FALSE PROMISES

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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 must come up, every so often, with new "solutions", requireing new efforts, to the same old problems. In spite of the "New Deal", the "New Frontier", the "Great Society" and similar catchy slogans of the past, life is still quite imperfect, as it is likely always to be. Winning smiles, ebullient optimism, and even bigger budgets will never change that. Illness and death are conditions that will persist forever in spite of election-day rhetoric.

Since expenditure of public funds is dependent on demonstration of some results, all public agencies spend much time, energy and money on the preparation of annual reports that list their activities and that would hopefully prove that they are indispensable. Activities are often valued, therefore, not so much by the real 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 desirable data. What happens in the buildings, the quality of the programs, how patients are treated and whether they got well cannot so easily be documented, and such all-important questions are, therefore, often described in meaningless terms, de-emphasized or ignored altogether. Immeasurable and needless suffering by a great many individuals is the result.

The enormous size and complexity of government and public agencies, by

comparison with which an individual is powerless and seems miniscule, is the only explanation why such conditions are allowed to continue existing. No person would spend his or her own funds in a way that not only does him no good, but that also is useless to others. As a society, we do so regularly.

The changing fads in treating chronically ill mental patients is one case in point. Large state hespitals were built at one time far away from the communities, to isolate and shelter the deranged that psychiatry was unable to cure. Reversing the trend, it has recently become fashionalbe to measure therapeutic success by the rapidity with which such sick individuals are "returned to the community". Institutions compete with each other and compare such "achievements", with the thoughtless consent and cooperation of psychiatrists turned bureaucrats. Being on a hospital or public payroll apparently changes the outlook of many physicians, and patient-populations, rather than the individual patient, become the focus of attention. Many sad, shabbily-clothed and strange looking people are frequently seen in certain parts of Detroit and its suburbs, at street corners, cheap coffee shops or simply wandering in the streets. These lost souls represent the human price in agony of the wish to proudly cite high discharge figures and brevity of 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 such papers as the New York Times.

De-institutionalization is the magic and guilt-discharging name whose appeal propells this insane medical fad. 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. It looks better this way in the annual report. 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 authority-figures, thus playing havoc with the lives of those who need on-going custodial care.

Psychiatry must bear a special responsibility for assuring that medical rather than political considerations determine the way patients are treated. If definitive treatment is not available for these chronic patients, the least that can be done is 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 questionalbe 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, especially not in an election year, nor will long-held convictions of administrators, some of them physicians themselves, easily be given up. The livelihood and self-identity of these people depend on ever continuing and ever expanding programs, regardless of their merit. Yet, physicians must act according to the sacred oath they took to at least do no harm, and they must practice their profession without regard to fads and popular pressure. The tragic and sometimes disasterous results of cooperation in questionable practices dictate that we remain true to the real interests of our patients and to ourselves as well.