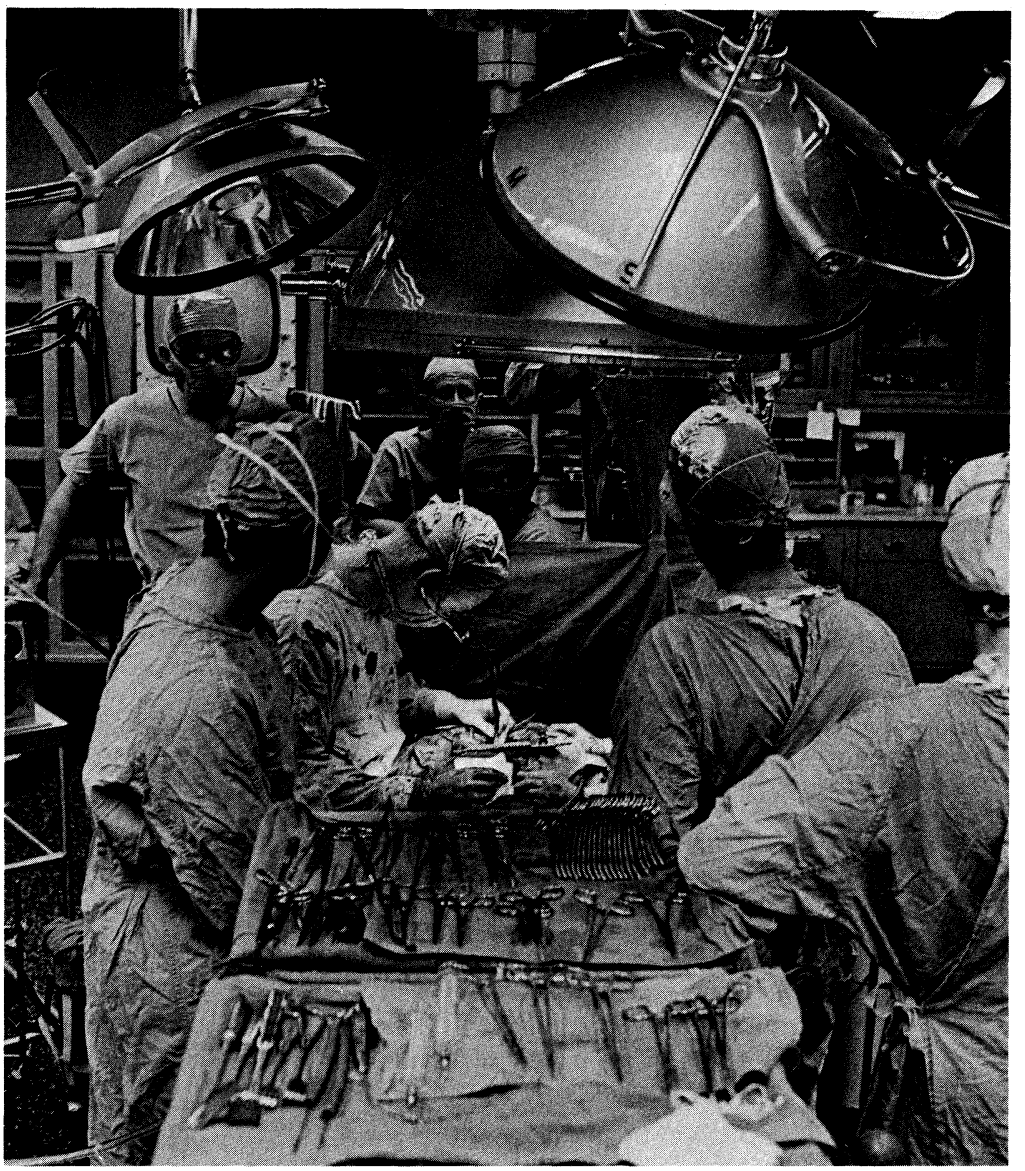
healer of madness, existential philosopher, New Leftist social critic, guru of LSD, Buddhist monk, and radical critic of the family. Now he is posing as devoted paterfamilias, basking in "happy" communications with his children. Cooper is often wrongheaded, but is honest. Laing is often level-headed, but is he ever honest?

Thomas Szasz's latest book is *The Myth of Psychotherapy.* He teaches psychiatry at the State University of New York's Upstate Medical Center in Syracuse, and contributes frequently to LR. The present review is reprinted by permission from the British magazine, *The Spectator.*

Doctoring the figures

MARSHALL E. SCHWARTZ

Defective Medicine *by Louise Lander. Farrar, Straus and Giroux, 242 pp., $10.* Pain and Profit—The Politics of Malpractice *by Sylvia Law and Steven Polan, Harper and Row, 305 pp., $12.95.* The Malpractitioners *by John Guinther, Anchor Press/Doubleday, 347 pp., $10.00.*



One-third of all surgical deaths and half of all surgical complications are probably preventable.

DURING A FIVE WEEK period of 1976, many doctors in Los Angeles county withheld their services in protest against the soaring malpractice insurance bills they had received. A most curious and disturbing sequel to this story appeared in the newspapers last October: During this period, when surgery declined by nearly 60 percent, there was a significant drop in the death rate in Los Angeles, climbing again (from 19.2 to 26 per 100,000 population) during the first five weeks after the doctors went back to work.

If these figures are a true reflection of the state of American medicine, then perhaps the continuing malpractice crisis is the best medication possible for the health of the American public. Unfortunately, the sad state of American medical practice—as evidenced by statistics like those from Los Angeles—and the much-bruited malpractice crisis of the 1970s are both symptoms of the same underlying malady. Yet the burgeoning studies of this crisis are devoted mainly to detailed symptomatologies—identifying such ailments as the overspecialization of American medicine; the ever-increasing use of hospitals rather than the home or doctor's office to treat patients; the poor self-regulation of the medical profession, with its high yield of incompetent practitioners and unnecessary surgical and diagnostic procedures; the contingency fee system for attorneys; overgenerous jury awards; poor underwriting practices; the use of increases in malpractice premiums to make up for insurance companies' stock market losses; and the foisting off on the public and on regulatory agencies of deliberately false and misleading figures by the insurance industry—rather than to root causes.

And that's what journalist John Guinther and attorneys Sylvia Law and Steven Polan offer us in their new books on malpractice—along with their own personal, statist solutions to this peculiarly American problem. To be sure, both of these studies are overflowing with useful information, particularly Guinther's revelations about the insurance industry's quasi-legal financial manipulations, and Law and Polan's clear and exhaustive explanations of both the common law roots of malpractice law and today's tangled legal spiderweb. But neither book—despite occasional telling observations which, inexplicably, are never followed up—addresses either of the fundamental defects which have distorted American medicine: the unending regulation by federal, state, and local governments, and the absorption of the medical profession into the American corporate state.

Defective Medicine by Louise Lander is more difficult, if not impossible, to cat-

egorize—exasperatingly so, at times. For Lander delves further than any of the other authors toward finding the first causes. And so many of her analyses, her descriptions, her polemics are tantalizingly libertarian in tone. In fact, there is nothing in her book, if examined from the appropriate perspective, that is antilibertarian in nature. Yet she, too, never quite arrives at her apparent goal, never *names* the statist excess that continues to lead American medicine to the brink of disaster, but only describes it. The libertarian reader is left with the impression of someone giving an incredibly compelling description of an elephant, but being unable to call it "elephant" because she just doesn't know the word.

For libertarians, this is not a major defect, however, for we are able to supply the needed words, *name* the names ourselves, once we are presented with all the vital details from the proper perspective. And that is a task Lander performs admirably.

Her approach is delineated in the book's subtitle, *Risk, Anger, and the Malpractice Crisis*. Observing that only a small fraction of incidents that could be considered acts of malpractice ever result in a claim being filed—much less ending in payment to the claimant—Lander points out that a second factor must also be present before a malpractice claim occurs: The patient must be *angry*—at a doctor, at a hospital, at a nurse or attendant, at *somebody*. And, Lander argues, those factors that cause anger in the patients also force patients to undergo more procedures, both diagnostic and therapeutic, that put them at risk of injury.

To Lander, a major underlying cause of the problem is the ideology of modern medical practice, an ideology that "has very little to do with the human experience of being sick." Instead of dealing with the whole person—how the illness affects what the person does, how what the patient does affects the illness, and how the patient himself can affect the illness—the ideology of modern medicine "has much more to do with the needs of physicians for a conceptualized framework that will focus and simplify their work and that will justify the segmented, episodic, superspecialized, individualistic character of their work arrangement." In other words, physicians have aimed at constructing an ideology, a medical model, if you will, that justifies the corporatization of American medicine.

The resulting construct is "the biomedical model of medicine":

> the notion that a given disease can be explained by a distinct, well-defined biochemical or physical abnormality. . . the general assumption that a disease reflects disordered biological mechanisms that can ultimately be described in terms of chemistry and physics and that are independent of social behavior or intrapsychic processes. The model is reductionistic, explaining complex phenomena by invoking a single ultimate principle; dualistic, reflecting a separation of mind and body; and mechanistic, reflecting a view of the human body as a machine.

This model provides a "theoretical" basis for the specialization of medicine organ by organ, and for the structure of insurance reimbursement, procedure by procedure. There is no place left to view the patient as a whole, with this fragmentation leading to higher risk and greater alienation for the patient. Ultimately, this "biomedical model makes of doctors the priests of a secular religion, a variant of the more general secular faith that technology is the answer to all worldly ills and that what is newer is by definition better." That piece of commentary by Lander sounds as if it could have been lifted whole from one of Dr. Thomas Szasz's attacks.

And, as with any corporate model, the "theory" is self-aggrandizing and self-perpetuating. As a result, you will rarely find a patient and his doctor discussing "his backache, headaches, or bellyaches in the context of his life situation," so that they could be dealt with by the patient attempting to change "his job, his marriage, his neighborhood, his diet, his activities, or his general manner of relating to other people." Instead, the biomedical model protects the vested medical interests by refusing to look at the patient as a whole. Otherwise, Lander remarks,

> The physician would lose not only income from return visits but also the psychological gratification of feeling that the patient is dependent on his professional expertise. The pharmaceutical industry would not only lose a participant in the immediate sense but would possibly also lose a participant in a lifelong symbiotic relationship with that industry that most people enter into much to its profit. The whole referral structure of specialists, diagnostic equipment, and hospitals would suffer a loss of both income and the exalted status it has come to be accorded.

As a result the "healing" relationship dies—the "trust," the "altruistic concern," even the "nonrational" elements identified by Szasz in his dissections of modern psychotherapy. What is left is medicine as a commodity, and the doctor as a corporate executive (aided by the prodding of physicians' journals and professional management firms). This approach must inevitably increase the chances for a malpractice suit, for "if the patients see medical treatment sold like goods and services they buy in the commercial arena," Lander declares, "then it is only natural that patients feel anger and seek economic redress when the medical product or service turns out to be in some sense defective."

Commodification of medicine has another dangerous ramification: the standardization of a profession which, above all others, *must* be individualized if it is to be truly effective. All this would be unthinkable without the biomedical model, for it is relatively easy to standardize an organ or a "diagnosis-and-age combination," but impossible to standardize the whole person.

And standardization inevitably goes hand-in-hand with regulation—whether government-imposed, or self-imposed and government supported. For if a physician and his colleagues are trying to standardize their treatments of various "disease entities," using a fallacious theory as the basis of their action, how can they reply to the patients of a nonstandard practitioner, one who refuses to dress in their garment cut from whole cloth?

Both Guinther, in *The Malpractitioners*, and Law and Polan, in *Pain and Profit*, address the subject of regulation, as it affects both medical practice and the insurance industry. But while both books highlight many of the unavoidable consequences of both regulation and official monopolies (the only kind that can ever be maintained), none of the authors gives up on regulation and legislation as tools that will ultimately, somehow, solve the malpractice mess.

Thus Law and Polan draw the following picture of the relationship between today's medical profession and a true free market:

> The assumption of a free market for services is basic to our political and economic system. It is based on the concept that people cannot have everything they want, and the concept that no one knows what is best for individuals better than they do themselves. These principles, whatever validity they may have in the general economy, have little application to physicians' services. . . . The inherent difficulty of informed consumer choice is

made worse by professional restrictions on the dissemination of information about alternative medical care. The medical profession closely controls the supply of medical services. For all of these reasons, the laws of supply and demand do no assure that the supply of physicians will correspond to people's needs for medical care.

The biomedical model which has corporatized medicine leaves no place to view the patient as a whole.

That's a pretty fair description of a state-endorsed monopoly, where control over new providers' entry into business is in the hands of current providers. Guinther gets more specific. In discussing foreign medical graduates (FMGs) and the role they play in allaying the apparent shortage of physicians in this country, he observes:

> The vacuum in medical services the FMGs filled was one created and maintained by American medical schools under policies established by the AMA. . . . The AMA maintains that enrollment limitation has been beneficial, that because of it the United States enjoys a "superlative medical system.". . . Competitive reasons, however, are probably dominant. The restrictive admissions policy was adopted by the AMA in the 1930s when physician income had declined precipitately due to the Depression. At that time doctors reasoned that if enrollments were held back, there'd be more patient money to go around for those already in practice, and there seemed to be no reason to abandon this attractive thesis when the post-War boom years arrived. Around that time a new economic motive evidenced itself as increasing numbers of medical students began to specialize in surgery, where their incomes would be 25–50 percent higher than in general practice. Since too many surgeons meant too small a slice of the pie for everyone, the answer was again to keep enrollments down.
>
> It was not until the federal government began handing out grants to medical schools for each student they accepted that the system was broken. As Guinther puts it, "it has been this federal bribery, not any desire on the part of American schools to produce enough doctors to meet American medical needs, that instigated the recent increase in American medical school enrollment."

Naturally, when you are dealing with a state-supported monopoly, all the incentives for quality of service and cost-effectiveness that the free market imposes perforce disappear. One consequence is that it is nearly impossible for a physician to lose his (state-granted) right to practice because of incompetence; even in states where disciplinary machinery exists, the profession has turned a short run into a steeplechase course by adding obstacles wherever possible. For example: In New York, Law and Polan note, "*nine* separate administrative reviews must be completed before a doctor's license can be revoked," and two judicial appeals are possible even after all that. "It is widely acknowledged, even in professional medical circles, that state medical boards have done a wholly inadequate job of finding and disciplining chronically incompetent physicians," they add.

Some high-ranking state and federal officials have estimated that as many as five percent of all active doctors are "definably incompetent," Guinther points out. Yet as of the beginning of 1976 "incompetence, negligence, or malpractice was a grounds for revocation or even suspension of license in only twenty-three states, so that, throughout most of the country, no matter how inept he is, a doctor has no worry that he will lose his license for those reasons, even temporarily." Not surprisingly, he adds, only some 430 doctors each year (barely one-tenth of one percent of those in practice) "receive notification *of any kind* from a state license board about the way they practice medicine, and the overwhelming majority of those communications cite the doctor for advertising his services or misprescribing narcotics, not for any negligence in his practice." Law and Polan report only 134 revocations throughout the United States in the three-year period 1973–75.

In general, malpractice insurance rates are based only on the doctor's location, specialty, and whether or not the company has paid a claim against that doctor. Since what little information that is gathered about physician incompetence is neither centralized nor readily available in any form, doctors who are at particularly high risk of malpractice cannot, as a rule, be identified by insur-

ers. As a result, Law and Polan state,

competent and conscientious doctors, who are in the majority, must pay malpractice premiums which reflect not only their own risks but also the risks of the majority of physicians who are addicted, incompetent, or dishonest. All the evidence indicates that a small proportion of the medical profession is responsible for a very large portion of the rapidly increasing malpractice premium.

"The state-supported medical monopoly has made it nearly impossible for a physician to lose his right to practice because of incompetence."

Guinther correctly observes that hospitals have been doing at least as poor a job of quality control over medical care as have the state boards—especially important since the site of most malpractice incidents is the hospital. He quotes a 1970 HEW study on malpractice to show that although only one-third of all hospitals could have expected no claims against them that year if malpractice cases were distributed randomly, in fact *more than two-thirds* had no claims filed. Thus, a small minority of all hospitals must be doing some things very wrong indeed. This lack of control also helps to explain such astounding figures as an estimate by a House of Representatives committee that in 1974, 17 percent of the 14 million elective operations performed were unnecessary—leading to nearly 12,000 deaths. Or the report of the American College of Surgeons and the American Surgical Association that one-third of the 245 surgical deaths and half the nearly 1700 surgical complications studied were preventable.

Neither Lander nor Guinther offers proposals on alleviating this particular aspect of our national medical conundrum. Law and Polan, however, rely on the time-tested fallacy of letting the federal government take charge. Since the Joint Committee on the Accreditation of Hospitals hasn't seen to it that its member hospitals adhere to the uniform standards they profess, "we need a national, publicly accountable agency to set and apply standards for hospitals," Law and Polan declare. They blithely ignore the fact that regulation of state-supported monopolies—whether by the state or by the industry itself—has benefited only the monopolies. When the state outlaws free competition, there is little incentive left for improving the quality of one's product or service. They are on the right track when they observe that "these reforms, while of some use, will be of limited effect so long as the basic organizational structures for medical-care delivery are so rigidly hierarchical." But they fail to see that the reason the hierarchy acts as an obstacle to "reform" (in this case, improved quality) is that it is cast in the mold of the corporate state.

If the medical profession as a whole has no vested interest in improving the standard of care, who does? Is it the insurance industry, which must pay for so many preventable errors? Far from it, according to the data Guinther, Law, and Polan present—the epitome of how state "regulation" benefits only the regulated industry.

While the medical profession's regulatory agencies seem to know what's wrong with their industry, although they do little to correct it, state insurance commissions—according to the picture painted by Guinther—are easy marks for the insurance companies' confidence game. Typical suckers, they take the companies' figures as gospel and then play the game by the rules their opponents have established. The only losers, of course, are the people.

In such fields as life, health, and automobile insurance, competition acts as a barrier to such flim-flam games. But various factors have created monopoly markets for malpractice underwriters, and here such tactics thrive, Guinther reveals. A typical example is the manipulation of loss reserves. These are funds set aside against unresolved claims, so that even if a claim must be paid, the company can earn interest on the money during the two, three, or even seven years the claim is being negotiated and litigated. Because loss reserves are legally considered to be liabilities, such funds are not taxable, Guinther points out.

Hence, the more that goes into the loss reserve, the less tax the company pays. Moreover, since companies are permitted to use loss reserves for interest-earning purposes, the more that is put into them, the larger the company's source of tax-free investment capital.

Inflating the loss reserve also has another value for an insurance company. Whenever it is seeking a rate increase before a state insurance commission, it is permitted to prove its need not only in terms of actual payments to claimants, but also by the amount that has been set aside for future payments. If this figure is exaggerated, the company's claims position looks worse than it is, and it is more likely to get the change it wants than if it had presented a truthful picture. Once the rate increase is obtained, the company can then re-reserve accurately, shifting money in this fashion back into surplus.

Since insurance commissioners generally come to their jobs from the insurance industry—the old story of the industry regulating itself, even when the state is apparently doing the regulating—"some of them are not as vigilant about company practices as the public might hope." Even if they were, Guinther explains, they would have great difficulty proving the companies' figures wrong, because the commissioners just don't have the actuarial staffs to provide independent evaluations.

How much overreserving is going on? One group of Pennsylvania doctors, fighting a 200-plus percent increase in malpractice insurance rates by Argonaut Insurance, hired a private actuary to investigate. The study found that the company "had overreserved—by 100 percent—137 of 139 consecutive claims closed between May 1975 and March 1976." This exaggerated figure for projected losses had been used to substantiate the tripled insurance rates. A related practice is that of reserving losses for incidents *even before a claim is filed*. These cases arise when a doctor reports an incident to his insurance carrier because he feels a claim might occur. A study by HEW found that in some 40 percent of such cases, the injured party never makes *any* effort to seek damages. "Therefore," concludes Guinther, "to the extent that these non-asserted claims are assigned dollar values, the company doing so is showing losses on its books that it never incurs, and at the same time is showing a seriously inflated picture to the public of the actual frequency at which malpractice claims occur." One result of this practice, Law and Polan report, is that, as of 1976, "malpractice insurance profits, without considering reserves for unreported claims, had risen to 20.1 percent, as contrasted to industry-wide profits on all lines [of insurance] of 4.3 percent."

Perhaps the most damning evidence of the complicity of insurance commissioners in this con game is presented by Law and Polan. 1975 was the prime year of the malpractice insurance crisis in the United States, with companies demanding—and getting—massive rate increases because of claimed losses. So in December of 1976 a committee of the National Association of Insurance Commissioners met to consider a report prepared by its staff on the profitability of each line of insurance in each state.

The report disclosed the explosive information that malpractice insurance, in the year of the industry's "crisis," was, on the whole, a *profitable* line for the industry. While the operating profit (which measures income from premiums and investments against losses, expenses, and taxes) for all lines of insurance had been 1 percent in 1975, for malpractice insurance it had been 9 percent. . . . Most of the state commissioners who make up the association had previously accepted the industry's position that malpractice was a losing proposition and had, accordingly, approved substantial rate increases for both 1975 and 1976. Hence, disclosure of this information could prove a source of great embarassment. . . . The committee voted not to release the report, though many state departments were then considering 1977 premium requests.

But what else can you expect when the main purpose of state regulation of insurance "has been to prevent insolvency," Law and Polan claim? "Prior approval of rates, for example, is not intended to keep premiums low, but rather to assure that companies will be able to meet all future policy obligations." But the insurance companies have gone far beyond mere solvency in setting malpractice premium rates, if the detailed calculations of income, expenses, and losses presented by Guinther are anywhere near the mark: According to his figures, in the period 1970-76 inclusive, "the *industry profits . . . reached over $1 billion* . . . or almost 30 percent on premium income compared to the 5 percent profit margin the industry itself says it tries to maintain."

If the potential for this massive hoax existed all along, why did the insurance industry wait until the mid-1970s to perpetrate it? The precipitous stock market decline of 1973-74 is the answer Guinther gives. Insurance companies routinely invested their legal reserves in the market. As long as the Dow Jones Index continued to climb during the late 1960s and early 1970s, this practice produced substantial profits in the way of capital gains and dividends. Many companies tried to "buy" business—to get more premium income they could invest—because any underwriting losses would be more than made up by market gains.

Then the bubble burst. The Dow fell from over 1,000 in 1972 to the low 800s in early 1974 to a bottom of 607 in the third quarter of that year. As Guinther relates:

In 1974 the combination of rising claims and inflation caused casualty underwriting losses estimated at $1.8 billion, a situation made desperate by the fact that the stock market losses for that year alone reached $3.3 billion. As a result, the insurers began to sell off their stock holdings for whatever they could get in an effort to achieve cash balances for their upcoming annual statements, in that way hopefully keeping stockholders unaware of the real size of the losses that were being sustained. Unfortunately for them, the largest scale selling occurred at the very bottom of the market...

It was during the year that the stock market crisis was at its worst that malpractice premium income rose from $500 million to $1 billion, and in the year following climbed another $500 million. Was there a connection? . . .

There was one malpractice insurer that didn't ask for big rate increases between 1974 and 1976. . . . The lone holdout. . . , the only company that writes only malpractice and the only company to admit it makes a profit doing so. . . , had conservative investment policies and therefore took no bath in the stock market and had no losses it had to recoup. . . . In short, the gamblers, having dissipated their money, demanded that the people who had given them the money in the first place now not only make good their losses but guarantee them a profit in the future.

"But if the state had not ordained what these doctors have been taught, the marketplace would provide quality control."

As a result, insurance commissions approved unwarranted rate increases and state legislatures changed laws to meet the insurance industry's demands. "Between 1974 and 1976," Guinther asserts, "publicity caused legislators across the land to enact laws based on false and misleading statistics, which eroded citizens' rights by responding to insurance company profit priorities and to the medical establishment's factually unfounded assertion that the only way to solve the crisis was to make it difficult for people to sue and limit the amounts of money they could win."

These authors perceive the true nature of state regulation (or self-regulation within a state-endorsed monopoly) well enough to cite the many examples given above. But somehow this doesn't stop either Guinther on the one hand or Law and Polan on the other from offering more state regulation as a solution to the malpractice mess.

Guinther is less offensive, since he also presents a few procedural suggestions that might be useful: offering both nonbinding arbitration and "free medical evaluations" in malpractice cases (both paid for with public funds, but undoubtedly saving more than court expenses would otherwise cost), and having the attorney's contingency fee added on to the jury award (so that the jury won't have to distort the award by guessing at what arrangement the plaintiff and his or her counsel may have made). But he also proposes offering malpractice insurance at the same flat rate to all doctors, written by one national company operating under federal guidelines.

Law and Polan, typical of corporate liberals, give us cures more deadly than the disease. To them, at the "heart of the malpractice problem is the fact that many patients receive care from doctors and hospitals that is well below any reasonable standard." Their "plain answer" is that "more rational controls must be exercised over who can practice medicine, where they can practice, what specialty procedures they can perform, and how they will be paid." Why do they feel such drastic strictures are necessary? Because "the incentives provided by the existing market are destructive ones. It is not reasonable to assume that professional self-regulation will run counter to these market incentives. Laws that attempt to regulate the excesses of fee-for-service medicine without addressing the root causes of the problem are likely to produce bureaucracy and regulatory red tape that are both ineffective and oppressive."

With a few small changes in wording, any libertarian

could agree with that last explanation. Of course, Law and Polan have different "root causes" in mind than we do. Yes, it is true that many physicians place themselves above criticism—not only by their patients, but also by their peers. But this godlike posture comes not from anything inherently wrong in fee-for-service medicine itself, but rather from the fact that doctors, like judges, have been given nearly irrevocable, lifetime sinecures by the state. They are left accountable to no one but themselves. But if the state had not ordained as the one true medicine the methodology these doctors have been taught, barring all others, the marketplace would provide quality control: Our only yardstick would be the results a doctor achieved, not the fact that he had been mystically sanctioned by the state. The recent appearance of local "consumer guides" to doctors is a first step away from state-sanctioned monopoly, a trend that is bound to grow in impact.

Law and Polan offer nothing better regarding the insurance industry. They claim that

> although the malpractice "crisis" was precipitated by the actions of the insurance industry, the only legislative response on the insurance area has been to fashion immediate solutions to availability problems, rather than to address the underlying regulatory void which the crisis made apparent. Regulatory reform is absolutely essential, not merely as a response to the demonstrated excesses of a few malpractice carriers, but because the entire insurance industry has taken extreme advantage of the abysmal regulatory job done in the majority of states. . . . Some, if not all, insurance regulation must be transferred to the federal level.

Unlike Lander, who can accurately describe an elephant but doesn't seem to know the *word* "elephant," Law and Polan give us a slightly distorted view of the same elephant and then call it rhinoceros. Although they have carefully shown how regulation, for medicine and insurance, is controlled from within the industry and benefits only the industry itself, they fail to understand that this condition *necessarily* follows from all imposed regulation, under any guise. And *that* is the malady of which the malpractice crisis is only one symptom among thousands.

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Readings from a Christian genie

JOANN ROTHBARD

The Joyful Christian *by C.S. Lewis. Macmillan, 235 pp., $7.95.*

IN THESE DAYS OF Moonies and Hare Krishnas it is rare to find an intelligent religious work, and in these times of charismatics, both Catholic and Protestant, it is uncommon to find an intelligent Christian. C.S. Lewis, who died fifteen years ago, was certainly a Christian and definitely intelligent. And not only that: He was sensible and wrote beautifully.

C.S. Lewis was a scholar. He taught Medieval and Renaissance English literature for thirty years at Oxford, and then became a Professor at Cambridge University for the last nine years of his life. Beside the several works he wrote in this field, he was a prolific writer in other areas: theology, children's books and science fiction. Strangely there are people who are fans of one kind of his writing and unaware of the rest. *The Chronicles of Narnia* are seven books for children. *The Space Trilogy,* of course, is three books of science fiction. Probably his most well known religious book is *The Screwtape Letters,* letters from an old devil to a neophyte devil on how to woo Christians from their belief.

The Joyful Christian is not a book written by Lewis, but a compilation (by William Griffin) of 127 readings of Lewis, from 17 books. The selections are short; typically about two pages, but a few are longer or as short as half a page. They are arranged by topic, with all of the pieces on miracles in one section, all the pieces on prayer in another. Even if one has read some of the books from which this assortment is taken, it is useful, because of the careful selection and arrangement. There is also a bibliography of Lewis's works in the back of the book.

"Joyful" is an appropriate word to use in any book of C.S. Lewis, for the word "joy" was important in his life. When Lewis was a child he first experienced "joy", a a feeling of longing for he-knew-not-what: *Sehnsucht.* Joy was not something he could summon up; it came rarely and unexpectedly. During his teenage years, when he was an atheist, he associated joy with a feeling for Norse mythology and for the music that Wagner composed for the "Ring of the Nibelungen", based on that mythology. Finally, in his early thirties, when Lewis was converted to theism and then Christianity, he found joy lodged in religion. He called his autobiography *Surprised by Joy.* In his late middle age, he married a woman named Joy, who died shortly thereafter.

One often hears from atheists that Jesus may not have been the Son of God, but was certainly a wise man, like Buddha and Mohammed, whose moral teachings the world should heed for its own good. Lewis, on the other hand, points out many instances of Jesus's saying things such as: "I am the Anointed, the Son of the uncreated God, and you shall see Me appearing at the end of all history as the judge of the Universe," or "I am begotten of the One God, before Abraham was, I am." Lewis concludes from this:

> On the one side, clear, definite moral teaching. On the other, claims which, if not true, are those of a megalomaniac, compared with whom Hitler was the most sane and humble of men. There is no halfway house and there is no parallel in other religions. If you had gone to Buddha and asked him, "Are you the son of Brahma?" he would have said, "My son, you are still in the vale of illusion." If you had gone to Socrates and asked, "Are you Zeus?" he would have laughed at you. If you had gone to Mohammed and asked, "Are you Allah?", he would first have rent his clothes and then cut your head off. If you had asked Confucius, "Are you Heaven?" I think he would probably have replied, "Remarks which are not in accordance with nature are in bad taste." The idea of a great moral teacher saying what Christ said is out of the question. In my opinion, the only person who can say that sort of thing is either God or a complete lunatic . . .
>
> We may note in passing that He was never regarded as a mere moral teacher. He did not produce that effect on any of the people who actually met Him. He produced mainly three effects—Hatred-Terror-Adoration. There was no trace of people expressing mild approval.

Lewis also gave short shrift to Christians who profess the faith but stick at the Virgin Birth. "I can understand the man who denies miracles altogether, but what is one to make of people who will believe in other miracles and 'draw the line' at the Virgin Birth? . . . In reality the Miracle is no less, and no more, surprising than any others." He considers that God had his hand in every conception of man and of animals, and in this case, He took off his glove, so to speak.

Lewis has a similar view of other miracles of fertility, such as the conversion of water into wine, and the miracles of the loaves and fishes. God makes all wine from water, but "Once, and in one year only, God, now