the gutter, not narcotized past the point of coping with daily problems, and not compelled to steal. Others point out that, while antagonists as presently administered will not stop those who want to use heroin, they can help prevent the impulse "fix," which may be of particular help to the adolescent in resisting peer-group pressure to use drugs.

Antagonists are not the solution to the drug problem. But since the problem seems unlikely to go away, the antagonists, as is true of other methods, can play a potentially important role in treatment. They can be, as one addict put it, "like having a friend in your pocket."—ALLEN L. HAMMOND

Health Radicals: Crusade to Shift Medical Power to the People

Not long ago, critics of health care in America routinely blamed everything that was wrong with medicine in America on the American Medical Association. Liberal doctors and others would rhetorically agonize over the AMA's artificial maintenance of physician scarcity, its exclusion of minorities, and its preoccupation with large profits. The government's inattention to many of the glaring inequities in medical service was frequently blamed on the AMA's well-heeled lobbying efforts.

While the AMA is still the object of great scorn, from many directions, the elevation of health care to the stature of a full-blown national crisis has left the doctors' organization just one of the many combatants in the current free-for-all over health care. The now familiar and depressing statistics detailing American infant mortality, distribution of services, rising medical costs, and declining life expectancy (which were once offered by the liberals as evidence against the AMA) are now listed by both the Nixon Administration and Senator Kennedy as reasons for enacting their particular national health insurance plan. Indeed, countless politicians and special-interest groups have their own ideas of what needs to be done about health care in America, and most of them are talking in terms of vaster reforms than bringing to its knees an AMA that now counts fewer than half of the nation's doctors in its membership.

Among the more notable forces emerging in the health care battle of the 1970's is a coalition of radical professionals, students, health workers, and community activists, which might be called, for lack of a better term, the radical health movement. Its members range from vaguely dissatisfied doctors and medical students to committed revolutionaries, and, until now, no organization on the national level has represented the movement. Last month, however, the Medical Committee for Human Rights (MCHR), a 7-year-old organization with some 20,000 members in 40 local chapters across the country, embarked on a "National Health Crusade" in the hope of providing the movement with a national focus.

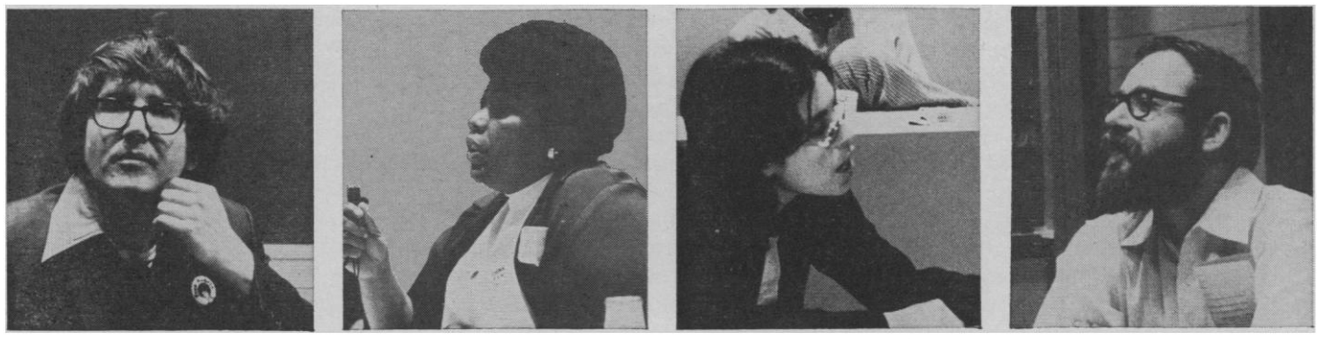
Begun as a group of mostly young, white, male doctors who offered money and medical assistance to the civil rights movement—its members provided aid, for example, on the long march from Selma to Montgomery—MCHR at first abstained from any direct political involvement, fearing such activities would compromise its professional influence. Eventually, however, the organization evolved first into "the voice of humanist medicine" that spoke out from time to time against the AMA and then into a more radical group whose members, particularly at the local level, carried out a wide range of activities from the staffing of community controlled free clinics to confrontations with established health care institutions. Each new step of political advocacy taken by MCHR has led to the attrition of some of the doctor-members who thought the action to be "unprofessional," with the result that MCHR now consists largely of house staff, medical students, and young middle-level health professionals such as nurses and laboratory technicians. And in its current national crusade MCHR hopes to recruit an increasing percentage of nonprofessional health care critics.

"What we're trying to do in the health crusade," Quentin Young, a Chicago internist and the organization's director told *Science*, "is show the ubiquity of the health care problem—so that the coal miner in Appalachia and the slum resident in a big city can see that their health problems have a common origin." According to a recent pamphlet, MCHR will "Begin educational programs in schools, neighborhoods, unions and hospitals; conduct letter writing campaigns; collect petitions; and go to radio, television and the press in our fight."

Unlike the politicians who seek to reform the health care system with plans for national insurance, health radicals challenge many of the basic assumptions underlying American medicine. The radicals seek primarily to give the recipient of health care a voice in controlling the institutions that deliver health care. This in turn has implications for the nature of professionalism, the uses of technology, and the distribution of social and economic power. Although for the most part the health radicals are aiming peashooters at well-entrenched fortresses of political strength, they've already exerted influence far out of proportion to their numbers. Typically, the radicals heap equal scorn on the private practitioners and their AMA, the more liberal hospital- and university-based physicians, as well as almost every other element in the established health care system. In the words of the staff of the Health Policy Advisory Committee (Health–PAC), a group which has offered a good deal of analysis in support of the radical health movement:*

> Traditionally, liberals have explained that America is not a healthy place to live, in either a medical or a social sense, simply because health and other social services are low priority items in a nation whose resources are committed to military and economic expansion. "If only we could spend all the money we spend in Viet Nam on hospitals, housing, schools . . ." goes the refrain.
>
> So we have reasoned. But on looking

* This quote is from Health–PAC's book *The American Health Empire: Power Profits and Politics* (Random House, New York, 1970). The organization also publishes a monthly bulletin. Subscriptions are $7 per year, from Health–PAC, 17 Murray Street, New York 10007.



Some of MCHR's leaders (from left to right): Quentin Young, Chicago internist, national chairman; Ann Garland, Philadelphia nurse, national treasurer; Bern Weiss, Philadelphia social worker, staff director; Eli Messenger, New York psychiatrist, last year's national chairman.

closer, we begin to understand that national priorities are only part of the problem, perhaps the more manageable part. Billions of dollars could be diverted from America's aggressive, defensive, and interplanetary enterprises with no appreciable effect on the quality of health care. For even within the institutions that make up America's health system—hospitals, doctors, medical schools, drug companies, health insurance companies—health does not make the top priority. Health is no more the top priority of the American health industry than safe, cheap, efficient, pollution-free transportation is a priority of the automobile industry. The victims, then, are not just the poor, the blacks, the Puerto Ricans, who cannot afford to buy what the health industry is selling, but also millions of middle-class and working-class people who try to extract health services from the health industry.

The priorities are misplaced, say the radicals, because profit, power, or personal aggrandizement take precedence over the prevention of illness. Doctors, they say, guard their professional knowledge as though it were an arcane ritual, leaving the patient mystified, confused, and dependent on the seemingly omnipotent doctor. Hospitals are accused of investing in fashionable and expensive equipment or complicated but questionable procedures, such as heart transplants, when allocation of the same resources for preventative medicine and less academically interesting treatments could save more lives. Society's social inequities, the radicals claim, are reflected in the health establishment's treatment of women and minority groups, both as workers and as patients.

Even Kennedy and Nixon have pointed out the emphasis on treatment over prevention of disease. But while Nixon advocates a massive extension of private health insurance and Kennedy would accelerate the concentration of medical power in the huge university-based medical centers, the radicals offer a different solution: demystification of the medical art and direct control of health institutions by health workers and the people they serve.

Some MCHR members have authored their own health insurance plan, which may soon be introduced as legislation by a sympathetic congressman. Any national health plan, says a recently issued MCHR leaflet, must:

1) End profit-making in health care. Health care is a service, not a business.
2) Pay for all services with a progressive tax on total wealth. One without loopholes that makes corporations and the rich pay their share.
3) Provide complete and preventative health care with no charges for health services.
4) Administer medical centers locally through representatives of patients and workers.
5) Create a federal non-profit corporation to produce and distribute drugs and medical supplies.

Such sentiments mark a significant shift in the character of MCHR, where the conflict between professionalism and political advocacy has made the organization's steady movement to the left a continuously painful process. This is particularly evident in the group's medical support at political demonstrations, which began during the civil rights movement. Until recently MCHR's instructions to its volunteers declared, "If you must demonstrate, remove your indentifying garments," thus maintaining a clear distinction between medics and demonstrators.

Termed "medical presence," the idea of providing aid to demonstrators under the guise of neutrality was continued for many years as one of MCHR's primary functions, even as the focus of the demonstrations switched from civil rights to the war. Nowadays, young, long-haired medics, often wearing motorcycle helmets and laboratory coats with the initials MCHR on their sleeves, have become a familiar sight at antiwar demonstrations. But recently, some MCHR members have advocated a shift in the rationale for their presence.

Writing in the newsletter of the New York chapter, Ann Hirschman, a nurse and an MCHR regional representative, said that although health schools today still maintain the attitude of "neutrality, professionalism, and cooperation with civil authority, we have come to realize that there can be no neutrality or equality in an unequal, oppressive system, and we have 'taken sides' with the community we serve against this system. We must," she concluded, "take our stand first as participants in the struggles that will be taking place against war and oppression, and then use our skills and share our skills if they are needed."

Quite apart from such changes in philosophy, MCHR volunteers have experienced increasing difficulty at demonstrations, even when they wished to remain neutral. During the 1968 Democratic convention in Chicago, MCHR members set up extensive first-aid facilities in anticipation of treating bad drug trips and cases of diarrhea in the thousands of youths who converged on the city. Instead, they treated hundreds of people for injuries from police clubs, tear gas, and Mace. They were rewarded with split skulls for many of their own members and, ultimately, a subpoena to appear before the House Un-American Activities Committee. "The demonstrators must have come looking for trouble," reasoned Mayor Richard Daley. "Why else would they have brought their own medics?" At the antiwar demonstrations in Washington this past May, many MCHR medics were rounded up and arrested, along with almost everyone else in the streets.

The debate in MCHR over the proper political role of professionals has not been confined to tactics during street demonstrations. During their annual national conventions in 1965 and 1966, MCHR members refused to take a public stand in opposition to the war in Viet Nam, not because they favored the war, but because they feared such a pronouncement would compromise their professional integrity. The following year the organization did embark on a course of antiwar activities, but these too led to conflicts.

For a number of years, MCHR doctors conducted physical examinations for young men threatened with the draft, with the result that many of them avoided conscription. In the Los Angeles area, MCHR has participated with lawyers and other doctors in an organized network that offers physical examinations and legal counseling for draft-eligible men, a practice that has aroused the interest of a Los Angeles federal grand jury which doubtless suspects some of the examinations to be fraudulent. In addition to the grand jury's interest, the practice has attracted the wrath of many of the MCHR's more radical members, who charge that it tends to be available predominantly to white, middle-class men, thus leaving those without access to a liberal doctor or lawyer open to induction. Replying to these charges, a member of the Los Angeles chapter said, "There are thousands of young men, hundreds of them black and brown, who are free and not in the Army, prison, or Canada because of our draftee examining panels."

Organizing the Military Medics

Nevertheless, at their last national convention, MCHR members voted to concentrate their antiwar activities on health workers who are inducted into the military. To this end, MCHR opened an office near Fort Sam Houston, Texas, to organize some of the several thousand health workers who are scheduled for induction this summer. One of those involved in this particular project is Howard Levy, a member of both Health-PAC and the MCHR staff, whose own refusal to train Green Beret medics resulted in a 3-year jail sentence.

The health establishment, as opposed to the military establishment, however, remains the prime target of MCHR. Although for years MCHR, as a national organization, has done little besides hold meetings and issue occasional pronouncements, MCHR members in the local chapters have been associated with a good many challenges to established health institutions. Many of the young interns and residents involved in the much-publicized confrontation between the Puerto Rican community and the Albert Einstein Medical School (over control of Lincoln Hospital in the Bronx) were members of the organization. In Chicago, the Northwestern Health Collective, a group that includes many MCHR members, recently passed out handbills to patients in Cook County Hospital, advising them of their "rights." "The doctor and the hospital," begins the pamphlet, "are *not* doing you a favor to see you." The handbill then lists the patient's rights, such as informed consent, confidentiality, and privacy, along with a number of questions the patient might ask the doctor, such as: "Is this treatment for my benefit or for research?"

Less likely to generate nightmares in hospital administrators are the projects of students from the University of Kentucky Medical School, who transport poor people to the available free medical services miles away, and a door-to-door screening program organized by Washington, D.C., chapter members, who check residents of some of the city's poorest neighborhoods for a variety of commonly undiagnosed disorders.

The diversity of these activities reflects a wide variation in the character of MCHR's local chapters. Some of the chapters do nothing. Others hold regular meetings, sponsor several simultaneous projects, and publish their own newsletters. Many of the newer chapters, particularly in small cities, are centered around medical schools and replace the now defunct Student Health Organization in advocating issues such as curriculum reform and increased minority admissions. The Los Angeles chapter consists primarily of private practitioners, while the Washington, D.C., chapter has been dominated by physicians working at the National Institutes of Health.

In opposing the health establishment, the radicals offer an alternative model—the community-based free clinics, where volunteer doctors treat free of charge anyone who walks in the door. A recent issue of MCHR's newspaper, *Health Rights News*,† listed over 150 free clinics across the country. "The free clinics are a model for community control, absence of fees, and innovations in preventative medicine," said *Health Rights News*. "Whatever health care looks like in the future will bear the strong stamp of the free clinic movement."

In the Washington, D.C., area there are two free clinics. One provides comprehensive care for thousands of families in the poor, black, Anacostia section. The other, in the basement of a church in the Georgetown section, serves primarily the young, white "street people" who congregate in that area. A clinic is held every weekday evening, and 20 to 50 people are seen every night at each of the clinics.

A visit to both clinics reveals an atmosphere strikingly different from that found in the usual clinic, doctor's office, or hospital. It is often impossible to tell the difference between the patients, the doctors and nurses, and the community volunteers, who perform tasks ranging from scrubbing the floor to taking records and assisting the doctors. The waiting rooms resemble more of a social gathering place than a clinical setting.

A Nonclinical Atmosphere

Even the "doctor-patient relationship" is often different. For example, Ava Wolfe, a pediatrician who works 1 day every 2 weeks at the Georgetown clinic, makes a concerted effort to explain and demonstrate to a child's parent everything she is doing during an examination. "The idea," she says, "is to get the parent to take an active part in the examination and the diagnosis. Patients have a right to know what is being done to them or to their children, and a very important aspect of preventative medicine is health education. Hopefully, people will learn more and more to keep themselves healthy."

Other free clinics exist for more specialized purposes, although in most cases the clinics are run by a representative board selected from the patient population and staffed through the local MCHR chapter. The 1012 House in Syracuse is one of several centers offering rap sessions and other forms of assistance to teenagers with emotional or drug problems. San Francisco MCHR members staff a mobile free clinic that offers care to residents of several of the rural communes in northern California. One day a week, the free clinic in Berkeley is run en-

† *Health Rights News* is MCHR's monthly publication detailing the activities of the health movement. Subscriptions are $3 per year, from MCHR, 710 South Marshfield, Chicago, Ill. 60612.

tirely by and for women. In some areas the free clinics, along with free stores and food buying cooperatives, represent an important aspect of the youth-oriented counter-culture. Some of the clinics remain apolitical while others have been organized by groups such as the Black Panther Party for distinctly political purposes.

For the most part, however, the free clinics are still an experiment on a small scale. With a few exceptions, such as the Anacostia clinic, which has become a major health facility, the free clinics lack access to the established medical resources and thus have no means of offering care beyond routine outpatient treatment. As Thomas Bodenheimer of the San Francisco MCHR chapter puts it, "A single free clinic, isolated in a ghetto neighborhood, is very limited. It needs linkages to hospitals, laboratories, x-rays, and other specialized services so that it can provide truly comprehensive care. In order to force institutions of the present health care system to provide such linkages and services to free clinics, these existing institutions must be changed."

Such aspirations form the basis of MCHR's campaign to push the national health system in the direction of a nonprofit, community-controlled enterprise. But MCHR's crusade is hardly likely to make health care in America become a gigantic free clinic, with salaried instead of volunteer doctors, in the near future.

For one thing, a very tiny percentage of the people concerned with revising health care in America would identify with the radicals. H. Jack Geiger, chairman of the Department of Community Health and Social Medicine at Tufts University, who, as the originator of some of the Office of Economic Opportunity's neighborhood health centers, qualifies as the archetypal medical liberal, launched a concerted attack against the radicals in an article in *Social Policy* (March/April 1971). Although admitting that some of the radical's criticisms come "painfully close to the truth," Geiger declared that some of the radicals' aspirations pose dilemmas such as "expertise versus elitism, professional morality versus political morality, human versus political priorities, and accountability and responsibility [which], threaten unwittingly to construct a professional model that incorporates and repeats the worst aspects of the current system and abandons the crucial gains of the past 60 years." Geiger said operating free clinics is "playing house, not responding to the real needs."

In an article responding to Geiger's criticisms, Howard Levy declared them to be "far from the truth." Yet, the validity of his allegations aside, Geiger's attitude indicates the extent of resistance to the notion of a radical restructuring of the medical profession—even among the more liberal physicians. This resistance is multiplied several times over among the rank and file of private practitioners. On two occasions when representatives of MCHR attempted to address annual AMA conventions, they were greeted with catcalls and hurled ashtrays.

In addition to the resistance within the medical profession, the radical health movement, like most other segments of the radical movement in America, is characterized by a variety of ideological splits. At the last national convention of MCHR, the delegates spent at least as much time accusing one another as they did in laying plans to challenge the health establishment. Furthermore, community control, which is the movement's main rallying cry, remains as much an abstract concept as a working model.

However, many of the radicals' ideas have doubtless plucked a responsive chord, for, as few politicians have failed to notice, Americans of almost every social and political persuasion are fed up with the health care they receive. It is just possible that they are fed up enough to demand more direct control over the technology and the technocrats whom they depend on for their good health.—ROBERT J. BAZELL

Lead Poisoning: Risks for Pencil Chewers?

In the 16th century, graphite replaced metallic lead as the main ingredient in pencil points, but the term "lead pencil" has persisted through the centuries. Although the term "lead" is a misnomer, recent tests, including one by the Department of Health, Education, and Welfare's Bureau of Community Environmental Management (BCEM), indicate that the paint covering the common wooden pencil might be yet another lead poison hazard.

In the BCEM study, completed in July, all the pencils tested were found to have paint with lead contents that could be hazardous. In one group of pencils —all of the same brand—the paint contained approximately 12 percent lead. The maximum amount of lead generally regarded as safe in paint is 1 percent. The actual weight of lead in each of the pencils in this group, the report said, was more than 47 milligrams. Pencils of this group were considered a "serious health hazard" for a pencil-chewing child who habitually ingested even a small portion of the pencil's painted surface.

The paint on the other pencils tested in the BCEM study—nine pencils were examined, two from three brands and three from a fourth brand—had, according to the report, lead contents that are "great enough to be hazardous for a child who is a habitual pencil chewer and [who] chips paint off relatively large areas—for example, a third or more of the total surface." The weight of lead in these pencils, the report said, ranged from 0.1146 to 1.037 milligrams.

Although the percentage of lead in the latter brands was below the safety standard of 1 percent, the project directors contend the tested pencils are still dangerous. The important consideration, according to Barry King, science adviser to BCEM and one of the project directors, is that the actual amount of lead (weight) is sufficient to induce lead poisoning. "Percent lead content of the paint," states the report, "is not, *per se*, a satisfactory criteria; the health hazard for a child ingesting a paint chip is related to the amount, specifically the weight, of the lead he ingests." The amounts of lead in all the pencils tested, King said, were high