In A Nutshell

Spring 2003

Executive Director Retires

by Jim Gifford

Barry Niles, longtime Executive Director of the Mental Patients' Association, retires from his position as of March 15th. He was interviewed by Jim Gifford, 'In A Nutshell' editor-in-chief, in Barry's office on Friday morning, January 31st.

JG: Barry, what year did you come to the MPA and what were the circumstances and motivation for doing so?

Niles: I was first made aware of the MPA by Bill Galey, who was working here, and I came in 1985. I went through the harrowing experience of being elected by the membership as Executive Director. I had previously worked in the corporate world and, when I was hired, it was rather like falling through the 'rabbit hole' and arriving at the 'Mad Hatter's Tea Party.'

JG: During your tenure, what were the most significant changes that you observed in the Mental Health field?

Niles: Now there are tremendous numbers of supports and services that weren't in place when I started. But, as a (prominent psychiatrist) from the United States once said, although we have one of the best systems of community based Mental Healthcare in North America, we should not become complacent because we're probably top of the B Class.

During my tenure, MPA has tried to offer and construct varied opportunities and programs for the needs of the client membership we serve. We've been able to cover a lot of areas but there are still some gaps.

JG: What were those needs that were filled and what are the gaps?

Niles: I think we filled a need for economic advocacy, advocacy at Riverview Hospital, both systemic and individual. We dealt with looking after people in the community, in licensed care facilities. We've added about 185 supported independent living units, while branching out from Vancouver, to areas such as Maple Ridge. So I think we've been able to cover a lot of people's needs.

JG: How has your personal attitude evolved, over the years, towards those afflicted with mental illness?

Niles: Well, I've always been empathetic to the needs of people that are suffering from mental illness. I have been overwhelmed with the courage, tenacity, and the will to continue on by people that have severe mental illness. I'm constantly amazed by the abilities to look

(Continued on next page)

Spring is in the air and the rhythms of nature move towards longer days. Make the most of the season!

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In This Issue:

on the bright side, oftentimes, always have a smile and a joke. It gives me a great deal of inner power. I'm in awe of people with destructive disabilities.

JG: Barry, what do you consider your personal legacy, in terms of accomplishment? Somebody once mentioned, to me, that they thought it was housing?

Niles: Not only housing, I'm pleased that with the efforts of management and staff, and the input of members, we've been able to develop and supply, one of the most comprehensive array of services in the Lower Mainland. I'm also pleased about the numbers of individuals that we've been able to help over the years.

JG: Looking to the future, what do you see as the priorities and direction of Mental Health Care, and the MPA, in particular?

Niles: Well, I believe that the MPA should continue to try to get the funders of contracts (we currently have about 38 contracts, through the Vancouver and Fraser Health Authorities), and also Mental Health, to look at dealing with mentally ill individuals in a pro-active manner. We must try to support them, in the community, before they get sick, as opposed to waiting until they decompensate, then dealing with them in crisis management situations in acute care. It's not economically feasible, it's the worst way to manage a potential problem, and it's certainly unconscionable that mentally ill people should be allowed to become sick without support, until they need to be committed.

JG: Why at this juncture have you decided to move on?

Niles; Well, I'm tired. We have four unions here and that can be a little trying as I don't like to work in conflictual situations. My time has arrived to step aside for somebody who's got more energy, and is up to the challenge. I've always enjoyed those challenges but, with the restraints that are happening, the work is not as enjoyable as it used to be, and I think the time is right to move on.

JG: Would you talk about your plans?

Niles: Well, I've looked for years at how I would be able to retire and have enough money. I started to look in Asia and was fortunate enough to meet someone in Thailand who has become my partner. We're looking to a future that gives me the opportunity to have a modest lifestyle without worrying about working until I drop dead. In fact, we've opened a restaurant and rented a condo. I'm excited about living in a culture that is basically non-combative, has a different spiritual outlook, and have, I think, their priorities in the right place. The lifestyle seems to be a lot more conducive to what I'm looking for than some of the pressures we're subjected to in Canada.

JG: One more question. Do I really look like Jonathan Winters?

Niles: Yes you look like Jonathan Winters, but you're nowhere near as funny!

(laughter)

JG: Barry, thank you for your service to our community and our cause.

The Editorial Board of "In A Nutshell" welcomes letters, articles, and poetry on mental health issues from you, our readers.

Warning! Do not abruptly stop psychiatric medications! Most psychiatric medications are powerful drugs and should be withdrawn from gradually under the care of a physician or other health practitioner.

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In Peace, Not Wanted. In War, Wanted - and Dead

by Sam Roddan

"The truest statements about war are made under one's breath, the most false on public platforms."

- Vernon Watkins, Welsh poet and Second World War veteran

For many veterans back from overseas, the most famous stop before they settled down to civilian life was the old Georgia Pub. It was a kind of halfway house loaded with the myths and legends of our time.

There, at the outbreak of war, we said farewell, shouted valedictions, made lengthy toasts to speed ourselves and parting guests to war. Years later, it is VE Day and some of us and back at the old stand, survivors, the lucky ones.

But many of us found our places at the tables crowded out by strangers, interlopers, trespassers. A new generation of gatecrashers had already moved in, beaten us to the gun. Or so it seemed. Jack Scott put it well in his column, Our Town in The Vancouver Sun.

"Every born wanderer, turning his face once more to the place from which he came, must feel alarm. After four years away, I felt like a stranger in an alien land."

But there were many soldiers, like my friend Jack Kelly from Bella Coola, who had never been near the Georgia. For years their headquarters had been in the dark lanes around Hastings and Gore, in jungles at the foot of Campbell Avenue, in bread lines and in the columns of Hunger Marchers heading up Hastings.

Joe was a classic example of the contradictions in a distraught world. In peace, a discard and reject. In war, a warm and welcome body.

For months before the war, Joe lived in the jungles of False Creek. His home was a piano box covered with tarpaper. He got most of his meals at the White Lunch on Hastings, with handouts and meal tickets from a Mission church.

His only clothes, as I remember, were a sweater, rough woolen pants and a pair of moccasins made from a discarded rubber tire.

Weeks after Canada declared war, Joe was in the army and sleeping in a warm hut at basic training camp in Vernon. He now sat down to a breakfast of hot porridge, bacon and eggs, steaming coffee and all the toast and marmalade he could eat

On his feet he wore solid leather boots. He had warm khaki clothes, underwear, a great coat, thick woolen socks. Every night before going to bed he drank hot chocolate. He wrote a social worker at a Mission church in Vancouver to say that in two months he head put on 25 pounds.

On the afternoon of Dec. 27, 1939, Joseph Kelly was watching a gun crew set up a two-inch mortar on the firing range at Vernon. Suddenly one of the shells lobbed accidentally out of the mortar and exploded 20 yards down range. A shell fragment severed his carotid artery and lodged in his right lung. Joe Kelly choked to death in his own blood.

Joe Kelly was now a part of history. Three days later the Dirty '30s ended.

Today my own army record is an obscure archival document, a tiny fragment of military history. My discharge papers arrived one day in a plain brown envelope. My statement of service in Europe is all there. At the end of my discharge document there is spaced allotted for "remarks." In bold print I read the enigmatic "nil."

I was a poor student in the arts of war. The army wasn't my thing. I had no nerve for killing and under fire I was bustled out of the front lines at Arnhem. A white tag, with the word neurasthenic on it, was hung around my neck, for me a mark of Cain, an albatross, a trademark of an outcast.

Every soldier has his dreams and nightmares. And sometimes they last for years buried deep in the soul, grow into whispers, haunt and disturb, become palpable, especially around times like a VE Day.

I lost good friends in the war. Obelisks in parks and public squares remind us "Their Name Liveth For Evermore" and "Lest We Forget." I shake my head in disbelief. But suddenly the name of Joe Kelly comes to mind. The same Joe Kelly, Hunger Marcher of the '30s, who tried to live in a world in time of peace, a world that didn't really want him.

■

Satya's Soapbox

by Satya Devi

I went down to the demonstration
to get my fair share of abuse.

Jagger & Richards

Being a misfit as a child, myself, I can't say it was necessarily compassion that first drew me to the underdogs. It started off being in empathy and in finding kindred spirits that I first came to feel for the unfortunate ones.

Showing early signs of Schizophrenia, I was put in the "Special Needs" class, with the 12 yr old pregnant girl, some Immigrants who could not speak English and the mentally challenged, except we weren't called "Special Needs" back then - back then it was the Dummies (capital's mine). It was not without benefits, though.

We could do almost anything we wanted and were saved the horrible fate of having to get a formal education. So, really we were Beatniks on an incredible journey of self-discovery and forming a rather pure, unadulterated view of the world, from the point of view of those who have nothing to lose. The 1960's politics hit everywhere and our class was no exception and we were decidedly left-wing.

Our first project was to get Sgt. Barry Sadler's "Ballad of the Green Berets" taken off the radio time. Those of us who could read and write English wrote to the local newspaper, but as we were just kids, we didn't have much credibility and seemed not to have any effect on the radio play. But then, and this is why I know there is always a way, this wonderful eccentric named Will-Yum arrived in our class and stirred us up, and helped shape my left-wing politics to a lot of the way they remain today.

Will-Yum used to bring Time magazine to class and tell us all about the lies in the press and how we had a revolutionary duty to fight for honesty and justice. The ESLers could speak, read and write English by now but still were not placed in regular learning grades - "racism" - Will-Yum pointed out. Soon everyone said Will-Yum was in the Dummies because he was a Communist-fairie, but it did not bother Will-Yum; he was proud of what he was and first and foremost a revolutionary.

He said we have to protest the war in Vietnam, and other atrocities wherever they are. So we began to write in earnest in the newspapers, but we knew we weren't making any headway until Will-Yum came up with a marvelous idea, why not use the school typewriter and use pseudonyms. I considered the idea, it was true, letters to the Editor were often signed, "Concerned Parent" - we decided we would give ourselves a little clout and painstakingly typed up letters signed, "Concerned Parent", "Distressed Doctor", and my favourite, "Mother of Six". Someone had written a deplorable letter to the Editor, pro-life, and signed it "Lamp Lighter". It was time for a pro-abortion stand, and "Mother of Six" got involved.

A hot feud ripped through the community and letters for both sides came pouring in, but it was the weekly dual between "Lamp Lighter" and "Mother of Six. And hot it was - scathing quotes from the Bible abounded, but "Mother of Six", and a few others including a strange "Radical Priest" kept the pro-choice side of the argument fuelled. The protests and the letter-writing went unresolved, as Toronto called and the big tolerance and possibilities against the small town narrow-mindedness called. Will-Yum and "Mother of Six" moved to Toronto where we joined a Commie Co-op to shelter Draft Dodgers. I found out some years later that "Lamp Lighter" was my mother and the "Radical Priest" was none other than, you-know-who.

We got involved in left-wing Pacifist politics in Toronto and before long, went to our first anti-war march. Will-Yum got maced right away and had to be taken to Emergency. I had gotten away from the rest of our group and was left alone. I decided to walk with the Quakers and asked a policeman where they might be. He took me by the collar and whisked me to a group of women, saying, go march with the lesbians. I came back into the middle of the street and defied an order to clear the streets, and got arrested and put in a paddy wagon. The police were none to gentle down at the station and processed us very quickly. I asked to be able to take my Dilantin (for seizures) with me into my cell and their reply was, "no hippy, you've had enough dope for today" and was unceremoniously thrown into the cell where I had a full-blown convulsion, to which my cellmates reacted with "far-out" and "bummer trip".

Fast-forward to 2003 and the protests against the possibility of War on Iraq. When the Sixties anti-war protests went on, the War in Vietnam was well into it for years, but, proudly, these protests are before a war

starts. Now, some protesters brought their camcorders and taped each other committing soft-core civil disobedience, but a good spirit was there and there were Mothers of Six and Radical Priests, and hopefully, there were some Lamp Lighters there, who must think enough of post-born kids not to want to see them killed.

By the time this goes to press, the war will either have started or be stopped by the voice of sane peoples. There are more protesters than are being covered in the press but I believe the flame is still lit from the old protest days and passed on to a new generation. ■

Man Bites Black Dogs - New Briefs From All Over

Compiled by Scott Dixon

"Roasted Nuts" – That was the headline in a Trenton, New Jersey newspaper about a fire at a local psychiatric hospital. The publisher apologized for the headline, and the paper is now running a free "anti-stigma" advertising campaign. Nobody was hurt in the fire.

A Brandon, Manitoba radio station agrees its morning DJ exhibited bad taste when he named the following song titles as "Christmas Carols for the Psychologically Challenged"
Dementia – "I Think I'll Be Home for Christmas"
Schizophrenia – "Do you Hear What I Hear?"
Paranoid – "Santa Claus is Coming to Get Me"
Multiple Personality Disorder – "We Three Queens Disoriented Are"

The owner of a roadside attraction in Texas called "The Mental Ward Haunted House" says he didn't mean to offend anyone. But Kenneth Matthews, professor of psychiatry at the University of Texas, said, "The name is doubly damaging. "For the people who aren't patients, it feeds the stigma that there is something really bizarre about people with a mental illness," he said. "For the patients, it makes them feel even more bizarre than they feel. They already feel out of sorts with society." ■

The Food Bank

by Ms. Neide M. Dos Santos

Vancouver, October 1994

After my moving to Franklin's Hotel Residence, and out of the shelter, I had to reorganize my financial life, as well. When all the payments were done, including the installation of my phone (I had to pay with the rest of my money brought from Quebec), I had no money left for groceries.

Feeling very embarrassed, I gave a phone-call to my financial worker for help. 'We cannot give you money for food. Go to the nearest food-bank to your place!'

I was devastated: for the first time in my life, I had to ask for it; secondly, the food-banks in my culture are for homeless people; finally, I was educated to help them to increase their stock, never to decrease.

Nevertheless, I had no choice. The day after, first thing in the morning, I was looking for the church in my neighbourhood. All of a sudden, I saw that little and poor church, in front of me,

Feeling very uncomfortable, I came in. The place was very unclean and dark. People began coming in and lining up. Most of them were old and drunk, and it was just early in the morning. First of all, we had to attend the mass, to pray before receiving the food. During the half-an-hour I passed in the church, my mind flew back to Brazil... to Rio de Janeiro.

My mother used to prepare a big basket of different kinds of foods, and clothes as well, collecting among all our family, once a week. After, she would donate to the catholic church. Before moving to Quebec, I had donated most of my furniture, books, kitchen wares, clothes, etc. to that charming church in my Leme's Beach home.

Now, almost six years later, there I was, lining-up for food, thousands of miles away from home. That new place was supposed to be my home, too. How can it, if you have to go through this kind of sorrowful experience?

All of a sudden, I felt my throat closing- up and tears in my eyes; and I just left, without getting any food... . ■

Minute Particulars

by Andrew Feldmár

I came across the following words that were written twenty years ago by Robert Motherwell, the painter, in an introduction he wrote to a book on abstract expressionist painting in America:

"With *known* criteria, the work of the artist is difficult enough; with no known criteria, with criteria instead in the process of becoming, the creative situation generates an anxiety close to madness; but also a strangely exhilarating and sane sense too, one of being free — free from dogma, from history, from the terrible load of the past; and above all a sense of nowness, of each moment focused and real, outside the reach of the past and the future, an immersion in nowness that I think non-creative persons most commonly parallel in making passionate love under certain circumstances — or perhaps in their dreams, where one knows there are meanings, but meanings so charged and so ambiguous, so transformed and cryptic that one is astounded by one's own imaginativeness and richness of connections, and frightened too."

Change the word *artist* to *psychotherapist* and the statement becomes a pithy expression of the essence of the practice of therapy, as I have come to know it during the past 34 years, working with people who have consulted me in varied states of pain, suffering, confusion and perplexity.

Artists have to have *faith* that their work matters, that what comes through them is valuable, even without the reassurance of success, acceptance and fame. Psychotherapists must have *faith* that it is possible to participate in and glimpse at the emotional truth of what's going on between patient and therapist. W. R. Bion proposed that faith is the very essence of the therapeutic attitude, defined as a *radical openness* through which one aims at the ultimate emotional reality of the moment, which is, strictly speaking unknowable in its infinite complexity. The therapist needs faith that reaching out for emotional truth is worthwhile and even necessary. Bion calls for the inhibition of dwelling on memories and desires. Neither the past nor the future is to distract the therapist from practicing a radical openness, faith, the ability to partake in the sacrament of every living moment. Artist and therapist both need to make a decision to surrender to something greater than one's own knowledge, ego, will, theory, dogma.

What do I mean by *surrender*? One could call it cognitive love: total involvement, suspension of received notions, pertinence of everything, identification allowing close emotional and other associations, and risk of being hurt. My encounter with my patient must be able to transform me, change me, otherwise I will have learned nothing new. That would be a loss not only to me, but also to my patient. My arrogance in treating her as already known, an instance of previously formed categories, would violate her infinite otherness, her unique, never before encountered person. She would feel objectified, manipulated, unseen, unmet. Kurt Wolff, in a book on epistemology (how do we know what we know?), says the following:

"My encounter with my patient must be able to transform me..."

"In order to live and let live, in order to manifest reverence, charity, and faith in men, it is necessary that men talk with one another, for 'servitude, falsehood, and terror' ([Camus, *The Rebel*,] p. 284) silence men and prevent them from working together at their condition: there must be 'clear language and simple words' (p. 283), at least to prove despair unreal ... or simply to find out more clearly than without open discussion what is the case; speech, including the silence that is a mode of it ... has marvelously many meanings, ways, and effects."

Without faith, Bion's radical opening up and letting go, a therapist is bound to induce "servitude, falsehood, and terror" in the patient, leading to a deeper and more despairing silence.

Motherwell spoke of "immersion in nowness", "making passionate love", and "dreams" in one breath. Psychotherapy, when it's working, is made up of dreamlike, passionate moments as patient and therapist wrestle for connection, relationship, co-presence, communion. In therapy, as in *any* loving relationship, there has to be enough room for both patient and therapist to be unabashedly themselves, for both to be able to drop out of roles, for both to laugh, to cry, to bless, to curse.

My faith as a therapist is fueled by what I learned from my experience as a patient. The love that I have received, I try to pass on. Saint Catherine of Siena (1347 – 1380), a Dominican nun, wrote this as if God were speaking:

"I require that you should love Me with the same love with which I
love you. This, indeed, you cannot do, because I loved you without
being loved. All the love which you have for Me you owe to Me, so that it is not of grace that you love Me, but because you ought to do so. While I love you of grace, and not because I owe you My love. Therefore to Me, in person, you cannot repay the love which I require of you, and I have placed you in the midst of your fellows, that you may do to them that which you cannot do to Me, that is to say, that you may love your neighbour of free grace, without expecting any return from him, and what you do to him I count as done to Me..."

Every mother, every father, every therapist could say the same thing. Yes, even today, in 2003.

■

PSYCHIATRY'S UNHOLY TRINITY - FRAUD, FEAR, AND FORCE: A PERSONAL ACCOUNT

by Leonard Roy Frank

(appeared in "Ideas On Liberty", November 2002)

Leonard Frank has co-founded the Network Against Psychiatric Assault, based in San Francisco, and has edited The History of Shock Treatment, and three books of quotations.

In 1959 a revolution took place in Cuba, the Cold War was in full throttle, the Eisenhower era was drawing to a close, and I moved to San Francisco where I would soon find myself in a hellish world of imprisonment and torture.

Born and raised in Brooklyn 27 years earlier, I had graduated from the University of Pennsylvania's Wharton School. After a two-year hitch in the Army, I managed and sold real estate in New York City and southern Florida for several years. Despite a poor record, I continued working in real estate in San Francisco.

A few months into my new job, things began to change for me - more internally, at least at first, than externally. Like so many of my generation, I was highly conventional in thought and lifestyle, and my goal in life was material success - I was a 50's yuppie. But I began to discover a new world within myself, and the mundane world seemed, comparatively speaking, drab and unfulfilling. I lost interest in my job and, not surprisingly, soon lost the job itself. Thereafter, I spent long hours reading and reflecting on nonfiction books that I found in secondhand bookstores and at the public library.

The book that influenced me most at that time was *An Autobiography: The Story of My Experiments with Truth* by Mohandas K. Gandhi. I adopted for myself his principle of nonviolent resistance, his interest in religion, and his practice of vegetarianism. In that book and other writings of his, Gandhi referred to the works that had helped shape his life. I was soon reading *The Bhagavad-Gita*, the *New Testament*, Henry David Thoreau's essay on "Civil Disobedience," Leo Tolstoy's *The Kingdom of God Is Within You*, and the essays of Ralph Waldo Emerson. In keeping with the subtitle of Gandhi's autobiography, I started my own experimenting, and this led to a complete revaluation of my previously held values. Toward this end I broadened my reading to include, among many others, the *Old Testament*, Lao-tzu (*Way of Life*), William James (*Varieties of Religious Experience*), Henri Bergson (*Two Sources of Religion and Morality*), Joseph Campbell (*Hero with a Thousand Faces*), and the writings of Abraham Lincoln, Carl Jung, Arnold Toynbee, and Abraham Heschel.

The learning acquired during this exciting, wonder-filled time advanced my self-awareness and my understanding of the world. During this transitional

period, however, my parents, who lived in Manhattan and visited me several times in San Francisco, became concerned with the changes they perceived in me. That I was living on my meager savings and not "gainfully employed" upset them. Perhaps more important, my newfound spiritually centered beliefs and vegetarian practices challenged them in ways they couldn't handle. We were at loggerheads: if one side was right, the other had to be wrong, and neither side was willing to compromise.

The situation seemed to call for a parting of the ways, at least for a time. But my parents weren't willing to back off.

They attributed the rift between us to my having a mental disorder. The changes I regarded as positive they regarded as symptoms of "mental illness." They urged me to consult a psychiatrist. I had done some reading in psychology but, while finding a number of valuable ideas, had rejected its overall approach as being too narrow - psychotherapy was not for me. For more than two years the struggle between my parents and me intensified. Eventually, because I wouldn't see a psychiatrist, my parents decided to force the psychiatrists on me. The way that was and still is being done in our society is by commitment, a euphemism for psychiatric incarceration. I was locked up at Mt. Zion Hospital in San Francisco on October 17, 1962.

During the same week that the world's attention was focused on the Cuban Missile Crisis and the possibility of nuclear war, two physicians in a San Francisco hospital were focused on me and the possibility on my being mentally ill. They decided I was and gave me a "tentative diagnosis" of "schizophrenic reaction." The case-history section of the "Certificate of Medical Examiners" they signed reads as follows: "Reportedly has been showing progressive personality changes over past 2 or 3 years. Grew withdrawn and asocial, couldn't or wouldn't work. Grew a beard, ate only vegetarian food and lived life of a beatnik - to a certain extent."

"Symptoms" Listed

On October 20 I was sent to Napa State Hospital, northeast of San Francisco, and from there, on December 15, to Twin Pines Hospital in Belmont, a suburb of San Francisco, where I remained through the first week of June 1963. Early on, I was diagnosed as a "paranoid schizophrenic," a label reserved not only for serial killers but also for almost anyone else in a mental institution who refuses to knuckle under to psychiatric authority. Scattered throughout my medical records, 143 pages of which I obtained in 1974, were the "symptoms" and observations that, according to psychiatric ideology, supported the diagnosis. These included "condescending superior smile"; "vegetarian food idiosyncrasies"; "apathetic, flat affect"; "has a big black bushy beard and needs a haircut, he is very sloppy in appearance because of his beard"; "refuses to shave or accept innoculations or medication"; "patient declined to comment on whether or not he thought he was a mentally ill person"; "no insight"; "impaired judgment"; "stilted, brief replies, often declines to answer, or comment"; "autistic"; "suspicious"; "delusions of superiority"; "paranoid delusions"; "bizarre behaviour"; "reclusive"; "withdrawn, evasive and uncooperative and delusional"; "negativism"; "passively resistive"; "piercing eyes"; and "religious preoccupations."

Soon after being imprisoned, psychiatrists tried to gain my consent to shock treatment - at first electro-convulsive treatment (ECT) but after being transferred to Twin Pines, "combined insulin coma-convulsive treatment." When I was "extremely resistive" to undergoing the latter procedure, the hospital filed for a court order authorizing force in administering it. In the closing paragraph of the seven-paragraph letter to the court, the treating psychiatrist wrote, "In my professional opinion, this man is suffering from a Schizophrenic Reaction, Paranoid Type, Chronic, Severe, but it is felt he should have the benefit of an adequate course of treatment to see if this illness can be helped. In view of the extremes to which the patient carries his beliefs it is felt that the need of hospitalization and treatment under court order is a necessity as he is dangerous to himself and others under these circumstances."

On January 10, 1963, after a hearing at which I was present, the Superior Court of California in San Mateo County "ordered (me) committed to Twin Pines Hospital." The next day, the series began; there were in all 50 insulin coma treatments (ICT) and 35 electro-convulsive treatments.

Combined insulin coma-convulsive treatment was routinely administered to "schizophrenics" in the United States from the late 1930s through the mid-1960s. ECT was sometimes applied while the subject was in the coma phase of the ICT; sometimes the procedures were administered on separate days. Individual insulin sessions lasted from four to five hours.

Large doses of injected insulin reduced the blood's sugar content triggering a psychological crisis manifested in the subject by blood pressure, breathing, heart, pulse, and temperature irregularities; flushing and pallor; incontinence and vomiting; moans and screams (referred to in the professional literature as "noisy excitement"); hunger pains ("hunger excitement); sobbing, salivation, and sweating; restlessness; shaking and spasms, and sometimes convulsions.

The crisis intensified as the subject, after several

hours, went into a coma. Brain-cell destruction occurred when the blood was unable to provide the sugar essential to the brain's survival; the sugar-starved brain then began feeding on itself for nourishment. The hour-long coma phase of the procedure ended with the administration of carbohydrates (glucose and sugar)
by mouth, injection, or stomach tube. If the subject could not be restored to consciousness by this method, he went into what were called "prolonged comas," which resulted in even more severe brain damage and sometimes death. According to the United States Public Health Service Shock Therapy Survey (October 1941), 122 state hospitals reported an insulin coma treatment mortality rate of 4.9 percent -121 deaths among 2,457 cases.1

After gaining my freedom, I tried to find out how psychiatrists justified their use of ICT. One of the clearest statements I uncovered came from Manfred Sake, the Austrian psychiatrist who introduced the insulin method in 1 933 and, after arriving in the United States a few years later, became its most active promoter. In a popular book on the state of psychiatry published in 1942, Dr. Sakel was quoted as follows: "With chronic schizophrenics, as with confirmed criminals, we can't hope for reform. Here the faulty pattern of functioning is irrevocably entrenched. Hence we must use more drastic measures to silence the dysfunctioning cells and so liberate the activity of the normal cells. But can we do this without killing normal cells also?
Can we *select* the cells we wish to destroy? I think we can" (italics in original).2

Lost Memories

I didn't see it that way. For me, combined insulin coma-convulsive treatment was an attempt to break my will, to force me back to an earlier phase of my spiritual and intellectual development. It was also the most devastating, painful, and humiliating experience of my life. Afterwards, I felt that every part of me was less than what it had been. Except for memory traces, some titles of the many books I had read, for example, my memory for the three preceding years was gone. The wipeout in my mind was like a path cut across a heavily chalked blackboard with an eraser. I did not know that John F. Kennedy was president although he had been elected two and a half years earlier. There were also big chunks of memory loss for experiences and events spanning my entire life; my high school and college education was effectively destroyed. I came to believe that shock treatment was a brainwashing method. Some years later, I found corroboration for this opinion in a professional journal describing ECT's effect on patients by two psychiatrist-proponents of the procedure: "Their minds are like clean slates upon which we can write."3

Aside from being a flat-out atrocity, the use of combined insulin coma-convulsive treatment necessarily involved the violation of certain human rights; some are proclaimed in the Bill of Rights, all are cherished in a free society:

Freedom from "cruel and unusual punishments" (Eighth Amendment). If insulin coma treatment is not a torture, nothing is. Readers of the professional literature, however, receive barely a hint of this reality. The barbaric aspects of this procedure, if mentioned at all, are glossed over in understatement and euphemism. For example, one psychiatrist cautioned against allowing new insulin patients to see other patients further along in their treatment, thus saving them "the trauma of sudden introduction to the sight of patients in different stages of coma - a sight which is not very pleasant to an unaccustomed eye."4

I recall the horror of coming out of the last coma: severe hunger pains, perspiration, overwhelming fear and disorientation, alternating phases of unconsciousness and consciousness, strangers hovering over my strapped-down body (none of whom I recognized although I had been thrown in with them months before), being punctured with needles, heavily sugared orange juice ravenously drunk, and later being held up by one or two attendants in a shower where the filth was washed away. Brain damage caused by the treatments destroyed my memory of what previous sessions had been like.

However, I remember what happened a week or two after completing my series when, having returned for lunch from "occupational therapy," I was sitting in the day room that was separated from the insulin-treatment area by a thick metal door. Suddenly I heard an indescribable, otherworldly scream. The metal door had been left slightly ajar and one of the new patients, a young musician, was undergoing insulin coma down the corridor on the other side of that door, and he was venting his pain. Almost immediately an attendant shut the door tight, but the scream, now muffled, lingered on for another few seconds. I don't recall any of my own screams; I will never forget his.

Freedom of thought (implicit in the First Amendment). The words of Oliver Wendall Holmes Sr. ring as true today as when he first wrote them in 1860: "The very aim and end of our institutions is just this: that we may think what we like and say what we think." 5 The brain-damaging force of insulin coma is second only to the lobotomy operation; it impedes the ability to think, to create, and to generate ideas. Every ICT survivor experiences impaired thinking and knows what it means to lose memories, words (you have the idea but

can't call to mind the word to fit it), and trains of thought - not just once in a while, but repeatedly, hour after hour, day after day, I have keenly felt these losses.

Freedom of religion (First Amendment). As noted above, the phrase "religious preoccupations" was among the symptoms recorded in my psychiatric records. One of these preoccupations concerned my beard, which the staff at both Napa State and Twin Pines Hospitals had been urging me, without success, to remove. In the midst of the series - after I had undergone 14 insulin treatments and 17 electroshocks - the treating psychiatrist wrote my father, "In the last week Leonard was seen by the local rabbi, Rabbi Rosen, who spent a considerable period of time with him discussing the removal of the beard. I felt it was desirable to have the rabbi go over it with him, as Leonard seems to attach a great deal of religious significance to the beard. The rabbi was unable to change Leonard's thinking in this matter."

At this point, the San Francisco psychiatrist who had been advising my father was brought in to interview me. After noting in the "Report of Consultant" that I was "essentially as paranoid as ever," he recommended that "during one of the comas his beard should be removed as a therapeutic device to provoke anxiety and make some change in his body image. Consultation should be obtained from the TP (Twin Pines) attorney as to the civil rights issues - but I doubt that these are crucial. The therapeutic effort is worth it - inasmuch that he can always grow another." On March 11, the "Doctor's Orders" read: "Pts beard to be shaved off & to be given hair cut - Observe very carefully today & tonite for any unpredictable behaviour re suicidal or elopement (escape) REJ." The same psychiatrist wrote my father ten days later, "Leonard's beard was removed this last week which caused him no great amount of distress . . ." The shock therapy in combination with the beard-shaving therapy "worked": I was soon shaving on my own. I have no direct memory of struggle over my beard or of even having had a beard during this period.

Right to be let alone. In a 1928 Supreme Court decision (*Olmstead v. United States*), Associate Justice Louis D. Brandeis wrote, "The makers of our Constitution . . . conferred, as against the Government, the right to be let alone - the most comprehensive of rights and the right most valued by civilized men." Without having been proved guilty of violating anyone else's rights, I had been deprived of my freedom and made to undergo corporal punishment disguised as medical treatment. In the truest sense of the term, I was minding my own business, exercising my right to be let alone. As a young man, I thought that in the United States this right was protected. I was wrong. That was 40 years ago, but it's still happening as literally millions of innocent people every year are being locked up, for short and long periods of time, in psychiatric facilities where their rights are trampled on and they are subjected to psychiatric treatment against their will or without their fully informed consent

Aside from the serious and permanent memory loss, other effects of those nearly eight months of confinement and forced treatment include a general slowing of the thought processes and a loss of drive and stamina. But by psychiatric standards, I am still "essentially as paranoid as ever." I still have my "vegetarian food idiosyncrasies." I have regrown my "big black (now graying) bushy beard." And, what is more, I have maintained all my "religious preoccupations."

1. Franklin G. Ebaugh, "A Review of the Drastic Shock Therapies in the Treatment of the Psychoses," *Annals of Internal Medicine*, March 1943, p. 294.

2. Marie Beynon Ray, *Doctors of the Mind: The Story of Psychiatry* (Boston: Little, Brown, 1942), p. 250.

3. Cyril J.C. Kennedy and David Anchel, "Regressive Electric-Shock in Schizophrenics Refractory to Other Shock Therapies," *Psychiatric Quarterly*, vol. 22, 1948, p. 318.

4. Alexander Gralnick, "Psychotherapeutic and Interpersonal Aspects of Insulin Treatment," *Psychiatric Quarterly*, vol. 18, 1944, p. 187.

5. Oliver Wendall Holmes Sr. *The Professor at the Breakfast Table* (New York: E.P. Dutton, 1931 (1860), chapter 5.

■

"Intelligence is quickness in seeing things as they are."

George Santayana

Mental Illness: From Shame to Pride

(Appeared in "Ideas On Liberty", November 2002)

by Thomas Szasz

Thomas Szasz (tszasz@aol.com) is professor emeritus at SUNY Upstate Medical University in Syracuse. He is the author of the Sixties ground-breaking work "The Myth of Mental Illness." His latest book is Liberation by Oppression: A Comparative Study of Slavery and Psychiatry (Transaction, 2002).

In the nineteenth century people were ashamed and embarrassed by their mentally ill relatives. This was especially true for parents who had a mentally ill child and for adult children who had a parent incarcerated in an insane asylum. Today, such persons take pride in having a mentally ill "loved one," make a career of speaking and writing about his "illness," and fight for his "right to treatment."

The attitude of journalists, writers, and social commentators toward psychiatry underwent an analogous transformation. In the nineteenth century they were critical of psychiatrists who locked up innocent people in insane asylums and excused criminals as mentally ill. Now they view and admire them as scientifically enlightened, caring doctors.

How and why did this change come about? One impetus for this transformation - which psychiatrists call the "remedicalization of psychiatry" - was the publication, in 1961, of my book *The Myth of Mental Illness* and Erving Goffman's book *Asylums*. Another was the fleeting interest of a few lawyers, stimulated by these books, in freeing mental patients from their psychiatric life sentences. (Sadly, these "civil rights" zealots were more interested in promoting themselves than in protecting liberty and responsibility, and showed no interest in opposing the insanity defense.)

These assaults on psychiatry as a medical speciality and on involuntary mental hospitalization as a species of preventive detention made psychiatrists close ranks and launch a well-organized and highly effective counteroffensive. The psychiatric defense of mental illness as brain disease and of psychiatric deprivation of liberty as medical treatment comprised several mutually reinforcing measures. One was the creation of a group of chemicals dubbed "antipsychotics," a term intended to resonate with the term "antibiotics." These chemical straightjackets were successfully sold to the public and the press - though not to involuntary patients - as "miracle drugs."

The psychiatrists' second line of defense was equally inspired. State mental hospitals had acquired a bad name. Keeping persons "hospitalized" for years and decades did not conform to the image of how real doctors use hospitals. With wages rising sharply after the 1950s, the cost of such prolonged hospitalization was also becoming burdensome to the states. The solution was to "discharge" the hundreds of thousands of chronic mental patients, attribute their forcible expulsion to the therapeutic effectiveness of "psychiatric miracle drugs," and call the eviction "deinstitutionalization". The enterprise was a fraud from beginning to end. But it looked like the "right thing to do," just as formerly the chronic hospitalization of mental patients looked that way.

Still another important element of remedicalization consisted of sanitizing the psychiatric vocabulary. The classic diagnoses of hysteria, neurosis, and homosexuality were declared to be nondiseases and were quickly forgotten. So-called "severe" mental diseases were authoritatively declared to be "brain diseases," a claim supported by the invention of a new neurochemistry (in fact, a neuromythology) and the popularization of the view that such illnesses are due to "chemical imbalances in the brain."

Significant as these developments were, perhaps the single most important impetus for the change I am describing was the formation of a new social organization and political lobby, the National Alliance for the Mentally Ill, or NAMI.

NAMI

The NAMI website describes the organization as follows: "NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these diseases. . . . Founded in 1979, NAMI has more than 210,000 members who seek equitable services for people with severe mental illnesses, which are known to be physical brain disorders."

The NAMI rhetoric conceals that the organization is composed of, and controlled by, principally the

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Mandala No. 1

by Al Todd

My mind is a mandala:
a child at each corner,
the adult mid-centered.

Whirling spheres of light
cut through the walls:
my brain erupts
and I vomit
a hundred dragonheads.

For Danny Rice

by Al Todd

Where are you now, Danny,
so kind, so numb, so undone?
Were there no maps of the mind,
straits of fire,
beggars in Samarkand?

Or were you a Jonah, who
washed up on a dry beach,
traded its bleak light for
a never ending battle with
total darkness?

Interview with a Psychiatrist No. 1

by Al Todd

I have seen
gaseous people,
Christ in the desert,
Jerusalem in the bole of a tree;

angels incarnate
while two computers argued about
the size of the Gordian Knot.

Yes, yes, but what does it mean?
What does it all mean?

Yesterday, I heard of two stones
that were identical,
of trees that locomote,
and frogs that dream of flying,
in formation
to Los Alamos, Santa Fe, and Mazatlan.

The Clenched Fist

by reinhart

having packed my baggage
numerous times;
filled with adage,
cliché and rhymes,
it should really come as no surprise,
these be but garment
that anguish, pain and fear disguise,
and years of rage ferment.
a means to cope, when, and,
her love alone is the only balm
for the clenched fist that bites the hand
and holds the teardrops in its palm.

but it matters not
wherever i may go,
for this hurt and anger's got
me packed just so.
and a history that we all must share –
malice, abuse and ill intent –
and we all cry out this is not fair –
this be our lament.
then my rage feels justified and
i hardly feel a qualm
when the clenched fist bites the hand
and holds teardrops in its palm.

and i strive to keep this rage wrapped up,
to seal it up inside;
though sometimes overflows my cup,
and i am forced to hide.
yet i struggle on with providence,
put my shoulder to the wheel,
try and make a difference,
regardless of how i feel.
while rage and love boil in my heart and
i battle to stay calm –
the clenched fist that bites the hand
and holds the teardrops in its palm.

Bookworm

The Psychoanalytic Mystic

By Michael Eigen
Wesleyan University Press, 1998

Reviewed by Andrew Feldmár

There have been a few authors I have come across in my life, whose work has so impressed me that I have made sure to read *everything* they ever wrote. D. H. Lawrence, Simone Weil, D. M. Thomas, Phyllis Chesler, Henry Miller, Maria Torok, Lawrence Durrell, Jane Gallop, R. D. Laing, Alphonso Lingis, Wilfred Bion, D. W. Winnicott, Jacques Lacan, Mark Epstein, Emmanuel Levinas are some of them. Michael Eigen is a recent addition to the above list. I find his writing candid, spirited, generous and given the complexity of the topics he addresses himself to, surprisingly lucid and readable.

Christopher Bollas writes on the cover of *The Psychoanalytic Mystic* that "Eigen's voice is unique; his vision is singular yet embracing, his mysticism is of this earth yet transcendent ... Do we know of any one who writes like an evocative amalgam of William Blake, Mark Twain, Freud, and Raymond Chandler?"

Eddington's remark, "Something unknown is doing we don't know what," summarizes not only the scientist's but also the psychotherapist's challenge. Talking of Winnicott, Eigen remarks that too much "sanity" kills spontaneity. A touch of madness adds taste to reality. This book is mad, and very tasty.

Winnicott, Bion and Lacan are not easy to read, but Eigen's illuminating romp through the work of these great authors inspires one to try again. For this alone, the book is well worth reading.

Buber wrote that "All real living is meeting." Eigen adds, "A new meeting can change one's picture of what self and other can be." In each other's company we learn that we must and can survive the worst. The most important learning in therapy is that "over and over, we come through the worst. We survive ourselves, build up tolerance for ourselves, make room for ourselves."

"Therapy may involve skill, but is also a form of prayer," Eigen writes. *Seeking is opening.* Opening to the unimaginably other Other, to unknowable reality, we become vulnerable to emotional storms, deep and surprising disturbances. Relationship might realistically be thought of as simply making the best of an already bad thing. We challenge, frighten and upset each other with our differences, our infinite otherness.

"If lies poison, truth explodes," says Eigen exploring Bion. "Facing truths about one's life explodes the lie one lives." Can a liar be psychoanalysed? Bion suggests that if not, no one can, since a liar (the psychoanalyst) also does the analyzing. No one is exempt from lying, therapist and patient struggle with the same basic problems. We are *all* in the same boat. "Nothing is more devilish than so good a fit between pretensions and reality that one never wakens," comments Eigen addressing both patients and therapists.

Often I have had the intuition that the person seeking therapy was unhappy, and confused because (s)he received insufficient love and care in childhood. The patient, however, just as often denied the validity of my hunch, remembering the love (s)he enjoyed as a child. The following remarks by Eigen allowed me to realize that for many of us it wasn't love that was missing. It was *respect.*

"Most patients I have worked with met with insufficient respect as individuals from birth on. Many were subject to love without respectful boundaries. They were treated as parental possessions, playthings, plugs to fill holes in parental psyches, rather than as persons in their own right. They were loved to death, or to madness, in some way crippled by love. In these cases parental love was intensely egocentric, so that the child was flooded by parental needs. The child was bound on the parental altar, under threat of destruction by what was life-giving, simultaneously supported and drowned by love ... Paradoxically, excess of love unmitigated by respect, becomes indistinguishable from lovelessness. Children often feel dropped into an affectless void, as parental attention swings between too much and too little. The parent who idolizes the child and expects idolization is, also, indifferent, insensitive,

and self-absorbed, so that the child goes from feeling pumped up with admiration into wastelands of neglect, too visible one moment, invisible the next."

I quoted the above so extensively because I value every word of it. Since I have come across it, I read it to many of my patients. Each time tremors of recognition flitted across their faces. The literal meaning of *respect* is "to look again". Therapy gives a chance for us to look again, look fresh, look with respect at each other.

Eigen refers to the best writers in the field of therapy: "You have all these psychoanalytic singers and poets trying to express their aesthetic experience: of a session, of the emotional content of a session, or of the impact a patient generates in session ... It's all portrayed as a cultural microcosm. We have all these wonderful and moving psychoanalytic singers opening up worlds of experience, and it's a matter of whether someone moves you along at a certain point, promotes your own growth towards openness."

Eigen is a great singer, a moving poet, and *The Psychoanalytic Mystic* is a memorable read.

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Mental Illness: From Shame to Pride

(Continued from page 11)

relatives of so-called mentally ill persons and that its main purpose is to justify depriving such persons of liberty in the name of mental health. So convinced is NAMI of the nobility of its cause that its website once offered this scenario:

Sometime, during the course of your loved one's illness, you may need the police. By preparing now, before you need help, you can make the day you need help go much more smoothly . . . It is often difficult to get 911 to respond to your calls if you need someone to come & take your MI relation to a hospital emergency room (ER). They may not believe that you really need help. And if they do send the police, the police are often reluctant to take someone for involuntary commitment. That is because cops are concerned about liability . . .When calling 911, the best way to get quick action is to say, "Violent EDP," or "Suicidal EDP." EDP stands or Emotionally Disturbed Person. This shows the operator that you know what you're talking about. Describe the danger very specifically. "He's a danger to himself" is not as good as "This morning my son said he was going to jump off the roof." . . . Also, give past history of violence. *This is especially important if the person is not acting up. . . .* When the police come, they need compelling evidence that the person is a danger to self or others before they can involuntarily take him or her to the ER for evaluation. . . Realize that you & the cops are at cross purposes. You want them to take someone to the hospital. They don't want to do it . . . Say, "Officer, I understand your reluctance. Let me spell out for you the problems and the danger." . . . *While* AMI/FAMI *is not suggesting you do this, the fact is that some families have learned to "turn over the furniture" before calling the police.* Many police require individuals with neurobiological disorders to be imminently dangerous before treating the person against their will. If the police see furniture disturbed they will usually conclude that the person is imminently dangerous.

(This material is no longer posted at the national NAMI site. But it can be found linked from the Athens, Ohio, NAMI site at www.seorf.ohiou.edu/~xx091/911calls.html.)

Giving false information to the police is a felony. Except, it seems, when the falsehood serves the avowed aim of providing mental health treatment for a "loved one."

Am I tilting at windmills? How important is involuntary mental hospitalization in our age of deinstitutionalization, when mental illnesses are said to be brain diseases like Parkinsonism, and forced psychiatric confinement is considered an anachronism? The authoritative text, *Mental Health and Law: Research, Policy, and Services*, edited by Bruce D. Sales and Saleem A. Shah, published in 1996, states: "Each year in the United States well over one million persons are civilly committed to hospitals for psychiatric treatment."

Quod erat demonstrandum.

■

Dual Review:

Beyond the Public-Private Debate: An Examination of Quality, Access and Cost in the Health-Care Systems of Eight Countries

(Vancouver, BC: Western Sky Communications Ltd., 2001. 66 pages. For printed and bound copies: ph. 604-726-3274/fax: 604-689-1525. Or, to download from the Internet, go to www.davidgratzer.ca)

by Cynthia Ramsay

Mortal Peril: Our Inalienable Right to Health Care?

(Reading, MA: Addison-Wesley Publishing Company, Inc., 1997. 532 pages)

by Richard A. Epstein

Review Essay by Byron Fraser

Introductory Quotes:

"...It is frequently assumed that systems that permit a private sector component – especially for the financing and/or delivery of acute care – discriminate against lower income individuals, offering them a lower quality of care or even denying them any care whatsoever.

This study explores the validity of this assumption....

Contrary to the common belief in Canada, the health index demonstrates that either a publicly or privately funded health-care system can deliver timely, quality medical care to all residents. First place Singapore relies heavily on private sector financing of health care and puts much responsibility on patients to finance at least a portion of the costs of their care, while second-place United Kingdom has a private system that operates alongside the National Health Service.

As well, Canada is not the only country in the world that values universality. In terms of access to care, all eight countries have measures that attempt to ensure that their citizens receive health care when they need it, regardless of their ability to pay....

The index used in the study is calculated in the same way as the United Nations Development Index....

Singapore has the 'best' health-care system, followed by the United Kingdom, Switzerland, Germany, Australia, Canada, the United States and South Africa. The recent WHO World Health Report 2000 – the first attempt by any organization to rank countries' health-care systems worldwide – yielded similar results...."

— Cynthia Ramsay, Beyond the Public-Private Debate, "Executive Summary," pp. 4-5.

"...The overall social level of production necessarily caps the amount of benefits that can be provided. The less wealth that is generated, the less wealth that can be redistributed. The social problem of coerced giving therefore is not solved simply by getting a stock of existing goods to persons in need. It also requires a set of rules to induce their production in the first place. These constraints on production cannot be ignored simply because discourse describes health care as a 'right' that should be respected independent of the market. What good is there in creating a set of positive rights that exceed the ability of any society to provide them? And what dangers lie in creating a set of positive rights that reduce the level of goods and services that are generated?...

— Richard A. Epstein, Mortal Peril, p. 44.

"...A state system on its face purports to guarantee its recipients the satisfaction of minimum needs. But the illusion of security that it creates is subject to constraints that even the state cannot control, for once demands outstrip resources, the painful process of contraction must take place. The common law system offers no grandiose guarantees that help will be forthcoming, but it relies on the decentralized efforts of private groups to fill the vital function. It is too easy to be misled by the rhetoric of rights, when the issue is overall levels of performance in the long run. What reason is there to believe that the current system will be able to deliver the health care it promises? It is not sufficient to set the aspirations of the legal system high; it is also necessary to reach the target. It is just at this level that the current system is beginning to crumble....

...When the state coerces the transaction, it must decide, without knowing quite how, that differences in utility justify the forced transfer of wealth, even though this coercive transfer reduces the

total amount of available wealth. It is easy to make a moral case for averting tragedy by talking about the cases of 'extreme want' that everyone recognizes.... Those extreme cases are surely the easiest for any system of private charity to identify and correct. It is far more doubtful whether any system of public coercion can respond to those cases without overshooting the mark and creating collateral disabilities of its own."

— Richard A. Epstein, Mortal Peril, pp. 40-41 & 48-49.

"...at no time does the overall resource constraint disappear because affirmative rights are created. We could declare generally that each person had a right to an income of $1 million per year and forget about funding health care by decree in our new age of abundance. But the massive inflation that comes from having more dollars chase fewer resources would leave everyone worse off than before. [Or, in a similar vein, as with numerous underdeveloped nations' 'socialist experiments', we could 'guarantee' everyone 100% free care and absolutely equal access to all health goods and services, only to discover that 100% of nothing is still nothing. – B.F.] In an environment with constant pressure to use expensive and heroic techniques in the treatment of well-nigh hopeless cases, how do we scale down ambitions to manageable levels? Not by giving everyone a right to health care on demand, which imposes intolerable burdens of over-utilization. [The flip-side of open-ended high maintenance unchecked spending is, of course, the situation where unthinking and unlimited "free" access at non-acute levels of care destroys the capital base for – and leads to life-threatening rationing of – services to those in the most dire need. This, also, has been a prominent feature of numerous socialist health care system models in practice. – B.F.] Health care may well be 'special' to some, but even if it is not rationed by price, it still must be rationed in some other way. Scarcity and self-interest do not disappear just because market systems of allocation are rejected."

— Richard A. Epstein, Mortal Peril, pp. 47-48.

"Chronic capital shortage is a standing weakness of the public economy."

—Madsen Pirie, Dismantling The State: The Theory and Practice of Privatization (1985), p. 62.

"...[all countries are] facing common challenges to the sustainability of their health-care systems.... Health care costs continue to rise, whether a country has a mainly public or mainly private financing or delivery system. Most governments see these rising costs as problematic....

...Health-care systems, whether public or private, are financed on a pay-as-you-go basis, whereby the focus is only on funding care that is required in the present.... No one is saving for the future's elderly and sick. The problem with this method of funding is that, as the population ages, there will be less people funding a more costly system.... Such a system is unsustainable. What needs to happen is for people to start saving today for health care they need tomorrow – these savings are put aside for the time being, invested as capital and, therefore, generate new capital. Only in Singapore is such an approach being taken."

— Cynthia Ramsay, Beyond the Public-Private Debate, pp. 22-23.

Some wag famously said, "There are statistics, and statistics, and just damn lies" – and I've always thought that that was a pretty good cautionary note to keep front and center when approaching the heady world of policy studies. Empirical datum is virtually never presented without a whole lot of bias, sins of omission, commission, context-dropping and exclusivist "reframing", etc. We all know this. And, nevertheless, from time to time, there appear very good quality technical/analytical studies which do exhibit a great deal of inherent integrity and skill, as well as doing a significant service by graphically collating, in a succinct fashion, relevant/timely facts we most need to know. I believe that Cynthia Ramsay's work falls into this category. And that is why she is one of the most respected health economists in Canada.

I first came across Cynthia's work several years ago when I read her 1998 study on Medical Savings Accounts: Universal, Accessible, Portable, Comprehensive Health Care for Canadians shortly after it was published by our local Fraser Institute. I had read the now "classic", rather massive (696 pages) parent-volume which first introduced similar thinking in a big way to the American health-care scene (— and actually went a long way towards revolutionizing their thinking, virtually overnight), John C. Goodman and Gerald L. Musgrave's Patient Power: Solving America's Health Care Crisis (Washington, D.C.: Cato Institute, 1992) circa 1993 and was anxious to see the Canadian "translation". And of course Cynthia's brief overview was quickly somewhat eclipsed by Dr. David Gratzer's very well-known, more definitive, book-length treatment, Code Blue: Reviving Canada's Health Care System

(1999), but as an illuminating reader-friendly introduction to the subject, I must say that I was tremendously impressed with it. The ideas of returning purchasing power to the patient, while at the same time providing guaranteed universal catastrophic care coverage and well-capitalized funding for indigent care (what is covered in Singapore, for example, by their Medifund provision), and also factoring in incentives (tax-deductions/exemptions/deferments and negative income tax or tax credit schemes for poor people) so as to constructively build a capitalization/savings component looking toward future needs, all made eminently good sense to me. And the implications for the mental health field were obvious: what if the phoney state-monopoly attempted cover-up scam-label "consumer" actually became a reality and real "sovereignty" were returned to individuals and their mental health care choices vis-à-vis "alternatives"? What if you put the money arbitrarily "taken" from them back into their pockets in a meaningful way, allowing them to demonstrate their real preferences with dollars they truly controlled – while, at the same time, facilitating easily specified advance directive stipulations re treatment options in their health insurance policies? Is there any way in hell, in other words, any fully informed real "consumer" with real purchasing power would choose neuroleptic drugs or ECT and so on? Every honest ex-mental patient knows the answer to this one: you'd have to be right out of your ever-lovin' mind!

In any case, I should also say, right off the top, that as a libertarian, I cannot sanction the coercion entailed in such nominally private but heavily state-regulated schemes as "The Singapore Model" so widely touted by Friedmanite conservatives, et. al. As critics from both the Left and the Right (e.g., "Austrian School" economists) have correctly pointed out, this is a varient of political-economic "fascism", in the precise historical/ideological – and not merely rhetorical/sloganeering or pejorative – sense of the term. The clear operative distinction between fascism/national socialism and outright socialism/communism is that, under the former, some private property and market mechanisms are allowed – but with strict and all-pervasive state intervention through regulation – whereas, under the latter, there is complete state ownership of all property plus similar extensive regulation[1]. "Fascism" was only "Right-Wing" in terms of the Old Left and Old Politics categories (circa early-to-mid 20th Century) and is, properly speaking, a varient of socialism and conservative statism (which, historically, are very intimately linked and today, for all intents and purposes, amount to the same thing[2]). The really "Radical Right", in both its classical liberal and modern-day "market liberalism"/libertarian-anarchist forms, has ever and always been opposed to conservatism/fascism/socialism/communism which are simply viewed as, essentially, "of a piece" on a similar end of the Right/Left spectrum. The fact that Old Left ideologues desperately tried to keep the "total dialectic" confined to the advantageous (to them) categories/terms of right-wing socialists (fascists) versus left-wing socialists (communists/Marxists) for many years, confused a lot of political ideology neophytes for quite some time — and the residual effects of this still requires us to make such a preliminary distinction for purposes of "on the same page" intelligible discourse – however these are the current accurate realpolitik categorical basics.

To return to Ms. Ramsay's Medical Savings Accounts study, though, I thought that, while far from my "perfect" ideal, it certainly was a magnificent breakthrough "step in the right direction" in terms of facilitating a practicable transition-phase program that was "real-world" politically feasible. Ditto for her more recent study, Beyond the Public-Private Debate. And what I see her doing here – again, in a very concise, easily readable/digestible form (though there are some minor obtuse technical sections which can be profitably skipped over by non-specialists, without losing her drift) – is creatively expanding the bounds of what is permissibly thinkable/doable in the health care field. Let's face it, we've all been inundated with national socialist clichés on this subject for umpteen years, even told that a socialist monopoly in this area was somehow part of our Collective "Identity" (needless to say, also having the added "virtue" of making US inherently distinct from – and morally superior to THEM damn "Ugly ['compassionless'] Americans" [why are chauvinism/jingoism/collectivist-thinking slanders/ ruled totally "out of court" for any references to race/gender/cultural diversity but still considered totally O.K. for trying to muster support for this last bastion of the 20th Century socialist movement's legacy?]) – which I'm sure was true for the numerous Public Employee self-proclaimed "socialists" who found that de rigueur line conveniently self-serving while making out like (legislatively privileged) bandits with the requisite "social concern" cover for doggedly amassing as much personal private property ("Marx" bless them!) as their "public choice" demands on the system would bear – but which, for the rest of us, has all become just so much tiresome cant. We've seen through "the veil" and we know it's time for some fresh thought and alternative solution-focus.

So Cynthia expands our horizons here by giving us these comparative systems synopses which really go a long way towards shaking up erstwhile commonplace presumptions and expectations traditionally held on both "the Left" and "the Right." I personally like this approach, too, because I've often found that what has

log-jammed progress more than anything else in similar areas of ideological debate has been mainly ostensibly "opposed" factions not seeing any way to "move ahead" simply because of stultifying old-thought categories which will not admit of any broader frame of reference which can incorporate, perhaps slightly modified, the essential validity and/or worthwhile contributions of the "contradictory" point-of-view – thus putting an end to the "at cross-purposes" missing the point (or same goal-realization identity). For instance, consider the basic socialist insight: private (legislated/mercantilist) monopolies are bad and unjustly deprive ("exploit") workers of their due property right by virtue of their labour's "true value". However, if workers were to risk pool their assets, in imitation of the very successful market innovation of capitalist insurance companies, multiple "social benefits" would accrue to individual members and, moreover, with ONE BIG MONOPOLY – or all the private means of production confiscated by "their" State – and no private property, there would be redistributive abundance and "economies of scale" that competitive markets couldn't achieve. Sounds good on paper. And most people who were originally sold on socialism bought it because it looked like it would profit them personally more than anything else being offered – that is, it seemed to make the most rational appeal to selfishness or self-interest. More than this, it wasn't all that far wrong – however, there proved to be several extremely large devils in the details. Namely: 1) "economies of scale" due to firm "bigness" only obtain in non-monopoly truly free (from corporate entities propped up and given an exclusivist share by government "barriers to entry" legislation [which, by definition, is what a monopoly is]) markets where there are genuine incentives to economize, 2) with even the minimal private property right to their mutually consented to value-price in their labour-product zone ("communized") under socialist regimes, workers were far more devastatingly "exploited" (with no recourse to even strike or unionize in any meaningful sense – de facto and de jure serfs and slaves, in other words, for the most part) under Total Statism than they ever were under market conditions, and 3) because of the elimination of the efficient market mechanism for non-arbitrary (State-"planned") allocation of resources via a free price system reflecting aggregate cardinal utility – or pertinent information about actual supply/demand/scarcity – and, therefore, any possibility of rational calculation (— i.e., the far greater levels of realistic planning and co-ordination routinely achieved in the marketplace – specifically by not engaging in some merely ordinal numerical computation), the indispensable basis for capitalization over time was completely destroyed[3], with the result that 4) the cumulative effect of the aforementioned State-exploitation of the workers through not only scamming off a far greater percentage of their labour-product, but also squandering/mismanaging/dissipating that product, was the anti-"social" reality of less total "benefits" for distribution or, in economic terms, a net "deadweight loss" situation. Witness the history of State Socialism.

Cynthia will hopefully excuse me this digression but, to return to the central point, we can see how it is constructive to grant that "the other side's" end-goals and motives are probably not so different from one's own. Moreover, it takes a genuine "reaching out" attempt to fully appreciate others' points-of-view, to conceptually master their specific terms of reference, and thereby (hopefully) to transcend rigidified and divisive ideological/semantic obstacles which really need to be slashed through. This I see her doing by graphically demonstrating that it is far from a foregone conclusion that any monolithic no-choice-but-socialism worldview must rule this field of service provision. That is the presumption that has been dominant to date – but, as she ably shows, it is assailable right across-the-board, not only on the brute empirical evidence ready-to-hand, but also according to the best modern economic theory which can be applied to the raw data. There are choices, options, funding alternatives – in other words – which can and do embrace the best features of private property rights and voluntary contractualism ("the marketplace"), as a proven great problem-solver – with the concrete realization of essentially "traditional socialist goals" (e.g., universality [in one form or another], virtually equal access/distribution, and maximal quality care – for all). In fact, it is now more than evident that only the increasing adoption of market-oriented solutions is likely to save or "rescue" these original socialist ambitions which have fallen prey to all-pervasive problems of "government (or State-managed) failure". So a more accurate title for Cynthia's study might have been: "Beyond the stage the Public-Private debate has been at" – which, in truth, has been for decades, essentially: "nowhere"; we've been living in a one-sided vacuum of no debate, for all intents and purposes. And we're now seeing the first halting, but sure, steps towards that impasse being breached.

As to the specifics of her study, there are only 3 major subject-heading areas of focus: "Comparative Health Systems, "The Determinants of Health", and "Ranking Health Systems". The brief historical overviews and capsule summaries of relevant legislation and systemic mechanisms in place under the first are excellent "neat" glimpses of the bigger international picture. Not too many surprises for me personally here but I suppose there are still many Canadians who aren't

yet aware that the United States has not had a "private" system for many, many years now (close to half of all health-care spending is "public sector") and nor, in spite of the fact that 16% of the population is uninsured – and the persistent mythology, together with occasional anecdotal evidence supporting it, which we tend to harbour – are persons routinely turned away from hospitals when in need:

"...being uninsured in the United States does not mean that a person will not receive medical care if they require it. By law, neither public nor private hospitals are permitted to refuse treatment to an indigent patient. [This has been "officially" the case since 1986, however, was widespread de facto practice for many years previous with most hospitals routinely voluntarily setting aside approximately 10% of their annual budgets to deal with indigent care. – B.F.]" (— p. 13)

Otherwise, the many different public/private "mixed-medleys" are ably elucidated with highlights, again, on how many governments are looking to the private sector to relieve the burdens and reduce pressure on public hospitals and public budgets thus freeing up and maintaining an ongoing capitalization base consistent with sustainability.

The most noteworthy finding under "The Determinants of Health" section was what Cynthia refers to as "The apparent disconnection between health-system factors and health status... reflected throughout...". Canada, for instance, (many of our readers will be happy to know), actually ranks first in terms of overall per capita "health status" – which is an indicator independent of how our health-system ranks vis-à-vis those of other countries on the broad spectrum of total other variables. As well, "The strongest relationships with health status seem to be with the socioeconomic, rather than health-system, determinants of health". (The implications of this general finding and its enormous significance when applied in the context of ongoing mental health care reform are, of course, currently becoming very well-known and will not be lost on readers of this journal. As she says:

"..., recent focus has described how socioeconomic status affects health status. The notable socioeconomic factors [include]... the availability of housing and whether people have the social support systems to get them through a crisis.

..., there is the worry that too broad a scope will only result in more government and non-governmental agencies being involved in the promotion of health, and little constructive action that improves health status. Given a limited number of resources, it is important for policymakers to be clear in their own minds as to what problems they are addressing. For example, if the main determinants of health are socioeconomic, then more public sector attention should be directed towards improving these factors than to... elements of the medical system.")

Concluding, then, on this primer to the health care debate which, to paraphrase John Paul Jones, we have "not yet begun (to have)", I'll simply say that there are many more fascinating details and even paradoxical or expectations-challenging datum awaiting the interested reader therein. Not a bad starting point, all in all, for those wanting to get a firm handle on current realities governing the field, in a clear and comprehensive – yet abbreviated – form.

For the sake of the more stout-hearted, however, who are ready to move beyond "Beyond the (Non-)Debate", I have decided to also make mention of Richard Epstein's Mortal Peril: Our Inalienable Right to Health Care? The reputation of economics as "the dismal science" has probably not so much to do with its technical intricacies being inherently uninteresting, in my opinion, as it does with the fact that it often brings home to us many "hard truths" which we'd rather not hear about or "deal with" – but actually very much need to, in any case. And Epstein's book is a very courageous "next step" treatment which squarely faces virtually all of the really "hard questions" in the field of health economics. A very highly regarded legal scholar in the U.S., Professor Epstein is also one of those polymaths who is equally conversant in economic theory and has a wide-ranging multidisciplinary expertise – a fact which is amply reflected in the versatility of his many other (often quite "controversial") published writings. He is also a long-time libertarian, like Yours Truly, and if modern-day libertarians are "traditional anarchists who have learned something about economics", as one popular saying has it, then Richard certainly "fits the bill" – and in spades. He also possesses a truly inimitable, crisp/cogent – and continuously innovative – literary style (commented on by most reviewers) which makes him a constant delight to read. This is the guy, too, who's done all of the relevant, more complex, concept-mastery homework, so some people find him a little bit difficult to follow without having to take frequent stops for checks of the referent-definitional roadmap. (That is to say that, many people whom I've talked to who have read him have complained about his writing like "Well doesn't everyone just know this?" or of having some difficulty keeping up with the level he thinks at. So "be prepared".)

In any case, I don't have space here to do more than give the broad outline of the book and hint at some of its salient features. I should say, too, that although Prof. Epstein's immediate focus is more particularly on the American health care scene, the broad scope of issues covered – from foundational political philosophy to economics to law, bioethics and

current controversies – makes it completely relevant and applicable to everything that's most topical in Canada right now as well. This is also, in contrast to Ms. Ramsay's overview, a very extensive analytical work: there's lots of thorough argumentation, contextual historical background, and detailed relevant references here (fully 42 pages of "Endnotes" alone, e.g.).

The book is divided into two parts: the 1st consisting of 8 Chapters under the rubric of "Access to Health Care", and the 2nd consisting of 12 Chapters dealing with "Self-Determination and Choice". Some sub-section subject-matters covered in the former are "Positive Rights", "Demanded [rights to unlimited care on demand] Care", "Necessity and Indigent Care", "Wealth and Disability", "Community Rating and Pre-existing Conditions", "Medicare", and "Clintoncare: The Shipwreck". And, in the latter, we find: "Organ Transplantation", "Alienability and Its Limitations: Of Surrogacy and Baby-Selling", "Active Euthanasia", "Physician-Assisted Suicide", "Abuse", "Incompetence", plus 3 Chapters on Liability Doctrine; its history, efficiency, and the need for reform (NB: Epstein is something of a specialist in this area, having written an important book, A Theory of Strict Liability: Toward a Reformulation of Tort Law [San Francisco: Cato Institute, 1980] – which, believe it or not, this crazy reviewer read many years ago – and many published papers on the subject). So you can see already that there's no shirking from tackling a whole host of the "really tough questions" in the field of health care here.

As I say, though, there is no space here to even begin to go into the substantive answers Prof. Epstein gives to these questions – only to point the direction to them. One very noteworthy discussion I would like to comment on, however – which is unmistakably emphasized and alluded to in my introductory quotes selections, and goes also to Cynthia's main point about the need to break through stultifying conceptual impasses in the Left/Right dialogue – is the basic philosophical divide, with us for many decades now, often described in terms of the distinction between the "negative liberty"/ "freedom from"/individual or common law rights (Rule of Law)/ tradition, on the one hand, and the "positive rights"/ "freedom to"/ collectivist or state-"entitlement" rights/ tradition, on the other[4]. Can this gap be constructively bridged such that the material abundance engendered by a free market economy, predicated on retaining the fundamental justice/integrity of "freedom from" natural rights to life/liberty/property, can be translated into completely adequate voluntarist-type "social safety net" or "minimal (dire needs and comprehensive insurance) entitlement" sorts of charitably-subsidized contractarian "freedom to" rights arrangements – without "killing the Golden Goose", as it were? That has become the perennial sixty-four thousand dollar question. And I think the answer is "yes"[5].

Clearly we cannot "turn back the clock" to the unsustainable "government failures" of socialism – which repeatedly have simply not "delivered the goods" to poor and needy people. But we need to respect the very valid moral intuitions which attracted many people to its broad "social"-goals, in the first place, regardless of what an unmitigated disaster its means made of all attempts to realize these in practice. As the good Prof. puts the matter:

"...we possess, and act on, some powerful intuitions in dealing with health care questions. On matters of health care, side by side with the market is an extensive network of voluntary charitable organizations that are, and should be, a part of any decent society. But the key to the argument lies in the futile efforts to transform that moral intuition into a legal right." (— p. 31)

And it is just here that I want to sound a small note of dissent. While I fully understand this criticism of State-mandated and open-ended "positive" legal rights, and all of the very real net social harms, inequities and injustice attendant to them, my thought, somewhat along the lines of the noted Canadian philosopher, Prof. Jan Narveson[6], is that might it be not only politic but astute to grant the validity of these "leftist", so-called, desires for secure insured legal claims to basic needs (food/shelter/health care, and so on) but – without violating libertarian (non-aggression against the equal rights of others) principles – to simply concretize these rights on a voluntarily subsidized contractarian basis? Something like the Singapore Model Medifund – and like schemes – could relatively easily be facilitated and capitalized in perpetuity from the proceeds of widespread privatization (just "for instance", in the Canadian context, it is estimated that the national debt could be paid off – and social welfare benefits multiplied many times over – virtually overnight, any time the government chose to do so by lifting its moratorium on water sales to underdeveloped nations in need [see especially the findings of the Winnipeg-based Frontier Centre for Public Policy: www.fcpp.org]) or simply from general revenues and/or charitable tax-deductions, etc. Then everyone would have the much-desired security of legal rights for insured basic needs claims, albeit within a properly judicious and prudent voluntarist "checks-&- balances" framework. Something to think about!

Notes:

1) See especially on this the "Epilogue" added to the 1969 edition of the classic study, Socialism: An Economic and Sociological Analysis (London: Jonathan

Cape, 599 pages), by world-renowned economist, Ludwig von Mises, under the sections on "Fascism" and "Nazism", pp. 574-82.

2) See further on this — and especially on the close affinity between the thought of Marx/Engels and European Conservatism – the excellent essay by Stephen J. Tonsor: "The Conservative Origins of Collectivism" in Liberty and the Rule of Law (College Station and London: Texas A&M University Press, 1979), edited by Robert L. Cunningham, pp. 224-41.

3) The definitive work on this which drove the last nail through the coffin of the theoretical corpus of socialist economic thought, in terms of all recognized serious scholarly work on the subject, was Economic Calculation in the Socialist Commonwealth (Auburn, AL: Praxeology Press, 1990) by Ludwig von Mises, originally published in 1920. Of course, it took a good deal longer for the incarnate body politic "history lesson" of socialism's "passing" to reach us with abundant empirical evidence of what Mises had so clearly deduced and demonstrated a priori – at a time when few paid his message any heed. That, thankfully, is no longer the case. (Cardinal as opposed to ordinal numbers are those containing a subjective value-input component rather than a merely random order ranking – which does not constitute useful information [real "utility"] in any economic sense. Socialists tried to argue for years that, with the advent of computers, the "knowledge/information" problem of centralized State-planning without market prices would be solved; you would just survey everyone's needs/wants virtually instantaneously, do the [computerized] math, and then allocate on that basis. The fallacy operative here, of course, was that the problem was one of calculation and not "knowledge". You could have all the raw data in the world and, without numbers tied to demonstrated preferences, your decisions based on it are worthless in terms of economizing, "meaningless" for efficient [capital building and optimally sustainable] resource use and planning. This was not a technical/cybernetics glitch in translating theory to practice as early socialists had hoped/supposed, but rather an inescapable logical impossibility which has forever doomed the practicability of their ideological enterprise – and achievement of its goals – on their own terms. [See, also, for a great summary overview of this controversy as it played out historically: Economic Calculation in the Socialist Society (Indianapolis, IN: Liberty Press, 1981) by Trygve J. B. Hoff.])

4) These defining "lines in the sand" which have essentially demarcated the classical liberal/free market position off from, or over-&-against, the left-liberal/social democratic one, for at least the last half-century – and a good deal longer, in one form or another – are most commonly associated with the seminal distinctions outlined by Sir Isaiah Berlin in his Two Concepts of Liberty (Oxford, 1958).

5) For some suggestive ideas on not only how this has been successfully achieved historically but also what can be – and is being – done right now, along these lines, see especially: The Tragedy of American Compassion and Renewing American Compassion (Washington, DC: Regnery Gateway, 1992 & 1996, respectively) by Marvin Olasky. Also: From Mutual Aid to the Welfare State – Fraternal Societies and Social Services, 1890-1967 by David Beito.

6) See especially his The Libertarian Idea (Philadelphia, PA: Temple University Press, 1988) and For and Against The State (1996) for more on contractarian solutions to bridging the "Negative Liberty" vs. "Positive Rights" dilemma.

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Richard A. Epstein is the James Parker Hall Distinguished Service Professor of Law at the University of Chicago and an adjunct scholar of the Cato Institute, Washington, DC. He is the author of Simple Rules for a Complex World and Takings: Private Property Under the Power of Eminent Domain, among other books, and a noted authority on Tort Law.

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The Alternative & Integrative Medical Society (AIMS) at UBC publishes the free AIMS Wellness Directory: Lower Mainland Guide to Complementary Health. It contains approximately 250 paid and many unpaid listings dealing with a broad spectrum of mental, physical, and spiritual aspects of healing. For a Directory and/ or more info. about the Society, phone 604-822-7604. Fax: 604-822-2495. E-mail info@aims.ubc.ca. Web: www.aims.ubc.ca. AIMS, University of British Columbia, Box 81 – 6138 SUB Boulevard, Vancouver, B.C. V6T 1Z1. Office: B80A Woodward Building, UBC.

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Location: CMHA (Vancouver-Burnaby), 175 West Broadway Phone: 604-872-4902, Ext. 236 (Alan)
* Our newsletter 'All About Us' is created by Resource Centre volunteers and staff.

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http://aix1.uottawa.ca/~nstaman/alternatives/
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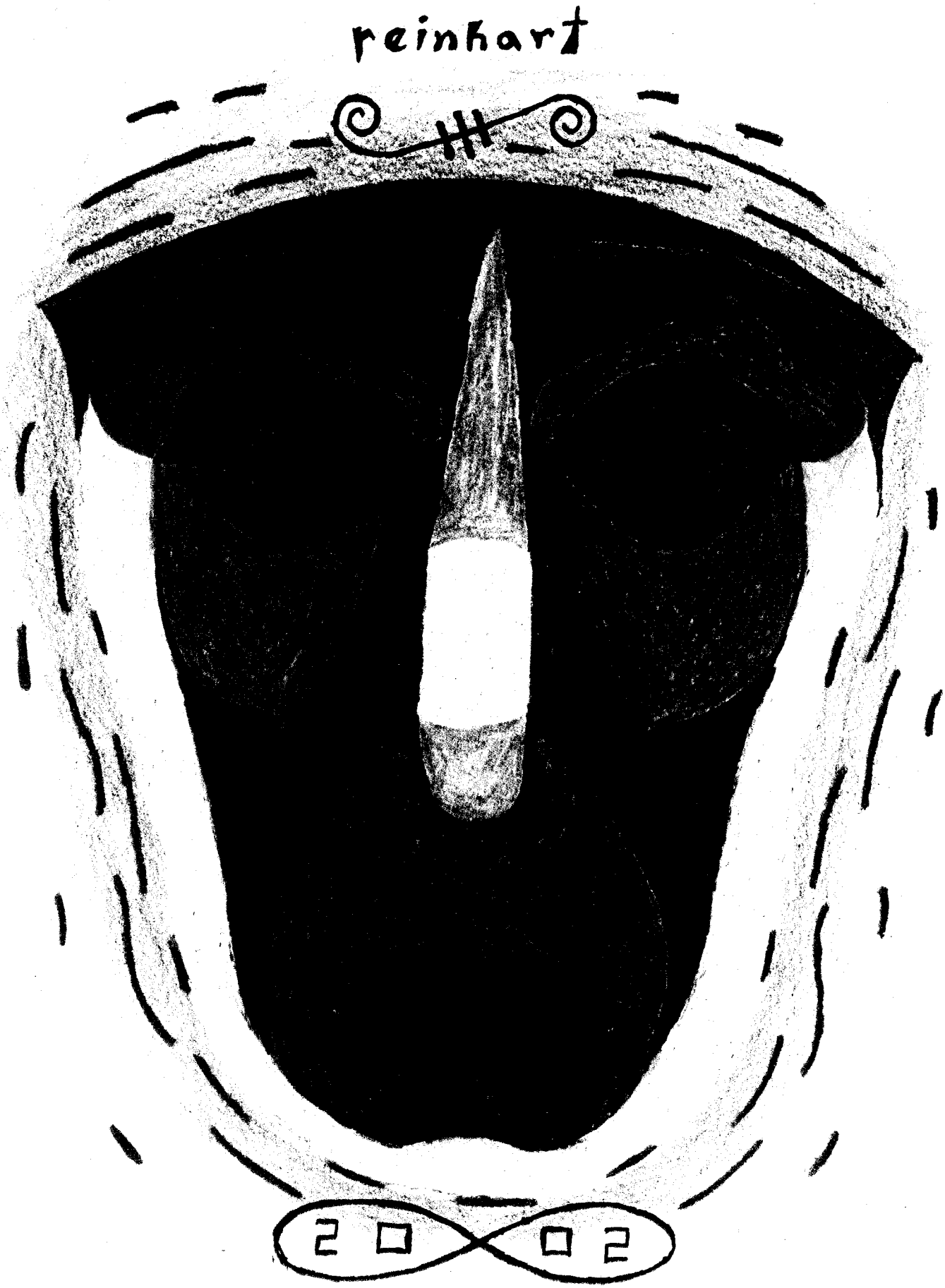
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