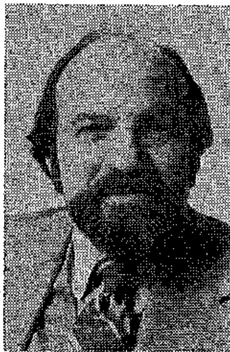
Editor's Page

Insane Treatment Of The Insane

Chronically ill mental patients are being treated these days in a way that provides fascinating, if tragic, lessons for all physicians. In the past, large state hospitals were built far out, away from the communities, to shelter, but also to isolate, the deranged that psychiatry could not cure. Reversing the trend, it has recently become fashionable to measure therapeutic success by the rapidity with which such sick individuals are "returned to the community," once their symptoms are masked with the aid of powerful chemical agents. Institutions compete with each other and compare such "achievements" with the thoughtless consent and cooperation of psychiartists-turned-bureaucrats.



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Being on a hospital or public payroll apparently changes even the outlook of physicians, and they, too, begin seeing patient populations rather than the individual patient. As a result, sad, shabbily-clothed and strange looking individuals can now be seen in certain parts of Detroit and it's suburbs, at street corners, cheap coffee shops or simply wandering aimlessly in the streets. These lost souls represent the human price in agony of the wish to proudly cite high discharge figures and brevity of hospital stay. The tragedy of neglect and exploitation of such sick individuals in "nursing" and rooming houses is largely overlooked, in spite of conscientious reporting in many papers, including the *New York Times.*

Bureaucracies everywhere have one perpetual interest that supercedes all others: to assure their continued existence. Since they are made up largely of honest men and women who would find it difficult to collect their salaries without believing that they are doing useful and important work, they come up, every so often, with new "solutions," requiring new efforts, to the same old problems. And yet, even after the "New Deal," the "New Frontier," the "Great Society" and other catchy slogans of the past, life is still quite imperfect. Winning smiles, ebullient optimism and even bigger budgets have never yet succeeded in eliminating illness and death as persistent and ever present conditions.

The expenditure of public funds depends on demonstration of at least apparent results, and all agencies spend much time, energy and money on the preparation of annual reports that will hopefully prove that they are indispensible. Activities are often valued, therefore, not so much by the actual good they produce, but by their emotional appeal and by their ability to show up well in statistical summaries. New buildings, programs and staff, numbers of patient "contacts"(?!), admission and discharge figures are all good examples of such desiderata. What happens in the buildings, the quality of the programs, *how* patients are treated and whether they got well, are not so easily

documented. Such points are often de-emphasized or ignored altogether. Much needless suffering is the common result.

De-institutionalization is the magic and guilt-discharging name of this insane medical fad, which is also known as the revolving-door. While patients with diabetes or arthritis are re-hospitalized without stigma when their condition is exacerbated, determined efforts are often made to resist even short-term-re-hospitalization of mental patients who barely manage in the community. The annual report looks better this way. A brain child of psychiatrists in bureaucratic robes, de-institutionalization is supported by budget bureaus eager to trim their figures and pushed by reformers with a zeal to "improve" the lot of the mentally ill, "languishing" in "impersonal," large institutions. It is foolishly supported by suspicious civil libertarians who often confuse physicians with untrustworthy and frightening authority-figures from their personal pasts, all playing havoc with the lives of sick and silent people.

Psychiatry must bear a special responsibility for assuring that medical rather than political considerations determine the way these patients are treated. If definitive treatment is not available for these chronic patients, the least that can be done is to create a more humane environment for them, not simply change their address. Politicization of professional standards and practices always prepares the soil for the proliferation of questionable fads. This was true in the pre-scientific days of surgery as it still is often true in psychiatry today.

The situation is not likely to change quickly, nor will long-held convictions easily be given up. The livelihood and professional identity of many administrators and psychiatrists depend on continuing and even expanding such programs, regardless of their merit. Yet, physicians have taken an oath at least to do no harm, and they must practice their profession without regard to fads or popular pressure by ignorant "consumers" and their opportunistic spokesmen. The tragic and sometimes disastrous results of cooperation in unsupportable practices dictate that we remain true to the real interests of our patients and to ourselves as well.

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