sibility of women students had elicited a special set of arguments—physical weakness, threats to feminine modesty, and the danger of improprieties of deportment in the classroom. The regents had induced members of the medical faculty to yield by granting them an additional $500 salary for teaching women and by agreeing to segregate the anatomy class. (Seventy-five years later Harvard-Radcliffe mathematics classes remained separate, after all others had merged, for a different reason—that women would be unable to compete.) The first woman to earn a medical degree at Michigan graduated with honors, but at commencement "she was hooted and showered with abusive notes" from male undergraduates.

Such episodes were the exception. Women were soon taken for granted on the campus, in the classroom, and in the non-university rooming houses where, as a matter of course, men and women lived in adjacent rooms and used the same plumbing much as they do today in the newly liberated coeducational dormitories. Nevertheless the case for women in higher education had to be made again and again as the opposition coalesced around new arguments. Initially it seemed enough to say that women were intellectually inferior. While their scholastic records quickly demonstrated the fallacy of this thesis, another argument, the danger of intellectual activity to delicate feminine health, was mobilized in a widely read book, *Sex and Education, or a Fair Chance for Girls*, by a Massachusetts physician, Edward H. Clarke. Again, administrators produced ample evidence that college women were on the whole less prone to physical and nervous disorders than their less intellectual contemporaries, but opponents of higher education were soon citing later marriages and smaller families among women college graduates to show that education inhibited breeding capacity, an argument that acquired special overtones for turn-of-the-century Americans as they observed the flood of southern European immigrants with large families.

But the most telling factor in the reaction against higher education for women that set in around 1900 was probably the very enthusiasm with which women had seized upon the expanding opportunities of the preceding decades. At Michigan in 1899, women received 53 percent of the Bachelor of Arts degrees, a phenomenon that frightened its male alumni as it did those of other institutions where the same trend was evident. Between the founding of Pembroke College at Brown University in 1891 and the 1950's, McGuigan points out, no additional all-male universities let down the bars.

The book, of course, has its heroines. Lucinda Stone, whose own college aspirations, never fulfilled, had been ridiculed in her native Vermont, taught in the University of Michigan's preparatory school in Kalamazoo and well knew the frustration of bright girls who could go no further. It was she as much as anyone who stimulated sufficient interest among the Michigan regents to effect the admission of women in 1870. And there were the students themselves, quietly courageous pioneers among whom were Alice Freeman Palmer, later president of Wellesley, and Dr. Alice Hamilton. There are heroes in the story too, notably James Burrill Angell, who assumed the presidency of the university in 1871 and with his wife befriended their fellow newcomers, the women students. In 1904 his son James Rowland Angell, professor of psychology at the University of Chicago, wrote a strong defense of coeducation as the reaction against it picked up momentum.

What happened in the next 50 years is summed up in a few pages with the apt title "Revolution in slow motion." The stocktaking in the final chapter, based on the wisdom and experience of Michigan's highly successful Center for Continuing Education of Women, effectively generalizes the situation for educated women in the present day. This book is an excellent introduction to the subject of women's current status in academia.

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The Poor State of Health

The American Health Empire. Power, Profits, and Politics. BARBARA and JOHN EHRENREICH. Random House, New York, 1971. viii, 280 pp. $7.95. A Health-PAC Book.

The Quality of Mercy. A Report on the Critical Condition of Hospital and Medical Care in America. SELIG GREENBERG. Atheneum, New York, 1971. xx, 388 pp., illus. $6.95.

The President of the United States has told us that our medical system faces a "massive crisis," and medical commentators can enumerate profound problems the way youngsters can recite batting averages. Several bills have been introduced in the Congress, the various forces and interests are aligning themselves, and the stage is being set for what appears to be a major political confrontation that will bring forth much rhetoric in the next few years. It is already apparent that the dominant theme in the debate—whatever the suggested legislative resolutions—is the steep, uncontrolled rise in health care costs, particularly hospital costs. Among the many subsidiary themes are the need for an adequate system of primary care, the health problems of the poor, the inadequate distribution of health manpower and facilities, and poor quality control. It is the cost factor that brings together such diverse forces as labor unions and employers, who bargain over the health benefit package; government, both state and federal, which pays two-fifths of health care expenditures and is increasingly anxious about open-ended commitments; the large providers of health care and the medical schools, which seek better financing; and the middle class, which has been paying higher prices for increasingly impersonal services as new public programs reinforce the seller's market. Whatever the merits of Medicare and Medicaid, they impressively illustrate that to increase investments in health care substantially without altering the framework in which services are delivered will only exacerbate the inefficiencies and absurdities of the current organization of medical care in America.

It serves us well to consider what people expect from the health care system, which is not necessarily what the providers wish to offer. Most basically, people seek to have a personal physician or a comparable source of care readily accessible and reasonably convenient to use. They want and ex-

pect their care to be competent, but they are equally concerned that those who provide it have an interest in them as people. They expect also that an adequate system of more specialized services will exist, should they need them, and that the price of these services will not threaten them economically. Implicit in the provision of such care are adequate manpower and facilities properly distributed—not only socially and geographically but among the various medical and other health functions—and fitted in some reasonable way to the needs of people. Similarly, such care must be so organized that it is reasonably accessible to those who are worried, ill, or otherwise in need, and sufficiently interconnected with other services that continuity and comprehensiveness can be achieved. How best to provide such services for all to a reasonable degree within realistic economic limits is the most basic issue our health care system faces.

As public debate deepens we can expect an outpouring of popular books on the subject. Barbara and John Ehrenreich have prepared a volume representing the efforts at analysis of some ten full-time people at the Health Policy Advisory Center, a group that views itself as part of the health care movement seeking radical social change in American institutions. Selig Greenberg, a medical journalist and liberal commentator on health affairs, has distilled the innumerable difficulties, dilemmas, and suggestions for reform in an intelligent and readable book that presents the judgments of active participants and various experts in health care. With all due credit to Greenberg's passionate and sensitive journalistic account, it is perhaps inevitable that what results from merging the experiences and viewpoints of involved persons is an assemblage of truths, half-truths, and assorted fictions. It is unfortunate that in the field of medical care glib commentary substitutes frequently for serious analysis of the problems and the collection of data that might help resolve them. Thus, although Greenberg's book provides the reader with a sense of the profound difficulties and a view of needed reforms, he makes no serious effort to sort out the contradictory diagnoses and suggestions for reform so characteristic of the national discussion of our health care system. The result is perhaps an increase in one's adrenalin level, but no clear conception of how to tackle the medical, moral, organizational, and political dilemmas we face.

The Health-PAC book, although probably offensive to health professionals and more limited in the scope of problems it deals with and in the detail it presents, is a more serious attempt at a coherent analysis of core problems in the delivery of health care services. The book has so many shortcomings that it would be easy to reject the issues it raises; it abounds in simplistic statements, generalization by anecdote, and a tendency to take whatever position fits its polemical argument at any moment. It depicts the large, eminent voluntary hospitals of New York City as an enemy, and is unrelenting in uncovering their evils, conceding to them no virtues at all. It poses research and teaching as villains, and although in more sober moments it points out that these functions have some merit in their place, it evinces little sympathy for the special problems characteristic of medical research and teaching. If, however, one can persevere in the face of these impediments —and I must admit that at times it is difficult—one will find that the book does raise issues and points of view that are not characteristic of the liberal dialogue and significant questions not typically raised in the national debate.

It is the contention of the Health-PAC authors that under present arrangements health care is only a by-product of profits, research, and training, and that the only way to change our health system fundamentally is to make it completely public and place it under community control. They contend that the system has taken on a highly organized, institutionalized, and centralized character which interconnects and serves major health financing institutions, government, and the health commodities and equipment industry. They argue that medical empires, and particularly those in New York City and other major urban centers, grow not out of necessity but rather to protect existing interests and maintain status and prestige. The growth of medical technology and research, and even education, is visualized not as an improvement in the potentialities for service but as devices supporting the industrial complex and profit making. The poor, in their view, are used and misused to serve research and teaching interests, and get appalling treatment that reflects not only the pathology of health institutions but our misguided priorities and social institutions generally. They contend that

> National health insurance will fail because it fails to face the fundamental questions about our health system—control, accountability, accessibilty, priorities, responsibility to the community.

The Health-PAC group raises some important questions, but the solutions it proposes hardly offer serious remedies to any of our major problems. Although such mechanisms as nationalization, community control, the elimination of hierarchical authority, and shared decision making may well be worthy of discussion, they are presented here in the form of slogans and dogma rather than as a part of a serious examination of the implementation of change. The fact is that medical care systems around the world, regardless of the ideologies on which they are based, face many of the same problems and dilemmas and appear to be responding in similar ways, which reflect the nature of the human dilemmas brought about by growing knowledge and technology and changing social expectations. This is not to suggest that technology should command the direction of future growth independent of human priorities and social values. Indeed, American medicine can be characterized by the unrestrained growth of technology unshaped by assessments of relative social need. It is quite proper, indeed mandatory, that we ask ourselves why we have invested so much in hyperbaric chambers and heart transplantation, developing and duplicating these facilities beyond any reasonable requirements, and so little in preventing infant mortality, lead poisoning, and a variety of other common pathologies. Perhaps the answers are not so simple as the Health-PAC group would like to believe, but there is too much substance in what they say about this and other matters to dismiss them as a "bunch of radicals."

The Health-PAC group is quite right in arguing that our health care problems, and particularly those of the poor, are the product of the larger sociopolitical context. As long as these problems are regarded as nothing more than maladjustments in what is basically a sound system from a structural point of view—and this is the position of the current administration—then it is unlikely that we shall see many signifi-

cant improvements. It should be abundantly clear that the poor, the group with the most profound health problems, are not a sufficiently powerful interest group to compete effectively in the establishment of priorities or in the distribution of available facilities, manpower, and services. Moreover, the problems of health care are only one part of a more complex pattern of social, economic, and environmental difficulties. The health care needs of the poor can begin to be met within a larger and more basic reconstruction of health care that insures access to medical care for all and establishes guaranteed levels of health service irrespective of social status or geographic location. The word "guaranteed" is not used casually, for to promise service without taking steps to put manpower and facilities into underserviced areas is to insure nothing at all. And effecting such policies would require efforts beyond anything as yet suggested.

It serves us well to recognize openly that an underlying issue in the medical care debate involves some redistribution of utilities. The reallocation of scarce medical resources inevitably entails taking from some to give to others, and the givers do not yield willingly, particularly when their share is not also growing. Medical care is a matter that few people take lightly and, given the inadequacy of present manpower, the irrationality of the allocation of health functions, the difficulties of geographic distribution, and the strength of vested interests, it is difficult to see how greater balance can be achieved without government's imposing firmer direction on the training of health personnel, its allocation among varying functions, and its distribution throughout the nation. In reviewing the President's proposed health strategy, not only is it difficult to find strong incentives for major change but it also seems likely that the poor in the wealthier states will receive smaller benefits than they now have. Moreover, there is no clear mechanism even to control costs, which give every indication of continuing to soar. What the President's proposals appear to do is shift the burdens and uncertainties to employer and employee, and probably to some of the poor as well.

Although it is obvious that the shape and intensity of our attempts to alter the structure of health care must be fought in the political arena, it should be equally plain that however we resolve the structural and economic organization of medicine, innumerable personal, moral, and social dilemmas will persist. How does one weigh the relative merits of delivering the care we now know how to give against the need to develop and enlarge basic knowledge and interventions? How do we cope with the moral meanings of life and death relative to the growing numbers of persons whose lives are sustained in name alone? How do we encourage personal responsibility for and consciousness of health without running the risk of increasing the prevalence of hypochondriasis? How do we achieve a reasonable balance between growing technology and the need to deal with the more pervasive and common troubles that people bring to doctors? Perhaps most important, how do we develop a tighter, more efficient system of delivering health services without frustrating the essential personal and social elements of medicine as a humane institution?

In the last analysis, resources are limited and we cannot have the best of all possible worlds. We must make difficult choices for which we often lack the knowledge or the judgment to foresee what the future will hold. That we as a nation are not facing up to such choices is apparent for all to see; and for the most part we have let the resolution of our problems depend on the active clash of dominant interests. It is perfectly clear that the resolutions arrived at in this way penalize the poor and the powerless, and the consequences of this are pervasive. It is my view that the nation can and must assure at the very minimum that access to basic health services is available to all, and that necessary manpower and facilities are developed and distributed so that this goal is feasible. The enactment of even this modest outcome will threaten some and will require public action which is far from implementation at the present time. It will necessitate changes in federal financing, in medical education, in licensing and other legal aspects, the use of paraprofessionals, and even some restrictions on professional prerogatives. Such minimal services, adequately distributed, have been available elsewhere in the world and under social and economic conditions posing far greater pressures on national resources. We have the capacity to do this without threatening the overall quality of care, the integrity of medical education, or the potentialities for continued innovation in research and development. If we do not have the will or the inclination to take on the vested interests that will resist, perhaps the radicals will turn out to be right after all.

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Laws and Morals

Marijuana—The New Prohibition. JOHN KAPLAN. World, New York, 1970. xii, 388 pp. $8.50.

Some months ago, the Surgeon General of the United States escalated his warnings to the American public regarding the dangers of cigarette smoking. He even suggested that a society sincerely interested in public health ought to prohibit cigarette smoking in crowded public places, in order to protect nonsmokers from discomfiture and possible (though unproven) risk of lung injury and as a means of emphasizing its opposition to the cigarette habit. Predictably, this proposal was greeted with cries of outrage from all points on the political spectrum. Common objections were that there was no proven medical justification for such a prohibition and that laws imposing direct controls on private vices were undesirable. The supreme courts of Illinois and Kentucky expressed the same objections in 1911 and 1914 respectively when confronted with local ordinances prohibiting cigarette smoking in public.

Needless to say, there is today no such uniformity of opinion on the inadvisability of criminal sanctions against the use and sale of marijuana. Until the last two or three years, in fact, legislative, judicial, and public opinion was uniformly allied in favor of severe criminal sanctions against the "killer weed," a condition that has prevailed since the 1920's and 1930's, when antimarijuana laws first appeared on the statute books. Now, however, it