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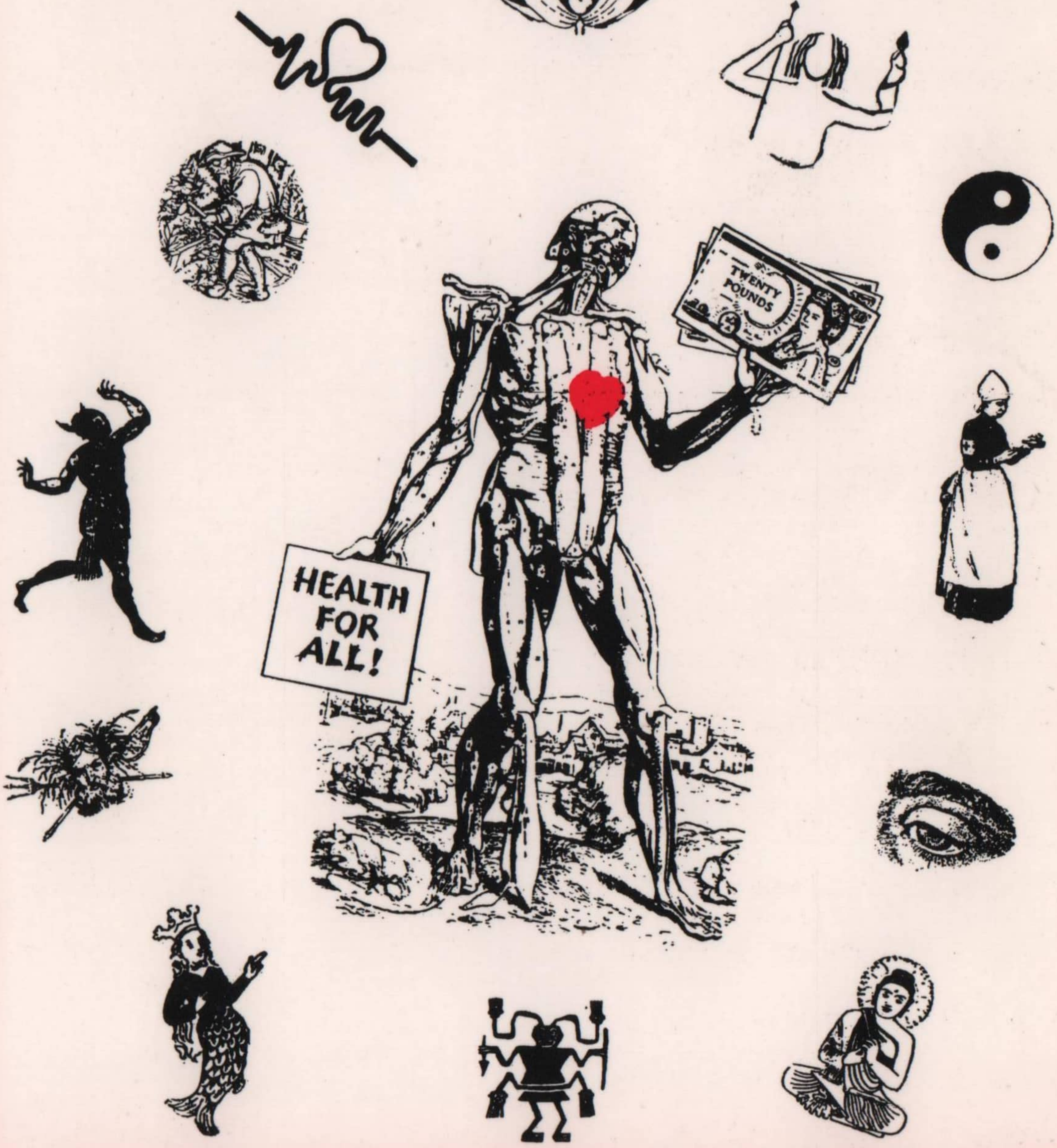

THE RAVEN ANARCHIST QUARTERLY 15

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Volume 4 Number 3 ISSN 0951 4066 July-September 1991

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cover illustration: collage by Silvia Edwards

Silvia Edwards

Introduction

'And freedom will bring health' John Hewetson

The subject of health scores high on most people's scale of priorities and preoccupations and therefore it has not been difficult to attract interesting contributions for this issue of *The Raven*. What has been difficult however has been trying to strike a balance between articles on mental and physical health, though such a distinction is becoming increasingly blurred in recent times.

The question of health care has been given an immense amount of media coverage over the past year. Issues covered include the setting up of Hospital Trusts as part of an almost inevitable dismantling of a National Health Service which was once the envy of the world. Despite its cosy connotations, the present Community Care Policy, drawn up to care for people leaving large psychiatric hospitals, is causing grave concern. Its gross underfunding has resulted in the grim reality of many ex-psychiatric patients begging on the streets of London. Only one day care place has been provided for every six patients leaving long-term care. Ever-increasing homelessness and its attendant physical and mental health problems, the continuing spread of AIDS and HIV infection; increased drug dependency; sexual and alleged Satanic abuse of children; GPs playing the dual role of doctors and businessmen; the list goes on and concern about many of these issues is reflected in the contributions in this quarterly.

Hospital Trusts touting for business have led to the sinister inclusion of 'non-disclosure' clauses in their policy documents. These have been dubbed 'gagging clauses', because as a result hospital personnel are now wary of speaking out against defects in the services. A case in point is that of Graham Pink, a nurse from Manchester working for a Hospital Trust. He has been penalised, that is threatened with dismissal, for exposing the chronic understaffing on geriatric wards in a large Manchester hospital. These staff shortages have led to gross patient neglect and to old people being left to die alone as staff are too busy to attend to them. Thus it seems that previously non-confidential information is currently shrouded in secrecy and lifting the veil can end in savage disciplinary action.

The connection between poverty and ill health is well established. Only last month a meagre half-column in *The Times* told of an outbreak

of dysentery affecting 145 people in Hull. Medical officers attributed most of these cases to poor living conditions in the east side of the city. This is redolent of Engels study of the poor and John Hewetson's well-documented research on the correlation between poverty and illness, more than a century later.

So if the government trend to develop a two or even three tier health system succeeds, what then? What model of health care can we as anarchists present as a satisfactory solution? Though it closed in 1951 the impact of the Peckham Health Centre is still felt. The ideals behind it have inspired health care enthusiasts for many years. Though Dr Scott Williamson would not have called himself an anarchist, the centre was undeniably run on lines compatible with our attitudes.

The philosophy of a neighbourhood-based health centre run by local people with facilities directly or indirectly concerned with health and well-being could be expanded to cover the country. But a health service, however well organised and egalitarian, cannot cure society's ills. A social restructuring where individuals can feel valued is the first requirement for a healthy society.

The rise in popularity of alternative, complementary and New Age remedies, therapies and aids to health underlines the fact that people are no longer satisfied with nor confident about orthodox curative medicine. But what seemed to begin with genuine therapies, seems now to include quackery and a whole new growth industry. Nothing is too outlandish nor too costly it seems.

The irony is that despite these costly remedies people appear to be no healthier and thus the burden on the health care system has not been eased. It appears that the alternative therapies have become either the last resort of the disillusioned or simply fashion accessories for the affluent.

Whatever health service we have it can never cure the ills of the nation, for as Ivan Illich stated in *Medical Nemesis*,

> For more than a century analysis of disease trends have shown that the environment is the primary determinant of the state of the general health of the population.

What we need is a move from cure to prevention. Sewers, piped water, slum clearance and a balanced diet are more beneficial to health than doctors and hospitals and we have these in part, but equally important are equality of opportunity, feelings of self worth and the control of unbridled ecological pollution and the avoidance of industrial and nuclear disease and disaster.

Simon Kinsey

Shifting Models in the NHS

'It is our job to make sure that there is better healthcare provision for those living in deprived areas', went on the confident, clean-looking man from the Health Authority. Although he wore no badge on his lapel it was evident from his suit, pin-striped, from mirror-polished shoes to conservative-blue necktie, and from his zealous belief in a political theology which had saved him, that we were in the presence of a man from the New Management. This was a man from the new breed of mankind. This was a man with a vision far beyond that of the mortal public. A man with a mission. Or an incurable disease.

'We believe. . .' or had I come to an evangelist meeting by mistake? '. . .that a Trust Status for this hospital will mean better continuity of care and a better quality of care through the retention of good staff and attracting better staff by the better rates of pay we can negotiate.' And so the speech continued. 'We can give greater priority to local service developments through a sale of redundant NHS property. . .' The wards closed five years ago due to staff shortages can now be sold.

The audience to this 'public consultation' over the proposed trust status of the hospital numbered about 40 and had one thing in common – they all lived in the real world. They had experience of suffering in a bed waiting for treatment, and of visiting elderly relatives in forgotten community homes. Their ideas came from their experiences, whereas the New Management's ideas came from ideologies handed down from Conservative manifestoes, like sacred texts, worshipped and swallowed whole.

'Why is this called a public consultation when you've already decided that the hospital is to adopt trust status anyway?' asked a frustrated man. Other questions in a similar vein showed that the audience knew that consultations, costing more than £2000 in staff pay to organise, the same again in local publicity and a cool £10,000 to produce a glossy consultation document were a gimmick. In spite of previous ballots showing around 95% of the people were opposed to the change, the change had already happened. They already had purchasers, providers, contracts, service specifications, marketing strategies, competitors, and patients had become consumers. The public knew that a consultation was not designed to consult the public on the way the NHS should be

managed, and the New Management gave speeches knowing that they would not have to persuade the public about the virtues of the trusts. The consultation was instead a part of the system of changing the way the public thinks about the NHS.

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It goes without saying that the new terms applied to the NHS come from the financial world. By brutal means the structures of the NHS have been modified to mimic the market place. It is now not possible to think about the NHS without using financial terminology. I used to attend a hospital as an outpatient. I now attend a provider unit as a consumer, providing that my health authority has a contract with the provider unit.

To think about the NHS I need a mental model of it in my head – a collection of related concepts which refer to the NHS. To understand discussions about the NHS I need the same concepts in my head that others are using in the discussion. Once these concepts were 'patient', 'doctor', but recently they have become 'provider' and 'contract'. So in my head I have a mental model based on these and a whole lot of other business terms. I can now no longer think about the NHS without using business thoughts. The business world has been implanted into me.

Fortunately many people are having problems with the new terminology. Few can understand what a purchaser is or does and the concepts are becoming confused. The public are having trouble adapting their thinking to the new way of viewing the NHS. I for one, who work daily with the new ideas, have trouble with them. Part of the problem is that the new concepts don't fit reality too well. There is no concrete difference between the Royal Free Hospital of yesterday and the Royal Free Hampstead NHS Trust of today. I can tell the difference between a doctor and a chocolate biscuit or an MP and a strawberry blancmange, but the Royal Free Hospital and the Royal Free Hampstead NHS Trust look remarkably alike. I am told of changes in management responsibility but so what? As a patient (user/consumer), I look at it in terms of nurses, consultants, and ambulances, not in terms of management structures.

The new mental model is being imposed on us from a financial ideology of a government which views everything in terms of cash flows. People are money, wars are money, hospitals are money. A mental model should come about from what structures already exist in the world. To impose a way of thinking on it does not help us to make sense of it. It distorts. It fools. It is propaganda. It lies.

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'But we don't want a health service which competes between health authorities,' insists a lady in the audience. 'We don't want the people in our community to be treated at the expense of those in neighbouring authorities. We want a NATIONAL health service, where skills and expertise of one authority is shared with other authorities, so everyone benefits. We want cooperation, not competition.' The sentiments expressed sent ripples of approval throughout the audience and the temperature of the discussion raised. The New Management were beginning to sizzle a little under the heat of the audience. The chairman of the meeting stepped in as a thermostatically controlled fan blower. 'I must remind the audience that this consultation is only concerned with the proposed trust status of the hospital and not to confuse it with the issue of the purchaser-provider split. Please try and keep your comments to the trust issue.' The heat was reflected inwards to become resentment. But some already knew that the new mental model had been punctured with the audience's own concepts of 'cooperation', 'neighbours' and 'national'. The New Management were having to think in terms of the audience's viewpoint which fitted reality, rather than their own ideological viewpoint. Many present had rejected the business jargon and were returning once more to their own communally accepted terms.

The meeting ended. 'As you go out can you please fill in a voting slip according to whether or not you want this hospital to adopt a trust status? Thank you for coming along to what has been a lively debate on what is, you will, remember, OUR health service.'

Results of the ballot were announced two days later. As usual, 42 against the trust, three for it.

Comment from the New Management: 'Many in the audience just didn't understand what trust status means'.

Simon Kinsey works for a Community Health Council in London, which was set up to make health authorities more responsive to their patients' needs. The views he expresses in this article are his own and not necessarily those of the CHC.

Jim Brown

Are You Normal? God Help Us!

'If I could turn you on, if I could drive you from your wretched mind, if I could tell you – I would let you know.' So said R. D. Laing in his book *The Politics of Experience*. What Laing is saying here is, there is no way in hell you are going to convince the so-called normal man that his world is extremely sick and if he doesn't wake up and change his ways soon, there won't be much left of the planet. According to Laing and other psychiatrists the normal man is alienated from others as well as from himself. This normal man has killed over 50 million of his fellow men in recent history. He has just had big parades celebrating the latest carnage in the Middle East War – probably 200,000 deaths. No remorse, no guilt – more like a Nintendo game. The terrible misery and suffering of so many people has no effect on that normal man.

Any half sane person is revolted by the fact that trillions of dollars have been wasted on building the most fiendish war machine the world has ever seen. So horrible that if ever used it may mean the end of life itself. And yet, the normal man still goes along with building more of these nightmarish weapons, with spending trillions of dollars on these ghastly weapons while millions of people starve. A few years back a peace movement aroused some protest for a time but the inertia of the normal man would not allow for a healthy response.

Today responsible scientists are stating the planet is endangered from the vast over-kill of toxic poisons and carbon dioxide which is polluting the planet. Some have stated we may have passed the point of no return, pointing to the green house effect which is rapidly warming the planet. And still – normalcy prevails.

If everything stated above were all lies, only someone very ignorant or deliberately distorting the truth would deny the disintegration of the cities, where crime, rape, child abuse, drugs, homelessness, AIDS, keep getting worse.

Hope? A way out of this madness? Ludicrous! What could possibly awaken and enlighten this normal man who spends six hours a day being entertained by television and votes into power Ronald Reagan and George Bush?

What is needed is an absolute miracle. And who in an influential position has a viable plan to restructure this decrepit political system?

How many people understand the nature of our problems? How many people have the wherewithal to confront this political structure and build a viable movement to reconstruct healthy institutions? Anyone who does not recognise the need for basic change in the power structure cannot effect healthy change. (Liberals, Democrats and Republicans take note). When change is needed and people are not ready for healthy change, they will accept what evil the sick leaders offer. (Nazi Germany, the development of nuclear weapons, the ecological breakdown of the planet, wars and more wars.)

The saddest fact of all is the normal man can't be any different from what he is right now, given his exposure to the sick conditions of modern life. A caring person with a conscience along with a keen awareness is the product of healthy experiences; conditions of growth which build those qualities from early infancy. These favourable conditions are lacking in this highly competitive, highly materialistic, deterioriating society.

Laing drew a lot of criticism by claiming that some schizophrenic patients were healthier than normal people because they didn't adjust to insane conditions. He claimed that adjusting to sick conditions leads to madness.

And so his final sentence, which I go along with – '. . . if I could drive your from your wretched mind, if I could tell you, [talking to the normal man who perpetuates the world's madness] I would let you know.', expresses the despair of the twentieth century. Incidentally Laing was not singling out the so-called man on the street. The leaders of the world indeed reflect the insanity of the current conditions.

Therefore the danger for the non-normal person who still possesses some open qualities, who is still sensitive and has a conscience, is of succumbing to despair. There is very little if any hope that that which is needed will emerge without a miracle. And what is needed is the development of awareness and caring qualities in millions of people who would dedicate themselves to taking political power and establishing a democratic socialist government with the intent to bring about a socialist world government. A world government where victimisation and exploitation of people would cease. Where love and understanding would prevail and wars would be no more; and the healthy balance would be restored to the ecology of the world.

Yes, that is the phantasy and instead of that dream we will continue to watch, in a relatively short time, the now over five billion people on the planet double to ten billion; bringing about more starvation, disease, riots, more sickening wars, the over-heating of the planet, millions of tons of toxic poisons continuing to pollute the air, land, and water.

Without those necessary basic changes in our institutions we will be witnesses to the continuing destruction of this beautiful planet.

Unless the normal person is personally affected with a mugging or loss of job, all this world chaos does not affect him much, his defences see no evil, but the sensitive person with a conscience who loves life and the planet cannot readily adjust to what is obvious madness. And what to do in a dying civilisation is a big problem.

What might be redeeming, for any of us who are in despair about the world's plight, would be to reinforce our love of the planet and life. We can act as if we could save the planet, even though there is little hope we can do so. Our other options are not too great – compromise and go along with the existing system; join the normal sleep walkers; build some inner defence system and deny the threats to the planet. Or ignore the causes – work on one of the many sick symptoms and delude ourselves we are going to save the planet by saving the whales, recycling cans or electing nice liberals to Congress. Not very satisfying options. Acting as if we could save the planet is not easy. The sustaining power of great leaders such as Gandhi and Martin Luther King was a faith and belief in their cause. We would have to believe in the rightness of what we were doing, but some of us who realise how little readiness there is to make the necessary basic changes, have no illusions. Ignorance, apathy, a decrepit but entrenched political system and time, are working against healthy change. The number of aware, caring, knowledgeable people, willing and able to build some kind of a force for change is few indeed.

Just imagine creating a little miracle like pulling together the hundreds of environmental, women's, peace, labour, civil rights, etc. groups into a cohesive force; building a vast network of grass roots groups who would get out by the millions to make those necessary changes. Imagine taking the power away from the military industrial complex and using those billions to rebuild healthy institutions which would encourage a cooperative caring society! Imagine giving people authentic hope in the future and actually starting to save the planet! Now wouldn't that be something!

Jenny Corbett

Watching and Listening: a paediatrician's career, 1944-1986

The medical model of disability has been much criticised in recent years and the traditional power of the doctor to diagnose, direct practice and provide services is now being challenged. Paediatricians have been accused of making crude assessments of potential ability in young children, damaging the quality of family life in the process. Yet, the Cleveland affair admits ambiguities in the public perception of paediatricians. Are they to be advocates for their vulnerable clients or partners of parents? Can they be both? Medical attitudes arise from the political and social culture in which practitioners are learning and operating. In this paper one paediatrician shares his reflections on a 42-year career, during which period medical, social and economic changes were to radically alter his practice and perceptions.

Belonging to the Medical Profession

Many disabled people describe the feelings of 'belonging' to the medical profession who define us in terms of our diagnosis 'she is a spastic', e.g. who assess and define our rights to physical or financial assistance, who plan and manage our health care, whose signatures to bits of paper override our own judgement in even the most personal and fundamental areas of our lives. (Mason & Rieser, 1990, p.14)

For disabled people, the notion of belonging to the medical profession is regarded as an unjustified intrusion on personal liberty. Among their non-medical colleagues involved in the care of children, medical practitioners are often seen as preoccupied with diagnostic categorisation, with the disability rather than the child and with technical rather than social issues. Fulcher (1989) challenges a medical discourse as depoliticising, professionalising and individualising disability, deficits resting with patients not 'experts'.

The 'expert' is exonerated from responsibility, professional integrity remains intact, traditional wisdom and values are not questioned, and the existing social order goes unchallenged. (Barnes, 1990, p.6)

Doctors are people, not 'experts'. They are as prone to foolishness, arrogance and vanity as anyone else, especially when being asked to make judgements. They also inevitably reflect the attitudes and knowledge of their own period in history.

In a fascinating autobiography, *Janos, the Story of a Doctor*, (Plesch, 1947), a Hungarian scientist and physician of international repute who became Professor of Medicine at Berlin University, reflects on almost fifty years observations since be began as a practitioner in 1900. This, I particularly liked:

> Every time there is some new step in the development of medical or other scientific knowledge a storm of enthusiasm is aroused, and the world almost feels that the panacea for all evils has at last been found, but then the second stage invariably arrives – the stage of disappointment, when further practical experience shows that not all the hopes placed in the new discovery, whatever it is, have been fulfilled. And after that comes the third stage of misgiving, when it gradually becomes clear what harm can be done with the new discovery when it is used indiscriminately. The fourth and most satisfactory stage often takes years to reach; that is when scientists have obtained sufficient experience to form an objective judgement, and separate the wheat from the chaff. (Plesch, 1947, p.463)

What he emphasises is that doctors are learning, making errors, and learning some more. I would, however, challenge his inference that there is something intrinsically 'objective' about the judgement of scientists. As a scientist, he makes this judgement:

> The strict observation of regularity in the evacuation of the bowels seems to be a characteristic of civilized society. Amongst savage tribes, and even amongst less civilized Europeans, the daily evacuation of the bowels is by no means a necessity, nor is it a physiological necessity. (Plesch, 1947, p.492)

Surely this comment owes more to cultural values than to science. As a women, his following 'scientific' observation incenses me:

> The natural tendency of women is towards masochism, whilst the natural tendency is men is towards sadism. In her love life the woman requires a certain amount of sadism on the part of her lover. She likes to be ill-treated up to a point, to feel pain, and she is grateful for it. The man will unconsciously comply with this requirement of his beloved. (Plesch, 1947, p.525)

Would these 'expert' views go unchallenged in 1990?

The value of having access to the observations of this medical practitioner and international 'expert' is that it places medical knowledge and perceptions firmly within a social and cultural context. Plesch was, no doubt, a dedicated practitioner. He was also living in a culture and at a period of social history in which patriarchy was the convention and

the oppression of social groups, perceived as inferior, was standard. His 'science' reflects attitudes he would not think to question.

I call this paper 'Watching and Listening' for two reasons. It seems to be what doctors have to do in diagnosis and observation of patients: they look and listen in order to guess. It is also what they should be engaged in doing, in order to avoid the arrogance of assuming they always know best. They have to watch and listen to signs of disquiet in their patients and to signals of doubt in their own minds. Watching and listening requires that 'experts' will sometimes admit that they don't know or that they were wrong.

This paper has resulted from a dialogue with a recently retired consultant paediatrician (my father, Dr Richard Pugh, FRCP) in which I attempt to understand the medical model as it evolved during a professional lifetime and beyond. As my introduction implies, I reject the notion of scientific objectivity in relation to practitioner perceptions. The views that will be described are those of a doctor who worked exclusively for the National Health Service throughout his career. From the outset, I will acknowledge that I admired and respected my father's commitment to his work although I often challenged some of his attitudes. This paper will clearly indicate both my perceptions and his. It makes no pretence to be other than subjective but to offer personal reflections on recent medical practice.

Issues are discussed around four core themes: the doctor's role in society; the effects of social and economic change; the effects of new medicines; the effects of attitudes on practice.

The Doctor's Role in Society

Patients tend to seek reassurance and guidance from doctors, anticipating that they will produce solutions to problems. This assumption might be partly responsible for the scenario of a doctor playing the role of an infallible magician-cum-deity. Cosbie Ross recalls his father, early this century, conducting,

> a largely working class practice in the suburbs of Liverpool. Though working mainly single-handed he had an imposing array of helpers, such as a dispenser, a nurse-attendant and a chauffeur. His manner with patients was invariably kind and courteous, and he habitually wore a morning coat, even when on holiday. (Cosbie Ross, 1989, p.517)

This facade, Cosbie Ross explained, was necessary to compensate for the paucity of available therapeutic resources. A demeanour of authority and certainty was his principal strength in performing a vulnerable role

as a healer. He could not be seen to dither over diagnosis and the grandeur of his manner served to placate anxieties.

My father's memories of his student days in the early 1940s were of makeshift arrangements and casual acceptance of the frailty of life:

> As students, we catnapped in hospital until summoned to accompany a midwife on our bikes, carrying the obstetric kit and plenty of brown paper. Women at that time (1942-43) often had five or more babies and were not surprised by the occasional tragic loss. Mothers still sometimes died in childbirth and obstetric flying squads with emergency blood transfusions could be lifesaving. Labour was much less commonly fore-shortened by surgical intervention and some children survived with cerebral palsy, without, I might say, any blame being attached to the midwife or doctor – very different from today.

It might be suggested that, with advances in modern medical practice, doctors are no longer deified but held to account. Today, doctors, however eminent, face a society well aware of the breadth and scope of contemporary medicine and with the highest expectations. Professional conduct is freely questioned and resort to litigation is snowballing. An extreme consequence of the results of massive awards against doctors and midwives has resulted in the virtual collapse of obstetric services in Florida (Symonds, 1989). Thus, the exercises of patients' rights and the exposure of medical fallibility may be self-defeating.

The public role of the doctor can be seen to have changed over time. The part played by a paediatrician has also developed with changing resources and perceived needs. My father reflected on his career as a member of the National Health Service:

> To understand what the NHS has meant to paediatric services, one must recall the situation prevailing in the 1930s. Up to and during the second world war, relatively few doctors worked exclusively with children in a consulting capacity based upon hospital paediatric departments. One basic aim of the NHS was to make generally available throughout the United Kingdom services which, hitherto, had been confined to centres of excellence. As a first step, consultant paediatric appointments were made – not infrequently the appointee was single-handed and required to start from scratch. The first post I applied for in 1950 was to be a paediatrician in the West Riding of Yorkshire with duties centred upon Wakefield, Pontefract, Castleford and Dewsbury – a massive responsibility for which I was rightly considered too inexperienced – an area which was later served by six paediatricians.

Not only did he see paediatric services proliferate but he saw what was regarded by the medical profession as a peripheral interest develop into a complex area in its own right:

> The British Paediatric Association has expanded tenfold since the introduction of a National Health Service and the annual meeting is now an international

high pressure conference in a university setting while it was once an informal gathering of friends in a lakeside hotel, with time off for golf in the afternoon.

This growth in status of a relatively new branch of the medical profession serves to remind us of the artifice and fragility of social roles. An unrecognised need becomes an imperative, as attitudes change.

The Effects of Social and Economic Change

Throughout his period as a consultant paediatrician, my father worked in Hull, a city where economic necessity forced men to sea:

In 1957 there were still a substantial number of slum houses in streets radiating out from Hessle Road where, traditionally, the deck hands from the fishing trawler fleets lived. The men worked in deep sea off Greenland, fishing for up to three weeks with only two nights at home and perhaps one trip off each year. Their lack of involvement in home life often meant that the house was neglected, families were unreasonably large and grandmothers ruled. The Victoria Children's Hospital in Park Street, Hull, was strategically placed to serve the children of fishermen's families, who filled many of the available beds. Tuberculosis, contracted in crowded conditions by men at sea, was spread by equally crowded conditions on leave as, on a lower plane, was scabies.

He recognises the correlation between disease and economic status: poverty creates crowded and insanitary conditions which spread infection. Yet, there is an inference in the use of terms such as 'neglected' and 'unreasonably large' that value judgements are being made on these families. Barton (1990) notes that 'early professional intervention will often be in the home, thus the question of invasion of privacy by people whose experiences, values and priorities are very different, becomes a major issue' (p.18). Domiciliary visits to sick children expose their families to an unequal level of scrutiny.

Poverty fostered malnutrition as well as infection:

One forgets that many deprived children 40 years ago were malnourished. A lack of calories would impair growth and maturity (hence school milk and meals), a lack of meat and eggs would make iron deficiency anaemia very common and severe, resolved by National Dried Milk which had added iron and was cheap. National Dried Milk also supplied Vitamins D and C. Previously, rickets and scurvy were common amongst the poor. In Britain in the early 1940s we used to ask, 'What does s/he eat?' and the answer was often given in slices (white bread and margarine or dripping). Cooking was unfamiliar in many families.

Again, there is a delicate balance between concern for the adequacy of children's diets and imposing class values. Similar medical attention has recently been paid to the poor health of children living in bed and

breakfast accommodation (Howarth, 1987). Perhaps the professionals concerned have to ask themselves how they would cope in the same situation and what practical measures might alleviate difficulties.

The general health of children, observed by my father as a practitioner, improved over the years with the effects of smaller families, better housing and diets, more fathers living at home (with the loss of the fishing fleet in Hull) and mothers going out to work. Fewer children were admitted to hospital on either social or health grounds.

He paints an overall picture of changes over time:

> A paediatrician consciously looking back to the time before the NHS was established, 40 years ago, would see astonishing changes in every aspect of child care; few of which could have been anticipated. Hospital paediatric medical staffing has exploded while hospital provision for sick children has changed radically from inpatient to outpatient care. Parents, once displaced, now participate actively in their children's care. Many diseases have all but disappeared, many are subdued, some new ones discovered and many children now survive illnesses which were once inevitably fatal.

Social and economic factors have clearly influenced these changes but so too have advances in medicine.

The Effects of New Medicines

Medicines in the 1940s were remarkably crude. Malt and cod liver oil, Mist. Ger. Alk. (a worthless astringent tonic) and iron preparations were dispensed to our patients. Some could be positively dangerous:

> We used morphine freely and the toxic mercury preparation, Calomel, was still on offer to jaundiced babies. Self medication was common and a serious disease of infants and young children called Pink Disease was discovered in 1952/3 to be due to mercury poisoning from teething powders!

Before the discovery of new drugs like Penicillin, acute illnesses dominated paediatric experience. In this period, among the range of life-threatening children's diseases were pneumonia, gastroenteritis, streptococcal sore throats, osteomyelitis and meningitis. Gastroenteritis was the usual cause for an emergency admission in infancy and the mortality rate was 10 to 20 per cent.

During his days as a young doctor at Great Ormond Street Hospital in the early 1940s, my father recalls being part of a mobile flying squad who responded to epidemics of gastroenteritis:

> I remember going to Fulham (residential nursery), to Salisbury and to a maternity unit in Dewsbury – all very exciting.

Saving lives is exciting. It is perhaps this element of the doctor's task which preserves a magician-cum-deity role. Most of the time, however, the doctor is cast to play an altogether more human part. My father's reflections on his learning experience during the 1940s was of mistakes being made and lives being lost:

> Babies admitted for a planned operation in the '40s might well contract an infectious disease and could die. Surgical problems in children were worrying and few surgeons showed special expertise. Deaths from appendicitis were not unknown.

It is salutary to realise that death is a shifting reality. In the 1940s, most children with cystic fibrosis died in their first two to three years and almost all babies with spina bifida and hydrocephalus were allowed to die quickly. Lack of knowledge creates untreatable conditions. People with cystic fibrosis can now expect to live into their thirties, 'but only if aggressively treated'.

This emphasis upon 'aggressive' treatment helps me to understand some of the dilemma of medical practice. The public are often critical of the seemingly oppressive intervention by doctors in using drugs and fierce approaches to combat disease. For the patient, this aggression can be debilitating and intimidating; for the doctor, the illness is life threatening and has to be attacked by medical force.

Another dilemma facing doctors is that of constantly raised public expectations. The more improvements that are made in paediatric and obstetric practice, the less parents expect their baby to be born with any difficulties. Thus, practitioners can reach a stage where they fear to become involved in a delivery in case anything goes wrong and the parents sue (Symonds, 1989).

Saving lives of extremely premature babies has been one of the most significant developments in paediatric practice. In 1957, out of every 1000 babies, over 40 died perinatally. In 1986, the figure is about 10 per 1000. Gastroenteritis in infants, once a common cause of death, has become milder and only rarely requires admission to hospital.

In his career, my father has seen many changes brought about by advances in medicine:

> Acute poliomyelitis was still terrifying up to the epidemics of 1960/61 but new cases then stopped with oral immunisation. Acute rheumatism and allied diseases were common until the mid-60s but for 20 years have been virtually unknown. This coincided with better housing, smaller families and Penicillin. New school buildings were better ventilated and children better fed. Tuberculous infections, which spread rampantly in the war years from parent to child and in the air raid shelters, responded to new drugs (Streptomycin and Izoniazid Acid were the first) and to improved living conditions. Tuberculous meningitis was common enough in 1957 but very rare now.

Changes in medical resources, coupled with improved living conditions, brought about changes in hospitalisation for children.

Whereas he acknowledged that 'the demand for hospital care and excellent nursing was great' when there was 'so much acute illness in large families living in slum houses and in poverty', my father noted changes in provision as living standards rose. When he took up the post as a consultant in Hull in 1957, he was one of two paediatricians responsible for 138 sick children's beds in six hospitals in addition to two busy maternity units. Now there are five paediatricians and only 50 beds for medically sick children, all in the one hospital.

The effective treatment of bacterial infections, vastly improved junior medical staff, the introduction of intensive care techniques, the availability of paediatric surgery and improved newborn care have all changed hospital practice. The paediatrician today will be working much more in outpatient facilities, avoiding hospital admission. As for the change from two to five paediatricians for the same area of work, this probably indicates that younger doctors will not accept the intensive level of overtime which my father and his colleague were conditioned to cope with.

The Effects of Attitudes on Practice

I am going to discuss the effects of changing attitudes upon practice in relation to diagnosis, categorisation, approach to handicap and role in special education.

More Effective than Guesswork

Is diagnosis anything more than guesswork? When my father was a student, he had an experience which suggested it was not:

> I shall always remember, as an apprehensive student on night call, being summoned to accompany an assistant surgeon to examine a man in abdominal pain and being asked for an opinion. I referred to all the usual possibilities until he stopped me and asked, 'Do we open him up now or go back to bed?' which, of course, was the issue. The assistant surgeon rightly taught that 9/10 cases of acute abdominal pain in the night were due to drink, tobacco and anxiety – the trick being to spot the 1/10 which were not. In my prime, I became expert in spotting the organic from the psychosomatic, but far too many children have their appendices removed in the night, when the cause is an emotional upset.

As doctors are only human, they can hardly be expected to always guess correctly; unfortunately, the consequences can be severe when they get it wrong. Collee (1990) indicates that diagnosis is thorough:

> The standard diagnostic thought process goes a bit like this: 'If A is true, then ask B, if B is true, then ask C. If A, B and C are all true, then the problem

must be D and the treatment is E'. This can make a doctor's life rather boring, but as a way of curing illness it's much more effective than guesswork. (Collee, 1990, p.74)

Diagnosis has to be seen to be thorough and effective as it leads to prognosis, specific implications for that patient and their family.

The way in which paediatricians have learnt to diagnose babies with cerebral palsy indicates why the issue of 'milestones of development' gained prominence:

> In the first 6 to 8 weeks of life, for example, even anencephalic babies may behave relatively normally if they survive (Peiper, 1964). It is for this reason that it is so rash to predict that a baby who appears to have made a good recovery from apparent birth injury, by the age of a few weeks, will later be normal. Much is still to be learnt about the prognostic significance of abnormalities of behaviour in the newborn period (Prechtl & Beintema, 1964). The first manifestations of hemisphere lesions in the infant may be that he is late in reaching some of the milestones of motor, linguistic, adaptive and social behaviour. Developmental diagnosis – the ages at which the patient has reached particular milestones of development – is thus of great importance (Gesell & Amatruda, 1941; Thomas & Saint Anne Dargassies, 1952). (Ingram, 1966, p.377)

The implications are that, without developmental diagnosis, doctors could convey a false optimism. To tell parents that their child was perfectly healthy and then leave them to cope with the gradual realisation that the child's development was delayed or abnormal was seen as too great a risk. Whilst it might be philosophically desirable to accept each child for themselves and not to measure them against a standard norm, Ingram's argument helps us to understand why doctors were so careful in their diagnostic process, setting such store on milestones of 'normality'.

My father found from his experience that:

> Parents like to know what is wrong and why. They may appreciate a short note. They need to know what to expect in the future and whether it is likely to happen in any future children. Many syndromes associated with severe mental handicap have well documented other features which it is important to know about, for example, short stature, self mutilation, epilepsy, extreme constipation, deafness, muscular weakness, abnormal configuration of face or extremities.

Hannah Shaw (1989), the parent of a statemented child, describes her son's detailed assessment at a Child Development Unit as a positive experience for both parent and child:

> The important thing was him as a 'whole child' and although there were certain things which were difficult they never lost sight of his personality. (Shaw, 1989, p.29)

Not losing sight of the personality is vital if diagnosis is not going to degenerate into crude categorisation.

People not Categories

The dehumanising process of rigid categorisation has appeared acceptable until very recently, as this frightening attitude testifies:

> Fletcher's (1972, 1974b) approach in reducing his 20 indicators of humanhood to four, of which the base is minimal intelligence, would essentially resolve the dilemma of physicians working with retarded children: patients with IQs less than 20 are not human – and may therefore be treated accordingly. (Accardo & Capute, 1979, p.181)

This policy might be seen to operate today on the Greek island of Leros, where this 'base' group are treated as less than human (*Observer*, 10 September 1989). As early as 1866, Seguin warned doctors of their ethical responsibility to respect human rights.

One of the issues to emerge from the recent Cleveland child abuse scandal was the notion that it is the *children* and not their parents who are the clients of paediatricians, and their perceived needs will take priority. As a paediatrician, my father saw himself taking responsibility for protecting 'the handicapped child from being subjected to an unreasonable intensity and duration of treatment towards unobtainable goals'. This could involve cautioning fellow professionals if necessary. He was also careful to 'be alert to disturbed relationships within the family aggravated by handicap'. These disturbances might manifest as 'over-protection, isolation within the home, exploitation, abuse of all types'.

Maintaining such vigilance on behalf of a child reveals another dilemma for doctors. The public expects and demands that doctors take responsibility for protecting vulnerable children. Yet, this 'listening' for underlying signs of stress in parents can block the flow of dialogue such that problems can be exacerbated through increasing the level of anxiety. Booth (1987) found that parents of children attending a child development centre, because they had Down's Syndrome, were being expected to display pathological disturbance. It is almost as if the stigma of parental abnormality has to accompany the child's label.

Diagnosis and labelling are emotive issues. Again, the doctor is assuming an awesome role in influencing family dynamics:

> In seeking to understand the processes by which a child is identified as disabled, we need to recognise that during those early stages of a child's life medical definitions will often be powerful constraints on the definitions parents have of their child. Parental perceptions are shaped in interaction with others and

the significance of key professionals in this process becomes crucial. (Barton, 1990, p.16)

Barton is asking for parents to be given a positive image of their child at the same time as learning the specific nature of their difficulties. My father's experience included occasions when his acceptance of the child was met by parental rejection. In some instances, disabled babies are abandoned in hospital, the parents refusing to take responsibility for them. Is this the fault of the doctor?

There is a tension between the sheer challenge of finding out what the 'condition' is and the need to treat individuals with kindness and consideration. Johnston & Magrab (1976) recognise the difficulties inherent in the role of 'professional truth-givers', who experience a 'continual confrontation with their own vulnerability, and inevitably their own humanity' (p.12). In his experience of preparing parents for their children's deaths, my father learnt,

> never to spring it on people, but to work up to the truth gradually. Also, never to say the death was merciful in the circumstances. I did occasionally meet mothers in the street in Hull who claimed that I had prepared them to expect the worst in 1960 and that he now has two of his own.

Perhaps this uneasy confrontation with vulnerability sometimes leads doctors to display arrogance and insensitivity because they are simply not able to 'work up to the truth gradually' without damaging relationships in the process. Their own concept of 'truth' has to be recognised by them as a facet of their humanity and, as such, subject to external influences.

Looking Less for 'Cure' of Handicap

My father's paediatric training in 'handicap' during the early 1940s was 'fragmentary and overshadowed by acute illness'. The inference is that life-threatening epidemics had to take priority and, until new medicines provided a cure, the needs of children born with disabilities were neglected.

During his career, new learning about disability had a significant impact. Firstly, in the 1950s, paediatricians realised that some children with cerebral palsy were mentally alert. They had previously been assumed to be mentally handicapped as well and treated as such. Secondly, in the 1960s, new techniques were developed to arrest the progress of congenital hydrocephalus and spina bifida. This created great professional interest in these children. In the 1970s, however, a reaction set in as some children were seen to have complications, including learning difficulties and the limitations of these techniques were realised.

This introduced the 'quality of life' debate. New techniques and medical advances are always up against moral and ethical issues. In relation to some of the children who received 'aggressive' medical treatment in the 1960s, how did this effect their quality of life as young adults in the 1980s? How did it influence the family when they needed a high level of care? Looking for cures and solutions can often lead to more complications. My father suggested that:

> nowadays we look less for 'cure' of handicap and more to prevent secondary consequences and to foster the skills the child does have.

As Potts (1982) illustrates, learning about the precise biological causes of disability will not necessarily help to overcome the problems parents will have to face. Fostering skills is a more positive approach than looking for cures and one which rejects a deficit model of disability.

The Role of Doctors in Special Education

The paediatrician has traditionally played a leading role in special education, 'assisting in the assessment of handicap and prevention of deformity, authorising the supply of equipment, advising on attendance and mobility allowances, respite breaks, assisting in emergencies and arranging specialist advice in hospital'. If the paediatrician is sympathetic and understanding, the families are fortunate. If communication is difficult, famlies may go without services to which they are entitled.

In recent years, the prominence of the paediatrician has been usurped by the educational psychologist. A medical model has been replaced by a behaviourist model and the power of the paediatrician has lessened. However, when it comes to case conferences, my father indicates that, in his experience, both professionals dominate other participants:

> Those members most skilled in persuasion and communication may not be those with most to contribute and personal antipathies may cloud judgements. It is also true that those vested with legal authority in the matter of decisions may proceed regardless and without consensus. One is reminded of the Duke of Wellington who, on becoming Prime Minister, was said to have expressed surprise that, after members of his cabinet had been given their orders, they wished to remain to discuss them!

The implications are that the paediatrician and the educational psychologist (often both male) are in positions of authority whilst the teachers, social workers, attending parents, therapists and nurse (most of them likely to be female) are more passive observers. However, this multi-professional meeting does represent a progression from the days in which the doctor had total authority over placement and treatment and even this limited degree of consultation would have been inconceivable.

Watching and Listening

Change is a slow and painful process. As Booth (1982) says, 'the fact that there had been a general shift in medical practice does not mean that all doctors or parents were in agreement' (p.13). Ideas in medicine, once established, can be difficult to alter. Rutter (1977) describes the history of medicine and psychology as 'replete with examples of concepts reified by catch phrases which persist in spite of a mounting volume of contrary evidence' (p.1).

To return to my introductory discussion, doctors can only reflect the attitudes of their culture and their period in history. Knowledge is a movable feast: what is savoured at one stage falls out of favour at the next. My father observed that it is taxing for today's medical students, who have so much more to learn than was available to him as a student. Knowledge constantly changes but it can be difficult for practitioners to accept new levels of understanding.

Taking the diagnosis of child abuse as an example, how have doctors learnt about this aspect of practice? It has been a slow and painful process and pioneers have suffered for their insights:

> An awareness of emotional deprivation dates from the 1940s and (like the Battered Baby Syndrome) was greeted with disbelief. Bakwin (1941) described fever, lack of appetite, torpor and failure to thrive in institutionalised infants but, being a psychiatrist, he was laughed at!

There was an initial reluctance to accept the unacceptable: that some parents deliberately starve their children of food as well as affection; that some institutions are grossly neglectful.

My father was trained in the 1950s to recognise cases of battered babies from intercranial bleeding and longbone fractures:

> In Hull we saw about one new case each month of serious assault between 1957 and 1975. The police and the courts were always involved and this serious type appeared to become less common between 1975 and 1986. I imagine angry people thought twice if they knew it meant a prison sentence.

He had the knowledge and developed the expertise in diagnosing the Battered Baby Syndrome.

However, he was not trained to recognise child sexual abuse. This has not emerged onto the paediatrician's agenda until recently. Consequently, he responded to the new emphasis on this area with incredulity and scepticism. He was unfamiliar with such cases because he had not been trained to look for them. Almost certainly, he had treated children in the past who were sexually abused and he did not know.

New ideas in medicine are often resisted by practitioners because

they challenge long-held views and threaten cherished values: accepting new ideas can mean having to reject old ones. It has taken years before theories, which are now well established, were generally accepted by the medical profession.

This is why doctors have to watch and listen to interpret new signs and hear new voices. They have to be open to change and alert to unfamiliar influences. Barton (1990) suggests that critical self-awareness should inform professional judgement, including 'a genuine acknowledgement of our limitations and a recognition of the fragile basis on which many of our assessments and decisions are based' (p.19).

A lack of critical self-awareness can lead to loss of empathy. Booth (1982) cites research into inadequate infant 'bonding' with black mothers in an inner city area, which paid little regard to their desperate economic circumstances. The huge influence of Kanner's 1943 definition of autism angered me in its emphasis upon cold, mechanical mothering, thus compounding the pain of parents on flimsy evidence from a small sample in a private practice.

Paediatricians do have daunting responsibilities because, in general, they are working with families marginalised through poverty. Alibhai (1990), for example, illustrates that an issue for paediatric practice in the 1990s is that of high infant mortality among the Bangladeshi community in Britain. My father recognises that 'in paediatrics the major challenge will always come from the least advantaged families'. The paediatrician has a commitment to improve the quality of life for the most vulnerable.

Acknowledgement

I am grateful to my father, Richard Pugh, for his cooperation in compiling this paper, his willingness to share his experiences and his comment on earlier drafts.

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Tony Smythe

Health Warning

It is hard to know why I got myself so mixed up with health/illness services, shamans and doctors over the years. Maybe accident if you will forgive the pun.

Indeed, it was a serious car accident at an anarchist summer camp in the French Alps which gave me my first serious taste of hospital and medical repair. French and Spanish friends attended to the social needs of me and the family, the doctors fitted bones together rather badly so it had to be done again by the NHS, and the hospital administrators hovered around my bed like angelic debt collectors for weeks hoping, vainly, for the pay off. Many years later, when living in New York, I got to know how frightened people can become if they have to rely on a privatised system.

Our brood of five were always healthy no doubt because we followed the benign rule book for radicals on child rearing *The Free Family*.

All were delivered at home, except one. In this case, the hospital insisted and it was a mistake. The police were called to eject me from the delivery room into which we would only venture at a late stage in the proceedings.

I remember all the GPs in my life, most with affection but one or two who might have been better off employed as vets.

Of course, quite early on I understood that war and authoritarianism were bad for health. My grandfather's experience of being gassed in the trenches made him a life long closet, working-class pacifist. My father got blown up by one of the bombs he was supposed to be sending off to Germany and joined the Tory Party, for a while.

I used to brood a little that John Hewetson could not be my doctor as I lived on the wrong side of London and I wished that there were more Peckham Health Centres around.

I didn't meet real disease and life without health until my first visit to India and subsequent travels in the Third World have made me a little less flippant on the subject.

Mental health and its reverse were a mystery until I started representing patients at mental health review tribunals for the NCCL and later began my turbulent career with MIND. I vaguely recalled that people used to 'put their relatives away' when they became inconvenient.

A spot of Reich while teaching at Burgess Hill School, like Summerhill, and the fashion for Laing's books, was about as far as I got.

As Director of the National Association for Mental Health (later MIND) I needed quick indoctrination to enter an unfamiliar culture. Charities were quite comfy in those days. Middle-class ladies, who worked for pin-money, survived from an earlier era, but the bloated staff mainly comprised people who were paid too little to do not very much. The exodus was rapid and the slimlined MIND had some great talent who knew far more about it than I ever learned.

The first thing was to visit some mental hospitals. My previous encounters were as a young kid in Manchester when we used to climb over the wall to tease the loonies for dares. I was proudly shown round a hospital for mentally handicapped people in Bristol by a very eminent psychiatrist who was prominent in the organization and became a government advisor. There were a few problems, he admitted. Like the snake pit of forty-five agitated people supervised by one trainee nurse. Then there were all these pleasant very elderly ladies sitting in the sunshine. They didn't look mentally handicapped. They didn't sound it. Why, I asked them, were they there? Answer, teenage pregnancy followed by a lifetime of 'care'.

I must have got on someone's nerves. A long screed was circulated to all the bigwigs detailing my fantastic career in the peace and civil liberty movements. 'War Resisters' received covert funding from the Soviets . . . was also known to have a large communist following once Tony Smythe took over its direction.' I was a Soviet agent, close to the IRA and had 'effectively undermined the American war effort' in Vietnam. Quite a record. The IRA allegation was to be resurrected six years later, shortly before I left, by an eccentric back-bench MP. The public abuse started in the *Sunday Times* and continued without remission.

Strange to say our long suffering committee and successive Secretaries of State, on whom we relied for a substantial part of the funding, took very little notice. Good on them.

MIND itself was running several residential institutions, including two for 'wayward' teenage girls. The show piece of the regime was the seclusion suite, drooled over by visiting experts: padded cells, mattresses on the floor. This was for naughty girls who were uncooperative and did not respect authority. Not only could they be locked up for days on end but 'privileges' like clothing, visits and personal possessions, could be withheld. Now the pin-down scandal seems all too familiar.

Gradually, we got out of the incarceration business and the back-stabbing became routine. To be fair, we did run one exceptionally good school for highly emotionally disturbed young children.

These local difficulties were nothing compared with what happened

when we began to question ECT, the chemical cosh, and when we exposed the cruel world of the special 'hospitals' for offenders and a minority of dangerous patients or when, largely through the efforts of our first staff lawyer (an American genius who was later chucked out as General Secretary by the NCCL for being too civil libertarian) we proposed major changes in mental health law.

Every time I went to Broadmoor, Rampton or Moss Side, it was not the patients who worried me. It was the staff not least those from that noble institution, the Prison Officers' Association.

The idea that patients were people who needed rights and representation was not at all popular. Psychiatrists and others with a vested interest in keeping the institutions going felt threatened. Their retaliation was ruthless, if incompetent. Yet there were so many good people trying to make impossible systems work. When they blew the whistle they were threatened, ostracised and driven out.

A cross-professional group at Broadmoor asked to meet me. I arrived at the station to discover that to avoid being sussed out they had booked nowhere to meet. So we sat under the drizzle on some gravestones in a churchyard.

Change comes in cycles. The scandal of involuntary incarceration in the early fifties opened the way to the Mental Health Act 1959. There followed some technical advances in treatment and some noble experiments but the mental hospital system remained intact throughout the sixties and seventies and the professionals and politicians, who let it be said, have a lot to answer for. The vast majority of victim patients were in no position to defend themselves. The change in ideology came from outside and the pressure was due to publicity and a civil rights approach to exploring the few available remedies in law, most significantly, the use of the European Convention on Human Rights which offered opportunities not available within the system. Then 'patients' began to organise for themselves.

These human warehouses started to be closed in the 1980s. This at least meant that institutionalisation needed, no longer, to be heaped on mental distress. New and better forms of asylum could be provided. Care in the community became the feasible objective. Many have benefitted. Many have not. It is underfunded and other forms of institutionalisation and repression have emerged. The process of discovering and providing help with dignity is never ending. The scandal of residential homes is just being rediscovered.

I spent three years running the Association of Community Health Councils and dealing with a much wider range of NHS issues. The idea of community representation as a part of the NHS structures was a good one and to some extent it worked. The local CHCs are there to

represent the interests and rights of patients even when these conflicted with government, management and staff. The better ones spread knowledge of preventative work and the delivery of health care impressively. The more effective they were the more it became apparent that government and the professionals regretted the reform. The response has been to manipulate the funding and gradually reduce the right of consultation as plans were laid to strangle the better features of the NHS and return to the market.

And now I am back with that small segment of the health professions who regard war as a preventable disease and point out that governments, when they test, make, deploy, transport and threaten to use weapons of mass destruction, need a health warning round their necks.

The report of the IPPNW (International Physicians for the Prevention of Nuclear War) on 'Radioactive Heaven and Earth – The Health and Environmental Effects of Nuclear Testing' published by Zed Books, makes the point.

Katy Andrews

In the Belly of the NHS

I have been asked to write about my experiences as a worker in the National Health Service; this is a personal view and not intended to be an essay on the politics of health or mental health, and such essays are nearly always written from the point of view of being a patient. I want to say something, from the shop-floor perspective, about recent changes in the NHS and how they are affecting the health service and the people who work as providers of health care – whether medical, nursing or paramedical, or as part of the vast army of the rest of us who work as caterers, porters, maintenance people, cleaners, secretaries, clerks, clinic receptionists, etc. Not everyone working in these areas is an employee of the NHS – there are a growing number of contract staff, and a declining number of agency and temporary or short-term workers in all fields of health-care related work. I'm employed by a central London Health Authority in a busy local general hospital which is also part of a large teaching group.

The new internal market

I'll start by going over what is happening in the NHS (as far as I can make out – even the managers don't seem too clear); if you want to read up more about this you will have to look elsewhere, and plenty has been written on it (particularly by the Left, who of course mostly favour centralised State provision of all health and social services but have produced good critiques from their own point of view).

Before the NHS, of course, medical care was private, paid for through one's own purse or a variety of insurance schemes, many of them run by Unions. Hospitals were private institutions, maintained by insurance companies, charitable donations and fees. Some were built with money raised by private subscriptions and public fund-raising within the community they were to serve. When the NHS took these over, no compensation was paid to the local people who had voluntarily provided for them, although of course they continued to enjoy use of the hospital though with less community control over it. Now the NHS itself is

losing much of this stock which it acquired virtually free with the 'nationalisation' of health care. On 1 April 1991 57 hospitals in England and Wales became 'NHS Trusts' and 293 family doctor Group Practices became 'GP Fundholders'.

Some health-care facilities have been lost due to modernisation rather than reorganisation or privatisation, as new and better-equipped facilities replace old buildings which are difficult to maintain, hard to heat and short of up-to-date facilities. But this isn't always the case; for example, the Prince of Wales Hospital in Tottenham was recently demolished along with one and a half million pounds worth of brand-new operating theatres, and all departments moved either to St. Ann's (now almost exclusively out-patients clinics and long-stay geriatric wards) or the ever-growing bleb of the North Middlesex Hospital in Edmonton (now the only Casualty Unit for the area once served by the PoW, and have you ever tried getting from one to t'other when Spurs are playing at home?). Even where buildings or facilities may not be entirely modern, it isn't really justifiable to close them willy-nilly; e.g. the wards of the old Royal Northern Hospital in Islington have been gradually closed down over the past few years, leaving the building standing virtually empty for years on end whilst at the Whittington Hospital up the hill, to which RNH services are to be transferred, the new wing (being built with funds granted before the new scheme was a twinkle in Maggie Thatcher's steely eye) is only now nearing completion.

As with everything else, the trend has been towards amalgamations and central control, with a few big hospitals replacing the former network of cottage and general hospitals each serving a relatively small community. Health Authorities have been merged, creating big and unwieldy structures (some of which cross wage-weighting demarcation lines) and also a huge amount of wasted headed paper (the hospital where I work recently started a paper recycling scheme). This trend would hardly slow under a Labour administration. Such centralist planning is purely done to increase government control, and cannot be justified on grounds of 'efficiency'. It certainly isn't done to help the community or even in consultation with local people who are most affected by changes in their health-care provision.

As a result of Tory party policy, the other big trend – which sometimes seems to run counter to the above – is towards making health-care a consumer good. Hospitals are spoken of as being 'self-managing' (i.e. by opting out of local Health Authority financial control), but in fact are actually being pushed into a privatisation scheme in all but name in which an unpriceable commodity, good health, is supposed to be bought by paying customers in the form of general practitioners, other

hospitals or departments within hospitals, other regional and local health authorities, and ultimately – of course – the patients themselves. The Director of Acute Services in the newly-emerged Bloomsbury and Islington Health Authority (which covers much of the West End), according to a leaflet issued by them explaining NHS changes to local residents and patients, aims during the 1991/92 fiscal year to 'have agreements for contracts to provide hospital treatment and care to residents of 72 Health Authorities from all around the country'. So much for local hospitals! This is Tory pro-competition ideology run amok.

What this means for the future

In America, where health care is almost entirely privatised but still mostly financed through insurance schemes, private hospitals run purely for profit avoid the high-cost and low-profit services such as Accident and Emergency Departments and out-patients clinics (which are of most value to the local community since visits to either involve travelling time), preferring to offer expensive surgical and cosmetic operations with hefty hotel fees on top for food and board during in-patient stays. Although we are assured that every Health Authority here 'has a duty to ensure, within the resources allocated to it by the Regional Health Authority, a full range of health services to meet the needs of its local population', it is clear to anyone with a brain in their head that when services get priced the same sort of criteria as operate in America will come to apply, so hospital financial managers will be increasingly loth to expand out-patient or geriatric services, or to provide post-graduate training facilities for the next generation of specialist surgeons and physicians. Instead of operating an integrated health service, the government is pushing the NHS towards a focus on market opportunities.

This has already of course been forced on many hospitals by cutbacks in funding. Apart from schemes like renting out floor-space to overpriced shops (like St. Thomas's in Central London or the Royal Free Hospital in Hampstead), or roof-space as a satellite tracking station (at Hillingdon Hospital in West London), the only saleable assets hospitals have are medical facilities and trained staff, so that many NHS services have long been semi-privatised, with for instance breast cancer screening being offered privately by City and Hackney Health Authority and a growing number of 'pay-beds' and 'private' wards (not always a good idea; in 1986-87 Bloomsbury Health Authority wrote off bad debts of over a million pounds in unpaid fees for such beds).

But in a situation where some Health Authorities seem to have more vacancies for financial managers than for caring staff, selling off ward-

space which would otherwise be unused because HAs cannot pay the staff to run them has become a major source of income for many NHS hospitals. The private beds at the Royal Free virtually supported the rest of the hospital last summer; and last autumn because of ward closures at St. Thomas's a situation was allowed to arise whereby only private patients able to afford a 'pay-bed' could get in for open-heart coronary artery bypass surgery, which effectively meant that the Cardiology unit, using NHS-paid staff, was actually operating as a completely private service whilst ordinary NHS waiting-list patients were having their operations cancelled (sometimes at very short notice) because of an artificially-created bed shortage, and their operation slots then given to private patients, which is nothing short of scandalous.

The post-War idea of a National Health Service was to have a centrally-planned, uniform system of virtually free health care available to everyone, taking advantage of economies of scale and in accordance with state socialist principles. What is going to replace it, if the Tory party have their way (which they probably will), is an *internal market*, with each "care consortium" (group of specialities within a hospital), each hospital, and each Health Authority buying and selling each other's services at negotiated prices.

The hospital where I work has now got a 'Contracts Manager', who was given a £7,000 a year pay-rise to oversee its implementation in the absence of any prior process within the NHS for this sort of game. Mostly, the new job seems to have fuelled his cynical sense of humour; he admits he has no interest in the new scheme and took the post for "purely selfish reasons" (i.e. the money), justifying this by saying – with honesty as well as humour – that it's better than letting someone committed to making the system work do the job.

The whole scheme is a pig's ear, simply trying to move health-care wholesale into the market sector where it might then make a profit for private investors, although the experience so far of many US businesses setting up private hospitals here is that it doesn't – at least not while it has to compete with the larger and generally better-equipped NHS. Indeed, even in the more free-market economy of the USA, as an article in the prestigious "New England Journal of Medicine" stated a couple of years ago when the present reforms were first being put forward by the Thatcher government, private medical businesses there found that 'the fact that hospital care is a local service, with labour accounting for between 50 and 60 per cent of total costs, seriously limited the potential gains from economies of scale'. (Dr. Eli Ginzberg, 'For-Profit Medicine – A Reassessment'; *NEJM*, 22 September 1988; Vol. 319, No. 12; pp.757-761.)

To have a comprehensive health-care service and a network of compet-

ing services are mutually exclusive goals. Unless costs are left out of the equation completely, the best alternative to an internal market in health-care provision is probably a large-scale centrally-administered system, a bit like we used to have, really. If finance is ignored (under a moneyless system or possibly one where local communities provide free health care as of right from local resources, on the grounds that people do not want a price to be put on their individual or collective good health) of course the picture changes – but then we're talking about communism, mutual aid, anarchism and other desirables yet to be achieved; and until we achieve them perhaps the best we can do is try to stem the rot that's gradually engulfing all our social welfare and charitable institutions.

NHS reform is clearly aimed on the one hand at increasing central control over ordinary people and our lives, and on the other is but a part of the right-wing obsession with reducing everything to purely monetary terms and undoing the few socially-useful things left, many of which particularly rankle because they were brought about under Labour governments. (It's easy for anarchists to knock something simply because a government suggested, sanctioned or didn't oppose it, but this is not necessarily a useful critique.) Its effects are being felt already on the shop-floor, as well as by patients, about whom most is heard.

Theoretically, the advantages of reform are higher standards, more efficient use of resources, and more choice about treatment for patients and their family practitioners. This is spurious. In fact the most likely effect in the short-term will be even more cuts causing a *reduction* in choices available. In Bloomsbury and Islington Health Authority (which includes University College Hospital and the Middlesex Hospital, who treat so many patients from outside their own area that they are considered particularly vulnerable) the reforms have caused chaos and uncertainty, because no-one knew what funding would be available to plan for the new scheme. They have also caused massive cuts – at a public meeting of the HA in March it was reported that even if managers agreed 'steady state' contracts (providing the same services this year as last) with other hospitals and health authorities, B and I would still have to 'find' a way to 'save' £7.4 million in 1991-92. Hence bed closures and cuts in theatre sessions at the Whittington and other hospitals, and the early closure of the Royal Northern Hospital wards. This isn't caused by lack of other bits of the NHS wanting to 'purchase' services at the Whittington, UCH etc., but by the underfunding that has dogged the NHS for over ten years.

The long-term 'advantages' of having different competitors trying to 'buy' health care within the NHS are also not very likely to occur. The

fragmentation implicit in the new system will harm liaison between hospital departments and community health and social services, especially because if a patient's local hospital charges more for a particular operation or prosthesis (let's say) they may now be directed to wherever their GP practice or local HA has contracted to buy that service – which may be miles out of their local council district, the level at which most domiciliary care and housing allocations are presently organised. What is actually being produced is a patchwork of competing interests, with in-fighting instead of co-operation between specialities, consortia, hospitals and districts, and it is clear from experience in America that such competition actually reduces standards of care.

One obvious way in which standards will fall is through even greater reduction in staffing levels in a service already desperately short-handed and increased workloads for those still in a job.

With budgetting becoming even more important ('financial viability') and patient care the lowest consideration of the new managers and financial administrators brought in to run this insane scheme, reducing patient through-put times and cutting jobs are obviously early targets in the cost-cutting exercise, which can hardly help in meeting patients' needs when the NHS and those working in it are already over-stretched to near breaking-point. We need a health care service which starts from the needs of the individuals cared for by it and working in it, at the personal and community level; but with every step towards privatisation the NHS is being forced away from that towards the devil-take-the-hindmost yuppie mentality of latter-day capitalism.

Health care ought to be about getting vital work done in a human and relaxed atmosphere. But what is now happening is that instead of taking on more staff to do the necessary jobs (and offering working conditions and reasonable pay to attract high calibre staff) more and more people are being appointed as or promoted to managers. Whereas the old NHS was relatively cheap and easy to run, hundreds of new accountants and managers are now 'needed' just to administer the contracts and billing system and the 'care consortia' actually providing health care services; not to mention the myriad statisticians and programmers now required to monitor the effectiveness of the system, providing far more detailed information than the old NHS was asked to

The View from the Word-Processor

I've been working in NHS hospitals as a Medical Secretary since 1983. I'm not actually a secretary at all – I did work as a secretary once, and I probably typed about a dozen letters per week, some of them my

own; a Medical Secretary's job is basically about being a very overworked typist. For seven years, until last December, I worked as a temp for several different agencies. Two years ago I was working for the equivalent of £14,500 per annum; as a permanent member of NHS staff I now get paid leave and I've joined a Union, but earn £3,000 a year less, while in the same period inflation has occurred and my rent has more than doubled. But there is no work for temps any more. Whereas when I worked at St. Ann's in 1988 every single secretary was from an Agency, because of 'financial stringencies' (i.e. government-enforced cutbacks) hospitals cannot now fill their vacant secretarial posts with temps. Last summer St. Thomas's nearly collapsed when a ban was imposed on hiring secretarial temps (other than for maternity and sick leave cover) for a two-month period.

The temp agencies, whose profits depended on the commission they got from our work, dropped their rates (a drop immediately passed on to the workforce) to try to retain business; at the same time, good temps were forced into accepting permanent jobs. Almost overnight last autumn, first at the Royal Free and at St. Thomas's and then throughout London, just about every temp Medical Secretary was forced by lack of temporary work to become 'permanent', taking a hefty cut in income in the process.

At the same time, there has been an enormous increase in 'contract' staff, with hospital catering and cleaning departments in particular having to tender for contracts in competition with outside firms. At the Whittington Hospital, the cleaners are ex-NHS staff who now have to work for an 'outside' contractor, and where there used to be two cleaners per hospital floor there is now only one, yet the same work has to be done; in other words a 50% cut in the wage budget and a 100% increase in each cleaner's work-load, and a decrease in standards and job-satisfaction. (Last summer at the Royal Free a long-neglected staircase was finally cleaned and the worker who did the job actually signed a riser giving the date it was done!)

When I worked as a temp, I thought the solution to the secretarial shortage for the NHS in London, since they would not employ individual temps on a self-employed basis for bureaucratic reasons, would be to somehow get out of the Whitely Council scheme so that they could pay us rates compatible with those paid in the City and West End to typists and WP operators (then about £14,000 as compared to the £10,000 or so at the top end of the NHS scale) so as to cut out the Agency fees, which to my mind were the biggest wastage of money. The recession has put an end to any such hopes, and was beginning to bite when London's Medical Secretaries were forced into permanent

employment last autumn. Although most of us started on the top rate for the grade, the sudden drop in income was a big shock.

However, a worse shock was that this coincided with the start of the financial reforms introduced to prepare hospitals for the changes to the NHS which are now on top of us. Previously, the most important thing had been patient care and seeing that patients' services – including telephone and written communication between hospital specialists and family doctors – ran smoothly. If someone took annual leave or went off sick, or simply had a higher work-load than they could cope with, temporary help was engaged. Now, not only is there no such cover (half-time only for annual leave of three days or longer! – which makes a holiday of any length virtually impossible because of the backlog of work which would accumulate to be dealt with on one's return) but everyone is having more and more work piled on them as cuts and job-vacancy freezes decimate the work-force. The stress and lowered job satisfaction resulting from this has caused terrible loss of morale and turned many once happy hospitals into poverty-stricken grousing-shops.

Until last year, a Medical Secretary worked for a particular Consultant, and he or she was the person you saw about problems, leave and so on. Now, we have so-called Secretarial Managers (other secretaries with bigger wage-packets) and middle managers over them and senior managers over them, and so on up the whole chain – I'm not even trusted to order my own stationery or typewriter ribbons any more! The differences in working practices sound trivial, but for workers in the NHS the difference is profound. Any idea of 'owning the process' or involvement with decision-making about one's own working conditions has been thrown to the four winds, and this was a very important part of job satisfaction and self-respect. We have been deprived of much of the personal responsibility we used to have for organising our work, and the team-work secretaries used to enjoy as an ancillary part of a medical firm has been replaced by a feeling of being a humble minion at the bottom of a vast hierarchy. This goes for other ancillary workers too.

As much as anything, it's the new multi-tiered hierarchical system which is getting up people's noses. Short-cuts (which the Russians used to call *protektzia*) to cut through the inevitable slow wheels of a large bureaucracy can no longer be used worker-to-worker. Instead, everything has to be funnelled up through layers of increasingly budget-conscious managers and then channelled back down again. This slows everything down, costs money, and creates yet more needless paper-work, I'll give one example.

The NHS, like any large organisation, was always open to nepotism; until this year it was possible for NHS workers at all levels to recommend

friends and relatives for short-term summer work, particularly in clerical departments like medical records queries or the casenotes filing library. Because such people were known to existing workers, one could expect them to be capable of doing the work for which they were put forward and also to do the job well so as not to show their patron up. There was no advertising, no agency costs, no time-consuming interviewing – it was all arranged informally and generally worked very well (some youngsters, especially students, came back year after year requiring little training). This year, the new budgetting system dictates that since such summer work is not a designated post, no-one can be appointed to do it. This does not, of course, stop the clerical workers taking their holidays. Since their jobs still have to be done, the hospital is now paying a local employment agency (with whom they have an exclusive contract on the grounds that their rates are cheap, never mind about the quality of the staff they send us) to cover leave periods. Utter insanity!

All these changes have contributed towards poisoning the atmosphere at work. People go off sick, leave their jobs, crack up at work, or maybe just complain all the time. A young colleague of mine committed suicide in June, and depression about her job was certainly a factor; earlier this year I had a month off myself (at the tax-payers' expense) with 'stress-related anxiety syndrome' – previously I'd only ever had two days' sick-leave in a working life that started in 1974.

An Anarchist View

Labour's solution to problems in the NHS has always been – at least in their manifestos – to throw money and resources at it. The Tory solution is to throw managers and Friedmanism to improve cost-effectiveness, and in the absence of a serious free-market challenge to state-provided health provision to make medical care competitive by essentially setting the NHS in competition against itself (ludicrous!).

For anarchists the question is not simply one of whether the NHS should be (or can be) reformed or simply thrown away – and we're talking about a vast and expensive infrastructure which is already in place and with many advantages in maintaining and improving. Rather the challenge is to find a way to provide the high standard of necessary medical care expected in a civilised society in such a way as to meet the needs of individual people and of local communities.

Instead of money or managers, what should be thrown at the problem of how to provide decent health services is people – working people to do all the different jobs needed – doctors, ambulance-drivers, district

nurses, laboratory technicians, dieticians, physiotherapists or whatever. We need to address the need for health care in our communities by starting at the bottom, and asking what people need at all levels for a full and healthy life, not by starting at the top and asking how a health service geared up to high-tech medical intervention can be provided at some nebulous 'regional' or 'national' level, and especially not as a marketable commodity. And to do this we need a different approach and a new basis to the way people live and interact together.

We must give more thought than a government obsessed with politicking or profit will ever do to the basic conditions of health – decent housing, an adequate diet and the elimination as far as possible of social and mental stresses. We should also take into consideration the very real relationship of social class to general health and life expectancy in terms of poverty, access to information, housing, and hazardous working conditions. People's health and social welfare, like everything else, is affected by the divisions inherent in the capitalist system, and there is no point leaving the problem of how to address this in the pre-revolution here and now to the Marxist Left unless we're content to be anarchists only insofar as we can dream about a putative utopia from the comfort of our armchairs.

Everyone on this planet needs wholesome food (and saner means of producing it), and water that is clean and safe to drink; we need adequate clothing and shelter; we need the emotional security of being loved and cared for; and we desperately need a slower pace of life with more time for ourselves and each other. In short, we need a smaller-scale, human-centred society based on neighbourliness and provision for need. Every step towards a competitive, profit-orientated society is a step away from a sane world, a step away from anarchism and away from meeting our individual needs as civilised and happy human beings. Unfortunately, I see the Health Service being pushed into taking more and more of these steps every day.

Weary Mercy

The drudgery of wage-slavery is the root cause of ill-health. Only the abolition of the wage system and of all kinds of domination of man over man can bring freedom of access to the means of life.
And freedom will bring health.

John Hewetson

Song

The uniform I wear makes me look like a cake,
With icing on the top and trimming round the waist,
And the cot sides rip my tights at a shocking awful rate.
Ah – what I pay to play the part of dearie Nursie.
Ah – what I pay to play the part of dearie Nursie.

When Mrs. Oliver died you know it shook me up a bit,
And sister she told me off for crying in the kitchen.
She's young to be a sister – she's only twenty-four,
And already she's tired out with weary mercy.
And already she's tired out with weary mercy.

Molly she's the cleaner – she did her back the other day,
She only works part-time – now she's off sick without pay,
And I don't know how she'll manage – she's got her kids to raise
And her life is worn so thin with weary mercy.
And her life is worn so thin with weary mercy.

Alice she nursed her husband at home
Until the time came – she couldn't manage him alone.
Now here she is all broke, you'd think life would have shown
Alice something more than weary mercy.
Alice something more than weary mercy.

All the ambulance drivers, they struck out for their raise
But if us lot went on strike – you know what they'd say –
'A higher wage would frighten the right kind of gel away –
It's a privilege to dispense your weary mercy.'
It's a privilege to dispense your weary mercy.'

Everything's spread thinner than the butter on the bread
My mother can't get physio to strengthen her bad leg –
But there's some that jump the queue at five hundred quid a head
And for the likes of you and me – it's weary mercy.
And for the likes of you and me – it's weary mercy.

Mary was a nurse and midwife for forty years
She worked her fingers to the bone, now she ends up in here,
And the cycle's come full circle, and it fills my throat with tears
To find Mary in these arms of weary mercy.
To find Mary in these arms of weary mercy.

But sisters – aren't we doing what we're supposed to anyway
– Come to think about it – aren't we lucky to get a wage –
So shut your gob, and do your job, and remind yourself each day
Two a penny is the price of weary mercy.
Two a penny is the price of weary mercy.

Caroline Hodgson
Nursing Auxiliary

M. Boustred

Towards Human Ecology

Forty years on from the first printing of the pamphlets, 'Sexual Freedom for the Young: Society and the Sexual Life of Children and Adolescents' by John Hewetson, I support in full his conclusions that sex-negation manifests itself in the type of society we have today. I have reservations though, as to whether changes towards sex-affirmation have been very much helped, as Dr. Hewetson hoped, by work '. . . in antenatal clinics, postnatal clinics, in schools and universities. . .' which are themselves pillars and products of our current social structure.

He cites Bronislaw Malinowski's *The Sexual Life of Savages*, and I feel, too, that it is towards grass root levels that our society must look to find signs of any germination of seeds of change.

It has been my experience that in a small way, in a small remote area, a small group of people almost had the answer to our present problems. Unfortunately they were in no position to stem the tide of events which swept away the embryo pattern of new codes they were unwittingly forming, but the fact that I was able to recognise a little of what was happening was due in part to my also having been acquainted with an anthropological work – one which I had studied in connection with my interest in Music, and to which I will refer in order to support what, I feel, are the indications of subtle and barely discernible movements towards the practical incorporation of sex-affirmation into our society as, I think, Dr. Hewetson envisaged.

The Muria and Their Ghotul by Verrier Elwin was published in 1947 by Oxford University Press, Bombay, and the author, like Dr. Hewetson, was conversant with Malinowski's work. In the chapter 'The Origin of the Ghotul' in which he briefly describes various primitive social structures Dr. Elwin says of the Trobriand and Muria dormitories:

> . . .Between the bukumatula and the ghotul there are obvious resemblances (particularly the decorum and lack of any legally binding element) with the individual appropriation of characteristic of the jodidār ghotul. But the one great central ghotul house, heart of a hundred religious and social interests, carefully organized and disciplined, is fundamentally different from the Melanesian institution. (p.275)

This fundamental difference marks an evolutionary stage in social growth. It may denote the ultimate scene.

I quote the following extracts, first from the Preface, and then from the final chapter – 'Moral Standards in the Ghotul', in order to present the reader with a brief literary picture of the ghotul way of life and to illustrate that the desirable general characteristics of Muria society could only be rooted and nurtured in the village dormitories.

. . .The Muria Ghotul is an institution, tracing its origin to Lingo Pen, a famous cult-hero of the Gond, of which all the unmarried boys and girls of the tribe must be members. This membership is carefully organized; after a period of testing, boys and girls are initiated and given a special title which carries with it a graded rank and social duties. Leaders are appointed to organize and discipline the society; throughout this book I call the boys' leader the Sirdar, and the girls' leader the Belosa. Boy members are known as chelik and girl members as motiari. The relations between chelik and motiari are governed by the type of ghotul to which they belong. Two distinct types of organization are recognized. In the older, classical, type of ghotul, boys and girls pair off in a more or less permanent relationship which lasts till marriage. In the more modern form of ghotul, such exclusive associations are forbidden and partners must constantly be changed.

. . .There is little immorality in the ghotul. The outsider who looks on it as a place of unbridled licence and youthful corruption commits two errors, one of method and one of fact. His method of approach is wrong, for we cannot import our own ideas and standards into another culture and judge that by ours. But he is even wrong in point of fact. The ghotul is regulated by exact and far-reaching laws which are very generally obeyed. Its life, compared with the life of young people in other aboriginal villages, is marked by restraint rather than by excess. (p.654)

. . .For the rules are not imposed from without, but have been made by the ghotul-members themselves. Thus they are reasonable, adapted to the actual situation, and so easy to obey. (p.657)

. . .'In the ghotul no sin can be committed.' This is not strictly true, but it is sufficiently true to explain the wonderful innocence and simplicity of the chelik and motiari. There is no sin in sex, provided – as I have said before – sexual relations are enjoyed with the right people, at the right time, in the right place and in the right way.

Chelik and motiari must choose the right partner. They must strictly avoid the inner circle of forbidden relatives [a similarity here with other religions, M.B.]. Intercourse within the clan is forbidden, but is not regarded as very serious so long as no one knows about it and it does not result in pregnancy. In the jodidār ghotul, chelik and motiari must be faithful to one another; in the other, they must avoid too great attachments to special individuals. It is practically unknown for a motiari to have an affair with someone outside the tribe . . . It is possibly safe to say that no European has ever had anything to do with a Muria girl, and I am told by State officials that in the old days when, in the more 'advanced' areas round Jagdalpur, it was the custom for the village

headman to bring women for touring subordinates, this was never done in the ghotul villages of the north. I am told that chaprasis, forest guards and constables, who are sometimes such a menace to rural virtue, are never able to seduce the motiari of the ghotul, where the village dormitory remains to protect tribal honour. This opinion is confirmed by the fact that venereal disease is almost unknown among the Muria. In fact, the Chief Medical Officer of the State, Dr. W. P. S. Mitchell, has told me that in thirty years' service he had never seen a straight case of venereal disease among the Bastar aboriginals. (p.655)

. . . Sexual relationships must be conducted in the proper manner. 'When there is consent and love there is never sin.' But it is considered very wrong to force a girl to act against her will. Such cases of ghotul-rape are not common. It must be remembered that for a motiari to sleep with a boy does not mean that she is prepared to have sexual intercourse with him. The younger girls sleep for years in the arms of boys with nothing more than a little erotic play. Only after the menarche do they begin to have regular sexual congress. If then a boy forces a girl against her will, and others hear of it, he is fined. (p.656)

. . .The incidence of crime is very low. An experienced police officer, who had served in the ghotul area for twelve years, told me that in all this time there had been no cases of murder, riot, assault, hurt, or rape in connexion with the ghotul. There has not been a single case of rape against a Muria, though non-aboriginals have been arrested for raping Muria women. It is a remarkable thing that most of the crime in the Kondagaon and Narayanpur Tahsils occurs in the Mardapal Pargana and along the north-eastern border in just those areas where the dormitory system is moribund. The ghotul has almost disappeared from the Mardapal Pargana and the system is rapidly decaying along the border. A policeman told me that in his opinion ghotul-education was a most valuable preventative of crime, for boys and girls learn to share everything and to scorn acquisitiveness and the lust of possession. (p.657)

. . .'Jealousy and homosexuality are the two primary causes of the disorder of our passions', says this same scientific observer (Stekel) of the European scene. Will not even the reformer admit the advantage of a tribe which is so largely free from these evils?

So long as sexual relations do not overstep these boundaries of good taste and morals, there is nothing wrong in them. Sex is a good thing, healthy, beautiful, interesting, the crown and climax of love. Love indeed is meaningless, inconceivable without it. It is right and good for a chelik to love his motiari and to lie with her. Such is the simple Muria philosophy.

This accounts for the delightful freedom from self-consciousness that is one of the most remarkable things about ghotul life. When after a visit to the Kongera ghotul, Walter Kaufmann exclaimed 'This is the cleanest place I've ever been in' I think he meant that. There is no sniggering, there is nothing cheap or nasty, there is nothing furtive about the relations of these boys and girls. (p.656)

. . .We may consider how the ghotul boys and girls are almost completely free

from those furtive and unpleasant vices that so mar our Western civilization. There is hardly any masturbation, the scourge of the English Public Schools; where it is practised, it is due to the mistaken efforts of reformers to improve the ghotul. Prostitution is unknown, unthinkable. No motiari has ever given her body for money. Homosexuality, sodomy, bestiality are shocking things, unworthy of chelik or motiari and never indulged by them. Nor does Muria society known the thin frustrated spinster or the male neurotic so prolific in the modern Indian 'ashram', with his desiccated outlook and censorious judgements.

These are great gains. At the same time we must not forget that there are many things in our own society which would shock and offend the Muria. A chelik would be scandalized by the Public Schools in England – the atmosphere of competition, the corporal punishment, the bullying, the petty tyranny of senior boys, the segregation with its attendant vices, the common homosexual interests, the furtiveness of association with girls, the worship of sport which has no connexion with real life. The prostitution in our cities would seem to him an abomination, and he would be filled with pity for the unmarried together with a dread of what would happen to them after death. (p.660)

The above gleanings will, I hope have given the reader some aspects of another culture on which to ponder, and to compare with our own.

This I have done over the past ten years or so. I have tested it at every opportunity with as many incidents of family, or non-family, life as I could observe (or be involved in), scraps of conversation – participated in or overheard – together with media references – radio, newspapers, and television. Like the tin of pineapple in Jerome K. Jerome's book, *Three Men in A Boat*, I beat the Ghotul Idea from every conceivable angle, and still it held together.

★ ★ ★

During the 'forging' period I was fortunate to be living in a sympathetic environment – had I been living elsewhere this article would never have been written. The time and place were right. It took no great stretch of the imagination to link certain details of my immediate surroundings with those from the description of a Muria village. The general area was similar – rural, hilly, well-wooded and relatively isolated. Community effort kept the unmade road usable. Dwellings were small and single storeyed. Each had a garden, though none seemed as extensive or productive as Muria gardens which were described as 'substantial'. Homes were connected by footpaths and at a focal point in a compound was a large barnlike building. It was falling into disrepair, but its very presence, size and position gave me the opportunity to designate it the role of 'ghotul'.

Here, then, on my doorstep was a Muria 'village', with similarities of layout and size of home.

This latter factor had, I feel, some influence in the formation of the ghotul system.

For a Muria couple the size of their home built especially for them and into which they were established with all ceremony at the time of their marriage would be unlikely to alter much during the course of their lifetime notwithstanding the number of offspring they might have. The house did not grow with the children – nor was it necessary for the family to move to a larger place to accommodate them. The ghotul did that, and more besides. It was the one building with enough flexibility of design to adapt to fluctuations in the numbers of its inhabitants. In small homes with a limited number of rooms and thin walls, parental privacy would naturally be at risk. How sensible for the children to go off to the ghotul where they were warm, safe and well supervised.

But it also eased the parents in another way. As their married life progressed they would not be under pressure to extend the original home and provide extra bedrooms and facilities. This would mean a considerable saving in materials, money and human energy. Thus, compared with our society, the merry-go-round moves (with all the attendant trauma), from 'starter homes' to bigger houses and finally the reduction to a granny flat, council bedsit, or nursing home, just did not exist. How serene life without these constant problems of basically unnecessary upheaval and adjustment.

True, the Muria parents would have to work to provide food for extra mouths as they came along, but as the children grew so did their assistance:

> . . .the ghotul is only a night club; all day its members are engrossed in the quest for food and drink. The chelik are kept busy in both axe- and plough-cultivation, hunting, fishing, gathering honey, tapping the sago-palm, collecting fuel. The motiari not only work very hard at home, but they go out for roots, wild fruit and myrabolams, to pick broad leaves for plates, cups and pipes, to fish and to express oil. (Preface vii)

and earlier in the Preface:

> . . .Chelik and motiari have important duties to perform on all social occasions. The boys act as acolytes at festivals, the girls as bridesmaids at weddings. Both dance before the clan-god and at the great fairs. They form a choir at the funerals of important people. Their games and dances enliven village life and redeem it from the crushing monotony that is its normal characteristic in other parts of India.
>
> . . .In the first place it must be said that the chelik and motiari are wonderfully happy. Their life is full, interesting, exciting, useful. The ghotul is, as they

often say, 'a little school'. The chelik are 'like Boy Scouts', as I was told in a village which had a troop in the local school. There is no comparison between these children and the sad-eyed, dirty ragamuffins of villages at a similar cultural level elsewhere. In the ghotul the children are taught lessons of cleanliness, discipline and hard work that remain with them throughout their lives. They are taught to take a pride in their appearance, to respect themselves and their elders; above all, they are taught the spirit of service. These boys and girls work very hard indeed for the public good. They are immediately available for the service of State officials or for work on the roads. They must be ready to work at a wedding or a funeral. They must attend to the drudgery of festivals. In most aboriginal villages of the Central province, the children are slack, dirty, undisciplined, and with no sense of public spirit. Even those who attend school generally only develop a strong desire to advance their own interests at the expense of their fellows. . . It is at least one point in their favour that this sleeping together does not seem to do them a great deal of harm. There are no signs of corruption or excess; these bright-eyed, merry-faced boys and girls do not give you the impression of being victims of bestial lust. They are living a life of fulfilment and it seems to do them good. (p.658/9)

Simple all this was – and so too, in its own way was the life in the area in which I lived. At one time this affordable simplicity attracted teen-agers from the surrounding environs who came to live in some of the empty dwellings, which for our purposes could be regarded as satellite huts of the main 'ghotul'. These young people got on with their lives, settled their own differences and did not interfere with older neighbours but generally acknowledged them as they passed in the road, and by this action indicated that they regarded themselves as part of the community, although they worked outside it.

A new landlord changed it all. Acting on crude market principles, he forced the young people out.

Had it been the beginnings of a ghotul system? Almost perhaps.

By Muria standards, establishing a basis for emotional growth in late teens or early twenties, was far too late. Unlike the Muria children the local youth had not had the experience of sexual freedom and discipline associated with a ghotul life, and had begun co-habiting at an age when taboos and limitations against pregnancy would normally be lifted, not enforced.

Ghotul rules were complex for good reason: woven into the framework of ghotul organisation they were acceptable enough, and according to Elwin, generally obeyed:

. . .Sexual intercourse must not only be with the right people: it must be at the right time. It is tabooed before the greater festivals, before a hunting expedition, during the Pus Kolang dance, and most important of all, during a girl's menstrual period. It is also tabooed in certain places. Intercourse should occur

within the ghotul walls, within the supernatural fence that protects from evil. (p.655)

Dr. Elwin examines at length the fundamental aspects of ghotul life and how the rules and taboos effect the aim of pregnancy prevention. He does say that contraception methods (as understood by Western society – 1947), were not used. The number of pregnancies which occurred in the jodidār ghotul was about three per cent, with a slightly higher figure for the more modern ghotul.

It would appear, then, that the ghotul, whilst offering sex-affirmation required pregnancy negation, and almost succeeded in this respect. Such negation did not seem to affect the fertility of the girls (or produce side effects), to whom, after marriage, motherhood came smoothly and naturally. High fertility is a pre-requisite in both partners, so one can only assume that, in the security of the ghotul environment, the day to day associations of the boys and girls strengthened and increased healthy glandular and hormonal function.

In my view, the implementation of sex-affirmation whilst at the same time endeavouring to evade pregnancy during a lengthy growth period prior to, and immediately following sexual maturity, enabled the boys to develop a good deal of muscular-sexual control, which they must have employed during marriage in order to space out their families, but without denying their partner sexual satisfaction.[1] Sexual expertise at such a level would undoubtedly enhance marital relationships, thus probably contributing to the extremely low figures of Muria adultery and divorce which Dr. Elwin recorded.

★ ★ ★

In an urbanised and industrialised society, (heavily influenced by television), where the nearest institutions equivalent to dormitories are Public Schools, Youth Hostels (sadly declining), and Children's Homes (hardly ghotuls), the dormitory system at rural level may seem too far removed to be viable.

. . .The village dormitory is a symptom of a certain stage of cultural development. We ourselves consider that we have outgrown it: we may grow into it again. In the days when I shared the free and happy life of the Muria I used sometimes to wonder whether I was a hundred years behind the times or a hundred years ahead. I do not suggest that we should replace the Public Schools by ghotul and turn our own children into chelik and motiari, but I do suggest that there are elements in ghotul life and teaching which we should do well to ponder and that an infection of the Muria spirit would do few of us any harm. (p.663)

Restructuring our own village religio-socio frameworks due to de-centralisation and reduction in the use of the motor car, could be reinforced by introducing some essentials of the ghotul system.

The following account shows that integration of such essentials is possible even in more built up areas.

Recently, in a near-by town, a group of homeless youngsters squatted in a large empty house. They were just beginning to organise themselves when they were evicted. It has been suggested that the squatters were reinstated and that they be allowed responsibility for the house and under guidance do repairs and decorating – in other words, form an Urban ghotul. Although a councillor has acknowledged that the house could be used in this way, needless to say it remains boarded up whilst the local council deliberates.

But surely it is not beyond a group of able-bodied young people to build their own ghotul/hostel, whether it be in the town or in the country, using the Walter Segal techniques advocated by Brian Richardson in his article 'Architecture for All'.

The departure of our young people from our local community marked a change for the worse for all of us. To fulfil the greedy aspirations of racketeering landlords almost all the original small dwellings have been replaced by larger buildings designed to meet an urban concept of rural living and thereby causing the build up of incredible tensions within the landscape and local populace. The 'ghotul' has been demolished to make way for as yet I know not what, and the occupiers of the remaining small homes are being pressurized to leave and thus follow the criminal patterns set in our society.

One wonders how the Muria have fared through the years, but at a time of global ecological crisis, I feel that their ghotul system offers at least a modicum of human stability.

Note

1. For further reading on this subject I refer the reader to an article published in *SHE* magazine May 1985, called 'Any Man Can' – this was a review of the book of the same name by Dr. William Hartman and Marilyn Fithian and published by Angus and Robertson.

Clio Bellenis

Does Childhood Matter?

Children are the last remaining group in Western society to be generally regarded as not enfranchised, not complete citizens. In the past there have been many such groups. In the distant past perhaps the majority of people in the country were in this position under feudal lords. However, it is now generally accepted that an employer does not have total control over the life of an employee. Similarly, neither is a man considered to have rights over the person and property of his wife that she does not have over him. There is still considerable difference of opinion throughout Britain on this last point. Nevertheless few men would state boldly that they saw their wives as chattels even if in fact this is how they behaved.

The situation for children, however, is different. Children are born frail and helpless, and, to state the obvious, totally unable to take up the role of a helpfully participating member of a society or community. Children need care and protection, they need love, shelter and food. They also require a chance to grow, a chance to test themselves, and gradually a chance to separate completely from their families, becoming independent, autonomous human beings. How much care and protection has to be a matter for the individual child and their carer, and varies from year to year and from day to day.

Rearing children is not easy. It is a job without respite and a job which usually falls on a child's natural parents. There is an assumption that parents are the best people to care for a child as they will always have that child's interests at heart. It is assumed that there will always be a strong attachment between a child and their parents, and it is in fact this attachment which led to a change in the way children were looked after on Kibbutzim in Israel. Communal nurseries and kindergartens were thought to be a good idea in terms of bringing children up equally, and freeing parents from mundane tasks of child rearing, but the strength of the attachment between those children and their parents eventually had to be acknowledged.

Implicit in the idea of parents as protectors and developers of their children comes the rather less comfortable notion of parents as owners of their children and people speak very freely of parental rights. The parents then, having immediate biological power and authority over

their children, are given further power and authority over those children by the community at large with little thought as to whether that power may be abused. People (perhaps anarchists particularly) are loathe to interfere within a family, which is seen as the basic unit of society, when they might cry out in outrage if they did not believe the participants in a violent act to be members of the same family. Perhaps a good example of this is seeing a small child being walloped in the street by a frustrated adult, particularly if a mother; when if the smaller, dependent, defenceless person were also an adult our feelings might be rather different.

What can happen to children?

In the 1960s Kemp and Kemp published a paper about 'The Battered Child'. This paper had a very mixed reception from both medical and lay audiences. Children for years had been seen with mysterious and inexplicable injuries, but to ascribe these injuries to parents was too horrific to contemplate. Now, twenty or thirty years later, it is accepted that some parents do indeed seriously hurt their child, although even now it is frequently described as having 'gone too far' as if there were an acceptable level of beating someone smaller than oneself. (I always find this rather reminiscent of the old rule which stated that a man could beat his wife with a rod as long as it was no thicker than his thumb.)

In the 1980s a new horror was realised. That was that people, as well as physically abusing their children, could also sexually abuse them. Another of the easy assumptions people make is that sexual abuse of children is primarily a sexual act. In fact, just as rape is primarily subjugation by means of power and control rather than an act of sex, so is sexual abuse of children primarily an abuse of an adult's power over that child.

What actually is child sexual abuse?

Child sexual abuse (CSA) takes a wide variety of forms. It may begin with a period of seduction by an adult of a child. That adult may be a member of the close family or a stranger. It may be an exclusive or seemingly exclusive relationship as one within a family, or it may be part of a paedophile ring where children introduce other children, some of whom graduate to themselves abusing other children as they grow older. The condition then would seem to be so varied as to make little

sense in lumping the whole thing together and calling it CSA. There are, however, many common features and many common sequelae.

Perhaps the most obvious similarity is the demand for secrecy. This secrecy demanded by the adult may be reinforced in a number of ways. Perhaps the most common is a straightforward threat, 'If you tell I'll kill you', (I know of one instance where this threat was carried through) or it may be more insidious, 'If you tell you will be taken away and locked up', 'If you tell I will be taken away and locked up', 'If you tell your Mummy will be very upset and you will hurt her'. As children get older they become easier to quieten. What may have seemed normal to a five year old, even if unpleasant and painful, raises many more questions in a ten or eleven year old so that the child is easily able to think up their own consequences such as, 'Who will believe me', 'I am guilty', 'I am dirty' and the one almost universal belief, 'It was my fault'. Guilt can be induced in a child with just a look from an adult.

Older girls particularly may continue to allow the abuse in the usually mistaken belief that they are protecting a younger sibling from the same. Other children may see the sex as a trade for attention. It's worth putting up with the unpleasant part in order to get the extra attention or the gifts. It is noteworthy with respect to this last view that a very large paedophile ring involving men and boys in Brent came to light because the ring picked one wrong boy: a ten year old, who when playing with computer games turned into playing with bodily parts, told his mother about these strange, unpleasant men he had met. Up till this point other boys had kept quiet either for fear of their parents' reaction or because they saw the trade as being worth it (a disturbing reflection on the sheer number of sad parent and child relationships).

What then happens to children whose physical integrity has been assaulted in this manner? As I stated above an almost universal reaction is one of shame, guilt and a feeling of dirtiness. Relationships with other people are soured. Hidden agendas and ulterior motives are suspected easily from almost anyone. Self esteem reaches rock bottom, 'That's all I'm worth'. Children and young adults if not helped to understand and put the experience behind them broadly react in two different ways split to a large degree on gender lines. First, is to continue with the 'That's all I'm worth', with an added 'It is one way of getting what I want', so that a perpetuation of the victim role happens. This is commonly a female development. Girls may become extremely promiscuous very young, becoming child prostitutes; or even at pre-school age being unable to approach a man other than sexually. This frequently continues into young adulthood and later life, with the forming of relationships with abusive men and early maternity (frequently hoping that the child will love them in a way that they had not previously received love).

This frequently has the tragic consequence that such a child is themselves sexually abused or abused in other ways following from the simple idea that you can't give what you've never received. A young woman who has never received unconditional love or adequate protection would find it very difficult in her turn to give it.

The pattern for males may be as above, but more usually if the experience of abuse is not adequately dealt with emotionally, a boy can escape the victim role by identifying with the aggressor, thus he will himself become an abuser. This is thought to happen to about 60% of abused boys. Fatherhood for these boys is as difficult as motherhood for abused girls.

The wider implications of abuse

It is not only parenthood and the raising of the next generation that is difficult for children who have been abused, sexually or otherwise. It is that their whole life outlook is coloured by the sense that one is either a victim or one is an abuser, dominant in some manner or another. How difficult then for such a person to understand the concept of mutual co-operation never mind actually striving to achieve it. Far more likely is the philosophy of 'I'll get you before you get me', or 'You don't give a shit about me so I don't give a shit about you'. It is difficult to feel loved or cared for later in life if one hasn't felt loved and cared for in infancy.

Thus we get the cycle of deprivation and here I will restate the importance of 'you can't give what you've never had'.

Is good enough parenting possible?

The important phrase in this heading is good enough. Perfect is unattainable and perhaps might not be good enough even if it were attainable. Perhaps what is most important emotionally is the receiving of unconditional love. How many people have used the phrase 'I may not like you very much at the moment, but I still love you'. Respect must also be important. A person who has been respected can learn to return that respect and surely all persons must be in some way worthy of respect from the moment of birth till the moment of death. I see this as a fundamental anarchist principle. There is a ray of light here. So far I have been talking as if only parents cared for children. This is clearly not the case. There are friend's parents, neighbours, teachers, and it is quite possible for a child with access to other caretakers to gain a sense of self-worth from these people even if the child's own parents, through no fault of their own, cannot give the child that sense of esteem.

There are, of course, degrees of problems within families. I have dwelt at some length on CSA because of its current topicality, but more common and more insidious is the emotional abuse caused by a parent who simply cannot adequately love and respect their child's uniqueness. The effects of this are at least as severe as those of CSA, but the nature of the cruelty is not immediately obvious to the casual observer, and frequently obscured if the perpetrator is 'a nice chap' in other company.

The anarchist's dilemma

Where does one draw the line at allowing other people their own manner of behaving so long as it doesn't interfere with you personally. Is it that we see a family as inviolable and therefore we allow abuse (emotional, physical or sexual) to continue, turning a blind eye, and therefore provoking a repeat of the cycle of deprivation? Or do we rather see a young child as a valid person in their own right, one of a group of people who are vulnerable by means particularly of their voicelessness, who deserve the care and protection of any caring community? If we believe the latter then we are agreeing that it can be right to intervene in other people's relationships.

To state my case clearly: just as we should object and protest loudly if we see a group of adults being exploited, so should we object and protest loudly if we see a group of children being exploited. This then to be effective must also be applied to the individual. If one employee is effectively a slave then they need support. Similarly, if one child is effectively an adult's tool then we should also act. Who should act, and how, and when, is obviously open for discussion, but it must be remembered by detractors of this view that there is considerable research and empirical evidence (which I do not have room here to go into) that children with problems in their earlier relationships become adults with problems in their later relationships, and in an adult/child relationship it is predominantly the adult who sets the pace. The field of infant psychiatry is a rapidly expanding one where improved knowledge is taking the place of philosophising. The relationship between styles of parenting and their outcome are becoming disentangled, and the essentials of parenting for a healthy future are being understood.

An adult's outlook on life is necessarily related to these factors. Their competence, personal, social and political, seem likely also to be related to their childhood through the value a person puts on themselves and the value they put on other people's autonomy. For all these reasons I regard the mental health of all our children to be absolutely crucial if we are genuinely looking to create a different, more mutual society without the automatic assumption that there will be rulers and ruled.

Donald Rooum

The Satanic Child Abuse Epidemic, 1990-91

Sociologists at the London School of Economics are studying the epidemic of credulousness which recently afflicted social workers in the U.K., but their report will not be published before 1993. This article reviews the partial evidence which has already been published.

Social workers get all sorts of crazy rubbish through the post.

Reachout Trust, a charity set up in Rhyl to counter the dangers of occultism, circulates 'confidential papers' to social work departments. One such paper describes bizarre Satanist rituals: 'Adults dress up in masks and goats heads [. . .] The children are taught to hate God, Jesus, the Church, and everything that is good [. . .] Teenage girls and women have to sacrifice their own children [. . .] After the sacrifice, they take out the heart, spleen and eyes and eat them [. . .] The fat is used for candles and bones ground down and the powder is used for an aphrodisiac.'

Childwatch, a charity based in Hull, advises child protection agencies that about 4,000 babies a year are killed in Satanic ceremonies.

British associates of an American group called Believe the Children have sent a list of 'indicators' of Satanic child abuse to social work departments and police forces. Physical indicators are mutilations like missing finger-tips. Psychological indicators are bits of normal behaviour which adults may find annoying but not alarming: interest in death; preoccupation with urine and faeces; fear of ghosts and monsters; the child being 'clingy'; reciting nursery rhymes with indecent overtones; nightmares and bed-wetting; preoccupation with passing gas; making gas sounds with the mouth; wild laughter when the child or someone else passes gas. ('Passing gas' appears to be an American equivalent of 'breaking wind'.)

Behind these dotty documents is the 'Manichean heresy', the persuasion that good and evil are equally balanced. If the (good) Evangelical Alliance has a million adherents, then the (evil) Satanists must also have a million adherents. The complete absence of evidence is evidence of the cunning with which the Satanists cover their tracks.

In the ordinary way, we must hope, social workers ignore such documents, or file them under 'Missives from obvious loonies'. But in 1990 and 1991, a few social workers took them for the truth. Some 45 children,

in Manchester, Rochdale, and South Ronaldsay in the Orkneys, suffered the abuse of being forcibly taken away from their loving families. And if the police in Nottingham had done as the social workers wanted, the number of children thus abused might have risen to 80.

The myth of Satanic Child Abuse comes from America, where it may have started in 1972 with the publication of *From Witchcraft to Christ* by Doreen Irvine, the autobiography of a former high priestess of Satan. 'Many Satanists would be present [. . .] about eight hundred or more [. . .] All meetings included awful scenes of perverted sexual acts [. . .] My ability to levitate four or five feet was very real. It was not a hoax. Demons aided me.'

I leafed through this book in a Christian bookshop some years ago, and took it for an allegorical novel. Others have taken it literally. Since its publication, police in America have investigated more than 10,000 complaints of Satanic gatherings and found no evidence for any of them.

The splendid buffoon Geoffrey Dickens MP spoke in the House of Commons, in April and September 1988, about the prevalence of Satanic Child Abuse in this country. Up to 50 young children a year, he said, were being murdered. His evidence was the increased demand for occult books in libraries, the popularity of black magic videos, and the spread of 'New Age' shops. Dickens probably inspired the *Cook Report* show, 'Devil's Work', a melodramatic presentation of nonsense broadcast by BBC TV on 17 July 1989.

After that came the social work conferences on the theme 'Not One More Child'. The first of these, and perhaps the most important for spreading Satanic Abuse hysteria, was at Reading University, 15-17 September 1989. The organisers were Norma Howes, an 'independent social worker', and Pamela Klein, the American who had introduced the 'Satanic indicators' to Britain.

The star speaker was Detective Robert J. ('Jerry') Simandl of the Chicago police. He held up a plastic sheet, of the type which he said was used to wrap the bodies of children sacrificed at Satanic rituals, and described how the body would be buried in a freshly-dug grave the day before a genuine funeral. He told harrowing tales of sexual abuse of children in caves and underground tunnels, and of one case in which a child had been cooked in a microwave oven.

A year later, Mr Simandl was interviewed in Chicago by the *Mail on Sunday* (16 September 1990). He said 'My superiors and colleagues are sceptical when I tell them these stories. But it is so interesting being in England and Scotland and talking to people there. The rooms were packed, and everyone wanted to know more and more what was going on.'

One of the two main supporting speakers was Maureen Davies, at

that time Director of the Reachout Trust. Using duplicity as an aid to credulity, she told the conference that 35 cases of Satanic abuse were being investigated by 14 police forces.

The other main speaker was Judith Dawson, Child Protection Co-ordinator for Nottingham social services. I have seen no report of what she said to the conference, but she appears, using her official title, in *Doorways to Danger*, a video produced by the Evangelical Alliance. There she speaks of Satanic groups 'whose main aim in life is to destroy everything that is good about human life'. In order to insult Christ's love of children, she says, the adult members of these groups use the children as sexual and sacrificial slaves. Her evidence is a quotation from the New Testament.

The *Mail on Sunday*'s informant, 'a senior social worker who cannot be named for professional reasons', is quoted as saying 'The longer this went on the more sceptical I became. Where was the proof? Where were the bodies? But I admit I did not have the courage to get on my feet and voice my doubts. Everybody was taking copious notes. There was an atmosphere of hysteria which I found frightening.'

Howes and Klein organised another conference in Dundee, using the same speakers. Simandl increased the number of babies cooked in the microwave from one to four. There were at least two further meetings. Maureen Davies, for what her word is worth, told reporters she spoke to ten.

Some social workers, it now seems, took the frightening 'atmosphere of hysteria' back to work.

Two abused sisters aged seven and four, from Trafford, Manchester, were taken into care in October 1989. Not at once, but three months later, they began to tell stories of witch parties they had attended, where babies and animals were killed and blood was drunk. On the basis of these stories, eleven more children were taken into care and a man was arrested in January 1990. The man was released because there was no evidence against him. There was no evidence against the children either, but they were held for a further ten months. Eventually they were freed on the orders of a High Court judge, and the social services department 'accepted criticism of their methods'.

In November 1989, a six-year-old boy in Rochdale was found hiding in a school cupboard by the headmaster. He told of ghosts named Jim and Bob, a man growing to nine feet tall, stabbing big babies and little babies, and helping to dig graves to bury other infants. Two social workers who interviewed him later said they had 'already done some reading on Satanic ritual child abuse'. They decided the boy was telling the truth, except for the physically improbable story of the nine-foot man, which was evidence that he had been given a hallucinogenic drug.

The boy and his brother and two sisters were immediately taken into care. They are still in care, not because anybody still believes the Satanic nonsense, but because they are now deemed to have been neglected. The evening before the child hid in the cupboard, it has been learned, the family watched the horror video, *The Evil Dead*, twice.

Two children from this family denied all knowledge of Satanic rituals, but were not believed. A sister said she had dreamt of the rituals, which was taken as proof that she had attended them in real life. After months of interviews, the frightened brother and the dreaming sister implicated other families.

In June 1990, 16 children in Rochdale were roused at dawn to be dragged away from home. Three more were taken in July and September. Their families were not allowed to communicate in any way, not even to send printed Christmas cards, for fear they should contain hidden Satanic messages.

Following the release of the Manchester children in December James Anderton, police chief of Greater Manchester which includes Rochdale, said there were no grounds for detaining the Rochdale children. Nevertheless ten of them remained in custody until a 47-day High Court hearing had exposed the evidence as ridiculous, in March 1991.

Social work records showed that a little boy had admitted eating a cat. It emerged that the cat he had eaten was a cat-shaped piece of pasta in his soup. Another boy admitted watching the Black Master of Huddersfield stab a man to death. Asked why the rest of his family had not seen it, he said they were in the chip shop.

The day after the Rochdale judgement, the Director of Social Services resigned. The two who had 'done some reading on Satanic abuse' were transferred to other jobs.

The father of eight children in South Ronaldsay was imprisoned in 1989 for sexually abusing a daughter, and his family were in care. In February 1991 a girl from this family, said to be greatly distressed by the upset, told stories about her family and playmates gathering at the local quarry to chant, dance, and have sex with 'The Master', a man wearing a black cloak and a black mask, who would hook them out of the dancing circle with a crook. The stories were confirmed by a brother and a sister, but not by other members of the family.

'The Master' was identified as the local Presbyterian Minister, who had apparently been campaigning for the return of the family in care to their mother. Few men on a November night in Orkney would be warm enough for multiple sex, and the Minister was 68 years old and suffering from angina.

After consultations among police, social workers, and local officers of the RSSPCC, there were pre-dawn raids on the houses of the minister

and four families who had assisted his campaign. Objects suspected of being used in Satanic rituals were seized and nine children were dragged from their beds, to catch the first ferry to the mainland. One child was Jewish, and her parents requested that she be fostered by Jews. The request was ignored.

Five weeks later, all 17 children were sent home on the orders of a mainland sheriff. The seized objects were also returned. They included a video of the TV comedy show 'Blackadder', a novel by the detective writer Ngaio Marsh, and a model aeroplane made by a boy out of two pieces of wood, catalogued as 'one wooden cross'. The minister was asked to sign for the return of 'three masks, two hoods, one black cloak', but refused to sign until the inventory was altered to 'three nativity masks, two academic hoods, one priest's robe'.

A judicial inquiry is in progress.

During the 1980s an extended family in Nottingham had 'sex parties' involving children under the age of seven. In February 1989 eight male members of this family and a family friend were imprisoned, and by this time 27 young children were in care.

Suspecting that other men had also been involved in the 'sex parties', the police asked for regular meetings of the foster mothers, to report any new leads which the children might suggest. Judith Dawson, in her capacity as Child Protection Co-ordinator, arranged for the foster-mothers to be briefed by Jerry Simandl and Pamela Klein. Months later – surprise, surprise – the children began to recall Satanic rituals.

Dawson wanted 27 more children to be taken into care on the grounds that they had been exposed to Satanism, and when the police said they could find no evidence, she took her case to the media. Beatrice Campbell, author of a book about the Cleveland child abuse scandal of 1987, made a documentary about Satanism in Nottingham for the Channel 4 *Dispatches* show, broadcast on 3 October 1990.

In Rock Cemetery, Nottingham, there is an artificial cave, built for recreational purposes before the cemetery existed, called 'The Catacombs'. It is now locked, but one can gaze into its mysterious depths through the railings. This was one of two dark caverns (the other is the basement of the natural history museum) in which Nottingham children said Satanic rituals had taken place. Campbell's *Dispatches* programme produced 'corroborative evidence' for the story, in the form of a niche with an engraved cross on the wall of 'The Catacombs', remains of candles, torches, and old Christmas decorations on the floor, and from the nearby cemetery lodge a dildo, some pornographic magazines, and an application form for fostering.

An article by Judith Dawson, criticising the unco-operative attitude of the police, appeared in the *New Statesman* two days later. She quickly

passed over her own religious opinions to say of the social work team she leads: 'We are a secular team and the team does not believe in the Devil nor God'.

Nottingham Chief Constable Dan Crompton replied with a long press statement, in which he said the police had carefully investigated everything social services had reported. The difficulty was that all checkable facts had turned out to be false.

To quote just one example of the many he listed, a little girl had scars across her stomach. At first she said she could not remember how she got them, but after a time she 'remembered' that a female member of the family had cut her about with a Stanley knife while others watched. Dawson wanted the police to arrest the carver and the audience, but the police began by consulting the child's medical record. As a baby, she had undergone an operation for congenital weakness of the abdominal wall. The police traced the surgeon who had performed the operation, who examined the child and confirmed that the stitches were his.

'Surely', Crompton wrote, 'standards of evidence gathering, investigation and presentation have to be maintained if we are not to revert to the ducking-stool form of justice. If action is taken in the absence of sound corroborative evidence, the removal of children from the parental home could [. . .] be a monumental injustice, and the trauma [. . .] will be as devastating as child abuse itself.'

How pleasant to find a humane Chief Constable, and how unfortunate that other police forces were less insistent on evidence.

The affair is not quite over. On 23 September, after *The Raven* has gone to press, there will be a conference of social workers at Lancaster University. The topic will be 'The ritual abuse of children and young people: myth, fact, fiction . . . or reality', and among the speakers will be Judith Dawson and Beatrice Campbell. They have not said in advance whether they will apologise for the damage, accuse the Nottingham Chief Constable of cunning Satanism, or ignore the Satanic business entirely.

In any case, this particular epidemic of Satanic Child Abuse appears to be spent. But if anyone thinks the Evangelicals are harmless eccentrics, here is the evidence that they are dangerous.

Acknowledgements

Much of the information above is lifted from *Orcro Magazine*, an occultist quarterly which follows the activities of 'mad fundies', reprinting their literature and news items about them. Another source is *Fortean Times*, 57.

H. B. Gibson

Do Doctors Take the Sexuality of Older People Seriously?

A paper delivered at the Annual Conference of the British Society of Gerontology, September, 1990.

A friend of mine in his early sixties went to see his GP about a urological problem, and this doctor suggested an operation. When my friend asked whether such an operation would have any effect upon his sexual potency, the doctor responded with amused incredulity, and asked why a man of his age should be bothered about such a matter. This doctor was quite a young man. This set me wondering how many doctors and other health-care professionals imagine that sex after sixty does not matter at all, and believe that people of this age should be reconciled to living sex-less lives. I wondered how much the average GP knows about the normal functioning of older people in general, and what sort of education is being given to students in the health-care professions to acquaint them with the basic facts about gerontology and geriatric medicine. This matter is of particular interest to me, as I am engaged in writing a text-book entitled *The Emotional and Sexual Lives of Older People*, which should be published next year.

The work of Kinsey and his colleagues in the 1950s, and Masters and Johnson in the 1960s was partly instrumental in producing a revolution in attitudes towards sexuality in the Western world, a breaking away from Victorian taboos on the part of young and middle-aged people, but neither of these two teams of research workers had any significant number of old people in the samples they studied as they had assumed that it was hardly worth studying people over sixty, because everyone knew that for people of that advanced age sexual activity was rather uncommon and unimportant. Pioneers such as Butler and Lewis and Isodore Rubin, writing in the 1970s campaigned actively that doctors and all other health-care professionals should wake up to the fact that a consideration of sexuality in the last decades of life was important. It was not, however, until the end of the 1970s that large-scale surveys of ordinary people, and not just those coming for help to the surgery, demonstrated that older people generally regarded their sex-lives as an important aspect of their health and happiness. I refer in particular to the survey of Edward Brecher and his colleagues which studied over

4,000 men and women between the ages of 50 and 93, and that of Starr and Weiner which embraced 800 men and women between the ages of 60 and 91. Since then there has been quite a wealth of publications in medical, nursing and gerontological literature dealing with the problems of sexuality in later life.

That there are problems is undeniable, not the least of which is the fact that as we go up the age scale there is an increasing numerical imbalance between the two sexes, so many older women are denied the possibility of normal heterosexual experience. Looking ahead to the 21st century, a number of remedies have been proposed for this growing problem, including a form of polygyny as suggested by Victor Kassel, and lesbian associations between women who have previously been heterosexual. Such proposals may seem bizarre to some of you, but I have seen so many great changes in sexual morality during my lifetime, that I should not rule out any of such possibilities for the future. But one of the greatest obstacles to older people achieving sexual fulfilment in later life, is the legacy of past attitudes. Older people themselves, reared in a climate of disapproval of sexuality may now accept intellectually the recommendations of the World Health Organization that sexuality should be considered a means of enriching and enhancing personality, communication and love, but they may find difficulty in coming to terms with this attitude emotionally. Sadly, there is also a form of ageism expressed by some younger people who, for various motives and through various emotional hang-ups, do not wish the grandparent generation to enjoy the same liberties and fulfilments that they demand for themselves. It is very easy to invoke the folk-myths about the sex-lives of older people, that used to have a respectable following in nineteenth century medicine. The young doctor whom I cited at the beginning of my talk was doing just this. But there is now such a wealth of information coming from soundly based research, that we must accept that for the majority of healthy men and women, sexuality is for life.

In saying that sexuality is for life, I do not mean that people in their sixties and older should strive to live as they did in their twenties, for if they do they are bound to be sadly disappointed. The nature of sexuality and its integration with the total personality changes as we age, and unless people understand the normal physiological and psychological changes that take place with ageing, they are likely to encounter difficulties. It is now accepted that children should have some form of sex education to prepare them for the changes that take place in them as they grow up, so that they will develop into mature and responsible adults. It is perhaps a novel idea that many people entering the later decades of life, when physical, social and psychological changes will normally take place, are also in need of sex education. There is a need

for such education, first, to make up for the ignorance about sexual matters that used to be deliberately fostered in the mistaken belief that it was for the public good, and second, to counteract the absurd mythology about sexuality in later life which is still so common that many older people who are entirely normal in every way may regard themselves as unusual freaks because they still want sexual fulfilment.

It is not enough for professionals to give advice when asked. We have a positive duty towards the public to seek to maintain health and emotional well-being, as well as to initiate remedial measures when things go wrong. Dr. John Kellett, writing in the *BMJ* last October, stressed that doctors have three obligations towards their elderly patients. Firstly, to warn them that certain treatments may have side effects that may affect their sexual economy, and to explain and discuss this matter in plain terms. Thus certain drugs may be preferred to others because they have a lesser effect on libido. It may seem strange to explain this to an old lady who ostensibly lives alone with her cat, but I have known such elderly ladies who, unbeknown to the local community, have very satisfactory lovers of long standing, and are reticent because they do not wish to make the neighbours jealous. It is up to the doctor to break the ice in communication.

Dr. Kellett's second point is that doctors should instruct patients in the normal changes that take place in sexuality with ageing, and inform about the possible difficulties that may arise. If patients know that such difficulties, if they arise, can generally be overcome they will be ready to seek advice, rather than assuming that their sex-life, and that of their partner, has come to an end. My point here is that people who are ostensibly single, the widowed, divorced, and those never married, should be given exactly the same advice as is given to married people.

A lady I know divorced in her late fifties and went to live in a new town. There she registered with a new GP who discussed her general health, and as she had a slight physical handicap, began to give her some advice about making love. This lady cut the doctor short, saying that she had now, at her advanced age, finished with all that sort of thing. A few years later, this lady fell in love, to her intense surprise and began a passionate sexual relationship. She then went back to her GP and asked to be given the information she had rejected before. At least she knew that the doctor was sympathetic, and the relevant information was there for the asking.

Dr. Kellett's third point is that doctors should be fully aware of all the sexual difficulties that can arise from pathological conditions such as diabetes, arteriosclerosis, and dementia, and be prepared to advise on them. Patients must be in a position to take decisions themselves; for instance, after myocardial infarction the patient or the spouse may

be very afraid to bring on another heart attack through sexual intercourse, and be prepared for a sex-less relationship for the rest of their lives. However, if they are advised on the true risks, they can take an informed decision, and if their late-life sex education has been adequate, they will have learned that copulation is not the only way of making love.

I might as well quote the final paragraph of Dr. Kellett's excellent article:

> The sexuality of the elderly is no place for the evangelist. The recognition that continued physical intimacy benefits both the psychological and physical health of the individual must be tempered by a willingness to allow elderly people to make their own decisions, unpressured by those who are younger. The embarrassment of the patients will be overcome only if the doctor can take the lead in introducing the topic – which is not easy for those of us who were taught that elderly people don't do it.

I have used Dr. Kellett's article as a framework to give structure to my lecture, and to present my own points of view. He may not, of course, agree with all the points that I have made. His final reference to the difficulties encountered by those professionals who were originally taught 'that elderly people don't do it', brings me to the question of what medical students are now taught about these matters. Two tasks have to be attempted: to give students an adequate groundwork of factual information about gerontology and geriatric medicine, and to attempt to investigate, and if necessary to modify, attitudes to sexuality that may hamper their professional work, particularly in relation to elderly people. Young health-care professionals may find no difficulty in discussing sex with patients of their own age, but what about patients old enough to be their grandparents?

In seeking to find out how much gerontology and geriatric medicine is included in courses for undergraduate medical students, I have had the advantage of two studies carried out by Smith and Williams. In 1981 they sent a questionnaire to all the medical schools in the U.K. asking about the teaching of geriatric medicine, and followed it in 1986 by a repeat questionnaire. The details were published in the two journals as on my Reference list. I did the same thing earlier this year, but with the difference that I didn't use a questionnaire but sent an open-ended letter explaining that I needed the information for the book I am writing about the emotional and sexual lives of older people. Also, I mentioned gerontology as well as geriatric medicine, for I am concerned as to how much medical students learn about the normal ageing processes of healthy people in a social context, and what steps are being taken in medical schools to encourage mature attitudes to elderly people, particularly in contexts that may be embarrassing for them.

The response I received was magnificent, some consultants and others writing me long and thoughtful letters explaining how they tackled the problems of teaching medical students about ageing, with particular reference to the subject of my book. I wish I had time to quote them extensively, but perhaps I can give you some brief quotes. One professor makes the point that their object is not to train 'embryonic consultant geriatricians', but to equip the students:

> with the skills and attitudes necessary to care for elderly people. One particular lecture is given by an elderly lady who describes the sexual attitudes as they were when she was a girl and goes on to describe how her own sexuality (and that of her husband) evolved over the years. This lecture provides very pertinent insights for the young students.

One difficulty with teaching geriatric medicine is that medical students, who have to be taught all about disease processes, may get a biased view of later life, and come to believe that ageing involves developing all sorts of horrible conditions, that will pretty well spoil our chances of having fulfilling emotional and sexual lives. This point is dealt with by another professor of geriatric medicine, who mentions the extreme frailty of most of the patients they see, and writes:

> There is, of course, a real risk that this will give a distorted view of normal ageing, emphasising all the dreadful things that can happen, and leading the student to forget the fact that most elderly people are relatively untouched by such problems. This is an important issue which we address with our students in my introductory seminar.

This point leads me to mention the publication *Living, Loving and Ageing* that appeared last year. I have discussed this pamphlet with the seminar group I run for the Cambridge University of the Third Age. This group of people in their sixties and seventies found it an admirable publication on the whole, but commented that the image of sexuality in later life, as presented, was rather a grisly one. It highlights in great detail unfortunate things like amputated penises, faecal incontinence, implanted catheters, colostomy, prolapsed vaginas, and suchlike. As Wendy Greengross is a medical doctor with a reputation for helping the handicapped, she has no doubt seen a great deal of such unfortunate conditions, but as this booklet is addressed to the general public, it does seem unfortunate such sad disabilities occur, and some younger people may wonder if all this will be a probable concomitant of their love-life as they age. By and large, the major impediments to a satisfactory love life as we age are psychological rather than physical. Professional health-care workers can do a great deal to overcome the unfortunate legacy of the past, and to encourage their patients to look forward to a happy and fulfilled sex-life in their later years.

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Arthur Moyse

Crippen wasn't all bad

Many a reviewer has dismissed an autobiography or biography with a wave of the pale pinkie, by typing that is anecdotal, meaning that instead of having the reader sift through the garbage of analysed statistics, or the hour and the date when the subject did not meet someone they did not know, the writer has breathed life into the pages by humanising the subject under the typing lash. We learn more of the early Victorian period through their broadsheets, their gallows ballads, their pornography or their drear paintings than all the laboured works of the academics. For the work of the academics is a cottage industry in that it is cannibalist, in that they exist to feed on each other. This I know, that when the definitive history of our time comes to be written by the dour German American authority he/she will turn to sources such as *Private Eye*, *The Sun*, *News of the World*, *IT*, the strikers' leaflets and the ephemera of our days for captured within, without thought of truth, grammar or academic history, is as always the true mirror of the age.

We are at this same moment in time almost daily flooded by Britain's medical middle class with facts they pour down upon us from P.R. heavens, yet they never stay within the memory for they cancel each other out. Wards and hospitals opening or closing, nurses hired or fired, doctors working 168 hours a week and collapsing across the chest of the dead patient. True or false I know not, but to stand on a strike picket on a hospital's steps with junior doctors and nurses and maintenance workers is to know that things are ill in Britain's hospitals and clinical services and it is not only the patients. It is the young and the healthy who are the victims of the illusion that all is well with the health of the people for the medical profession have an enviable P.R. system in that literally no week passes when we are not shown on TV the image of the caring doctor or nurse in that soap opera wherein everyone has a cash free cure or dies a painless smiling death; wherein junior doctors are jolly, nurses are sexy and senior surgeons are saintly but grumpy. But as the grim years move on and age dictates our health we learn the futility and the primitive fumblings of what we always accepted as modern medicine. For in 1991 there are so many illnesses and internal agonies for which there is no cure. When I groan with my uncurable sciatica and I read that the archaeologists have dug up another mummified Pharaoh planted over three or four thousand years ago and the medical experts tell us that the poor sod suffered from arthritis, the aged of 1991 have a right to throw their walking sticks to the ground and weep that Hippocrates was a prick, as they watch the wonders of soap opera modern medicine and with justice ask where are the Wonder Cures? I am indifferent to the Hippocratic Oath that he gave to a bar room audience in that Greek century three thousand years ago with its cant of secrecy between doc and the patient, for anecdotally I have worked those long years wherein if one was poxed to the eyebrows the office clerk and the office staff knew within minutes of handing in the compulsory 'Doctor's Sick Certificate'. When, before the late great war, when one had to visit the local doctor one had to put on one's best suit and a tie and pay the receptionist for the doctor would not, publicly, handle germ covered money. As a child one would be taken to the local chemist for that good man to attend to minor illnesses and injuries.

A country with an army wherein the rank and file, without exception, detested the uniformed officer – and a doctor who, in his turn, detested the rank and file. Like the mad padre but loathe the doctor. I know that it is foolish to generalise about any group of people but I choose to believe that too many doctors come from a middle class background and a middle class home and after a few pleasant years, or hard studying years, at a medical college find that to earn their fat livings they have to work out their days in drear slum or semi-slum areas and to daily

come into physical contact with a class of men, women and children that socially they would never associate with. I will be anecdotal and type that I have seen two junior doctors and a tough nurse physically throw a drug addict down the steps and out of a hospital and at two in the morning and holding up a heart attack neighbour who wants to make moral protests. I know that one should not generalise against groups of people but this I know that no prison, no concentration camp, no insurance company, no army medical board did not have doctors on their pay roll and every doctor knew what he was paid his wage for. Of the six years of horror of the second world war one thing came out that one could take pride in, after all those years of pre-war street demonstrations, and that was the idea and the ideal of the British National Health Service. The top ranking medical officials in Britain opposed it day by day but it was finally born: that every man, woman and child should have medical attention throughout their lives without fear of economic cost, not when they were sick but throughout their lives. To the shame of the Labour Party they put the first pricing on prescriptions, meaning that the low paid paid for their pills no matter what the agony. And from then on the middle class milked a national health service dry for, by God, they knew what forms to fill and then they moved on once more to the private practice paying doctors.

I will be anecdotal for I will look at an old man pushing an old woman in a wheel chair, I will look at Harry the wino on Shepherds Bush Green knowing that he will lie in the cold rain no matter how sick the poor bastard is, I will listen to the little Turkish man on Wogan's Green showing me his 'pills' and telling me the cost from his small wage. And this I know is a revolution betrayed for out of that second world war came, call it what you like, anarchism, christian socialism or plain humanitarianism or the beginnings of a just and humane society. I do not believe that in my lifetime we will see that flame burn again, for Thatcherite greed has become rationalised and acceptable. And, comrades, how many among the lapsed subscription editors or readers have moved over to Thatcher rightwing greed and openly boast of their BUPA membership. I do not condemn them for that but that they laugh about the foolishness of us the rank and file. But it was ever so.

But always the question comes from the floor 'but what would you do comrade speaker?', and it is a just question that too many believe that there is no answer. It is the old and ancient question that has floored too many speakers on an anarchist platform. I will argue that environmental politics or just noble heavy breathers should argue the case that the health of the people is a major concern for every society and no part of the market place economy. That once every three, six or nine months, according to the wealth of their society every individual

man, woman and child should be requested to attend their local hospital at a particular time and date to be handed their Health File. Not to seek a cure for some physical matter or despite the fact that they are fit and healthy but that in a corridor of consulting rooms one moves from room to room for eye test, teeth test, heart test etc. and the result is entered on the individual's Hospital and Personal file.

No medical matter is attended to, just the fast moving queue for at the end the file is checked and the individual then is told what needs to be done relating to his/her health file and when. Please don't tell me this is authoritarian or will cost the State money or cannot be done when we know that women are called upon to queue for their breast cancer check and children, soldiers and prisoners receive a medical health check when it suits our society and comrade if it is good enough for the rich who regard regular health checks throughout their year every year as their norm then it is good enough for us the mass of the people. Let there be no illusions: medical attention like Grand Opera is a luxury and a society gets it for all if it has the material wealth to feed, house and clothe the singer and the doctor. But I believe that our society can afford it and comrade if you deny the need for it then stand in any major street of any proud city within these small islands and watch our sick and lame shuffling by and accept that their health is not a luxury but our necessity.

Johnny Yen

'Mental Health'* and Society: Empirical and Theoretical Approaches

Introduction

This essay is an incomplete and sketchy account of various approaches to the relation between 'mental health' and society. It is intended merely as an introduction to certain strands of thought, and the interested reader should refer to the bibliography for further elaboration of some of the arguments described here. I will begin by outlining some empirical approaches to the 'mental health'-society relationship. Second, I will describe attempts by critics of capitalism to find a liberatory theory of 'mental health'. I will discuss the question of how far psychoanalysis fits the bill. Thirdly, I will look at some approaches which question the very notion of 'mental health' as an entity existing outside our social constructions. Finally, I will attempt to tie some of these strands of thought together.

Empirical Approaches

It is widely acknowledged, at least in the social sciences, that there are historical and cross-cultural differences in levels of 'mental health'. For example, it seems that the English have become 'madder' over the last 80 years. An article in *Society Today* (8 November 1984) points out that in 1900, 90 people out of every 100,000 of the English population were admitted to psychiatric institutions. By the late 1970s, this figure had risen to 380 per 100,000.

'Mental illness' has not spread evenly through the population, however. A 'classic' study by Hollingshead and Redlich (1958) carried out in America suggested that there are clear class differences in levels and types of 'mental illness'. While upper-middle class people were more likely to suffer from 'neuroses', working class people were more likely

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★ The term 'mental health' will be placed in quotation marks throughout this essay to make the point that a 'health-illness' (i.e. medical) discourse regarding the mental should be problematised.

to suffer from 'psychoses' (i.e. 'madness'); further, the working class were vastly over-represented among all known psychiatric cases.

Other studies have appeared to demonstrate that two other groups are particularly vulnerable to 'mental illness': migrants (particularly West Indian and Irish-born) and women.

If the critic of the present social structure takes all these 'findings' as unproblematic (i.e. faithfully reflecting reality), the obvious conclusion for her or him to draw is that the most important cause of 'mental illness' is *stress* of various kinds – poverty, racism, social roles etc. For example, Brown and Harris (1978) argued that the reason working class women suffered from depression more than others is because they are more likely to experience such stressful conditions as loss of a mother, lack of paid employment and lack of a confiding partner.

Thus a strong parallel can be drawn between the occurrence of 'mental health' and *physical* health: both are distributed in the population according to class structure, both can be explained in terms of deprivation and exploitation. But the *ad hoc* empirical approach described above, and the analogy it allows us to make with physical illness, could serve to obscure the fact that the stresses produced by capitalism are a highly heterogeneous category of phenomena. To lump 'mental illness' and physical illness together by assuming that similar causal mechanisms are responsible in each case also falls into the trap of accepting too uncritically the medicalisation of mental suffering (more on this below). Hence a more fully theorised account of the relation between 'mental health' and social structure has been sought.

An Individual Solution to a Social Problem?

Since most psychologies take society as a 'given', radicals have sought a psychology which, in its theory of mental functioning or 'mental health', implies a *critique* of bourgeois social organization. Freud has been appealed to by a number of radicals, two examples being Wilhelm Reich and Herbert Marcuse. Both find an implicit critique of capitalist society in such works as *Civilization and its Discontents* (Freud, 1930) in which Freud argued that civilization represents the sublimation of otherwise antisocial drives. Reich (1929) suggested that the repression civilization is apparently predicated upon is necessary only to *capitalist* societies. Marcuse (1955) similiarly tried to make psychoanalysis less ahistorical. He argued that current technologically advanced societies are characterized by 'surplus repression', and that the 'reality' to which Freud refers in his reality principle is *fixed* by the facts of scarcity and the necessity to preserve society. In other words, society should be

changed to suit the desires of the individual rather than vice versa. However, if psychoanalysis is inherently critical as Marcuse has claimed, how is it that it can function in practice as yet another means of adapting the individual to society? Witness, for example, the rapidity with which psycho-analysis was appropriated in the USA between the two world wars. Although the word 'adjustment' does not appear in the indexes of Freud's works, in 1949 Ernest Hilgarde declared before a meeting of the American Psychological Association that the mechanisms of adjustment were the feature of Freudian theory that were domesticated earliest into American psychology.

It also seems to me that many neo- and post-Freudian developments, despite their radical garb, are equally if not more regressive than American versions of classical psychoanalysis. Take, for example, Abraham Maslow, the humanistic psychologist who included in his list of 'self-actualizing' (i.e. optimally creative or mentally developed) individuals such anarchists as Kropotkin, Pissaro and Whitman along with Presidents Lincoln and Jefferson. In his discussion of the implications of Maslow's ideas, Colin Wilson (1972) suggests that Maslow's postulation of 'higher needs' (e.g. the need for 'self-actualization') means that decency and kindness are not necessarily just sublimated sexual and aggressive impulses, and that therefore an anarchist co-operative society can work. The ambiguity of this last phrase is apt, for, as Wilson unblushingly admits, 'Maslow's eventual position might be described as capitalist anarchism' (p.180). Maslow's political naivity is revealed by Wilson's characterisation of the former's ideal society as one in which 'the boss-worker relation is . . . based on mutual aid and mutual need' (p.181).

Maslow argued that humanistic psychologists should have a thorough grounding in Freud, but it is clear from these quotes that, in the same way that he downplayed the important characteristics of the hidden parts of the mind (i.e. the unconscious), so too in his analysis of the problems of capitalist society he focussed only on its surface parts and did not consider its underlying structure (i.e. differential relations to the means of production) to be of theoretical importance.

The playing down of the unconscious, like the rejection of sexuality, is something shared by most of those neo-Freudians and humanistic psychologists who claimed to have made important advances on Freud's theories, when really their ideas were theoretically regressive, conventional and common-sensical. The phenomenological focus on the honest, open soul, the voluntaristic ego, the whole, conscious person, the basically integrated self – all these notions take us away from Freud's revolutionary notion of a non-unitary self, and back to the unitary, rational, Cartesian ego – the prototype bourgeois individual, in other words. Once the role of the unconscious is dropped or down-graded,

how little there is to choose between so-called post-Freudian and humanistic psychologies and those theories of 'mental health' which stem from a rationalist or cognitivist epistemology and ontology. On these accounts (e.g. Beck, Ellis), the problem of 'mental illness' is solved simply by persuading the 'sufferer' to think more logically, to drop all 'dogma' and 'ideology' except that of the rationalist, scientific discourse.

But how is it that such diverse approaches – the one locating the problem in society, the other locating the problem in the individual – have been able to claim Freud as a common ancester? It is important to note that in the nearly 50 years Freud spent developing psychoanalysis, he pursued many different lines of enquiry, some of which were contradictory; this is only to be expected in such a large and highly creative body of work. It is hardly surprising, therefore, that quite different types of discourses can be read in his texts. The selection of a revolutionary or a subversive discourse rather than a liberal or reactionary one depends on the purposes to which one wants to put psychoanalysis; as a whole, Freud's writings embody no consistent ideology.

It is also worth noting that a 'revolutionary' reading of Freud may itself rely on bourgeois underpinnings. In an interesting critique of Reich and Marcuse, Frosh (1987) makes the point that the freedom they describe is the sexual freedom of the *individual*; they fetishise the body in a way that is neglectful of social relationships.

However, I don't take this to mean that all critical readings of Freud must be constrained by the individualistic aspects of psychoanalysis. A case in point is Valerie Walkderdine's (1991) brilliant use of psychoanalytic theory to account for the subject position of working class women within capitalist society. The peculiar role of working class women in the class structure, as *reproducers* of the class structure, means that they are subjects of certain forms of surveillance. For the working class women in Walkerdine's study who had been through higher education, the particular conflicts experienced (e.g. guilt over class identity) required an explanation in terms of Freud's concept of the unconscious.

The reader may be aware that, in this section, I have conflated two separate issues: the theory of psychoanalysis and the practice of psychoanalytic therapy. It is now time to draw out the possible contrasts between these two.

Clearly, psychoanalytic theory has more critical potential than most if not all other elaborated psychological theories of 'mental health'. But what use is it in practice? It is not clear to me that psychoanalysis can be helpful in revolutionary situations; but perhaps analytic therapy can be helpful as a part of the preconditions for the revolution. In a reading of Freud similar to that of Marcuse, Collier (1977) stresses psychoanalytic therapy's *alloplastic* aims; this refers to its attempt to empower or

enable the individual to change the world to suit his or her needs. In the face of a debilitating internal conflict, according to Freud, the road to 'mental health' lies in changing what is external, while the road to 'sickness' lies in changing what is internal (e.g. having hallucinations). However, even if it is accepted that there are internal as well as external obstacles that make it difficult for us to create a free society, psychoanalysis (as presently practised) offers no mass solution, it being largely the preserve of well-off middle class people. Psychoanalytic therapy may sometimes be helpful to the revolutionary, but it certainly cannot be relied upon exclusively; like all psychotherapies, it is an individual solution to a social problem.

The Social Construction of 'Mental Illness'

At this point I will make explicit the problems of the concept of 'mental health' which I have been taking largely for granted until now.

A weak version of such a critique could simply point to the notorious unreliability of psychiatric diagnosis. For example, there is a truism that, since American psychiatrists are more likely to diagnose 'schizophrenia' than their British counterparts, the best cure for an American 'schizophrenic' is to get on a plane to Britain. And there is the brilliant study by Rosenhan (1973) in which 'normal' people presented themselves at mental hospitals claiming to hear voices. As soon as they were diagnosed as 'schizophrenic' and admitted, they stopped feigning symptoms; but only the other patients and none of the staff saw through them. Rosenhan warned other mental hospitals that the experiment was going to be run again; he didn't in fact send any more bogus 'schizophrenics'; but after his warning, senior psychiatrists turned away many 'real schizophrenics' on the grounds that they were 'fakes'.

These and countless other examples suggest very strongly that the category 'schizophrenia' is merely a catch-all for those people psychiatrists don't know how else to classify. The simple act of categorisation has serious physical consequences, however. The close relationship between the medical profession and the drug companies has meant that large numbers of people suffer sometimes irreversible side-effects of the chemical coshes they call 'treatment'. The valium handed out by the sackful by GPs leads frequently to addiction, and the major tranquillizers, such as largactil and modecate, lead to still more disturbing cases of medical iatrogenesis, such as tardive dyskenesia and virtual brain-death. In most cases, the claim is not made that these chemical solutions to mental problems function as 'cures'; they are merely 'symptom'-inhibitors.

By what quirk of fate has what is generally acknowledged to be a *mental* (i.e non-neurological) issue fallen under the remit of the *medical* profession? Although professional ideology (i.e. medics seeking to justify their 'indispensability') undoubtedly plays a role, it is inadequate simply to blame one small group and their ambitions. The issue might be better understood in its historical context. The rise of empiricism, and the discourse of scientific rationality which psychiatry and psychopathology embody, are intimately connected with the development of capitalism. Foucault (1961), for example, points to how the definition and evaluation of 'madness' has changed over time; in the Middle Ages the court 'fool' was influential, but since the rise of the scientistic outlook, 'madness' is the alienated object of science with which there can be no meaningful discourse. Presenting a less grand but equally interesting thesis, Doerner (1981) uses historical evidence to show how mental hospitals have been used to contain misfits and dangerous opponents of the state since at least as far back as the seventeenth century. In summary, psychiatry, the classificatory systems describing the 'mentally ill', and the very notion of 'mental health' itself are all aspects of a scientistic ideology, and historically relative.

Although usually voiced as part of a radical discourse, these kinds of analyses are open to criticisms because of the less than progressive consequences they sometimes entail. Firstly, there is the criticism that theorists such as Foucault and Goffman :1968; his famous book *Asylums* examines how 'madness' can be a self-fulfilling prophecy), who seem to argue that 'madness' is no more than a *label*, may be ignoring real suffering. Related to this is the way anti-psychiatry has been used by reactionary governments to suit their own ideological ends. For example, Laing's well-known scepticism to the 'schizophrenia' concept and its 'treatment' in mental hospitals, and Szasz's (1972) right-wing critique of 'madness' (which, he argues, refers to a *moral* rather than a *medical* issue), have inspired both radical and liberal discontent with the institutionalisation of the 'mad'. This well-intentioned anti-institutionism has served as a rationalisation for the Tory government's (money-saving and family-reliant) policy of 'Care (sic) in the Community' which has led to many ex-inmates of mental hospitals sleeping rough on the streets.

Conclusion

Is it necessary to choose between a radical approach to 'mental health' that sees social structure as a cause of real suffering, and an analysis that highlights the function of the 'mental illness' concept in serving bourgeois interests? It is difficult to deny that being poor usually results

in worry and stress; but this does not mean that we have to accept medical discourse, or any of the elements of a scientistic ideology to describe or explain the experience and development of what I shall vaguely refer to as 'mental problems'. Hence a rejection of the ontology of medicalese need not mean a denial of real suffering. The statistics given at the beginning of this essay might be interpreted in the light of the theories on the historical and social relativity of 'madness' and 'mental problems'; the disproportionate inclusion of working class, female and black people in such figures can be understood both structurally and in terms of the middle class, white, male doctor's predisposition to label such people as 'mentally disturbed' more than he would his own cultural group. Psychoanalytic therapy may be able to help some of those genuinely suffering to be more effective in changing their environment; it can serve as a valuable way of understanding our relationship with society, and the stress this interaction can engender. But as a means of liberation from an oppressive society, the effects of psychoanalytic theory and practice are likely to be only indirect, since only collective action can produce social structural change. 'Mental health' is thus not guaranteed by individual action, but is dependent upon the joint practice of society as a whole.

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F. A. Jenner

Healthy Beliefs

For centuries thinkers have tried to describe the world as it is and not just as we see it. Democritus of Abdera in fourth century Greece was one of the most significant materialists. He propounded an almost modern atomic theory in some detail, seeing reality as atoms and the void. However, in a reflective moment, as recorded in a fragment, we find him presenting the Senses talking to the Intellect. The latter asserts that reality is only the atoms and the void, while the former chides the latter for 'depending on us but denying our evidence'. Locke in particular, almost using Aristotle's ideas, distinguishes primary objects, for example extension in space, from secondary characteristics, for example colours. That which is primary exists whether we do or not. The secondary characteristics are perceptions, the products of atoms on the sense organs and brain. The colours and sounds etc. as we experience them.

Western science has progressed so successfully with that sort of materialist philosophy that it is difficult to gainsay it. It has led to physicalism as a type of realism, that is the view that everything is fundamentally physical.

The mind is therefore considered as a product of the body, and consequently obeys the laws of chemistry and physics. However, those laws have no room for telekinesis, the alteration of or initiation of

material movements by thoughts. Epiphenomenalism is the only philosophical position consistent with that type of natural scientific thought. That was once characterised by the adage that the mind secretes thoughts like the liver bile. It is an anti-dualist position of actions and causes only in one direction. There is no strictly logical way (of which I am aware) to repudiate epiphenomenalism; it isn't a logical contradiction in terms. However, we cannot live with such a belief in the irrelevance of our experiences and that which cannot be logically destroyed does not need to be accepted. Solipsism is an example: 'Mine is the only mind, the others are robots'. Further, we think in order to live more fully and intellectualising is only one of our activities.

To return, however, to epiphenomenalism, it is scientifically important to see that it is not consistent with Darwinianism. It does not allow any added survival value to consciousness for to do so requires conscious reflection to change or influence chemical or physical processes. They are all that is real.

Why, however, should a psychiatrist labour this sort of point? Well I do so partly because the march and progress of science so dazzled me that others may have been similarly influenced in believing there is no other profitable way of thinking. Just look at the long line of those who opposed the scientific progress made by Galileo and Darwin. They did so because their religions seemed threatened. They were not being rational. Sir Karl Popper has also elegantly, as it were, made the point that scientific theories are statements which resist experimental denial at least at the period of time when they must be held. There is, he is implying, no safer guide to knowledge.

While Popper is showing how wise and diplomatic the true scientist is, he isn't saying that reality is fundamentally just atoms in the void. The latter is to some extent an extrapolation, although possibly also the basic assumption which made so much possible. Kant's *Critique of Pure Reason* implies that it is the structure of our minds which makes us feel happy with causal and spatial answers. He is saying we resist explanations we cannot fit into that framework and always feel we need more research grants to get further. All the time we are holding much to be so for which the evidence does not exist. It is the human mind which is a fundamental part of knowledge. Of course, Kant writing in the eighteenth century could not know that the logic of science itself would lead to relativity and non-Euclidean geometry, about which we can write equations even if we cannot picture that reality in the mind's eye.

Like many contemporary thinkers, I now want to press home the difficulties of taking things at face value, and also of denying the reality before our eyes. Berkeley's statement about the existence of trees when we are not looking at them seems strange. Nevertheless, there is some-

thing odd too about the apparent fact that what is there has no colour in itself, makes no noise in the wind, it doesn't smell and isn't really solid. I don't need to go on and into the argument whether there are any primary characteristics left, although you can see I doubt it. Nevertheless, I can't live without (in my case) speaking English and talking about the sounds, colours, smells, etc. of the external world.

There are more mysteries too. I cannot believe I am just a machine and cannot interact with others without praise, approval, thanks and blame. Yet for me thinking critically I cannot understand what a self is to be responsible. We have arms, legs, brains, thoughts, memories and emotions, but is our real self more than a way of speaking? Intellectually I cannot work out the problems of self. For a psychiatrist that presents particular difficulties because to some extent schizophrenia is characterised *par excellence* by the failure to distinguish the self from the non-self. Sometimes that is referred to as a failure of the diacrisis or blurring of the ego boundaries.

My perhaps long-winded statements lead to what I want to designate as 'Necessary Beliefs'. Human beings need beliefs to live by. That fact leads to tensions because we do not wish to be seen to believe for convenience. We do want to talk about the world as it really is, but perhaps we are sometimes significantly safer talking about ourselves as we really are. This does not mean that anything goes. Clearly the extreme relativist or sceptic is mistaken in seeing all knowledge as relative. He risks being hoisted on his own petard; his statements are equally suspect. That extreme position is very different from a humbler position that our knowledge is usually precarious, yet we know our own experiences without doubt. Our problems begin in interpreting experience. We are more than entitled to postulate but seldom to pontificate.

It is my suspicion that in psychiatry the professional and the patient show too much apparent confidence in their own views. The reason in both cases is to make their position in the world more secure. The professional is a member of a great big club. Membership brings considerable status and rewards and to some extent defines what it is necessary to believe to be normal. The patient has failed to find a club and is at odds with most possibilities so he is alone. If he is deluded, he is described by the psychiatrist as holding tenaciously to views which are not explained by the milieu in which he lives.

In the fourteenth century, William of Ockham and John Dunn Scotus attacked the thirteenth century writings of St. Thomas of Acquinas, with many of the ideas I am trying to express, in fact with nominalist ideas. Nominalism in its strictest form holds that things have only their names in common. For this and related views Ockham was excommunicated. Answering them both before they expressed it, Acquinas had

felt our ability to communicate gave words more meaning than nominalism allowed. The debate was really over God's mind. According to Acquinas, Aristotelian logic reveals some of it to us. That, of course, is like Leibnitz' view that some things, indeed logic, must be true in all possible worlds. God could do nothing about them. Ockham, however, emphasised how that limited God's free will. Both sides held the concept of God still. My point is to suggest a similarity of difficulty in asking what is normality like today and what is God like in the thirteenth or fourteenth century. In certain ages the questions seem so important and excommunication is possible for heresy about them. The questions posed are not so much which beliefs will help this person to live more richly, but are they mad or heretical beliefs?

Now it is, of course, very mad to hold some things to be so, or at least to admit you do, in certain social contexts. That can vary from spoiling a dinner party to all those things to which Amnesty International constantly draw attention. I suppose I am struggling to posit in which way we must live. There is the historical fact that we are bounded by the ideas and language of our own time, the wisdom of 'if you can't beat them join them', and the pain of seeing how relative so much knowledge can be.

The advantage I would like to believe arises from my somewhat relativistic position is the ability to be human and loved, not for knowing what is so but for trying to understand in the fullest sense the others on our strange spaceship hurtling through space, or standing still in it, depending on choice coloured by the period of history. Madness seems to me very significantly an inability or refusal to comply, to be one of a possible real group in your own historical context. It is often a refusal to compromise and a failure to take the other into account when conversing with them. This is often for the good reason that it didn't seem to work previously. Of course, it could be because of perverse indifference to others. Yet by and large we live in our perceptions of the minds of others. To declare that reveals us as too vulnerable, to deny it is to fail to note our obvious need of others.

How far though can one use such ideas to displace the claims of neuropsychology, of the intriguing results of modern brain sciences, of psychopharmacology, of molecular genetics. Of course, I don't know. Much which I have written could be shown to be complete nonsense by real advances in those fields in explaining schizophrenia. For that reason alone I must be interested and encourage workers with those outlooks. Yet perhaps something more human will defy such reductionism, or more likely, as in so many past debates, it will be shown that the protagonists didn't notice much that both still held, which under-

mined the discussions. Hopefully, we will still be discussing how to live together and how we should react to each other.

In schizophrenia research it is now generally accepted that over-intrusiveness is harmful to patients, who it is implied are anyway too sensitive for genetic and constitutional reasons, perhaps due to viruses or birth injuries. That is from the results of studies of families showing High Expressed Emotion. Interestingly, the patients have been talking about that for longer. They talk about others reading their minds, inserting thoughts, taking thoughts away, controlling their bodily movements, etc. etc. They also frequently refer to their own greatness and importance (wishful thinking).

Emotional coercion can be subtle and it is an inevitable feature of human social life. We are really fairly adept at gauging what we are doing. Most of our politeness is a recognition of the sensitivity of others and it would be difficult to deny the virtue in it. The coercion can be however, and often is, very damaging. Moral blackmail is common within families and many patients have been so ensnared they can leave geographically but not spiritually. Their anger is dangerous as it may damage them as well as those on whom they depend. Again there is a problem or tension. We cannot really bring up our children to be totally free unless we believe human beings are innately good, noble savages. Surely they are human beings with personal needs, which can be negotiated with those of others. The normal and tolerable other is not a wild undomesticated natural animal. We must hope education is not a too crude brainwashing process and we can use euphemisms about allowing the person to develop himself but then we are back with the problems of self. Are we not anyway the products of society? The left in politics tend to exaggerate that, while Mrs. Thatcher felt there is no society. Yet clearly there is a difficulty in accepting either view, though both expressions need to be used. All we can be confident about is the fact of feelings. They too probably depend on expectations of what is reasonable behaviour from the other, but they are clearly what matters to us and are at the centre of questions of mental health.

My essay is contorted but that is to express my feeling that our view of the world must be contorted or delusory. Mental health does not depend on being either, but it does depend on feeling at home in one's world and with others, for although Sartre emphasised that Hell is other people (*L'enfer c'est les autres*), so is Heaven.

Judy Beer

Improving Standards? Whose?

Improving standards has been one of the main concerns regarding the care of the mentally ill in the past few years. Antipsychotic (Neuroleptic) drugs were introduced in the fifties – these drugs revolutionised psychiatry as they enabled staff to unlock wards and improve ward atmosphere, thereby making many patients amenable to psychological and social therapies, leaving behind the old custodial attitude for one of understanding and providing the ability to help patients.

The medicinal revolution has been backed up in principle by a more enlightened outlook, followed with various specified courses catering for all the different needs and aspects of Mental Health Nursing. Also on offer are grants and paid leave to study for degrees, counselling courses, therapy courses and others.

Unfortunately though, human nature, being what it is, often sees all these opportunities as a step up the ladder to yet another grade. (The New Grade System which was introduced in the NHS in April 1988.)

The consequence of this attitude is that the more able and qualified the less practical care nursing staff actually offer their patients. Instead these boffins of knowledge are for the most part trying to feather their own nests, attending endless meetings causing problems creating other meetings, this cyclic process has become an insanity in itself, resulting in memos that would give a legal mind food for thought. It doesn't matter though who reads them. This of course is done in the name of progress, to help our vulnerable mentally ill people with drink problems that are victims of an ill society, the young desperately feeling cheated taking drugs as a means of escape. You may argue that there are other reasons for drug/alcohol abuse. We all have our own opinions and nobody is ever wholly right. But are the weakest again in our society to be used as stepping stones, are we just a twentieth century cover up? If so we are less honest than our forefathers in their treatment of the mentally ill. What we must do is take a hard look at what is happening; there are people in our health service who really care, but unfortunately they are often removed and are quite powerless to bring about change. Their caring natures start them off with a disability, sensitivity is seen as a weakness, to want to remain in the lower grades working with patients means you are not sufficiently ambitious or motivated to want

to get on. I would ask, on what? For it would be wonderful to find yourself able to instigate change, but I believe before a caring person ever reached such dizzy heights they would have thrown in the towel. It will take a very special and brave person to champion the cause.

Is anyone out there!?

Tony Gibson

Alternative Therapy

The term alternative therapy refers to systems of treatment that differ from ordinary medical treatment both in the nature of the regimes that are employed and, quite often, in their whole conception of how the body works, and the basis of disease and malfunction. 'Alternative therapy' must be distinguished from 'complementary therapy'. The latter is carried out in harmony with medical treatment; thus, a doctor may sometimes refer a patient to an osteopath he knows to be a skillful specialist in the manipulation of joints. But he will make his referral only after he is satisfied that there is no disease pathology of the joint for instance, a tubercular infection. Such an osteopath is practising complementary therapy, and he relies on the doctor's medical skill to rule out conditions that he would not be competent to treat.

We learn that:

> If you approach a radiesthetist, or a radionics practitioner, you will be asked to cut off some of your hair, or prick yourself with a sterilised needle and let a drop of blood fall on a piece of blotting paper. To a practitioner of radiesthesia or radionics, the hair or the blood is your 'witness'; it represents you as much as if you had presented yourself in person. From it the practitioner claims to be able to ascertain your present condition, the best treatment to administer, and often any future illnesses that your body contains but has yet to manifest. This may sound far-fetched in comparison with most other alternative therapies, but radiesthesia and radionics have been practised for long enough for their shortcomings to be exposed. (Fraser, p.129)[1]

To me, this absurdity – radionics[2] – does not appear to be any more far-fetched than the other alternative therapies such as homeopathy,[3] the Grape Cure,[4] iridology,[5] naturopathy,[6] reflexology,[7] and a lot more. They owe their popularity precisely *because* they give a resounding slap in the face to common sense and the scientific approach.

The alternative therapist is generally uninterested in medical diagnosis. He may start staring at the irises of the patient's eyes (iridology), or pulling his toes (reflexology) in the hope that he (or more rarely) she, can both diagnose and treat the disorder. The defence of an alternative therapy that is often given is that, however plain barmy it sounds, it works! This is not to be denied absolutely, but in order to understand *why* an absolutely ridiculous system such as homeopathy may appear to 'work', we have to consider the nature of human disease and malfunction.

If I give a number of patients suffering from disordered livers a 'medicine' consisting of tap water coloured with some harmless plant dye, assuring them that this is a proven remedy for their condition, as long as they have faith in me as a therapist, a number of them will certainly improve, and attribute their improvement to the 'medicine' I have given them. This is known as the *placebo* reaction, and scientific research has shown that it can be very powerful indeed in certain circumstances and for certain disorders. There is nothing very mysterious about it; it relates to the fact that *all* disorders have two components, an organic component and a psychological component. In certain disorders such as eczema, asthma, indigestion, migraine, the psychological factor is very large indeed, and the severity of the condition at any one time is very dependent on the patient's psychological state. This is very well known, and people are not surprised when their eczema etc. gets worse when they are worried, depressed, over-worked and generally stressed. But even in conditions that are almost wholly organic, as in infective diseases, the psychological state is important in determining how effectively the body's natural defences cope with the invading agent. Thus, if a patient suffering from something like mumps has his toes pulled while he is told a cock-and-bull story that he is suffering from a congested spleen, (and it is well-known that there is a channel leading from the big toe to the spleen!) providing that he believes such nonsense, and is paying a high fee to have his toes pulled ('It must be worth it – after all I've paid out all that money!') he probably will feel better, and perhaps get over his mumps quicker than if he had had no such treatment.

The placebo reaction has been well known in medical research for quite a long time, and all new drugs are now tested in a double-blind trial to see if they really are more effective than an inert placebo.

In the course of any illness, even one that eventually leads to death, the patient has his ups and downs, feeling better some days, or weeks, than others. This is known as the 'natural variability of disease'. Emil Friereich[8] has pointed out how practitioners of alternative therapy can run a lucrative business by capitalizing on this natural variability. It

does not matter what their stock-in-trade is – it can be an elixir, a manipulative procedure, a form of posture control, an electrical hocus-pocus, a kind of psychotherapy – and it is immaterial how daft their rationale is, provided that it is as harmless as it is useless. All that is required is that the therapists should have the brass-faced effrontery and smooth-talking glibness to persuade sick and gullible people to believe in it.

Ideally, the treatment should be first applied when the patient is at the bottom of one of his 'troughs', for the chances are that he will soon begin to feel better anyway, and the therapist can take the credit for the improvement. If however, the severity of the complaint remains the same, the patient can be persuaded that at least the treatment has checked the further deterioration that otherwise would have occurred. What is needed now is obviously more intensive treatment (and more frequent fee-paying visits). If the patient's condition continues to get even worse, it is explained that this is because he delayed too long in coming for effective therapy (and perhaps messed around with orthodox medical treatment), and it will need a really long regime of intensive alternative therapy before any improvement can be expected. If the patient now dies, the therapist need not be abashed. 'If only he had come to me sooner!', he says, and points out to the grieving relatives that he is just one more victim of orthodox medicine that ruined his health with harmful drugs and unnecessary surgery.

Many people have a strong *wish to believe* in the non-scientific, the irrational. They live in a technological culture and feel constantly menaced by the dangers around them that they attribute to scientific advancement. Their belief-systems are based on some truths, half-truths and downright nonsense. As they perceive it, we live in a ruined world. The atmosphere is being polluted by the exhausts of motor-cars; the crops are being sprayed with harmful pesticides; electricity may be emanating from the power-lines and even, perhaps, domestic power-sockets, ruining our health; radio-activity leaks out of smoke-detectors and clobbers us; fluoride salts and other poisons are added to our drinking water by mad scientists; doctors menace our health with drugs and 'unnatural' procedures. There is no proof that contraception ruins women's health, makes them sterile and promotes cancer, but, well – it might. It hasn't been proved that it doesn't! Such people ignore the obvious facts about the vast improvements in public health during the past century in the more developed countries that have virtually wiped out many of the infective epidemics and greatly increased the expectation of life. To them 'scientists' are still the villains who menace us all, and scientifically based medicine is highly suspect. They would much rather go to therapists who promise them 'natural' cures, even though the

rationale of such therapies is sheer poppycock and does not stand up to any kind of rational examination.

Although iridology is only one of the many quack therapies in the alternative field, and probably no sillier than many, it will serve as an example of how believers like to put their trust in the irrational.

When Von Peczely's pet owl broke its leg, he noticed a dark band in the iris of its eye that he did not remember seeing before. Was this the result of the broken leg? He then pondered on the patterns that are to be observed in the iris, and speculated that they were connected with the various 'systems' of the body. The result of such speculation led him to declare that not only are all parts of the body represented in the iris, but that if there is anything wrong anywhere it will be represented by a change in the relevant part of the iris. It would seem to be a simple matter to determine whether or not iridology has any foundation in fact – can diseases be diagnosed by studying the iris? A simple investigation was carried out in Australia. Practitioners of iridology were presented with iris photographs before and after patients had developed an acute disease, and they were asked to say whether any change had occurred in the irises, and if so, what organ had been affected. The result showed the complete inability of the iridologists to detect any relevant change. Indeed, those conducting the study had included some photographs of the same iris taken after the elapse of two minutes, and this was alleged to show a significant change!

One ploy used by iridologists and other alternative therapists is to diagnose sickness where none exists. Some people who have nothing really wrong with them, other than hypochondriacal neurosis, plague doctors to make them better when they are a bit out of sorts. When the doctors find no discernible disorder, they often fob them off with tranquillizers (which may do harm in the long run!) and merely reassure them that they have not got cancer of the stomach, diabetes, tuberculosis of the lungs, a rotting liver, a brain tumour, degenerating kidneys, incipient haemophilia, syphilis of the blood, and whatever else has taken the fancy of such patients. Disappointed, such patients may go to an alternative therapist who will certainly diagnose *something*, and, most importantly, spend a lot of time sympathetically listening to all the patient's grumbles and fantasies (for which service the average hypochondriac is willing to pay high fees). The fantasy about having cancer of the stomach, etc., is confirmed by the therapist, but as there is nothing wrong with the patient, other than anxiety, an improvement and perhaps a 'cure' is easy to effect by means of any form of placebo treatment, and the patient tells his friends how this marvellous therapist can cure cancer, etc., by means of carrot juice, electric shocks, sticking needles in the ears, or whatever.

It may be argued that as the procedures offered by alternative therapies are harmless, and at least they will listen and give comfort while doctors are generally too busy to spend much time with patients who have very little wrong with them, we should not condemn such therapy because it is based on conning people. There is plenty of criticism that can be levelled at orthodox medicine which can, and does, do harm occasionally by the inappropriate use of drugs and unwise surgery. But alternative therapy can be responsible for doing very serious harm by default. Consider the following:

> There are two pieces of evidence, picked at random over the past few months. One relates to a child with leukemia whose parents refused chemotherapy and took her to a homeopath. The diet of fresh fruit juice and homeopathic pills unaccountably failed to do the child any good, and she died. The second involves a woman with miliary tuberculosis, a highly infectious form of the disease, who refused hospital treatment and went to a fringe practitioner instead. He diagnosed constipation and gave her a mixture of Epsom salts and herbs. The woman died, after a period during which time she distributed TB-laden sputum at large among those around her. (Sabbagh, pp.163-64)[9]

In a free society, people should be allowed to abuse and kill themselves in whatever way they see fit. But have they a right to impose their perverse conduct on children, or spread their untreated diseases to the general public?

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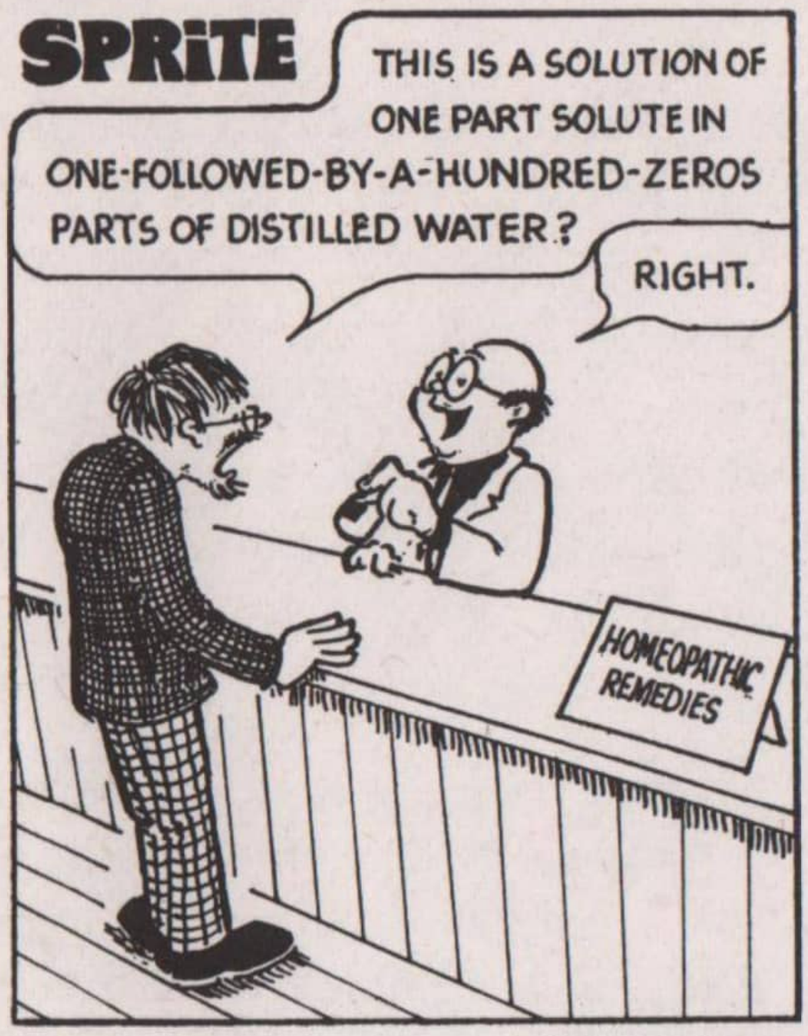

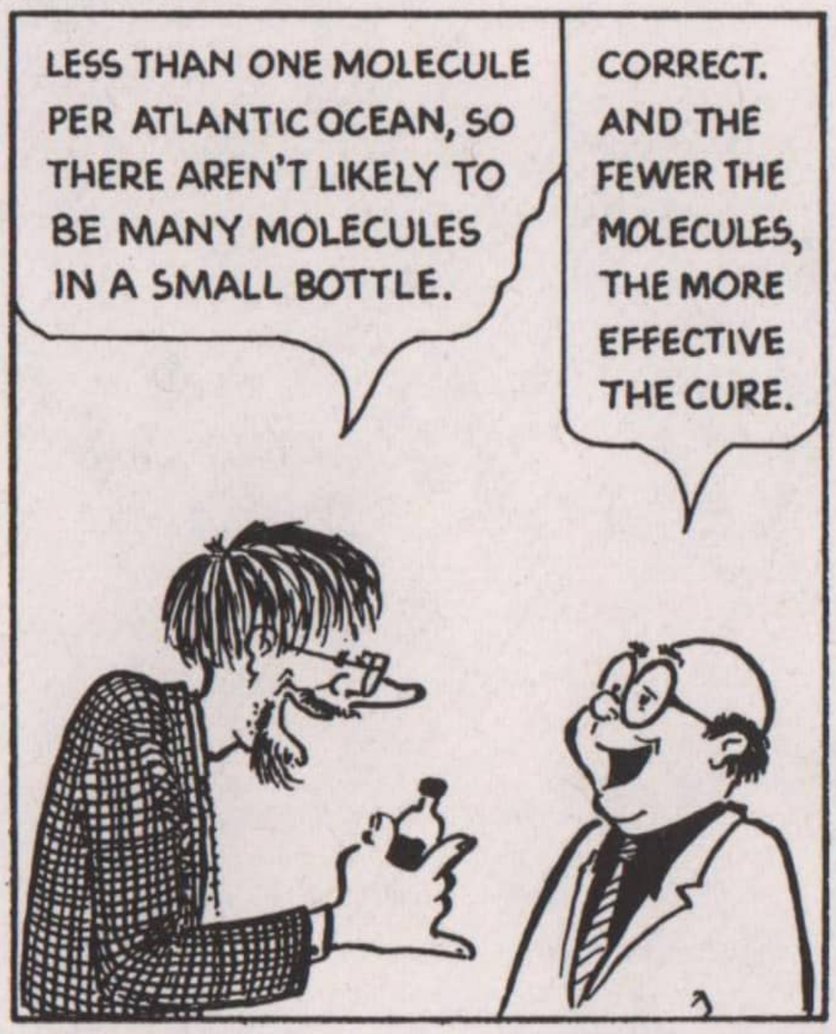

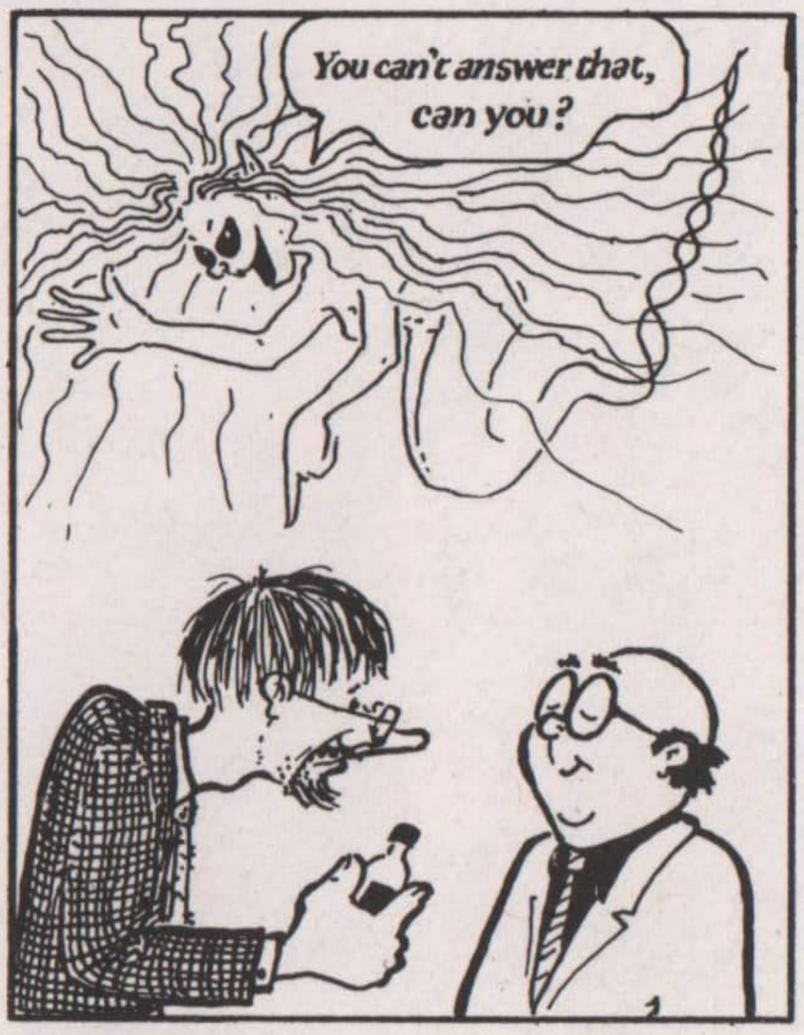

Cartoon by Donald Rooum from **The Skeptic**.

Mick Kidd

Well Oiled

Never having been in hospital except as a visitor it came as a shock when the X-ray showed I had pancreatitis and the doctor wanted me to remain in hospital for tests. It was the night the USA bombed Libya using UK bases, April 1986.

The following day I was diagnosed as having jaundice and gallstones. The cause of these and the pancreatitis was thought to be a rogue gallstone that had left the gall bladder and banged into my liver and pancreas causing the symptoms of nausea, tightness in the chest etc. The recommended cure was surgery, to remove the offending gall bladder.

Not only had I a fear of surgery and its aftermath, but I was also linked in with 'alternative' medicine seeing an acupuncturist once a month. He it was who put me on to a herbalist who knew a gallstones remedy that involved not surgery but swigging back a pint of olive oil laced with lemon juice.

Basically the treatment consists of fasting for 6 hours before commencement then swallowing four tablespoons of extra virgin olive oil every quarter of an hour for approximately two hours. In order to prevent nauseous feelings from slurping olive oil one also takes one tablespoon of freshly squeezed lemon juice per four of oil. Once begun you have to continue the treatment even if nausea overtakes you. The following day you look for gallstones in your stools.

I panicked at the thought of it going wrong and being racked with pain as gallstones got stuck in my intestine. Moreover anyone medical I asked seemed to think the chances of the oil working were nil or 50,000-1 against.

Consequently, I hedged my bets, booked up for the operation in June 1986 and took the olive oil in late May. To my amazement I felt no pain, staved off nausea until the end of the treatment and next day found gallstones in my stools. Now it could be told.

Consequently I cancelled the operation and asked for a further X-ray, to see if the gallstones had indeed gone. I had to wait two months for the results, an agonising wait, but the X-ray indicated the gallstones had gone.

Gallstones appear to be created from cholesterol so a way of reducing the chances of them forming are to lay off butter, eggs, cheeses, fatty

meats, milk and cream, etc. A low fat diet is the recommended aftercare. (I found it relatively easy to eliminate fry ups in the home but eating out's more tricky.) Nevertheless even with careful dieting, gallstones can recur – they did in my case but singly rather than in battalions. I repeated the olive oil treatment three years running and in the second and third year took a course of herbal tablets to help strengthen the gall bladder.

It is now five years from that time in UCH and I have had no scares or discomfort. Modern technology has created a laser bombardment as an alternative to surgery. You lie in a hospital bed and the laser beam pulverises the stones in your bladder. It is an expensive way of doing what £2.53 worth of olive oil and 38p worth of lemons can achieve in the privacy of your own home.

P.S. Every case is different and I've heard of gallstones sufferers who have flushed out the stones with olive oil only to have others form quickly – they chose surgery in the end.

John Hewetson

The Abolition of Ill-Health

from *Ill-Health, Poverty and the State* Freedom Press, 1946

To-morrow a man attired in rough clothes will come to fetch you to see a sick woman. He will lead you into one of those alleys where the opposite neighbours can almost shake hands over the heads of the passers-by; you will ascend into a foul atmosphere by the flickering light of a little ill-trimmed lamp; you climb two, three, four, five flights of filthy stairs and in a dark, cold room you find the sick woman lying on a pallet covered with dirty rags. Pale, livid children, shivering under their scanty garments, gaze with their big eyes wide open...

What will you prescribe for the sick woman, doctor? you who have seen at a glance that the cause of her illness is general anaemia, want of good food, lack of fresh air. Say a good beef steak every day? a little exercise in the country? a dry and well-ventilated bedroom? What irony! If she could have afforded it this would have been done long since without waiting for your advice!

Kropotkin *An Appeal to the Young*, 1880.

In general, conditions to-day are not so very different from when Kropotkin wrote, more than sixty years ago. Yet, with the immense advances in medical science, there is far less excuse for them. The mortality from particular diseases may have fallen remarkably; but the main burden of ill-health still falls most heavily on the poor. Indeed, as Titmuss has shown, the poorer sections of society are, *relative to the well-to-do*, actually less healthy than they were thirty years ago.

The usual attitude in the face of this misery of sickness is one of optimistic fatalism. 'Improvements are constantly being made. Rome wasn't built in a day' etc., etc. It has been one of the purposes of this pamphlet to show, however, that though progress in medical science has never, perhaps, been more rapid than now, an increasing proportion of ill-health is directly due to purely economic causes, *and is therefore preventable*. Yet those economic causes have hardly been touched.

The recognition of such a position inevitably leads to the demand for action to remedy the economic organisation which has kept the majority of people poor and, therefore, relatively unhealthy for centuries. Many writers on social medicine do, in fact, recognise this necessity. But they quail before the task of removing the evil of economic and social inequality. They, therefore, feel compelled to be vociferous supporters of *reforms* in health services, family allowances, social insurance schemes and the like. They are afraid to advocate the abolition of poverty, or feel hopeless about it, and so fall back on these lukewarm plans for merely attempting to mitigate its worst aspects. Such reformers were rightly ridiculed by Kropotkin in the quotations placed at the heads of Chapters Seven and Ten in the present pamphlet. The fact that Kropotkin's remarks were made sixty years ago, and yet still have force, is itself a sufficient comment on the inept optimism of piecemeal reformers.

★ ★ ★

Even the *Times* recognises the potentialities of economic well-being on the future of health, for on 17th February, 1938, it remarked of tuberculosis that 'what *keeps it in check* is probably good food' (our italics). And here is how Drummond and Wilbraham point the essential lesson from the famous experiment of Corry Mann:

> Meanwhile there is one simple test for malnourishment which can be used in every case and which seldom, if ever, fails, but which, unfortunately, is very rarely applied; improve the diet and watch the result. This was how Dr. Corry Mann demonstrated the inadequacy of the diet of children at an institution where the food has long been regarded as ample. A pint of milk a day for a year increased the average height of the boys by nearly one inch and their

weight by over three pounds. Even more important was the improvement in physical vigour and mental alertness. There could be no further argument; the boys had been undernourished before the supplement of milk was given.

Similar results were reported in 10,000 children in Lanarkshire who received milk supplements. We have already seen that the value of milk is officially recognised by the Ministry of Education. It is interesting to note, however, that compared with 1914, the price of milk has risen more than the price of food generally – that it has become less accessible as a food to those sections of the population who stand most in need of it.

The ease with which good food will make unfit people fit was demonstrated in the army several years ago. Thirty-three recruits who were not fit for army service (by peacetime standards, that is) were selected for treatment by special diets and exercises. After two weeks ten were up to standard; at four weeks, 19; at six weeks, 21; at nine weeks 23, and after three months, twenty-four out of the thirty-three had reached a standard of fitness such that they were now acceptable to the army. These men had been taken out of the 'normal' life of wage labour, and were introduced to a healthy régime, with plenty of rest, fresh air, and exercises, such as their civilian life could not possibly provide them with. They were also well fed. The cost of their extra food is instructive; it amounted to 7/6 per head per week – and that at the wholesale prices which only the army can command. A small sum, but – as Orr's figures show – one which is right outside the capacity of the majority of the ill-nourished to pay, and one, moreover, which reformists would hesitate to saddle the rates with. Thus even in men who had reached adult life and showed effects of malnutrition which one might have expected to be permanent, good food could still go a long way towards rectifying their ill-health and underdevelopment. This army experiment confirms a finding of hospital practice; that often the only treatment which improves the tired out housewives who attend for more or less vague chronic ailments, is a period of several weeks convalescence. In the convalescent home they get the rest which their overworked home life denies them, and better food than they are accustomed to. The improvement is sometimes startling. Similar improvement is noted in the children of the very poor who, too often, are obviously undernourished. A sickly, pale, languid and dispirited child can quickly be turned by good food and surroundings into a healthy, high spirited creature hardly recognisable as its former self. Paul de Kruif, in his highly coloured, but sincere and arresting book on the economic background of child ill-health in America, *Why Keep Them Alive?*, gives several examples of this kind of change.

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All the evidence presented in this pamphlet shows how much the incidence and severity of ill-health depends on economic factors and especially on the factor of inadequate food. It follows that improvement in economic conditions, bringing with it an improvement in dietary intakes, will be an immense factor in improving health. In fact it will almost certainly remove the majority of those universally found causes of illness and chronic discomfort, to say nothing of removing the commonest causes of premature death among the largest section of the world community, the working class. That this is no idle utopian hope is shown by the evidence from feeding experiments outlined above. It matters little that these experiments are rare and isolated phenomena, and in themselves make no sensible difference to the death rates and sickness rates. What does matter is the fact that they show clearly how those rates *could* be reduced if the peoples of the world got enough to eat, if in fact our economic system aimed at the satisfaction of the needs of all, instead of being dictated by the likelihood (or otherwise) of producing a profit for the few.

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What then is our conclusion? The achievement of full health demands a radical change in our economic system. It requires nothing short of the abolition of poverty, the placing of production on a basis of needs. Let us so organise our economy that when people need a commodity, that commodity is produced. It is necessary to destroy altogether the form of economic organisation which only produces when there is a prospect of selling, and which, therefore, inevitably deprives the working class, who cannot afford to buy, and who form the bulk of the community, of the basic necessities of life. This organisation lies at the root of contemporary ill-health. Full health is a mirage until profit economy is swept away. But it will be easily realised when the means of life are freely available to all.

Dr. D. M. Greet

The Nature of General Practice

We are fortunate in Britain to have one of the most comprehensive and effective Primary Health Care Services in the world. At the heart of this service and guaranteeing its uniquely personal nature is the family doctor. Every citizen of the U.K., regardless of means or social standing,

has the right to register with a GP to whom they may look for all aspects of health care.

With the exception of the Casualty Departments and Genito Urinary clinics, access to secondary health care (i.e. hospital services) is via your GP. Thus the GP has something of a filtering role, ensuring the most appropriate use of valuable hospital resources. More importantly, the GP is the patient's advocate, looking after their interests within the system and ensuring they receive the best available treatment. The GP is likely to have a detailed understanding of an individual's medical history and personal circumstances and thus be most suited to co-ordinating provision of necessary care.

A useful definition of the GP's role was provided by the Royal College of General Practitioners in 1972:

> The GP is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting room or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other GPs from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single handed practice he will work in a team and delegate when necessary. His diagnoses will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patients' health.

To highlight just three ideas which I feel are crucial to the spirit of general practice:

1. **Continuity of Care** If they so choose, a person can normally look to an individual GP for all aspects of primary care. It is this which underpins the personal nature of the family doctor service. Many contacts will be brief or of minor importance, but over time they contribute to the development of mutual understanding, a 'deposit account' of trust which can be drawn upon in times of crisis.
2. **Team Work** Since access to GPs is easy, they are presented with many problems which they are unable to deal with personally, either through lack of resources or lack of skills in that area. Equally, no medical problem can adequately be considered in isolation from its social context. It is therefore essential that GPs work closely with other Primary Health Care professionals and other agencies involved in the community.
3. **Intervention** Does not just mean writing a prescription. It is also

about care and support, education, promoting a greater understanding of health issues and encouraging people to take more responsibility for their own well being.

It seems inevitable that current moves towards GPs holding their own budgets will erode two important principles of general practice. Firstly, it will introduce a financial calculation into any transaction between doctor and patient, thus undermining the relationship of trust. Secondly, it will compel doctors to devote more time and energy to management of resources and personnel and therefore correspondingly less time to patient contact, thus undermining continuity and personal care.

So far there has been little enthusiasm expressed by GPs for the concept of budget holding, with less than 6% having taken up the option in the first year. However, it is possible that the politicians' response will be to drop the tactic of persuasion and substitute coercion or even compulsion.

Before the character of Primary Health Care is changed irrevocably, it is incumbent upon those who care about the service to consider whether any putative benefits to the balance sheet promised by the reforms outweigh the loss of mutual trust and personal care which have traditionally been the hallmarks of General Practice.

The NHS Reforms (comment)

An editorial in the *Lancet* in 1948 had this to say about the newly established NHS:

> It removes from medical practice much of the mercenary element that has been growing more conspicuous for 50 years or more. The new arrangements confer a great benefit on medicine by lessening the commercial element in its practice. Now that everyone is entitled to full medical care, the doctor can provide that care without thinking of his own profit or the patients loss and can allocate his efforts more according to medical priority.

Thus the NHS was founded on the firm principles of comprehensive health cover and allocation of resources according to medical need.

Forty three years on, the NHS is the largest employer in Europe with almost a million people on its payroll and the tenth largest corporation in the world. In an organisation of this size it would be surprising if there was nothing to criticise and no room for improvement.

However, one has to wonder whether the current wholesale reforms arise out of a serious analysis of the complex problems faced by the NHS or out of a burning desire to administer the simple panacea of

market discipline to all aspects of public life, however little they resemble supermarket merchandise.

Let's consider just two of the misconceptions on which the reforms are predicated:

- On the one hand we are told that the NHS is a top heavy bureaucracy with too many administrators. Then suddenly with the advent of the reforms we find that 300 extra administrators are appointed at a cost of 80 million pounds, re-christened managers and destined to save the service. If the USA is any guide as to what sort of adminstrative support the market place requires to operate smoothly then this is only the beginning. There, 12% of health expenditure goes on administration. Compare this with 4% for the NHS.

- Again we are told that the problems in the health service are not due to lack of, but rather misuse of, resources. In fact the NHS suffers from chronic under-funding. The proportion of Gross Domestic Product (GDP) spent on the health service between 1979 and 1988 actually declined and now stands at around 5.9%. Compare this with over 11% in USA, 9.4% in France, 9% in the Netherlands and more than 8% in Germany. Of the European nations only Greece and Portugal spend a smaller percentage of GDP on health care. Many of the current difficulties would not have arisen had the service been properly funded.

When evaluating the reforms, we should try to assess to what extent they undermine or reinforce the principles on which the NHS was founded. It would be a pity if the ideals of comprehensive care and provision according to medical need were quietly abandoned and the 'mercenary element' once again took the high ground.

Adrian Walker

Book Review

Some Lives by David Widgery

This is a book about the disintegration of a community seen from within. Over the past twenty years Dr. David Widgery, a General Practitioner in the East End of London has witnessed the erosion of traditional working class values, the disappearance of a major industry on which

the livelihood of many depended and a spiralling increase in inner city problems such as poverty, homelessness, drug abuse and long-term unemployment; as a medical man he views with horror the increasing problems of physical and mental health which go hand in hand with such social evils.

How did this state of affairs come about? Widgery argues that the creation and subsequent activities of the London Docklands Development Corporation was one of the prime movers in the creation of this tragedy, for tragedy it is. As he rightly says, you cannot sustain communities with a human face by 'abandoning planning and letting market forces rip'. The LDDC was the flagship of the Thatcher government's policies for regenerating inner cities. Its brief was to cut through red tape and inertia and to produce quick results. The result was a 'government financed estate agent which has done to the docklands what the Highland clearances did to the North of Scotland'.

Widgery is a writer in the mould of other perceptive commentators on the underside of London life – Orwell, Mayhew and Arthur Morrison. As well as drawing on his own extensive first hand experience he has obviously read widely on the subject – the bibliography lists more than fifty sources. Nevertheless if I have a criticism it must be that while he is accurate at diagnosing the ills that afflict the East End he does not really come up with any ideas for a cure. That aside this is a book that must be compulsory reading for anyone who cares about the quality of life in inner cities and about the wider issues of social justice and freedom.

Docklands seems to be like the Welsh coalfields, the Consett steelworks, the Clydeside shipyards and countless others, simply another name on the apparently endless roll call of working class communities consigned to oblivion by the apparently unstoppable forces of big business hand in glove with central and local government. What happened in the Isle of Dogs and Poplar was a very British sort of coup, small-scale and non-violent. As Widgery says, 'The LDDC installed a dictatorship with skilled financing and subtle PR rather than bullets and grenades'. But was it inevitable and can it happen again? The events of the past few weeks in the Soviet Union should give us hope. If the barehanded Muscovites can confront and defeat the armoured might of the KGB and the Red Army perhaps it's not too much to hope that in the future Londoners will similarly be able to take control of their own destinies.

Editors' Notes

This issue of *The Raven* has been compiled by Silvia Edwards to whom we are much indebted. We hope that she may have inspired others with a *Raven* subject in mind to offer their (unpaid!) services.

Raven 16 will be a mixed issue. When we decided to abandon the 'unplanned' *Raven* (see Editorial No. 9) we did however promise to keep 32 of the 96 pages in each issue for the 'unplanned' contributions. It hasn't worked out that way, as is the case with this issue. So *Raven 16* will include a number of interesting 'unplanned' articles. But we are still aiming to produce *Raven 17* on *Use of Land* and welcome suggestions and articles.

In 'Comments on the *Raven 12*' (No. 14 p.188) we published a letter from George Woodcock taking us to task for our references to the journal *Now* published by him in the 1940s. Unfortunately our reply was omitted when the pages were made up, and since we felt Woodcock had not presented the full facts we are including below the missing reply:

Woodcock misses the whole point because he stops at No. 2 when he became the publisher and FREEDOM PRESS the distributors. If he were concerned with the facts he should have added that this arrangement continued up to and including No. 6. The reference we made to *Now* trying to go commercial and paying writers started with No. 7. With that issue (and the two following) it was 'edited by George Woodcock', 'Business Manager Ingeborg Woodcock' and published by 'G & I Woodcock 24 Highgate West Hill London N.6'. No mention of FREEDOM PRESS as distributors. And by No. 8 the Editorial was about being 'Unashamed to Beg'! And with No. 9 it folded. Woodcock seems to suggest that the fact that FREEDOM PRESS sold 'only' 800 copies 'killed the journal'! What killed the journal was that it changed from being an anarchist political journal to one with a literary emphasis. But our point in referring to *Now* has really nothing to do with Woodcock's concern about circulation and ownership if he would only take the trouble to re-read the short paragraph where we refer to *Now*.

Our thanks to those readers who have contributed to the **Raven Deficit Fund**.

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