PASSAGE II

This passage is an excerpt from a critical literary essay on George Orwell's Nineteen Eighty-Four.

When we are speaking casually, we call *Nineteen Eighty-Four* a novel, but in a more exacting context we call it a political fable. This is not refuted by the fact that the book is preoccupied with an individual, Winston Smith, who suffers from a varicose ulcer, or by the fact that it takes account of other individuals, including Julia, Mr. Charrington, Mrs. Parsons, Syme, and O'Brien.

The figures claim our attention, but they exist mainly in their relation to the political system that determines them. It would indeed be possible to think of them as figures in a novel, though in that case they would have to be imagined in a far more diverse set of relations. They would no longer inhabit or sustain a fable, because a fable is a narrative relieved of much contingent detail so that it may stand forth in an unusual degree of clarity and simplicity. A fable is a structure of types, each of them deliberately simplified lest a sense of difference and heterogeneity reduce the force of the typical. Let us say, then, that *Nineteen Eighty-Four* is a political fable, projected into a near future and incorporating historical references mainly to document a canceled past.

Since a fable is predicated upon a typology, it must be written from a certain distance. The author cannot afford the sense of familiarity that is induced by detail and differentiation. A fable, in this respect, asks to be compared to a caricature, not to a photograph. It follows that in a political fable there is bound to be some tension between a political sense, which deals in the multiplicity of social and personal life, and a sense of fable, which is committed to simplicity of form and feature. If the political sense were to prevail, the narrative would be drawn away from fable into the novel, at some cost to its simplicity. If the sense of fable were to prevail, the fabulist would station himself at such a distance from any imaginary conditions in the case that his narrative would appear unmediated, free, or bereft of conditions. The risk in that procedure would be considerable: a reader might feel that the fabulist has lost interest in the variety of human life and has fallen back upon an unconditioned sense of its types, that he has become less interested in lives than in a particular idea of life. The risk is greater still if the fabulist projects his narrative into the future: the reader cannot question by appealing to the conditions of life he already knows. He is asked to believe that the future is another country and that "they just do things differently there."

In a powerful fable, the reader's feeling is likely to be mostly fear: he is afraid that the fabulist's vision of any life that is likely to arise may be accurate and will be verified in the event. The fabulist's feeling may be more various. Such a fable as *Nineteen Eighty-Four* might arise from disgust, despair, or world-weariness, induced by evidence that nothing, despite one's best efforts, has changed, and that it is too late now to hope for the change one wants.

PASSAGE V

This passage addresses the debates that surround healthcare.

Since World War II, considerable advances have been made in the area of healthcare services. These include better access to healthcare (particularly for the poor and minorities), improvements in workplace safety, and increased numbers of physicians and other healthcare personnel. All have played a part in the recent improvement in life expectancy. But there is mounting criticism of the large remaining gaps in access to healthcare, the unbridled cost inflation, the further fragmentation of service, the excessive indulgence in wasteful high-technology "gadgeteering," and the breakdown in doctor-patient relationships. In recent years, proposed solutions and new programs—small and large—have proliferated at a feverish pace, and disappointments have multiplied at almost the same rate. This has led to an increased pessimism—"everything has been tried and nothing works"—that sometimes borders on cynicism or even nihilism.

It is true that the automatic "pass through" of rapidly spiraling costs to government and insurance carriers, which was set in a publicized environment of "the richest nation in the world," produced for a time a sense of unlimited resources and allowed a mood to develop whereby every practitioner and institution could "do his own thing" without undue concern for the "Medical Commons." The practice of full-cost reimbursement encouraged capital investment, and now the industry is overcapitalized. Many cities have hundreds of excess hospital beds; hospitals have a superabundance of high-technology equipment; and structural ostentation and luxury are the order of the day. In any given day, one-fourth of all community beds are vacant; expensive equipment is underused or, worse, used unnecessarily. Capital investment brings rapidly rising operating costs.

Yet, in part, this pessimism derives from expecting too much from healthcare. It must be realized that care is, for most people, a painful experience, often accompanied by fear and unwelcome results. Although there is vast room for improvement, healthcare will always retain some unpleasantness and frustration. Moreover, the capacities of medical science are limited. Humpty Dumpty cannot always be put back together again. Too many physicians are reluctant to admit their limitations to patients, and too many patients and families are unwilling to accept such realities. Nor is it true that everything has been tried and nothing works, as shown by the prepaid group practice plans of the Kaiser Foundation and at Puget Sound. In the main, however, such undertakings have been drowned by a veritable flood of public and private moneys that have supported and encouraged the continuation of conventional practices and subsidized their shortcomings on a massive, almost unrestricted scale. Except for the most idealistic and dedicated, there have been no incentives to seek change or to practice self-restraint or frugality. In this atmosphere, it is not fair to condemn as failures all attempted experiments; it may be more accurate to say many have never had a fair trial.

PASSAGE VI

This passage deals with the issues involved in policymaking.

Because some resources must be allocated at the national level, we have created policies that reflect the aggregated attributes of our society. The federal budget determines the proportion of federal resources to be invested in social welfare programs and how these resources are distributed among competing programs. This budget is arrived at through a reiterative, aggregative political process which mediates the claims of groups interested in health, education, welfare, and so on, thus socializing the continuing conflict generated by their separate aspirations. The test of whether a policy is "good" under this system is whether it can marshal sufficient legitimacy and consent to provide a basis for cohesion and action. Technical criteria may play a role in the process, but the ultimate criteria are political and social.

Whether a policy that is "good" in the aggregate sense is also "good" for a particular person, however, is a different matter. If everyone had identical attributes, these criteria of goodness would produce identical outcomes. With any degree of complexity or change, however, these criteria will always produce different outcomes. Any policy negotiated to attain an aggregate correctness will be wrong for every individual to whom the policy applies. The less a person conforms to the aggregate, the more wrong it will be.

When a policy is not working, we normally assume that the policy is right in form but wrong in content. It has failed because insufficient intelligence has informed its construction or insufficient energy its implementation. We proceed to replace the old policy with a new one of the same form. This buys time, since some time must elapse before the new policy can fully display the same set of symptoms of failure as the old. We thus continue to invest our time, energy, and other resources as if every new discovery of a nonworking policy is a surprise, and a surprise that can be corrected with some reorganized model. But if policies based on complex, aggregated information are always wrong with respect to the preferences of every person to whom they apply, we should concentrate on limiting such policies to minima or "floors." Rather than trying for better policies, we should try for fewer policies or more limited aggregated ones. Such limitations could be designed to produce policies as spare and minimal as possible, for the resources not consumed in their operation would then be usable in non-aggregative, person-specific ways—that is, in a disaggregated fashion. This will require more than just strengthened "local" capacity; it will require the development of new procedures, institutions, roles, and expectations.

PASSAGE VIII

This passage provides information on antipsychotic drugs called neuroleptics.

In the 1950s, the development of antipsychotic drugs called neuroleptics radically changed the clinical outlook for patients in mental institutions who had previously been considered hopelessly psychotic. Daily medication controlled delusions and made psychotherapy possible. Many, who otherwise might never have left institutions, returned to society. Now, physicians have learned that there is a price to be paid for these benefits. Approximately 15 percent of patients who undergo long-term treatment with antipsychotic drugs develop a cluster of symptoms called tardive dyskinesia, the most common symptoms of which are involuntary repetitive movement of the tongue, mouth, and face, and sometimes the limbs and trunk.

Neuroleptic drugs interfere with the action of dopamine, an important neurotransmitter in the brain, by binding to the dopamine receptors of nerve cells. Dopamine is a prime suspect in the pathophysiology of schizophrenia. Large doses of drugs such as amphetamines, which stimulate secretion of dopamine, produce a psychosis resembling schizophrenia. Reducing the activity of this neurotransmitter alleviates the delusions that cause 25 percent of psychotic behavior. Although the inhibition of dopamine activity can control psychotic behavior, researchers now believe that the central nervous system of some patients adapts to long-term therapy by increasing the number of specific dopamine binding sites. The net result is dopamine hypersensitivity, which is correlated with the subsequent appearance of tardive dyskinesia.

The risk of developing tardive dyskinesia is not so great that doctors have considered abandoning the use of antipsychotic drugs. Patients generally are bothered only slightly by the physical side effects, though the abnormal movements are troubling and may hinder social adjustment. Additionally, early diagnosis and prompt discontinuation of the neuroleptics might result in a decrease in the incidence of the movement disorders. Unfortunately, without neuroleptic drugs, psychotic behavior returns. So, researchers have tried to achieve a satisfactory balance between the two effects, lowering dosages to a level that minimizes movement disorders yet controls psychosis. In a five-year study of twenty-seven psychiatric patients treated with neuroleptics representing all classes of antipsychotic drugs, researchers attempted to decrease drug doses to their lowest effective levels. Patient responses suggested that low to moderate doses of antipsychotic drugs could control psychoses just as well as high doses, and tardive dyskinesia symptoms stabilized and gradually diminished or completely disappeared.

The fact that psychoses can be controlled at the same time that tardive dyskinesia symptoms are reduced suggests that a drug more specifically affecting the mechanism of psychoses might not cause movement disorders. Sulpiride, a drug not available in the United States but widely used in Europe, where it was developed, may be one such alternative. The drug selectively blocks D–2 dopamine receptors, perhaps especially those in the limbic area of the brain, which is involved in emotion and behavior. It does not adversely affect the adenylate cyclase-linked D–1 dopamine receptors. Sulpiride has proven effective in the short term, but whether it suppresses tardive dyskinesia over a long period of treatment is not yet known.