

*Commentary*

SHALOM CARMY

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## *The Human Factor: A Plea for Second Opinions*

*Do not cast me away in time of old age; when my  
strength is spent do not abandon me.*

(PSALMS 71:9)

*After all, we live in an age which admires the expert  
and which expects him to tell how things are and  
how they ought to be done. The expert, on the other  
hand, does not tolerate any opposition; all we ought  
to do is listen to him and swallow his ideas.*

(R. JOSEPH B. SOLOVEITCHIK)<sup>1</sup>

“Satire” is Latin for a medley of fruits. Explaining what makes a particular satire funny, like so much else in philosophy, is often a thankless task. If you don’t get the point right away, you won’t get much pleasure out of having it analyzed in slow motion. If you do, you won’t care to go over it in detail, either because it’s unnecessary, or because too penetrating a review may yield more insight than you had bargained for.

What is the object of Dr. Shachter’s satire? It’s hard to read his “case history” without hating the psychiatrist, who self-righteously tortures a harmless old man, and is satisfied only when he has cured his patient’s

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religious practices by turning him into a vegetable. If one does not despise the ignorant grandchildren who, out of some combination of naivete, indifference and possible resentment, give the psychiatrist life and death power over their grandfather, it is only because the author devotes so little attention to them. At the same time, out of the corner of our minds, we recognize that the grandfather's behavior, as described by the psychiatrist and as judged by the standards of the world, is strange indeed. Is it so clear to us that their perspective is wrong, and why?

Yet these initial reactions to Dr. Shachter's story come up against the preface, intended to guide our interpretation of the satire. The preface instructs us to read the story as not in any way critical of psychiatric practice. The author is careful not to deny the possibility of such abuse; he only suggests that the reader should not think about it. One might be tempted to treat this disclaimer as an indication that the reaction of the psychiatrist in the story is an exaggerated version of tendencies within the profession, but we are warned in no uncertain terms that this too is an unacceptable interpretation. What, then, is being satirized? Methinks the author doth protest far too much.

One can't help wondering about the urgency with which the psychiatric sacred cow is editorially shielded. Either the author harbors terrible suspicions about the profession which he is reluctant to state openly, or he is reflecting anxieties that plague our own community, and have little to do with the trustworthiness of the average psychiatrist. I am strongly inclined to the latter alternative. In recent months, two pillars of the medical establishment have published books which discuss frankly, for the instruction of the intelligent layman, the fallible workings of the medical system: I refer to *Second Opinions*, by the Harvard oncologist Jerome Groopman, and *Intensive Care*, by John F. Murray, celebrated for his standard text on respiratory diseases.<sup>2</sup> Despite (or in reaction to) the blind worship of medical science, they, among others, invite us to consider the possibility that a hard-working doctor's judgment is often clouded by fatigue, ignorance, "professional deformation" (as when surgeons opt aggressively for the knife), personal bias or bad personal chemistry with the patient. Ask anyone familiar with life in a hospital or nursing home, and you will likely learn that it is vital for residents to ingratiate themselves with the staff, and to exploit every advantage provided by dedicated, vigilant family, in order to get adequate understanding and dignified treatment. Erving Goffman's sociological classic *Asylums* explains, for the benefit of anyone who needs to have it spelled out, that inmates in closed institutions had better tell

those in authority what they want to hear.<sup>3</sup> Psychiatrists, whose diagnostic categories, theoretical constructs and favored treatments, with all due respect, are far from assured, and are strongly affected by cultural perspectives, political pressure and axiological judgments, should not be immune to the doubts tolerated by oncology or emergency medicine. Few, I hope, are so haughty as to expect such blind deference.

In any event I can't help reading the story as it stands, regardless of the disclaimers. I can't help noticing that the true obsessive is not the patient, but the doctor. It is the doctor who cannot veer from his goal of uprooting the old man's concern for his "Temple." The relentless psychiatrist diagnoses (I was about to write "condemns") the old man for spending a few minutes looking up a *din* about the order of dressing in the morning. In his medicalized universe, getting decisions out of a book is the mark of an individual crippled by the inability to decide for himself. Yet the physician is himself totally enslaved to his professional jargon, concealing every moral or human judgment behind a rigid mask of authority. In a burning building, I think, the old man would long ago have escaped, placing the duty to save one's life above the duty to determine the correct order of putting on one's shoes, while the psychiatrist (based on what he reveals of himself) would still be seeking approval from the sub-paragraphs in the clinical manual he worships. The doctor accuses his patient of lacking self-insight; but the terrible punishment he inflicts upon the patient testifies only to the doctor's terrifying blindness.

To blame the unusual capacity for self-deception and willfulness represented by the caricature psychiatrist entirely on his profession, is an error and an evasion. The warped spirituality that Dr. Shachter describes with ghastly exaggeration is a common strategy in a variety of fields, among which the clinical practice of psychology may, or may not be, especially prominent. Despite their high visibility as villains in such literary productions as Ken Kesey's *One Flew Over the Cuckoo's Nest* or David Duncan's *The Brothers K*,<sup>4</sup> I have no reason to believe that psychiatric practitioners abuse and manipulate those under their influence more frequently or severely than others. With the exception of children, criminals and the aged and infirm who are at the mercy of others, most people who go to a psychiatrist do so voluntarily. In a hospital, the psychiatrist is subject to collegial oversight, for whatever that is worth. And even the craziest psychiatrist wants reimbursement from the patient's insurer, which places some constraint on the creativity of his or her diagnoses and therapies. That many of us feel anxiety, fear, and resentment about the power exercised by certain professionals is understandable, and in my opinion justi-

fiable. But it is a mistake to project our concern on one vulnerable specialty. Psychiatrists don't destroy people; people destroy people.

Authoritarian mind games and power plays are perhaps most prevalent among social professionals, whose insecurity about their competence is most in need of propping up, since they boast neither the assured knowledge of the natural scientist nor the tradition of individual self-reliance associated with the humanities. The custodian of power defines the values of his, or her, group as scientifically objective. This putatively neutral stance enables the authoritarian professional to avoid taking responsibility for her own moral judgments. Authority does not ordinarily require the brute force of ECT to reduce the deviant to anxious compliance or querulous despair. The very act of resisting the intellectual, moral, or even linguistic pretenses of authority, can be classified as a symptom of deviancy from the scientific norm. Power itself is exempt from the same inquisition. This abuse is typical of liberal authoritarianism in all its professional and social manifestations.

The religious individual must withstand the encroachments on our intellectual and spiritual integrity emanating from purveyors of authoritarian conformism. The reader may have inferred that I look to other disciplines to protect us against the social professionals. There is some validity in this hope. Because philosophers, creative artists, and historians show us that human beings have thought differently, imagined differently and lived differently than the contemporary herd, they are resources in our attempts to do so. The vocation of rabbis, interpreting to us the life that God wants us to lead, is to speak eternal truth to transitory power.

Indeed the human soul is too important to leave to the psychiatrists, with their all-too-human narrowness and flaws. But it is foolish to replace one elite with another set of elites. The alternative elites are also human, and to abandon our destiny to their wisdom is also simplistic, hence false. Humanists, especially the bossy kind, can be as blind to their own bad judgment and systematic defects as anyone. Professional and intellectual preoccupations with other matters often overwhelm clergymen, even insightful and well-meaning ones; they cannot consistently provide expertise and wisdom in areas to which they have not devoted sustained study and undivided attention. As for the ones whose moral compass is unstable, the less said the better.

In fact, calls for increased involvement by clinicians in the management of Orthodox life often feed on resentment and disappointment with the performance of the rabbinate. In our helplessness we invest the psychologist with the wisdom and benevolence once ascribed to such

paladins as the local Hasidic rebbe or Franklin Delano Roosevelt. It is interesting how often journalists or community leaders nurture their confidence by dubbing the object of their hopes a “trained psychologist,” as if the adjective itself guaranteed the right result. Rabbis and humanists have a great deal to contribute to our self-understanding, but I dread the day when their influence flows, not from the perspicuity of their words and reasoning, or from the content of their characters, but from assertions of expertise and specialized training which enable them to avoid taking personal responsibility for their convictions.

The human soul is too important and mysterious an affair to be entrusted to any group of experts. This is just as well because, when all is said and done, an expert is a human being, and an expert exclusively fixated on being an expert is an inferior human being. A human being is too fallible and too perverse to be trusted with the kind of authority we yearn to abdicate to experts, and that experts may yearn to be crowned with. The old question “Who will guard the guardians?” leads to an infinite regress.

## II

One might dismiss part of our psychiatrist’s behavior as the result of his lack of information about Orthodox Judaism. Such ignorance, however disastrous, is accidental and correctable. Clinicians today are almost certainly less liable to impose an explicitly anti-religious therapeutic agenda than they were half a century ago, and this is probably due to their being better informed, together with the economic pressures of supply and demand, and the humility born of uncertain outcomes and result-oriented customers. Where this pertains, the psychiatrist, upon being informed that the patient’s behavior is part of his religion, will back off, just as the competent but uninformed physician apprised of her patient’s allergy to penicillin will simply stop prescribing it. In the real world, however, failure to investigate the context of supposedly “pathological” behavior is disturbing. We could not dismiss the possibility that it reflects a secularist bias, antagonistic, or at the very least, tone-deaf, to religious orientation. Like other intellectually rigid, unimaginative experts, the psychiatrist in the story is misled, not only by misusing the power of classification, but by distorting the larger context of his patient’s life. He is obsessed with discrete atoms of behavior, even while avoiding any attempt to understand them in the context of the old Jew’s inner world. He has no idea or curiosity about what the Temple signi-

fies; the grandchildren don't have a clue; and the Jew seems either unable to communicate or unable to penetrate the closed minds arrayed against him. The physician carefully records the old man's periodic abstention from *tikkun ḥazot*, but fails to correlate it with the calendar. He has thus missed an enormous part of the man's life. To focus on *tikkun ḥazot* and ignore Shabbat and Yom Tov would be like a Martian anthropologist (to vary a term coined by an autistic patient of Oliver Sacks, which he borrowed as a title of his book<sup>5</sup>) who concludes that New York City exhibits irrational, unmotivated traffic patterns, because he knows nothing about the geography of employment in the city or the structure of the work week.

God's role in all these matters goes unmentioned. Had the old Jew connected his odd behavior to his love and fear of God, the secularist would no doubt dismiss this talk of a personal relationship with an invisible Being as one more delusion. In which case, therapy must proceed until the tortured old man is deprived of his knowledge of God. If so, the psychiatrist who insisted on pursuing this course would be squaring off against his true Enemy. Separating religious behavior from religious belief and experience, the psychiatrist does not have to come to terms with his own religious attitudes and therefore has less difficulty categorizing the behavior as meaningless.

Of course, the old Jew's isolation works against him too. As a member of a community of people committed to his ideals, the Jew cannot so easily be diagnosed as psychotic. The psychiatrist might assert that the entire Orthodox community is collectively psychotic, whatever that means, and that the individual is guilty only of being part of that collective. The negative judgment of religion remains pretty much the same, but the practical differences are substantial. One can't, for example, zap a collective entity with ECT, though some nice people wouldn't mind trying.

### III

The previous paragraph made the pragmatic point that there's protection in numbers. Behavior that is common to a community, or approved by it, is unlikely to be stigmatized. Why this is the case may take us deeper into the subject, and illuminate the questions alluded to in the author's preface. In certain respects, however, Dr. Schachter's old man is a bad example because his behavior is harmless to others and to himself. For this reason alone, it is difficult to imagine an observer, who is neither a psychiatrist nor a mentally disturbed person himself, taking such

notice of his nocturnal activities. It's hard to conceive of Medicare authorizing his treatment at all, let alone against his will, let alone with the aggressiveness described in the story. Therefore it may be useful to introduce a more appropriate example.

Imagine a man who insists on subjecting his newborn son's genitals to a surgical procedure. Removing the foreskin in the prescribed manner, he proclaims, is fulfilling a divine command. When asked why God requires the surgery, he maintains that no reason is necessary with God, adding that the circumcision marks a covenant between man and God, as a wedding ring signifies the relationship between man and wife; more tentatively he suggests that removing the foreskin may moderate his son's future sexual pleasure, which, astonishingly, he regards as a good consequence, one desired by the deity he worships. He concedes that he would refrain from the operation if it endangered the infant's life, but not for any other reason. All attempts at dissuasion are useless. When gently told that he will be prevented from carrying out the planned mutilation, he becomes highly agitated and screams about persecution.

There are significant groups in the United States today, dedicated to stigmatizing or even outlawing *milah*. Their case has been made in mainstream Jewish and non-Jewish print media. When Cosmo Kramer, in an episode of "Seinfeld," the most popular situation comedy of the 1990's, is driven by revulsion at what he regards as a barbaric, cruel rite to plot the kidnapping of a prospective victim, no counter-argument is presented. These efforts to demonize *milah*, combined with a parallel campaign to belittle the medical benefits of the procedure, may succeed in lowering the circumcision rate. Nonetheless few are seriously concerned that *milah* will be outlawed, or that its practitioners will be herded into mental institutions. Why not? Obviously because *milah* is recognized as an integral part of Jewish religious practice. Why does this make a difference?

1) In purely political terms, persecution will cause too much of an uproar. No judge, however enlightened, will risk arousing it. Numbers translate into power.

2) The fact that so many people are committed to circumcision predisposes judges, legislators, psychiatrists and other powerful personages to view it, from psychological and moral perspectives, as a normal practice. It is the opponents who appear fanatical, surely not the vice presidential candidate of the politically correct party and the legions of his co-religionists. Numbers define normality.

3) It is always possible to attach the label of mental illness to an indi-

vidual whose behavior or attitudes or beliefs one disapproves of. But the label will not stick unless we tell some story about that person that coheres with the label. The story may be biochemical: the individual is the way he is because of some chemical surplus or deficit. The actual biochemistry may sometimes be taken on faith, and the judgment that this particular biochemistry is unhealthy and that this particular person needs to be treated is, of course, a human conclusion. Alternately, the story may be social, revolving around early family history, traumatic experiences and so forth. Again, the story may be hypothetical; even when empirically verified, it is tied to certain valuations. What is essential is that the believer in the theory has some idea of what is being asserted when so-and-so is said to be obsessive-compulsive, narcissistic, paranoid and so on, through the current diagnostic register. Psychiatric man thus approaches the world of human individuals with his appropriate classifications in hand. That the patient interprets his own life in terms of beliefs about the "Temple," about God, and about other religious entities, can be ignored. The diagnosis defines reality; the deviant's own beliefs are epiphenomena, symptoms of the underlying condition.

What happens when an entire nation or religion incurs disapproval? Can an entire nation be paranoid? What exactly does that mean? The standpoint of methodological individualism would hold that a paranoid, or obsessive-compulsive society is one in which every individual is paranoid or obsessive-compulsive. But this would then entail that each person suffers from the biochemical abnormality or psychodynamic history associated with the mental illness by the accepted theory. This is incredible. It is far more plausible to believe that most members of the group are the way they are because they are conforming to the way the group is. Thus the mental illness is a property inhering in the group *qua* collective.

But it is impossible for a collective, as opposed to an individual, to have the same properties that psychiatrists ascribe to individual mental patients. The collective has no biochemical properties; only its constituent individuals do. The collective has no Oedipus complex; only its male members are eligible. Hence to describe a collective as paranoid or obsessive-compulsive requires a substantial adjustment of the term. One may hypothesize some causal factor that affects the religious orientation of all members of the group equally, though these individuals differ in their non-religious characteristics. One may say that leaders, or founders, of the collective, are paranoid or obsessive-compulsive, and that they induce in their followers the kind of mentality that would otherwise occur only if they were actually paranoid or obsessive-compulsive. Or

one might say that the collective is paranoid or obsessive-compulsive in a metaphorical sense. The group behaves in a manner that somehow resembles the mentality of the paranoid or obsessive-compulsive.

Now these re-definitions of psychiatric concepts no longer belong in any obvious sense to conventional psychiatry. If the psychiatrists had gotten their hands on a few really sick group members in time, these might have been cured of their ideas and convictions. The world would then have been spared the dissemination of whatever the psychiatrists find noxious, be it Nazism, Communism, Herzlian Zionism, or religious existentialism. But it is too late to nip these ideas in the bud. The ideas are out there, and have adherents who do not fit the psychiatric profile. The supposed similarities between the psychiatric conditions and the social and intellectual phenomena may be of interest, but they remain metaphorical.

To be sure, there are writers who lose track of the distinction, and apply psychiatric jargon to collective phenomena. For example, Christopher Lasch, a thinker much of whose work I resonate to, erects his sweeping *Culture of Narcissism* on Otto Kerner and Heinz Kohut's psychoanalytic conceptions of narcissism, which he goes on to assign to American society.<sup>5</sup> No doubt the sort of clinician who thirsts for a public role, and loves to educate a waiting nation on the psychopathology of persons he has never met—political celebrities, relief pitchers or the expatriate relatives of Elian Gonzales, will not be deterred by the logical niceties of our discussion. Nevertheless, an awareness of the philosophical impediments may strengthen our reluctance to allow the medicalization of mainstream religious practices.

The last of my three arguments differs from the first two. The first separates the safety in numbers factor from considerations of truth, morality or mental health. The collective is protected simply because it is imprudent to interfere with it. The second, by contrast, makes numbers probative. The collective should be shielded from interference because it is supported by a presumption of truth, morality and health. The third argument, however, covers the collective against the imputation of mental illness, but not against moral revulsion. For instance, it prevents us from identifying German Nazism with whatever mental illness is ascribed to Hitler or Goebbels. But it does not affect our judgment that Nazism is wicked and should be suppressed.

Let us return to the person who deems *milah* morally repugnant. He or she may submit unwillingly to the political realities raised by the first argument, and may or may not be swayed by the appeal of the second. The third argument leaves room for the anti-*milah* activist to keep up the

attack. All he or she must do is to stop using psychiatric language and switch to explicitly moral condemnation. Straightforward censure on moral grounds would have the virtue of honesty. It would not disguise moral or aesthetic detestation under the mask of scientific objectivity.

#### IV

Satire is a double-edged sword. If the psychiatrist's great lie is the disjunction between exotic pieces of behavior and the religious vision that animates them, the preface urges the Orthodox reader to ponder the uncomfortable possibility that the disjunction corresponds to reality. To the fear that religious individuals deserve psychiatric opprobrium the appropriate response is self-examination.

A student once approached a great contemporary Israeli *rosh yeshivah* with a series of questions relating to the order in which one should put on socks and shoes in the morning. "Sir (*adoni*)," came the reply: "If you consider these laws at the same level as the wearing of *tefillin*, then you're in trouble (*az oy va-avoy lekha*)." What should we really think about the observance of *tikkun ḥazot*? It all depends on the larger context. When a person, whose commitment to Torah and statutory prayer and so forth is weak to middling, suddenly discovers *tikkun ḥazot*, or becomes preoccupied with the more obscure technicalities of rising in the morning, I would be disturbed by the disproportion, whether or not the "disorder" can be located in the psychiatric *sifrei pesak*. When, by contrast, a person of formidable spiritual stature scrupulously devotes himself to elective rituals mourning the *ḥurban*, I would view it as a natural outgrowth of a vibrant religious existence.

What is true of the minutiae of behavior is just as true with respect to our beliefs and feelings. The old Jew repeats as his own conviction the talmudic teaching that one should regard each and every action as crucial to one's own destiny and to that of the world. The scandalized psychiatrist, who is equally adept at wielding power and disclaiming responsibility, rummages about in his diagnostic tool kit for the certified nomenclature. What are we to say? Do we stand with the gemara, or do we agree with the psychiatrist?

Once again, the spiritually healthy response requires reference to the larger context of the individual's life. The solemn conviction of the religious old man exists together with other attitudes. Our psychiatrist writes: "in his demeanor and bearing he gave an excellent imitation of a basically cheerful man." How wonderful, how awesome, to encounter an

individual who knows the magnitude of his responsibility before God, and yet serves Him with a joyful countenance!

How is this miracle of spiritual thriving accomplished? Not through a one-sided emphasis on one's shortcomings and a grandiose sense of guilt, but by apprehending the sense of infinite responsibility within the great framework of man's relation to God. The religious experience of sin is inseparable from the life of repentance: the Rambam cites the aforementioned Talmudic dictum in *Hilkhhot Teshuvah* (3:4), after he has introduced many of the fundamental concepts relating to repentance, which culminate (ch. 10) in the joyful, passionate love of God. Closeness to God is not a matter of stringing together disparate items of prescribed external behavior, but of creating an inner life of commitment. Whoever fails to understand this, knows nothing of the nature and destiny of man.

What if the old man does not live up to the integrated character ideal I just sketched? What if his behavior and demeanor give the impression of religious mediocrity, so that his meticulous attention to *tikkun ḥazot* seems to be at odds with everything else we know of him, like the observance of *milah* by otherwise assimilated Jews, or attendance at Shabbat services by people who neither keep the laws of Shabbat nor treat the prayers with respect? What if he is not as cheerful as the old man in the story, if he does not serve God with joyous countenance? What if his observance of *tikkun ḥazot* seems more an expression of general moroseness than a meditation on the grief of the *ḥurban*? Should that make him a candidate for compulsory psychiatric intervention, or even for voluntary submission to a psychiatric regimen? Before answering yes, please review for a moment your own inconsistencies, eccentricities, failures and hypocrisies.

It has been suggested that we compare our responses to the old Jew with our judgment of a hypothetical Aztec sympathizer mourning the fall of Tenoch-titlan, which my interlocutor considers "probably an event more historically significant than the fall of Jerusalem." Whether the last phrase is true or not depends on one's idea of historical significance, which in turn depends on one's ultimate spiritual orientation. Even an atheist, certainly a Jew or a Christian (perhaps a Moslem) would disagree with the suggestion that the fate of Jerusalem had less of an impact on human destiny than the Spanish conquest of Mexico. However that might be, our previous discussion would shed light on this case as well. One would want to know more about the reasons proffered by the Aztec sympathizer in explaining his behavior against its personal, social, and religious background: Is it isolated or does it reflect

communal values? What story about the destiny of Mexico, or the world, or his own life, lends significance to his mourning? How does it cohere with his other activities and ideals? This study might lead me to respect the ancient Aztec's mourning, or it might not. Quite likely a superficial inquiry would leave me indifferent to his spirituality or convinced of its silliness, though the latter, it seems to me, could hardly surpass that of many upwardly mobile people, enslaved to patterns of life that are neither satisfactory nor satisfying, addicted to meaningless tokens of status, driven to distraction by petty resentments, with whom I am far better acquainted. But the appropriate intervention, if any, would be moral or philosophical, not psychiatric. Perhaps we should meet the responsibility of perfecting ourselves morally and religiously before arrogating to ourselves the task of systematically coercing out of existence the silliness, peculiarities and harmless preoccupations of others in the name of some ill-defined psychiatric conception.

If our psychiatrist were to come after me, or after the old man, or after the Aztec, I might direct his attention to Samuel Johnson's philosophical novel *Rasselas*. One series of chapters (40-47) depicts an astronomer, enthroned in his palace of theory and calculation, who comes to believe that he controls the weather. He is saved from this delusion, less through its scientific refutation, than by emerging from the narrow prison of his thoughts into the rich daylight of variegated, concrete experience. Johnson's courageous delineation of the misfortunes that ensue when theoretical constructs are confused with truth, and melancholy with moral-religious conscientiousness, are valuable to all of us who wish to avoid them. Our psychiatrist, however, like so many others who conduct their lives on the basis of external conformity, probably fears works of imaginative literature, and would find some learned scientific reason to resist my offer.

## V

There's something strange about the perspective from which this story is told. The fictional psychiatrist judges, diagnoses and treats the old man. We, the authors invited to comment, and you, the readers of our symposium, judge the psychiatrist's judgments; we second-guess him and display our superior insight. Without the element of satire, it would be easy to fall in with the role of commentator. It would be easy to forget that most of us will not play the psychiatrist or his alter ego. In practical terms, our lives are more likely to be crucially affected by the way powerful oth-

ers judge us, without our intervention, than by the way we judge others weaker than us, without their consultation. One really ought to know better, young enough to recall the child unhappy in his little state, old enough to anticipate the nursing home that houses the unlucky at the end of the road. The double-edged sword of satire cuts through the illusion that being allowed to have one's say in this journal affords exemption from the old man's fate. It puts to question not only one's intellectual certitudes, but also one's illusions of confidence and invulnerability.

"Satire," replied a bulwark of the musical theater when asked for a definition: "Satire is what closes Saturday night." In part that is because satire is too subtle for the average audience. But a deeper reason is that satire often sucks us out of our protected psychological and intellectual harbors and forces us to consider situations we would rather not think about. The more burdened we feel, the more insecure, the less appetite we have for the deep and open sea. The less our certitude is anchored in the eternal, the less we wish to question our precarious accommodations with the conventions of our lives. We crave easy conversation and relaxing entertainment. Life is hard enough, we imagine; we do not need more complication than we already have. Perhaps that is why, in our modern Orthodox communities, satire is what never is given the chance to open in the first place. If the preceding discussion has not demonstrated why this is our loss, I don't know how to show it. The *Torah u-Madda Journal* is to be commended for creating the space for our analysis. One can only hope that it is the first of other fruitful opportunities.

Erev Tish'ah be-Av, 5760

### Notes

1. From a letter (August 11, 1953); copy in Louis Bernstein, *The Emergence of the English Speaking Rabbinate* (Ph. D dissertation, Yeshiva University, 1977), 561ff.
2. Jerome Groopman, *Second Opinions: Stories of Intuition and Choice in a Changing World of Medicine* (New York, 2000); John F. Murray, *Intensive Care: a Doctor's Journal* (Berkeley, 2000).
3. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (N. Y., 1961).
4. Ken Kesey, *One Flew Over the Cuckoo's Nest* (N. Y., reissue edition, 1989); David Duncan, *The Brothers K* (N. Y., 1991).
5. Oliver Sacks, *An Anthropologist from Mars: Seven Paradoxical Tales* (N. Y., 1996).
6. Christopher Lasch, *Culture of Narcissism: American Life in An Age of Diminishing Expectations* (N. Y., 1991).

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