held in Leros, professional workers from Greece and from other EEC member countries joined in pressing for immediate changes. The awareness of this situation by British psychiatrists, and their support (perhaps by writing to the Greek Minister of Health) may well assist in achieving results.

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REFERENCES

[1]DURRELL, L. (1978) *The Greek Islands*. London: Faber & Faber.
[2]COMMISSION OF THE EUROPEAN COMMUNITIES (1984) *Reform of Public Mental Health Care in Greece*. Brussels.

Culture-bound disorders

DEAR SIRS

It was interesting to read the letter on multiple personality disorder (MPD) by Ray Aldridge-Morris in the May *Bulletin*. In my opinion, multiple personality disorder is an