

## *Deinstitutionalization in Two Cultures*

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THE BRITON AND THE AMERICAN ARE SEPARATED not only by the Atlantic but also by a single language and the ghost of George III. It is not surprising, therefore, that British psychiatrists speak of "community care" when they could say "deinstitutionalization"—if only they knew the word. In spite of linguistic difficulties, the process itself was described in very similar terms by a Royal Commission in Britain and by a Joint Commission in the States.

The Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, reporting in 1957, said that

in relation to almost all forms of mental disorder, there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospitals as in-patients, or which make it possible to discharge them from hospital sooner than in the past. (Royal Commission, 1957: 207)

Compare this with the statement in the report of the Joint Commission on Mental Illness and Health, *Action for Mental Health* (1961), that

the objective of modern treatment of persons with major mental illness is to enable the patient to maintain himself in the community in a normal manner. To do so, it is necessary (1) to save the patient from the

debilitating effects of institutionalization as much as possible, (2) if the patient requires hospitalization to return him to home and community life as soon as possible, and (3) thereafter to maintain him in the community as long as possible. (Joint Commission, 1961: 270)

The unanimity of view is surprising. It seems most unlikely that there was any element of imitation or collusion. Certainly a group of American psychiatrists visited the United Kingdom in the 1950s. However, given the differing economic and social situations of our two countries, it is impossible that psychiatrists could have arranged that the populations of mental hospitals in Britain would reach their peak in 1954 and in the United States in 1955. Thereafter in both countries the hospitals' populations declined, albeit at different speeds and in rather different ways.

There have been numerous attempts to explain these changes in both countries. In Britain it was tempting to relate such alterations to the introduction of the Welfare State and the organization of the National Health Service after the last war (Bennett, 1973). In the States, Rose (in this issue of the *Milbank Memorial Fund Quarterly*) quotes Musto (1975) in support of a belief that deinstitutionalization was forced by the military who, in the Second World War, had to reject two million draftees on psychological grounds. A third element, common to these explanations, is the end of World War II. This was not only a significant and political social watershed but also one that, experienced by our two countries at the same time, could have triggered the decline in hospital populations. It is certainly as plausible as the belief that a reduction of mental hospital populations was due to the introduction of psychoactive and neuroleptic medication, a belief that has been seriously questioned by Ødegaard (1964) and others.

## The Rise and Fall of the Psychiatric Institution

Dissatisfaction with institutions is no new thing, but it was not felt at the beginning of the nineteenth century. At that time, in the States, most alienists considered that the origins of insanity lay in the stresses and strains caused by the breakdown of the old order and the instability of the new. According to Rothman (1971: 129), "the American environment had become so particularly treacherous that

insanity struck its citizens with terrifying regularity.” There was a need to create a different kind of environment for the insane, “one which would not only alleviate their distress but also educate the citizens of the Republic. The product of this effort was the insane asylum.”

Asylums, which were to have been stress-free islands in a changing world, later deteriorated first into centers for the custodial segregation of insane pauper immigrants, and then into places of last resort for those deemed incurable. As early as the time of the Civil War, a growing number of physicians insisted that the drawbacks of institutionalization far outweighed its advantages. What is remarkable is that asylums have endured so long.

But there have been changes. From 1930 to 1955, in both countries, there was a period of therapeutic optimism in psychiatry. This optimism may have had its origins in the successful treatment of GPI (general paralysis of the insane), and the success of other physical treatments in psychiatry, as well as in an increasing belief in the power of medical magic epitomized in the discovery of the sulphonamides and penicillin. There was also the wider introduction of voluntary treatment, followed by the liberalization of hospital policies with the “open door,” the “open hospital,” the “therapeutic community,” and so on. Patients who at one time might have been forced to enter hospital and stay there were now free to come into hospital and to leave. They could decide to have treatment, or no treatment at all, as long as they were not a danger to themselves and others.

Bott, studying the rise of the first-admission rate in one large British mental hospital, was surprised to find that the increase had started in the 1930s and was already slowing down by 1955. Bott (1976: 104) says that “like the hospital staff, I had assumed that the late 1950’s and the early 1960’s were the period of most rapid change both inside the hospital and in the demand for its services by the public.” She thought it was not only a belief in the curability of mental illness that attracted patients to the mental hospital, but also the lessened capacity of families to care for their ill members, especially the elderly, that led to a push for the admission of patients. She suggested that whether patients ended up as short-stay or as long-stay residents did not depend on the treatment offered, but on whether the hospital or the outside world offered the place where the patient was the more likely to survive.

There were changes not only in the pattern of care, but also in the greater freedom of choice allowed in hospital admission and discharge. As a result, psychiatrists were faced with rising admission rates. Anxious to reduce overcrowding, and conscious of the lack of staff, they did not oppose patients' requests for discharge. As rates of admission, discharge, and readmission increased, psychiatrists suggested that periods of life in society, even if interspersed with hospital residence, were more beneficial to patients (if not to their families) than a long hospital stay. Some long-stay patients who really wanted to stay in hospital were unsettled by all this "in-and-out" movement and took their discharge. One patient who had lived in the hospital for many years is quoted by Bott as saying, "There are so many changes and upsets here now that I may as well go home." Such remarks were not infrequent.

One can only speculate about the cause or causes of the rising admission rate and declining resident populations. There was certainly a widespread distrust of and dissatisfaction with institutional life, not only for the mentally ill but also for other groups, a dissatisfaction that, in Britain, owed as much to Dickens as to Goffman. Voluntary treatment, the use of medication, therapeutic optimism, or the availability of more adequate welfare provision, all had one thing in common: they represented a changed relationship between patients and staff and between patients and the public. Doubtless economic factors played a role, although it is impossible to say whether this was a part of the general economic climate, as Brenner (1973) would have us believe, or a part of a conscious political decision to achieve economies in psychiatric care, as Rose suggests. In Britain today, financial limitations are used as an explanation for a slowing of the process of deinstitutionalization. A Socialist secretary of state for health (Barbara Castle), presenting to Parliament in 1975 a plan for better services for the mentally ill, explained that

even in favourable economic circumstances it would obviously take a long term programme to achieve in all parts of the country the kind of change we are advocating. . . . Indeed the savings on expensive in-patient treatment should mean, taking health and social services together, little increase in total running costs. But the savings and the expenditure are not always simultaneous, and the net effect, overall, on running costs does not give a complete picture of the implications for different sectors of the health and social services. The policy can *only*

be achieved if there is substantial capital investment in new facilities and if there is a significant shift in the balance of services between health and local authority. . . . Without increased community resources the numbers in mental hospitals cannot be expected to fall at the rate they might otherwise have done. Delay in building up local services must mean too that it is unlikely that we shall be able to see in every part of the country the kind of service we would ideally like within even a twenty-five year planning horizon. (Department of Health and Social Security, 1975: iii)

It does not seem that our legislators are looking for the same savings from deinstitutionalization that Dr. Rose outlines. There has been some abuse of community care in Britain, when patients have been discharged to seaside hotels without adequate preparation or support, but abuse in community care is much less commonly reported than abuse in the mental hospital. In truth, the same shortage of manpower and economic resources that hinders the development of a community service impedes the improvement and adequate staffing of mental hospitals.

## Deinstitutionalization Since 1960

In the beginning, the "deinstitutionalization" of the early 1960s was little more than the recognition by psychiatrists and by planners that the population of mental hospitals was diminishing in spite of rising admission rates. True, there was a vague appreciation of changes in the relations of patients to staff and others. But it was not a policy. It was the recognition of a trend. It did not specify which patients needed, and which did not need, hospital care, nor the extent of provision needed in the community. In Britain, the Royal Commission's view of the public attitude was benign but vague. The extent to which patients could live in the community "must depend partly on the willingness of the general public to tolerate in their midst some people with mild abnormalities of behaviour or appearance. We believe the increasing public sympathy towards mentally disordered patients will result in a higher degree of tolerance in this regard" (Royal Commission, 1957: 207). Perhaps the Joint Commission (1961: 58) was more realistic, believing that, although people were sorry for the mentally ill, "they do not feel as

sorry as they do relief to have out of the way persons whose behavior disturbs and offends people.”

So both commissions recognized the importance of public attitudes in limiting the extent of change. As a result, their proposals were moderate by today's standards. The Joint Commission asked for no more than that any additional state hospitals should be built with not more than 1,000 beds, and that not one patient be added to any existing mental hospital housing 1,000 or more patients. In Britain, Enoch Powell (1961: 7) as minister for health, noted that in fifteen years' time “there may well be needed not more than half as many places in hospitals for mental illness as there are today. . . . This 50% reduction itself is only a statistical projection. . . . But that 50% or less of present places in hospitals for the mentally sick—what will they look like and where will they be? We know . . . they ought to be in the wards and wings of general hospitals.”

Most people did not object to these changes and, in the beginning, those chronic patients who could cope were discharged, or discharged themselves, from hospital. The Joint Commission urged that aftercare and rehabilitation are essential parts of all service to mental patients, and that various methods of achieving rehabilitation should be integrated in all forms of service, among them day hospitals, family care, convalescent nursing homes, rehabilitation centers, work services, and expatients' groups. In practice, provision did not match these worthy sentiments.

At its inception deinstitutionalization, if not a policy, was at least a sensible reforming movement. It attempted to go along with a public feeling about the disadvantages inherent in institutional treatment and to capitalize on a statistical fact: the decrease in the mental hospital population. In Britain the Hospital Plan was formulated in 1962; then in 1971 there was a dramatic change in policy. The Department of Health and Social Security (1971) decided that improvements in treatment and care made it possible to replace not half, but the whole, of the service previously provided by large separate mental hospitals. In the States, too, the recommendations of the Joint Commission suffered a sea change, for the 1963 Community Mental Health Centers Act was influenced as much by the writings of Goffman, Hollingshead and Redlich, and Lindemann, as by the Joint Commission's report.

In both countries, what had been a belief in a changing balance between care in the community and care in the mental hospital

became a campaign to abolish the mental hospital. The downward trend in the size of mental hospital populations, seen first as an opportunity for restructuring the service for the mentally ill, became a policy of hospital closure in its own right. This is almost as illogical as suggesting, at a time when the number of children in schools is declining, that this is a sound reason for closing all schools.

## United States and United Kingdom Go Their Own Ways

After 1961, British and American policies diverged. British psychiatrists did not share the belief of some of their North American colleagues that they were competent to determine and achieve a form of community organization that would provide mental health and prevent mental illness. To be fair, such views were heavily criticized, too, in the United States (Bennett, 1973; 1978c). In British psychiatry the major postwar development was in social psychiatry, with particular reference to psychotic patients in hospital. By contrast, the major development in the United States was in dynamic psychiatry, with particular reference to ambulatory neurotic patients (Aldrich, 1965).

These changes, and the development of the British National Health Service, led to a very significant parting of the ways between American deinstitutionalization and British community care. British community psychiatric services, unlike the Community Mental Health Centers, were always closely linked to mental hospitals, frequently sharing the same staff. The care and rehabilitation of chronic patients were major concerns, and nowhere were the elderly mentally frail handed over to the unsupervised mercies of the private sector. Thus, in Britain, the decrease in mental hospital populations is in the younger age groups, while in the States it is the older patients who have been discharged. This certainly made a considerable difference to the outcome of deinstitutionalization in the two countries, if not to the heated debate between those who wished to abolish and those who wished to preserve the mental hospitals. Issues were oversimplified and distorted, and important facts were overlooked and suppressed (Bachrach, 1976).

In both countries this seems to be an artificial debate, when we are moving rapidly toward comprehensive patterns of psychiatric

service in which a distinction has to be made between the words "alternative" and "substitute." It seems to be a limitation in our present thinking that alternative services are often considered to be substitutes. Thus some people speak of hospital care *or* community care when, in fact, both are needed at different times and in different circumstances and must always complement each other. Belief in the value for the mentally ill of maintaining their normal home and community ties has led some psychiatrists to equate progress in community care with the prevention of hospital admission. Shrinking the number of beds does not ameliorate human distress or reduce the incidence and prevalence of psychiatric illness.

Others have believed that the abuse and neglect of psychiatric patients can be prevented by moving care from hospital to community. Yet there is a tendency to reject and neglect the mentally ill, wherever they are. Is Hoboutopia in the mental hospital very different from Hobohemia in the city or by the seaside? Both communities are the outcome of the desire of some persons or some group to have the mentally ill out of their way. In this sense, the condemnation of deinstitutionalization policies, which purports to be based on a concern for the good of the mentally ill, is often a hypocritical desire to maintain their segregation.

Professionals should not be smug. It is not only the public who reject the mentally ill. In both hospital and community, professionals from all disciplines are not anxious to help those psychiatrically disabled patients who lack skills, are poor, often homeless, and do not have family or friends to support them. The tendency of professionals to refer such patients to colleagues with lower status or less training is well documented (Rudolph and Cumming, 1962; Rehin, Houghton, and Martin, 1964; Wittman, 1967). It seems fair to say that, in Britain, attention has been focused on the neglect and abuse of patients in mental hospitals; in the States, more attention seems to have been given to neglect in the community. It is not possible to say whether this reflects a reality or the nature of popular concern. Dorothea Dix moved patients into the mental hospitals to save them from neglect in the community. Now we are moving them back to the community to save them from neglect in the mental hospitals. It is ironic that it was Dorothea Dix's innovations that enlarged the populations and increased the size of mental hospitals, and her rigid insistence on protecting patients from any mishap that led to stagnation and institutionalization (Bockoven, 1963).



## Institutionalization and Socialization

Deinstitutionalization is linked in the public and in the professional mind with the prevention of desocialization. Some people still believe that discharging patients from, or preventing their admission to, hospitals will prevent this. This sort of thinking is not new. Bockoven (1963: 39) suggests that the reform movement aroused by Dorothea Dix's heroic activities held very similar beliefs. Its followers "jumped to the conclusion that the elimination of abuse in itself would result in the recovery of the incurable." Today's reformers jump to the conclusion that abolition of the mental hospital will result in the socialization of the mentally ill. But institutionalization is little more than socialization to the life and role of a patient in a mental hospital and desocialization for life in the outside world. If people have been mental hospital patients for some time, their discharge from the institution will not render them capable for life in society. If they are still mentally ill or disabled, their resistance to further desocialization in society may be diminished. Continued socialization depends on the ability and the willingness to heed the expectations of those with whom a person works and lives. This capacity is likely to be impaired by mental illness. Without help and rehabilitation, the capacity may be lost just as easily in the community as in the institution.

Abolition of the institution will not do away with desocialization, and treatment of mental illness may not reverse it. When considering desocialization, one has to think of the effects on the individual of community and hospital environments and judge each on its own merits. From the sick person's point of view, there are good and bad hospitals and there are good and bad wards. There are good wards in bad hospitals and bad wards in good hospitals (Wing and Brown, 1970). There are good and bad families, good and bad nursing homes, hostels, single-occupancy hotels, and so on. As John Wing (1978: 254) has said,

The quality of life lived by the patient and his relatives is the final criterion by which services must be judged. A good hospital is better than a poor hospital or a poor family environment. A good family environment is better than a poor hospital or a poor hostel. The same may be said of day-time environments—open employment, enclaves in ordinary commercial business, rehabilitation or sheltered workshops or

protected day centres. Universal denunciation of any one type of setting is likely to be harmful since it is clearly not based on rational principles of assessment, treatment or care.

It is equally important to recognize that Dorothea Dix's "immense emphasis on eliminating gross abuse of the insane had the most unfortunate effect of driving into the background any serious consideration of the requirements to be met in securing positive treatment" (Bockoven, 1963: 38). Our present uncertainties with regard to the relative value of hospital or community care, and the current criticism of deinstitutionalization, spring from a humane desire to prevent the abuse or the desocialization of the psychiatric patients. Unfortunately, the worthy supporters of this cause have allowed themselves to be trapped as partisans in a sterile round of criticism and have failed to develop a positive and rational scheme of assessment, treatment, and care (Bachrach, 1976).

One can sympathize with attacks on the Joint Commission's and Royal Commission's formulations of "deinstitutionalization" and "community care." Their limitations are all too apparent. They are so obviously outmoded that repetitious attack is just a waste of time. We have enough experience to know that although, in a psychiatric service based in a modern district hospital, it is possible to use fewer beds, patients do not disappear. They have to be cared for in other ways (Bennett, 1978b). True, there is a need for adequate community supports—not only from community agencies but also from hospitals, which, although some critics forget it, are both part of the support system and part of the community. But whatever facilities and resources are available, they should be used not just to reduce the number of beds or dispose of patients, but to decrease and contain disease, disability, and distress for the patient, the family, and the community.

This is not idealistic humanitarian rhetoric. It is hard-headed common sense. But it requires more than common sense to use the services in a way that is effective and efficient. This, in turn, demands treatment that not only takes account of biological and psychodynamic knowledge, but also is firmly grounded in the theories and findings of social psychiatry, psychology, and the other behavioral sciences. Then, according to Sabshin (1966), it is possible to reformulate community psychiatry as a use of the techniques, methods, and theories of social psychiatry, as well as those of the

other behavioral sciences, to investigate and treat the mental health needs of a functionally or geographically defined population over a significant period of time. According to this formulation, community psychiatry will be concerned with the mental health needs not only of the individual patient but also of the district population; not only of those who are defined as sick, but also of those who may be contributing to that sickness and those whose own health or well-being may, in turn, be put at risk.

This approach affords a way of working with patients that takes account of their clinical condition, the expectations and stresses to which they are exposed, and the social supports on which they may count. It provides no dogmatic statement about *where* patients should be treated or by *whom*. What matters is *how* they are treated (Bennett, 1978c). In other words, treatment, whether in hospital or in the outside world, must be grounded in the application of those theories and findings of social psychiatry that show how social factors cause, precipitate, exacerbate, minimize, or prevent manifestations of psychiatric illness, and how, in turn, psychiatric illness affects society (Wing, 1971). Such an approach takes a rational view of the individual's pathology, adaptive capacity, and social situation. It accepts the limitations of the medical model. It does not accept vague speculations (unsupported by epidemiological evidence) about the part played by structural, social, and cultural factors in the etiology of mental illness. Nor does it accept the illogical conclusion that mental illness will not be treated (or prevented) until these social structures are changed. It does not pursue such illusory goals as the rejection of all types of institutional care or the investing of all treatment in nonhospital agencies (Hawks, 1975).

Finally, if patients are to cope outside the mental hospital, desocialization must be prevented or reversed, and adaptive capacity must be maintained or developed. It has been stressed that this cannot be achieved by the oversimple expedient of avoiding or shortening hospital admission. Rehabilitation, the original missing requirement for community mental health center funding, is needed if the psychiatrically disabled person is to acquire the social and instrumental skills, the emotional control and motivation, that are needed for the performance of everyday roles in society (Bennett, 1978a). Even patients who have been rehabilitated, in the sense that they have been helped to make better use of their skills in spite of their handicaps, may not be able to be resettled in society. Some, as

“new long-stay” patients, will require continuing hospital care. Others will be able to fit in to alternative services in the community that compensate for their disabilities and inadequacies.

In spite of a developing social psychiatric approach to patient care, change is slow. It takes time to replace the monolithic institution with district-based differentiated services in which general hospital units and statutory and voluntary social services complement each other. It takes time to deinstitutionalize staff as well as patients, and to change public opinion.

In 1961, Enoch Powell, at that time minister of health, said that the elimination of mental hospitals was

a colossal undertaking, not so much in the new physical provision which it involves, as in the sheer inertia of mind and matter which requires to be overcome. There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside—the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault. . . . The resistance is not only physical. Hundreds of men and women, professional or voluntary, have given years, even lifetimes, to the service of a mental hospital or a group of mental hospitals. They have laboured devotedly, through years of scarcity and neglect, to render the conditions in them more tolerable, and of late they have seized with delight upon the new possibilities opening up, and the new resources available, for these old but somehow cherished institutions. From such bodies it demands no mean moral effort to recognize that the institutions themselves are doomed. It would be more than flesh and blood to expect them to take the initiative in planning their own abolition, to be the first to set the torch to the funeral pyre.” (Powell, 1961: 6)

## Functional Equivalents to the Mental Hospital

Enoch Powell’s statement brings us back to the central issue that still bedevils “institutionalization,” “deinstitutionalization,” “community care,” and all other attempts to secure the best possible level of social adaptation for those individuals who suffer severe mental disorder. Most people would agree that such persons have a right to be

helped to adapt so that they can make the best use of their residual capacities in the most normal available social context.

But what happens in practice is a very different matter, for psychiatrically deviant and disabled persons are in conflict and competition with the competent "normal" members of their society. Take patients out of hospital, and staff lose their jobs and politicians their votes. Provide adequate alternatives, and someone has to pay for these in taxes. Families, having made the difficult and often painful decision to segregate an ill member, are reluctant to take him back. They have closed the matter and wish to deny that there ever was a problem (Bott, 1976; Cumming and Cumming, 1957). Having insulated themselves they are unwilling to reopen this painful issue. Parents, worried about what will happen when they die, to their disabled offspring, often put greater trust in the permanence of mental hospitals than in community agencies.

Public attitudes are even more rejecting of those who seem insensitive to, and no longer governed by, society's norms. The sane seem to require the isolation of the mentally ill in hospital, not just for their treatment, but to maintain the necessary everyday state where people behave as they are expected to. In hospital, the staff are no more anxious to deal with unpredictable behavior than any other group. They cope by rendering the patients' behavior predictable, "probably through some invidious process of desocialization" (Cumming and Cumming, 1957: 139). The patient will experience segregation, possible neglect, and desocialization in the mental hospital, or rejection, possible neglect, and desocialization in society.

The pattern of denying mental illness and isolating the mentally ill has beneficial and harmful consequences both for them and for society. The conflict between society's needs and the needs of the individual poses a dilemma from which the only means of escape is through differentiation and specification. There should be less talk about "mental illness," "mental hospital," and "society" as if these terms represented anything but mere abstractions. (By the same token, it is useless to talk about "patient costs" unless one appreciates that for society and the family they may often include more than the direct financial costs of statutory care; "real" costs differ widely in individual instances.) Instead, the nature of impaired function, and the characteristics of ward or home environments, should be specified, and the beneficial or harmful effects of their interaction studied.

There has been a growing use of functional assessments that employ direct observation of a person's performance rather than psychological tests and questionnaires. There has also been a growth of individual, problem-oriented approaches to treatment and rehabilitation, associated with the establishment of differentiated "functional equivalents" to mental hospital care. Cumming and Cumming (1957) defined a "functional equivalent" as any item in society that, although different, does the same job. They noted that the difficulty, in trying to design functional equivalents of the "isolation pattern" of management for the mentally ill, lay in maintaining intact their useful qualities while getting rid of their harmful ones. The provision of equivalents for those former patients who have some social competence and show little deviant behavior has been generally successful. Such patients generate little conflict or competition with others in society. But where there is conflict, the provision of equivalents will have to be based on assessments not only of the individual, but also of his relations to his family and society. It takes time to overcome the resistance to new ways of caring. It also takes thought to conceive functional equivalents to the mental hospital that will survive attack because they work effectively and meet the needs both of society and of the mentally ill.

The history of care for the mentally ill shows that conviction and good will are not enough. But often the social and political pressures do not allow the time needed for thought or adjustment. In Britain, hospital staff have been reluctant, and the government has been unable, to provide functional equivalents for the few dangerous psychiatric patients from whom society still needs to be protected. As a result, many mentally disordered offenders will have to remain in prison until such time as adequate provision is made for them in "medium secure" hospital units, which are the proposed alternative.

In the States, I detect difficulties stemming from the use of profit-making organizations for patient care. Although profit-making enterprise has created a strong economic system in the States, proprietary systems often seem to be in conflict with therapeutic aims. This is true, not only in psychiatry, but also, for example, in blood transfusion (Titmuss, 1970). In psychiatric after-care, the need to make profit requires economies of scale that lead to the use of large residential facilities in urban areas. These impede both the care and the community integration of the residents, while their size and visibility, opposing society's need for denial and insula-

tion, evoke community hostility. These examples represent the failures to find equivalents for aspects of the mental hospital's work. They demonstrate the need for further thought; they do not invalidate the principle nor require the abandonment of deinstitutionalization or community care.

## Conclusion

Deinstitutionalization and community care, having very similar starting points in both our countries, have changed with time and the pressure of our different social and economic systems. Does this reflect an alteration of principle, or simply different approaches to the practical implementation of new provision? An even closer and more systematic study of deinstitutionalization in our two cultures might provide some useful clues in solving the riddle of providing a psychiatric service helpful and acceptable both to the patient *and* to the community.

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