1 MCHR:

AN ORGANIZATION IN SEARCH OF AN IDENTITY. What happened to the most important health organization on the Left.

30 Vital Signs
31 Peer Review

MCHR

The Medical Committee for Human Rights (MCHR) was on the Selma Bridge and at the Meredith March during the height of the 1960's civil rights movement. It attended to the injured during the Washington, D.C. urban riots and at the 1968 Democratic National Convention. It served the Black Panthers, Young Lords and other Third World organizations of the early 1970's. It was with women in support of abortion repeal, with welfare rightists fighting for supplemental food programs, with prisoners rebelling at Attica, with the National Liberation Front fighting to end the War in Vietnam, with hippies running free clinics and with workers struggling for occupational health and safety.

In short, MCHR was anywhere and everywhere there was movement in the decade from 1964 to 1974. There were, to be sure,
other health organizations that for shorter periods during that decade also played important roles. It is conceivable that in the long run some of them may prove to have been of greater historical importance. But as a reflection of the turmoil, conflict and contradictions of political movement in the past decade as it pertained to the health Left, only MCHR provides an adequate canvas on which to depict that period in the richness, color and tone required for accurate interpretation.

What follows represents an attempt at an analytic history of MCHR. It is our hope that this account will catalyze serious reflection, discussion and debate concerning the many issues confronted by the movement of the last decade, issues that promise to recur, albeit perhaps in different forms, in the movement of the coming decades. With this end in mind, we encourage readers to offer their responses—positive and negative—to the article. For its part, Health/PAC commits itself to publishing and distributing such comments in order to encourage continued and deepened debate and dialogue.

A word about our methodology: During the course of the last six months, the authors spoke with some 25 former and present MCHR activists. We make no claim that we touched all bases—a possibility precluded by exigencies of time and expense. We did, however, assiduously try to reach pivotal figures throughout the country who represented many differing shades of opinion and perspective about MCHR. The first draft of the article was submitted for comment to most of the people interviewed, as well as to selected MCHR members who had not been interviewed. We wish to thank such people for their helpful comments, many of which have been incorporated into what follows. In addition to these personal contacts, we perused organizational and personal files of MCHR members, with particular attention paid to the organization's early years. Readers will note that the article essentially concerns itself with the years 1964 to 1973, with only a superficial sweep given to the past two years. This orientation was motivated by our desire to have sufficient distance from the press of immediacy to enable us to be more reflective about the MCHR experience.

Finally, we note that the authors were both active in MCHR between the years 1969 and 1973. Given that personal involvement, we can make no claim to a detached impartiality. Clearly during our five years of activity we took and fought for positions within the organization, and many of those perspectives are reflected here. With time elapsed, however, we believe that we have been able to look critically at the limitations of our own as well as others' roles.

It will be obvious that MCHR suffered from many of the same unresolved theoretical and practical limitations as did the rest of the American Left. Further, its wane was coincident with that of the larger movement. This fact, however, provides scant solace or excuse for those concerned with building a viable radical movement. It is our contention that unless the shortcomings of the past are presented, understood, meditated upon and ultimately overcome, we can expect nothing but a repetition under new guises of the same errors that plagued us in the past and that still plague us. We realize that this runs contrary to a strong tendency pervading the American Left and having its roots in the character of American pragmatism: to forget or ignore the past and to turn optimistically to the future, vowing to "try harder next time." Nonetheless, it is our hope that such resistance can be surmounted and that at least the beginnings of such a process will be stimulated by what follows.

The Catalyst and the Context

One night in June, 1964 three civil rights workers were arrested for speeding in Neshoba County, Mississippi while investigating the burning of a Black church. The sheriff claimed to have released them shortly after their arrest. A month later their savagely beaten and mutilated bodies were found buried 18 feet under a clay dam. The names James Chaney, Michael Schwerner and Andrew Goodman flashed across television sets all over the country. Millions of Americans were shocked, angered and more determined than ever to complete the cru-
sade for which the young men had given their lives. Mississippi was to be liberated by exorcizing racism and hatred from its bowels.

The year was that of the Mississippi Summer Project or, as it became known, Freedom Summer. Though supported by a coalition of civil rights organizations including the Congress of Racial Equality (CORE), its phosphorescent guiding light, moral impetus and catalytic energy was provided by the Student Non-Violent Coordinating Committee (SNCC). The silent '50's were over as thousands of Americans, mostly students, trudged off to the front lines of Mississippi to be greeted by bombings, beatings, arrests, state troopers, ferocious dogs and sometimes death.

Up to this time the medical community had been mostly quiescent. There were, however, progressive medical organizations still functioning as holdovers from the Old Left of earlier eras. Despite their low energy levels, they represented latent forces for social commitment within the medical community and set the stage for MCHR’s emergence.

In New York City, the Physicians’ Forum held educational meetings, issued pronouncements on current issues and wrote legislative proposals that were almost invariably ignored by a Congress that with all deliberate speed was going nowhere. Not that members of Physicians’ Forum and similar organizations had never known struggle. Many had a history of political activity dating back to the Communist Party of the 1930’s; some had been on the front lines of the founding of the CIO; a few had been on the even tougher front lines of the Spanish Civil War fighting on the side of the Loyalists. They may in practice have accepted the 1950’s ideology of the end of ideology but, unlike their medical colleagues, they had been bitten and sensitized by the political bug. Their concern was heightened now by the fact that many had children who had gone South to join the fight for freedom and justice. With the killing of Chaney, Schwerner and Goodman, they, as well as similar groups in other cities, were galvanized into action.

Toward the mid-1960’s organizations sprang up within the medical community with a more explicit civil rights focus. In 1963, for example, a group of doctors, mostly from New York City, organized the Medical Committee for Civil Rights (MCCR) in response to the growing militance of the civil rights movement. Its first officers included John Holloman and Walter Lear, both destined to play central roles in MCHR. Other MCCR members later to join MCHR included Tom Levin, Aaron Wells, Charles Goodrich and Paul Cornely.

MCCR saw its role as challenging segregated medical facilities in the South and segregated local medical societies. In early June, 1963, MCCR wrote to the President of the American Medical Association (AMA) appealing for the "... termination of the racial exclusion policies of State and County Medical societies ... direct membership in the AMA [for] Negro physicians who are denied membership in their State and County medical societies ... opposition to the 'separate but equal' clause of the Hill-Burton
Act.” On June 20, following AMA inaction, 20 MCCR doctors, all wearing suits and ties, shocked the medical community by picketing the annual convention of the AMA in Atlantic City, New Jersey, in what MCCR described as a “dignified public protest.” Later that summer MCCR published its first newsletter, announcing its support for the upcoming March on Washington for Jobs and Freedom, which had been promoted by all the leading civil rights organizations. MCCR that year also testified before Congress in support of pending civil rights legislation.

Another group, albeit a nascent one, played a role in the genesis of MCHR. In the early 1960’s Tom Levin, a clinical psychologist in New York City, gathered together a mailing list of psychologists and social workers who had given money and support to the civil rights movement. The group, called the Committee of Conscience, became the first medically oriented group to make contact with the Southern-based civil rights movement when Levin went to Mississippi to obtain first-hand information about brutality against civil rights workers. The contacts Levin made, in particular with SNCC and CORE, later proved to be the direct link to MCHR.

In Los Angeles the Charles Drew Society had an ongoing concern with discrimination against Black doctors. In Chicago the Committee to End Discrimination in Medical Institutions (CED) was MCHR’s direct predecessor. Indeed, two of its members, Quentin Young and Irene Turner, were to assume preeminent leadership positions (nationally and locally, respectively) in MCHR.

**Mississippi Bound**

The killings of Chaney, Schwerner and Goodman resulted in a panicked telephone call to Tom Levin from James Forman, head of the Council of Federated Organizations (COFO). Although neither Forman nor Levin had a clear idea of what should be done, a series of hurried phone calls resulted in a meeting two days later of 25 to 30 largely older white and black professionals held in the office of Dr. John Holloman.

One of the doctors present was Edward Barsky, a surgeon who had served as the chief medical officer of the Lincoln Brigade during the Spanish Civil War. Perhaps out of his experience it was proposed that a “sort of Abraham Lincoln Brigade” be sent to Mississippi. By July 4, 1964, with a vague sense of action and little sense of strategy, the first team of doctors flew to the Magnolia State on what was called a fact-finding mission. The team included Tom Levin, Elliott Hurwitz, Chief of Surgery at Montefiore Hospital, Les Falk, a deputy director of the United Mine Workers’ health program, the national office of which was located in Pittsburgh, and Richard Hausknecht, a private-practicing New York City gynecologist.

Once on Mississippi soil the team scattered in different directions. Those more or less sharing a public health perspective, such as Falk, spent their time investigating segregation in local health facilities and exploring the local health establishment, particularly the Black medical establishment, in search of people willing to meet the needs of civil rights workers. They concluded that what needed to be done was to directly fight segregation in Southern health institutions. They suggested that the separate-but-equal clause of the Hill-Burton Act was a potential “action wedge” for such a program.

Tom Levin, on the other hand, spent most of his time “on the front lines” with Bob Moses, SNCC leader of the Summer Project. After touring the battlefield, Levin concluded that what was needed was “medical presence” to directly aid the beleaguered civil rights workers and to employ the prominence and wealth of Northern doctors in support of the civil rights movement (the idea, in fact, behind Levin’s Committee of Conscience).

When the team returned to New York City everyone agreed about one thing—that an organization was needed. At the suggestion of Falk, it was named the Medical Committee for Human Rights. As to exactly what, however, the organization was to be and do, there was disagreement—in a form that was to become prototypical of future debates within and about MCHR. At stake was the question: What is MCHR?

The seemingly more militant camp identified with CORE and SNCC, the most militant civil rights organizations and pushed the notion that MCHR should be a support organization for the civil rights movement, providing medical care on the front lines, that is, medical presence. Those less enamored of civil rights militance argued for a direct assault upon Mississippi’s two-class health-care system. Paradoxically this apparently less militant approach would have given the infant
organization an independent and self-defined role. The seemingly more militant approach of medical presence won out, however, and defined MCHR as an adjunct of the civil rights movement.

In this decision lay the kernel from which MCHR’s legacy would grow. Later the civil rights movement would be replaced at different times by the anti-war movement, the Black Panthers and the Young Lords, the American Indian movement, the prison reform movement, poor Appalachians and workers on the job. But MCHR would never escape the legacy (some might say the curse) of being a service-and-support organization attached to whatever movement was most current or fashionable at the time. And at every step of the way, those within MCHR pushing for the closest association and identity with other movements would be regarded as the militants and radicals.

In MCHR’s earliest days the position of the less militant faction was not helped by their nagging, mostly behind-the-scenes opposition to Aaron Wells, a Black New York City doctor, as the first chairman of MCHR. Several Black doctors who had been present alluded in retrospect to the opposition to Wells as the first sign of latent racism within the organization, a charge that was to be reechoed before MCHR completed the civil rights phase of its history.

**Freedom Summer**

Every two weeks like clockwork through the summer of 1964 MCHR sent 20 to 40 doctors, nurses and students into Mississippi. The nerve center of the operation was the Congregational Church (United Church of Christ) in midtown Manhattan which, at the request of Dr. Connie Friese, a member of the church and of MCHR, made space available free of charge. At first Tom Levin directed the project; later the job was assumed by Des Callan, a young New York City doctor working at the Columbia Neurological Institute. During this period John Parham, originally with the Urban League, had responsibility for the day-to-day operation of the national office. In the South MCHR found a dependable ally in Bob Smith, a Black doctor, who had been providing most of the medical care to the civil rights workers. MCHR decided to set up a full-time office and hire staff. By 1965 Dr. Alvin Pouissant headed the Jackson office.
Early leaders of MCHR stated their goals in amorphous terms, but most members shared at least some of the following purposes:

- provision of direct medical aid to civil rights workers;
- provision of a medical presence at demonstrations and marches, designed to forestall brutality against participants;
- appeal to the conscience of health professionals and the general public to gain support for the movement; and
- raising money for the civil rights movement.

With the exception of providing medical aid for civil rights workers, the remainder of the program was necessarily geared toward public relations and placed strong emphasis upon professionals, especially doctors. This posture was reflected by the operation of the national office of MCHR in New York City. An early advertisement in the New York Times, for example, raised an astounding $80,000. There was something incongruous about the high-stepping fund-raising parties and dinners at some of New York’s poshier hotels, the Columbia University Faculty Club and the Caprice Restaurant (“entertainment by Bobby Short!”), all ostensibly for the benefit of Black sharecroppers in the Deep South. In the bewitching spotlight of publicity in which MCHR doctors basked, the organization lost sight of the fact that much of the day-to-day nitty-gritty work down South was being done not by doctors but by nurses, who barely had access to the wings of the stage, let alone the footlights.

Nurses such as Phyllis Cunningham, who had formerly worked with SNCC, along with a few doctors such as June Finer, worked full time, night and day, traveling sometimes dangerous back roads of Mississippi to provide first aid for civil rights workers and community people and to hold educational classes on childhood diseases and nutrition for Black mothers. They also observed first hand the effects of segregated hospitals, clinics and doctors’ offices and became less and less enamored of simple medical presence.

Rhetoric and Reality: An Uneasy Truce

MCHR members originally thought of Mississippi as a battlefield and romantically envisioned themselves going to give first aid in the trenches. But, according to Des Callan, once MCHR doctors got to Mississippi they discovered that despite isolated physical attacks on civil rights workers, their gory expectations had been greatly exaggerated. This fact, together with the growing demands of SNCC militants and the perceptions of MCHR’s nurses, threw the emphasis upon medical presence and its public relations foundations into serious question. As Cunningham later commented regarding the visiting-fireman approach, “Pompous liberal doctors could think highly of themselves by daring a two-week voyeuristic trip to the wilds of Mississippi but then go back home and without batting an eye continue their lucrative, and often racist, private practices.” Most galling of all to the nurses was that while MCHR was paying them “peanut butter and jelly” wages for unstinting service, it, at least during the first year, was usually paying its doctors their plane fare and expenses for their brief appearances. Nor did it help matters when the doctors, according to Cunningham, referred paternalistically to the “grand work being done by our little maids in Mississippi.”

The tensions felt, particularly by non-doctors and women, were barely articulated in the ‘60’s but were to erupt with devastating fury by 1971. In the meantime, on the surface at least, MCHR appeared the picture of health. Participation increased and financial stability seemed at hand. In September, 1964 MCHR decided to form an ongoing national organization with locally based chapters. Chapters rapidly sprang up in New York City, Washington, Boston, Chicago, Detroit, Philadelphia, Los Angeles and San Francisco. By April, 1965, at its first annual meet-
ing in Washington, at-large membership was extended to people in cities where no local chapter existed.

Local chapters, as spelled out in the Executive Committee minutes, were "to have maximum local autonomy consistent with a functioning national body..." Ostensibly membership would not be limited to doctors or professionals, although those same minutes reveal MCHR's ambivalence on the question: "Anybody interested and who can function [italics ours] is welcome." On the question of voting rights MCHR's professionalism and paternalism were undisguised: "We should not restrict ourselves to medical personnel; the majority will always be physicians. Let us act in magnanimity and not limit ourselves."

Whatever the interpretation of the rhetoric, in the years 1964 to 1966 MCHR's style was dominated by doctors, though by 1965 there was a large influx of nurses and medical students into the organization. An indication of the leaders' real resistance, however, to consumer involvement was their reaction when a group of Mississippi Black people asked to address the 1966 annual convention in Chicago. After much haggling, each consumer was allowed one minute to address the dignified assembly. To compound the irony, the convention's keynote speaker was Dr. Martin Luther King.

**Drifting and Shifting**

As early as 1965 MCHR began to lose ground and support, at least of its original base, through quiet attrition. Early leaders such as Tom Levin began to drift away, in part because of the doctor-dominated atmosphere of MCHR. The Black doctors who had provided so much of the early leadership were also early departers. Some merely wished to devote more time to the pursuit of their growing private practices. Others moved on to organizations more appropriate to their social concerns than MCHR. Several turned toward the National Medical Association (NMA), and in 1966 John Holloman was elected to the NMA presidency.

At about the same time MCHR lost many of the public-health-oriented doctors who had made up its early roster. For some, who surmised that a movement could not be created to confront the Southern two-class, racist health system, the alternative was to push for foundation and federal money to establish community health centers to serve the Black community in the Deep South. Eventually Jack Geiger, one of the members of this group, succeeded in opening the much-heralded Mound Bayou Health Center in Mississippi. But the very decision to seek an alternative represented both the failure and the abandonment of the earlier struggle, and those sharing the alternative vision soon left the fold of MCHR—and the movement.

Still through 1966 there was no sense of crisis. MCHR tried to "keep on keepin' on" with the civil rights movement, providing medical presence as it marched that year through Mississippi on a mammoth voter registration drive. It was on this march that James Meredith, the first Black student admitted to Ole Miss, was shot. It was also during this march that Stokely Carmichael, a SNCC militant, first shouted "Black Power!"

The contagion of these two words threw the civil rights movement into disarray, as the more militant leaders and soon SNCC itself began to question whether white participation was more a hindrance than a help. Having been rejected by the very cause for which they felt they had sacrificed, whites abandoned the civil rights movement. White participation plummeted and with it white support and financial contributions from the North.

MCHR, no less than other organizations, was thrown into a tailspin. As one MCHR communiqué put it, "The financial situation has not improved during the summer and it seems that there is little interest by MCHR members since the Meredith March." Indeed,
only 25 percent of MCHR members responded to urgent fund-raising appeals. For the first time there was discussion of whether MCHR should continue and, if so, what its role should be.

By this time many of the prominent and busy doctors who had founded and shaped the early MCHR had left it. They had been happy to step into a heroic role when history called on them, but most had no ongoing radical commitment and certainly no ongoing commitment to MCHR. It had become clear that early MCHR had been dominated by too many generals and had too few soldiers. The generals had no patience to stick around at a time of great confusion to chart out a new course for the organization. To the extent that a few may have wondered about sticking it out, they were soon enough dissuaded from doing so by the shift to the left that MCHR was about to take.

A harbinger of this shift had taken place at the 1965 annual MCHR convention when younger members, mostly doctors and medical students, proposed that MCHR adopt a resolution denouncing the War in Vietnam. Although the resolution was defeated that year by a narrow margin, it was passed at the next convention.

The old guard within MCHR was not ready to take a stand on the War and could see little relevance of the War to MCHR’s civil rights concerns. Their qualms were greatly magnified by the fact that those who pushed the anti-War position were also beginning to vocalize, largely in response to demands of Black-power militants, the need to do something about medical care back home in the North. This meant attacks upon the medical system in which many of the older members had vested interests. This was the last straw; nearly all of the remaining older members bid MCHR adieu.

The Interim Years

By 1967 MCHR was a dead letter in New York City. But there was still vitality in Chicago and it was logical to move the national office to the Midwest. From that time on no name stands out more clearly in connection with MCHR than that of Quentin Young, who came to be regarded by many as ‘Mr. MCHR’.

In 1967 Young was a youthful-looking 44-year-old internist with a private practice catering to the mixed university commu-
nity of Hyde Park and assorted movement people. He had been active in MCHR since its founding in 1964. Earlier Young had been involved with the Committee to End Discrimination in Medical Institutions in Chicago and before that with various political activities of the Old Left. Even with this extensive political experience under his belt, Young clearly had his work cut out for him with MCHR.

With the eclipse of the civil rights movement Young inherited in MCHR an organization in danger of losing its raison d’etre. Nor was there any new issue current on the Left that could provide the holistic, even if transitory, sense of direction that the civil rights movement had so readily furnished. For a while it looked as if MCHR might be successful in turning the corner. In June, 1967 it was applauded with front-page headlines when, in conjunction with the Poor People’s Campaign, an MCHR member disrupted the AMA convention in San Francisco by seizing the microphone to denounce MCHR’s arch foe, while other activists picketed outside the auditorium. Aside from keeping the name of MCHR alive and helping recruit new blood to the organization, the event also served as a model for similar demonstrations at subsequent AMA conventions in other cities.

In 1968 MCHR again hit the front pages, this time for its role in ministering to the victims of the police riots at the Democratic National Convention in Chicago. Shortly afterward MCHR again gained prominence when Quentin Young was subpoenaed to testify before the House Un-American Activities Committee (HUAC) concerning MCHR’s role at the Democratic Convention. Again in 1969 MCHR was in the public eye as it provided aid and medical care to the 2,400 poor residents of Resurrection City in Washington D.C.

MCHR’s success in the newspapers, added to its earlier civil rights reputation, gave it an important asset. MCHR acquired a national prominence and recognition among the medical community that would bring it new recruits for years to come. More than that, these spurts of activity offered the hope of carrying the organization through a period of confusion and dissipation. For at no time was MCHR more in its prime than when it was responding to the dramatic medical needs of one or another movement group. A need which these spurts of activity did not fill, and in fact, may well have hidden, was the need for an ongoing political program, that could guide the organization when the dramatic requests faded and that could meaningfully engage the old members as well as integrate the new ones. When it came to articulating such a program MCHR fell back on grandiloquent pronouncements, such as “We argue maintenance men in American hospitals. The greatest concentration of hospital workers is in nursing services. They run the gamut from that health care is a human right . . . that our economy should . . . make available to all the people.” Hard to disagree with, but hardly a prescription for a program.

That MCHR could articulate no meaningful national program during this period should come as no surprise, for the years 1967 to 1971 were not in general good years for national organizations. Rather this was the era of suspicion of leadership, structure and central direction, of extreme local autonomy and of “doing your own thing.” While the national organization shrank to a mere vestige, local chapters attained varying degrees of apparent vitality.

New Faces

The year 1967 introduces an almost entirely new cast of characters into MCHR. As the older doctors left, they were replaced by younger doctors, nurses and, more importantly, by nursing and medical students. Many of the medical students, in particular, had been activists within the Student Health Organization (SHO), which had burst onto the radical health scene in 1966 (see BULLETIN, September, 1970).

This is not the place to discuss the politics of SHO, except insofar as they impinge on MCHR. Perhaps because its summer project orientation so successfully capitalized on student energy (even as Freedom Summer had) or perhaps because of its early success in gaining funds and support, SHO during this period was viewed by all as the more vibrant and vital of the two organizations. Many identified with both, and the more committed SHO members graduated into MCHR in the late ’60’s as they graduated from their medical schools.

It is important to recall that many SHO members had been recruited into political activity as undergraduates and were influenced by the Students for a Democratic Society (SDS) and the model it presented for com-
munity organizing, the Economic Research and Action Project (ERAP). For SHO as well as many MCHR members, this influence, in addition to the influence of Black power, was all important. SHO members tried to respond to the insistence of their former Black civil rights compatriots: They went back to their communities in the North to fight against white racism. This often resulted in projects seeking better services for Third World and poor white communities. When applied to health, these projects occasionally confronted institutions such as local health departments that denied adequate care to the poor or medical schools that refused to admit significant numbers of Third World students. By and large, however, early SHO and later MCHR projects had a distinctly service-and-support-oriented flavor. This was the genesis of projects like lead screening, sickle cell testing, childhood immunization and rat control.

But despite the new faces and the emphatic orientation toward local as opposed to national projects and organizations, much of what MCHR was during 1967 to 1971 was a continuation of what MCHR had always been—a medical support group for movements outside the health system itself. All that had transpired between 1964 and 1967 was that the unitary civil rights movement had fragmented into half a dozen movements, with MCHR now trying to serve them all. This is not to say that medical support work was bad. It was not, and often MCHR’s services were urgently needed. It is only to say that MCHR never developed a conception of itself that went beyond support, a fact that was to prove severely debilitating, if not devastating, as the political movement of the ’60’s moved into the disillusionment, fragmentation and demise of the ’70’s.

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Vietnam As the New Mississippi

No movement shows MCHR’s orientation more clearly than that against the War in Vietnam, which mushroomed beginning in the middle ’60’s. While the War may have been driven home to many participants by the threat of the draft, the tone of the anti-War movement was one of support and service to the Vietnamese people. It was for many the direct descendant of the civil rights movement transported by American militarism and imperialism some 10,000 miles away.

Like others in the anti-war movement, MCHR members organized opposition to the War in their own institutions. Leaflet and literature tables blossomed at medical schools, and contingents carrying bold banners inscribing the names of local MCHR chapters, schools and hospitals appeared at anti-War demonstrations. So overwhelming was this political thrust that for an entire year the New York City chapter of MCHR was literally submerged into the Medical Committee to End the War, which in the spring of 1967 turned out over 2,000 health personnel for an anti-War rally in Central Park.

MCHR went beyond general anti-War activities to play a more specific support role, serving as the medical arm of the anti-War movement. Hence almost all MCHR chapters set up a system of draft counseling and referrals for physical examinations to serve young men seeking medical exemption from the draft. One exceptional draft panel in Los Angeles proved an embarrassment to MCHR when it turned out that participating doctors were pocketing thousands of dollars in private fees for performing draft physicals.

An even more direct transfer of earlier tactics was the medical presence MCHR members provided at anti-War demonstrations and marches. In San Francisco, for example, the local MCHR chapter was largely absorbed by the pressing need for medical presence in the Bay Area. Hardly a day went by without the police attacking a group of demonstrators, often anti-War, but also Black students (as in the San Francisco State strike) and years later white community-control advocates (as in People’s Park). Necessary and commendable as such support work was, still the episodic nature of this sort of activity forestalled coming to grips with consideration of the development of a more organic program for MCHR members.

Counterculture and Free Clinics As the New Authenticity

Although a bit more complicated than the anti-War movement, the role played by
MCHR in the second great activity of the late '60s—the counterculture movement—was fundamentally similar. The year 1967 marked the birth of the Haight-Ashbury Free Clinic, the flower child and the long-haired hippie. The counterculture proved to have a magnetic attraction to young health workers and students (see BULLETINS, October, 1971 and February, 1972).

Indeed the counterculture suggested a way out to health-science students, interns, residents, nurses and technical personnel who felt oppressed by years of grueling study, regimentation, pleasure denial and hierarchically ordered health institutions. These young professionals had come to understand that health-science education involved more than learning about disease diagnosis, treatment and (least of all) prevention, but rather involved a total socializing process. Doctors and nurses were being taught to accept their class and professional roles, along with the attendant alienation.

If medical and nursing school and hospital medical practice seemed to embody the objectivization of young professionals, then the recovery of subjectivity that free clinics and the counterculture seemed to offer came as a godsend to many. They represented a strong antidote to the treatment of students as computer punch cards. (The “do not bend, fold or mutilate” mentality of college deans pertained no less to health-science school officials and hospital administrators.) In free clinics young professionals saw the promise of rebellion, a new lifestyle, immediate fulfillment and an overcoming of the personal alienation, ego disintegration and humiliation that had been their daily bread for all of their lives. Free clinics seemed to offer not merely a vision of the future but a utopia in the here and now. Moreover, so it was claimed, by the sheer weight of their example they would undermine the values of the health system.

While few local MCHR chapters actually set up their own free clinics, almost all chapters had members whose major energies were expended working in them. Some were attracted to this work by the “good vibes” of the counterculture, but many more politically sophisticated MCHR members rejected as fatuous the political claims made in support of free clinics. Indeed, for many MCHR members the attention paid to the middle-class, white hippie clientele of the earliest free clinics represented a self-indulgent waste and sellout of the needs of the most oppressed members of American society.

Free clinics, however, were not long to remain the preserve of the counterculture. Minus some of their countercultural accoutrements, free clinics fit perfectly into the community-organizing strategies of the Black Panthers, I Wor Kuen (a revolutionary group in New York City's Chinatown) and various revolutionary Chicano, Puerto Rican and immigrant white Appalachian groups in the Midwest and on the West Coast.

The dilemma in which MCHR activists working at free clinics found themselves illustrates a bind inherent in MCHR's service orientation. MCHR activists began by simply asking how their medical skills could be used to best advantage on behalf of movements for social change. They thereby unwittingly imported a medical model of social change. Given the free clinics' severely limited resources, their choice was to serve a miniscule number of people in a model of humanized care, in which case the clinic was medically irrelevant, or to accommodate a greater load of patients in traditional assembly-line fashion, in which case the clinic had abandoned its original ideal of providing an alternative to mystified, alienated and hierarchical forms of medical practice. In many cases, clinics tried to do a little of both, which resulted in no one being satisfied. The simple transfer of medical expertise to the service of the movement resulted paradoxically in not politicizing health care—an objective that should be the very quintessence of a health movement.

The attachment to the counterculture and to political free clinics were both misdirected approaches in that both obscured the socially determining role played by established health institutions in distorting health care toward dehumanized services for patients and an alienated work environment for health personnel.
The Pitfalls of Guilt

During the civil rights era, MCHR militants were those who, through medical presence, allied themselves most closely with the most militant civil rights organizations. Likewise, during the late '60s a similar identification took place, except that now MCHR militants were those who worked for the most politically "radical" free clinics. The analogy can be carried further: In both instances MCHR militants sought their identities through transference to groups that purported to represent a class, and often a race and culture as well, that were different from their own.

This search for identity through identification with society's most oppressed groups was not limited to MCHR members but was endemic to large parts of the movement. It stemmed from an unresolved and unmediated sense of guilt deriving from the activists' own privileged class and professional status. Without, however, coming to terms with this dilemma, MCHR members could not accept themselves as legitimate agents of change, much less consider the legitimacy of their own needs. The alternative for health radicals was to submerge their own needs (and hope they would not reassert themselves in too distorted a way) and to look to ostensibly more revolutionary groups for leadership. This is not to say that there is an easy resolution to the conflicting needs of these two groups—the poor, driven by their deprivation to seek material gain and inclusion in society's benefits, versus the more privileged, driven from materialism by alienation and a sense of their own impotence. At the very least a viable radical movement in America will have to recognize and deal with the needs of both groups.

Unfortunately, the tendency of the more politically aware MCHR members to define their identities through the eyes of a class other than their own led to what can only be called a compulsive need to constantly raise the ante: If political commitment was defined as service to radical groups, then one's self-assurance as a radical required constantly seeking out and attaching oneself to what appeared to be the most radical group on the scene. Anything less was a copout.

This dynamic meant that MCHR was at the beck and call of whatever group could most skilfully manipulate its guilt. In 1970, for example, a group of medical students at Northwestern University Medical School in Chicago, on behalf of a coalition of political free clinics, challenged MCHR's doctors' commitment: "... why hasn't MCHR contacted these bullshit physicians and demanded their participation?" The students went on self-righteously to demand that if the doctors refused to donate their time, "... they are to be removed from the organization." Finally, if this was not done, the Northwestern Health Collective threatened to "expose [MCHR] as a liberal front for health professionals. . . ." This psychological blackmail extended beyond MCHR doctors in Chicago. In December, 1969, for example, an MCHR statement extended the indictment to the rest of the nation: "To the people of America, we say that if the [Black] Panthers are destroyed, we are all guilty. . . ."

Aside from the personal debility engendered by the politics of guilt, there were other, no less serious, consequences. The point came when local MCHR chapter activity, like much activity of the New Left, degenerated largely into a set of political slogans and mindless rhetoric. It was apparent to many, for example, that the political free clinics could not meet the health needs of the poor and that—what was worse—their existence had taken people's attention far away from the institutions that were ultimately responsible for the denial and distortion of health services to the poor in the first place. Indeed, no amount of serve-the-people rhetoric could disguise the fact that the community people allegedly being served were, with few exceptions, disinterested in and aloof from the work being done at the most political free clinics.

The truth is that the orgy of guilt that permeated both MCHR and the Left in general in the late '60's had led to the divorce of political language from reality. Slogans—meant, after all, to crystallize people's comprehension of reality—instead made this reality more opaque than ever.

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opaque than ever. Middle-class radicals suffering conflicts over their identity were more concerned with their own radicalism and militance than they were with the task of convincing others of the correctness of their position. An observation of Norman Fruchter on other parts of the movement applies with equal force to MHCR: “Radicals . . . were rarely about to cut through their rhetoric to argue their position so that it connected with people outside the small, increasingly isolated circle of the radical left.” (Norman Fruchter, “Movement Propaganda and the Culture of the Spectacle,” Liberation, May, 1971.)

The Dissolution of Self

Russell Jacoby’s writings about the same years draw an even sharper conclusion, namely that the distortion of political thought and action that characterized the movement of the ‘60’s was not a mere accident or mistake but was the movement’s rhyme and reason. According to this perspective, its rhetoric concealed the movement’s driving force, which was an effort to recoup what advanced capitalistic society had taken away—the individual’s very identity and personal experience, one’s ability to act as the subject of one’s historical destiny. (Russell Jacoby, Social Amnesia, Boston, Beacon Press, 1975.)

According to this analysis, the creation of a mass of socially impotent men and women in American society ultimately stems from the expropriation by capital of the free labor of individuals, by which bourgeois society originally defined the free individual. The next stage in the historical process was the conversion by capital of these amputated individuals into a mass of supposedly free commodity buyers. But whether seen as a source of labor or as a potential customer, the individual had been robbed of the totality of personhood that alone defined his or her humanity.

The economic antidote for this dissolution of the personality has been the systematic effort of capital, with no small assist from its advertising, product design and packaging subsidiaries, to personalize the consumer products of advanced capitalist industrial society. As depicted by Marcuse, even the most intimate of human activities, such as sexuality, is grist for the mill of commodity production and sale. Nor has medicine escaped this fate, as a glance at the ads in any medical journal will demonstrate.

This analysis accounts for much of the common dissatisfaction with a medical care system that the health movement, in particular the women’s health movement, correctly perceives as being insensitive to need, bureaucratically administered and technologically determined. Such a system necessarily drives the human element out of the patient and at the same time necessarily deprives health workers of what should be the gratification of work based on serving people in need. Both health workers and patients become interchangeable parts of technologic machinery and as such mere tools for those who control and administer the health system for profit and aggrandizement.

In response to this loss of genuine subjectivity, MCHR, like the health movement and the rest of the movement in general, engaged in what Jacoby calls the politics of subjectivity. If monopoly capital had deprived men and women of their very selves and egos, the corrective, so the logic went, was to create a movement solely concerned with feeling, friendship, brother/sisterhood, good vibes, communality and the like. But “if the intensification of subjectivity is a direct response to its actual decline, it actually works to accelerate the decline.” As the cult of subjectivity spread to every movement group, individuals became less and less able to combat the brutal objective imperative of American society to “eclipse the individual.”

Paradoxically, the end result was that the two seemingly divergent movements—the countercultural and the revolutionary political—merged imperceptibly into one another. The counterculture drew its strength from its recognition, long denied by traditional Marxist/Leninists, that individuals and their alienation matter and are of political concern; it erred, however, in believing that alienation
could be righted with larger doses of subjectivity or, put another way, "with just a little help from our friends." Or to follow Jacoby, "To the damaged loss of human relations it proposed more of the same." The revolutionary political movement, on the other hand, insisted that "offing the pig" and "armed struggle" were the answer, refusing to understand that sloganeering unmediated by thought and analysis does "not serve to popularize thought but replace it."

Both thrusts were reverse sides of the same coin and both ultimately made the same mistakes—ahistoricism, contempt for theory and analysis and the flight from reality into wishfulness. Both parts of the movement finally opted to counter American society's drift toward the obliteration of the individual by seeking to create the experience of the individual here and now. Invariably, however, since the individual cannot now exist in society, this approach must lead to psychologizing reality, when in fact what is needed is an objective appraisal of reality. The initial need is for the development of an objective theory of subjectivity. From here one would hope for a political movement aimed at realizing the objective development of the subject.

Of course no one, either in the movement generally or in MCHR particularly, was equipped in the late 1960's to deal with these, and many other, underlying points of theoretical confusion. Still, unless they were dealt with, it was just a matter of time until its foundations of sand guaranteed the collapse of the entire movement. These weaknesses may have been invisible to MCHR as long as its members could believe that they were in the thick of "where it was at." But as the movements of the '60's began to wane, MCHR was once again left high and dry. Further, the nature of the support role by which the organization defined its existence had obscured (and possibly even created) inherent structural weaknesses in many MCHR chapters. These chapters had always drawn members in one's, two's and three's from widely diverse institutions, situations and interests. The very nature of chapter membership thus constituted an obstacle to developing an independent role for MCHR. Beyond service and support, the question of what MCHR should be doing seldom had an answer because it was asked of the wrong people in the wrong situation.

MCHR's service-and-support role illuminates one last curious feature of its activity. While everyone acknowledged the importance of the organization, it had a strangely peripheral relationship to many, if not most, of its activities. Most such activities would have gone on and most MCHR members would have participated with or without the existence of MCHR—which may be only to say that service and support, while they may facilitate or heighten the success of a project, cannot be the essence of either MCHR or of the outside project being supported.

Speck of Light

At long last in October, 1970 a group of health workers and MCHR members living together in Brooklyn who called themselves Hampton's Family, after Fred Hampton, the slain Chicago Black Panther leader, tackled many of the questions MCHR had stubbornly refused to recognize or had been unable to come to grips with during its first six years.

After suggesting that MCHR had failed both locally and nationally, the Hampton's Family Paper went on to say that "this failure at both levels can be traced to the fact that MCHR as a whole lacked a sense of its own proper role in these struggles, a clear understanding of who its constituency was, how to reach them, and in general, a strategy for challenging the health empires and their subsidiaries."

The paper went on to argue strongly for the development of a "progressive organization" that could organize "large numbers of middle level health workers" who would relate to community and worker (presumably lower-echelon) struggles. It suggested that MCHR be that organization and that its priority be a "commitment on the local level to build political activity in local institutions and health science schools." Hampton's Family thought an MCHR national office should exist "to provide and support a full time staff as well as regional coordinators," presumably to foster the local priority aims.

In summary the Hampton's Family Paper called for a membership drive designed to attract upper-level and middle-level health workers, concrete struggles around institutional organizing and a strengthened national office of MCHR to assist these efforts. Although the clearest exposition up to that time of MCHR's problems, the Hampton's Family
Paper was not without its own ambiguities. To begin with, its suggested role for the national office was left only implicit, a fact that was soon to have dire consequences for MCHR's development.

Further, when it came to concretizing its suggested theoretical program, the paper repeated many of the same errors that MCHR had already made. For example, it called for more and better (meaning "more political") service projects, medical presence, draft exams and support for sundry movement organizations and, finally, opposition to chemical and biological warfare. But it was precisely these diverse and multifaceted approaches that had up until then prevented MCHR from doing what in the main the Hampton's Family Paper argued it must do—define its identity around organizing in health institutions, with a constituency of upper-level and middle-level health workers and health-science students.

To be sure, as the Hampton's Family Paper argued, "Our perspective must be broader than our local hospital or medical school. We are part of a national and international movement and must link up in our struggles to other issues." Unfortunately, the national leadership of MCHR that was elected in the next year readily seized upon the "larger perspective" without ever bothering about the local building blocks that could have made such a perspective concrete.

The 1971 Convention: The Beginning of the End

Although the Hampton's Family Paper had grasped, albeit tenuously, the critical issues facing MCHR and had generated discussion within the organization, by the time of the 1971 annual convention, held in April at the University of Pennsylvania, it was an idea whose time had already passed. The paper was hardly mentioned at the convention and, insofar as it had any impact, it helped to push MCHR in directions diametrically opposed to the intentions of Hampton's Family. Even more ironically, despite profound differences bubbling just beneath the surface, an atmosphere of unanimity and good feeling prevailed at the convention in which there was little if any disagreement or debate. These anomalies stemmed from at least two sources.

First, there was little political sophistication or leadership in MCHR as of 1971. New
recruits swelled MCHR's ranks, but even old timers lacked the theoretical and practical political knowledge and experience to recognize the essential issues, think through their organizational implications, take an unwavering stance and engage the organization in meaningful debate. By shortly after the convention it became clear, in fact, that few enough of the members of Hampton's Family themselves really understood the implications of the position put forth in their paper, as several went over to articulating precisely the opposite perspective.

Second, the more politically experienced members, who might have been expected to take leadership, were intimidated from doing so by a sense of guilt for being largely white male doctors and professionals, although these had been among MCHR's chief constituencies in the past. This pervading sense of guilt was exacerbated by the theme and attendance of the convention but had its roots in developments taking place in the larger movement.

Organized around the theme "The Consumer and Health Care," the convention for the first time drew substantial numbers of articulate and organized women, Third World people, nonprofessional health workers and consumers. The growth of independent Third World groups, such as the Black Panthers, and the emergence of the women's liberation movement engendered in MCHR as in many other groups, a consciousness and concern about its internal racism, sexism, elitism, professionalism and organizational style.

This consciousness and concern were at once MCHR's critical strength and its critical weakness. They constituted the basis upon which the organization could broaden its membership. Yet at the same time, the guilt borne of the charges of racism, sexism and elitism led MCHR to throw out the baby with the bath water, repudiating a major part of its historical constituency (and those with whom it could work most effectively). Indeed, MCHR carried over a disdain for organizing doctors or medical students who, it was reasoned, if organized could only act ultimately in their own, already privileged self-interest, which would of course be counterrevolutionary. Instead, MCHR tried to transform itself into precisely what it was not—an organization of women and Third World nonprofessionals and consumers.

In this atmosphere MCHR charted new organizational directions, involving decisions on constituency, program and structure and elected a leadership that foreclosed in the immediate future the possibility of the organization coming to terms with the critical issues facing it. In many ways the subsequent years are but a playing out of those decisions, and it could be argued that our story could stop here. Yet what happened during and after the 1971 convention is worth examining in some detail, because the issues then faced by MCHR continue to be serious and unresolved ones, admitting of no easy solution. Moreover, while the fallacies of the course adopted by MCHR in 1971 are readily evident in retrospect, the approach, perhaps because it offers a simple formula, continues to have currency for many organizations and activists today.

**Constituency: Y'all Come**

The April, 1971 convention decided that it was paramount to open MCHR's doors to women, Third World people, nonprofessionals and consumers—a decision implemented in the context of a growing militant national women's movement, the influence of which was enhanced by the large number of militant women at the convention. To their strong voice was added that of the smaller but still significant number of Third World delegates.

While there was no disagreement on this decision, there were radically different interpretations of what it meant—differences that went undiscussed and unresolved. To some this decision meant addressing manifestations of racism, sexism and elitism within MCHR and opening up the organization to a broader though still limited constituency of middle-level health workers. To others, including what came to be the national leadership, it meant transforming MCHR into a mass organization incorporating all strata of In short, there was no one who was not part of MCHR's newly defined constituency.
health workers and of consumers as well. MCHR was to be the radical health vehicle of both the doctor and the dishwasher, the medical student and the ward clerk, the administrator and the consumer, the privileged and the poor, the Third World and the white, the man and the woman.

In short, there was no one who was not part of MCHR’s newly defined constituency. MCHR would no longer simply serve the vanguard—MCHR would be the vanguard by shedding its skin and wishing itself a new one. The impact of this shift was devastating. One minimal advantage of the previous serve-the-vanguard approach had been that at least it allowed MCHR professionals, especially doctors, to embrace their own identities. They could still be who they were and use their skills and positions, as privileged as they might be, toward the support of groups judged to be more revolutionary. With its new decision on constituency, MCHR lost even this.

Now MCHR was no longer simply at the beck and call of whatever outside group could lay the greatest claim to militance, oppression or other hallmarks of legitimacy. At least in that circumstance the organization had the theoretical right to decide where to give its support. Internalizing this process, MCHR now rendered itself superbly manipulable by whomever within its ranks was most adept at social-psychological blackmail. And because MCHR had indeed been guilty of racism, sexism and elitism, it now lost its right to question or judge the validity of their claims or how they fit into MCHR’s agenda. Those who tried could be discredited as racist, sexist and elitist.

Structure: Form Without Content

Two major proposals, both written and circulated before the convention, dominated the discussions of structure and spoke to the issue of broadening MCHR’s constituency. The first, written by the Chicago Chapter, argued for a strong national office. It met with hearty response, since many MCHR activists had seen the loose-knit, locally based, almost anarchistic structure of MCHR’s middle years dissipate energy in frenetic activity. What was not agreed on, incredibly enough, was the key question: Should a strong national structure exist to give central direction, create a national image and build MCHR from the top down, or should it rather exist to serve, support and coordinate local activities, building the organization from the bottom up (the Hampton’s Family position)? Debate eluded the issue, however, and once more everyone took home his or her own interpretation of the subsequent decision.

The second proposal, drawn up by the East Coast Women’s Caucus, also endorsed a strengthened national structure but emphasized expanding the leadership to include women, Third World people and non-professionals as a means of broadening MCHR’s membership. This broadening, they contended, could evolve only if MCHR adopted a collective style of leadership, a concept clearer in its criticism of the past than its prescription for the future. The women’s caucus at the convention demanded a guarantee that half of those comprising MCHR’s leadership structure be women, and the Third World Caucus followed suit, demanding one-quarter. The result was an elaborate structure that was to prove as unwieldy and dysfunctional as it was superficially democratic.

The convention agreed, virtually unanimously, to set up a strong national structure that would function in a collective manner. The National Executive Committee (NEC), the interim governing body, was to consist of four national officers and four representatives from each of four regions. Each set of four regional representatives was to include at least one Third World person and two women, assuring that the whole body would be at least 50 percent female and 25 percent Third World. Travel funds were assured so that no NEC member would be excluded from participation because of financial need or geographical isolation. Permanent caucuses of women and Third World people were to be established, which would be given the opportunity to meet at every MCHR gathering
and which would assure that women’s and Third World representation and participation in the organization met with their satisfaction.

Thus in 1971 MCHR painstakingly created the forms of democracy and egalitarianism in its national structure. In so doing it pioneered an approach to addressing issues by implementing changes in form rather than changes in substance—an approach that was to become the hallmark of the later organization. No one asked what MCHR had to offer women or Third World people, or how it would have to change to meet their needs sufficiently to give them a reason to make the investment that leadership requires. Rather it was assumed that having established the quotas and caucuses and having elected the right number of people of the right race and sex to the leadership, these problems would somehow resolve themselves.

The result was predictable. People were frequently elected to leadership positions because they fit a quota, not because they had necessarily demonstrated interest, commitment or leadership ability in MCHR. These representatives in many cases fell away as soon as they were elected, often, one suspects, because they had not resolved the questions whether MCHR was the most appropriate vehicle for their concerns and whether they were prepared to deal with its residual racism, sexism and professionalism.

The end result was that the newly elected representatives exercised little leadership and the old timers, intimidated by their own sex, race and status, withdrew from leadership—leaving a vacuum too inviting to go long unfilled.

Quentin Young was elected to head a strong, centralized national office, which was moved from Philadelphia back to Chicago. Felicia Hance and Barbara Maggani, both members of the Eastern Women’s Caucus and both part of Hampton’s Family, were elected vice chairperson and secretary, respectively, and Ann Garland, a Philadelphia nurse and leader of the Third World Caucus, was reelected treasurer. The convention also resolved to hire three full-time staff members, and shortly thereafter Frank Goldsmith, a former staff member of the United Auto Workers and a friend of Hampton’s Family, was hired as national organizer and Pat Murchie, a member of MCHR’s Chicago chapter, was hired as executive secretary. Later Tanganika Hill, a Black activist from Houston, was hired by the Third World Caucus to be the Third World organizer. (Her tenure was short and she was never replaced by the Caucus.) The three staff members shared one striking trait—all were virtually brand new to MCHR.

**Program: Jumping on the Bandwagon**

While the 1971 convention sported the usual panoply of workshops and passed the usual multitude of resolutions, it focussed primarily programmatic attention on national health insurance. In fact, an air of excitement pervaded the convention, for everyone felt that the country was on the threshold of this momentous change in health care. Just six months before Sen. Edward Kennedy had introduced his sweeping bill (the Health Security Act) into Congress, and the political climate of that time was such that it appeared to be a viable if not leading candidate in that arena. Everyone felt that national health insurance would be the major campaign issue of the 1972 election if it had not been passed before then. Indeed, it seemed that issues of health policy were reaching a historic moment in which MCHR might, just might, be asked to play a vital role.

Prior to the convention, Tom Bodenheimer of the San Francisco chapter drafted and circulated a national health care proposal embodying MCHR’s principles, which might serve as its alternative to existing national health insurance bills. The 1971 convention, again with seeming unanimity, adopted the national health care plan with minor alterations as the basis of a campaign of education and agitation; again there was little understanding of what this action would mean.

This campaign offered several immediate advantages to MCHR. It addressed an issue seemingly capable of uniting many diverse constituencies; it capitalized on the national interest and momentum around the national
health insurance issue; and it seemed tailor-made for the new national role that MCHR had adopted. Indeed, it offered the hope of being to the later MCHR what the civil rights movement had been to the earlier organization—with one critical difference. There was no popular movement afoot for national health insurance.

Thus the 1971 convention did not come to grips with the critical issues facing MCHR; it turned the organization in opposite directions. Whereas the Hampton’s Family Paper called for a broader but still focussed constituency, a more focussed program and a local orientation, the convention gave license for the national leadership to move ahead with a united-front approach to constituency and program and a centralist, as well as centralized, national structure.

Most chapters ignored or laughed off the National Health Crusade; some were incensed at its public-relations style.

Uniting All Fronts

At the urging primarily of Frank Goldsmith and Quentin Young, MCHR’s new program was dubbed the National Health Crusade and was designed to promote five principles, or perhaps more accurately five slogans, boiled down from Bodenheimer’s alternative health plan. These included an end to profit-making in health; financing by progressive taxation; provision of complete and preventive health care; local administration of health centers through patients and health workers; and nationalization of the drug and medical supply industries.

At the national level, the National Health Crusade (NHC) was to consist of a series of nationally coordinated local press conferences and the mass distribution of polls, petitions and a series of leaflets and brochures on MCHR’s alternative national health plan. The first leaflet came out in May, headlined “If you needed it [health care] right now... Could you find it? Could you pay for it?” It briefly critiqued present health care, set forth the five points of MCHR’s alternative plan and invited those interested to join MCHR. Local chapters were urged to distribute these leaflets at shopping centers and department stores, in addition to medical schools and hospitals, and to conduct press conferences, polls and petition-signing campaigns.

Most chapters ignored or laughed off the NHC; some were incensed at its public-relations style. At least one chapter—the one in New York City—actually attempted to follow the NHC’s directives, but came to an impasse when it could not figure out what was newsworthy enough to warrant a press conference. Many agreed with the NHC’s educational potential but, assuming success in educating and mobilizing people, no one could answer the question that followed: “What can I do?” MCHR did not wish to thrust people into the legislative arena to support existing bills (although later there was to be disagreement on this); it could not pass off its proposal as legislatively viable; and it could not point convincingly to local programs that would make it viable.

As criticisms of the programmatic poverty of the National Health Crusade grew over the summer of 1971, the national leadership became more and more defensive, until it eventually was arguing that implementation of the NHC could include virtually all forms of MCHR activity. Free clinics, occupational health initiatives, lead poisoning and sickle cell screening, institutional struggles, anti-War activity, military organizing, student organizing, prison health—any and all could be seen as implementing some aspect of the National Health Crusade. When by late summer some of the underlying questions about the viability of the National Health Crusade were raised at an NEC meeting, the doubters were resoundingly put down by the national leadership for being disruptive.

By the fall of 1971 the National Health Crusade had begun to quietly collapse under the weight of its own contradictions. But even as it fell apart, it highlighted important elements emerging in the style and politics of the national office. First the NHC had the form of a political program, but little consideration had been given to its content—the essence of political bureaucratism. But more than this, its lack of programmatic content pointed to the disturbing signs of political opportunism. Sometime between spring and fall it became clear that MCHR did not take
the goals of the NHC seriously in their own right and perhaps never had. Instead of asking what MCHR could do for a national health care plan, MCHR instead asked what a national health care plan could do for it. The answer was that it could project MCHR's name and image to facilitate its mass organizing and membership recruitment strategy. Thus its genius was closely akin to its vacuity: It could encompass all constituencies and mean all things to all people. Further, through the NHC it became evident that the idea of centralization of MCHR also embodied the idea of centralism. Dissent from within the ranks was not welcome.

The National Health Crusade was MCHR's last attempt to adopt a single programmatic focus and the last juncture at which that was possible. Shortly after its demise MCHR adopted the model of task forces as the answer to its programmatic problems. Task forces were designed to coordinate similar activities going on around the country and were modeled after the strongest and most successful programmatic undertaking of latter-day MCHR—the occupational health task force.

The occupational health task force was organized by a small group, including Phyllis Cullen from Denver, Don Whorton from Washington and later Dan Berman. They began by organizing a training session that could draw together interested workers (both union leaders and rank-and-file) and health activists. The task force spent much of the winter traveling from place to place generating interest and activity in occupational health. The task force raised (and personally contributed) money to hire a full-time staff member in the person of Dan Berman, who had previously worked with the Teamsters in St. Louis. Soon it was publishing a newsletter, pouring forth literature and holding conferences. Other task forces were encouraged to follow the pattern of raising money, hiring national staff, producing newsletters and literature and organizing conferences. Soon MCHR's list of task forces burgeoned to include prison health, national health plans, institutional organizing, community/consumer organizing, women's health, community health programs (including lead poisoning and sickle cell programs and free clinics), anti-War activities, mental health, rural health, patients' rights, nutrition, nursing, house staff, health-science students and health care for the aged.

However sensible it may have appeared, the task force approach had serious drawbacks for MCHR. First, it codified in a sophisticated form the more primitive do-your-own-thingism that had plagued MCHR's past. More disturbingly, it could be and was used to deflect or absorb those who argued that MCHR needed a programmatic focus. Now such dissenters could simply be told to set up their own task force. For the only programmatic approach acceptable to the national leadership was one which, like the unsuccessful National Health Crusade, could embrace all constituencies, a formula in which ultimately everything equaled nothing. Moreover, the task force model could be and also was used to abet MCHR's publicity and recruitment drive by magnifying embryonic and often virtually nonexistent projects. The vast majority of task forces represented nothing more than a handful of people scattered around the country who saw each other at MCHR gatherings. Yet when asked what it was doing, MCHR could point with pride to its vast array of task forces.

**Bureaucratism Run Amuck**

During the summer of 1971 the MCHR national office began to function as it never had before: Membership and mailing lists were organized; literature began to be massively produced; two internal communications, "The Office News" and "The Organizational Newsletter," were initiated and sent to key contacts on a regular basis; liaison with other groups was systematically established; and Health Rights News, MCHR's house organ, began to appear on a regular basis. During that summer MCHR raised $60,000 in foundation grants and received $20,000 more in membership dues. There was widespread ap-
preciation throughout the organization that there now existed an organized and responsible national office.

But with the appreciation there coexisted a growing apprehension about the style of that national office. The upbeat tone of office communications, while possibly appropriate for potential recruits, struck MCHR old-timers as overblown and condescending. "You received a sample of the national petition [for the National Health Crusade] which should be reproduced locally. Please do this as soon as possible so your friends and neighbors can Sign Up for quality health care," read an early office communication. Another enthused: "Now is the time to fill your local committees with active new enthusiasts. The last three months has proven that people are ready to move if they are just informed of the opportunities awaiting them with MCHR."

MCHR accomplishments as reported in the MCHR media were often magnified beyond recognition. When four MCHR members attended a two-day occupational health meeting, another internal communiqué characterized that fact as "This excellent attendance, spurred by MCHR's new emphasis in this health area...." And whenever an MCHR member participated in a project or a struggle, MCHR rushed to add that project to its burgeoning list of accomplishments.

Numbers became the standard of MCHR's success—numbers of chapters, numbers of members, numbers of names on mailing lists, numbers of leaflets and newsletters distributed, numbers of meetings, numbers of projects, numbers of letters and telephone calls made and received, numbers of resolutions, numbers of alliances. There was little concern for what the numbers meant and there was hostility toward those who asked. While heralding the formation of the fiftieth MCHR chapter, for example, the national organizer, when pressed, admitted that it consisted of three people, none of whom had ever met one another. Their names had simply been lifted from letters of inquiry received by the national office and, ipso facto, another MCHR chapter had materialized. Health Rights News became, at times, little more than a cheerleading sheet, recounting victories and editing out problems. The national office began reprinting any and every article laudatory of MCHR from the national media, some in spite of the fact that they contained serious misinformation about the organization including one, for example, in which it was claimed that MCHR supported the Kennedy-Labor national health insurance bill. And in addition to promotional reprints, brochures and buttons, MCHR balloons ascended for the first time at the October, 1971 American Public Health Association convention in Minneapolis.

The bureaucratic style and public-relations tone of the national office combined with its stance on programs make it clear that, all protestations to the contrary, the only significant concern of the national office during this period was membership recruitment, publicity and image-building and that all its activities were in one way or another tailored to that end. It appears, in fact, that the national leadership espoused a critical mass theory of social change, in which what members did was essentially irrelevant, so long as they indicated allegiance to the "right side," which would presumably grow and grow until by sheer force of numbers it would assume power.

The chinks in the armor of the national leadership were not hard to find. New recruits might for a short time buy MCHR's salesmanship. But for its older members—many of whom had been attracted to the New Left precisely because of their alienation from the Madison Avenue aspects of commodified American life and from the rigid bureaucracy, hierarchy and hypocrisy of their institutions—the style and tone of the new MCHR national office were thoroughly repugnant. Finally, no amount of glib salesmanship, hyperbole or Sears-Roebuck cataloguing of task forces and projects could disguise MCHR's lack of a focussed and actionable program.

Factions: The Dissidents

Some within the organization perceived the limitations of the national office's top-down bureaucractism. These members, largely from the older big city chapters, including New York City, Boston, San Francisco and Los Angeles, were unimpressed with the large numbers of new recruits flocking to MCHR. They saw the numbers as reflections not of the success of present leadership and policy but rather of the ferment created by the civil rights and anti-War movements, as well as the past reputation and visibility that MCHR had established for itself. What did impress them, however, was the fact that
both nationally and locally MCHR had become a gigantic revolving door. Interested people came to it, looked around for meaningful involvement, more often than not could not find it and then left in droves almost as large as those in which they had come. For this syndrome MCHR's array of task forces offered no remedy. This faction shared an acute sense of MCHR's being in trouble—not for lack of projects, but for lack of a unifying program, a direction that would inform not only national organizing but local struggles as well.

Correct as their criticisms may have been, this group found itself in an untenable position. Its members were united by little more than opposition to the style and politics of the national office and in answer to it, by a vague sense of the need to limit constituency and to focus on institutional organizing which itself went hardly beyond the level of slogans. What the group needed but lacked was both a theoretical and a practical sense of what it might do to actually act upon these vague parameters. Necessarily this shortcoming allowed the national office to charge, with partial plausibility, that the effect of the dissidents was merely destructive and obstructionist.

The true weakness of the dissidents' position stemmed from their inability to develop three elements critical to the launching of a successful strategy: a concrete, human and un-rhetorical explanation of how and why the existing health-care system devalues human experience; an analysis of the contradictions inherent in the system that could inform organizing perspectives by providing the bridge between theory and concrete reality; and finally, the incorporation within an organizing strategy of a means of realizing intermediate stages of an ultimate vision of a health-care system in which the needs of patients were the central focus and in which control was vested in an egalitarian workforce. Nothing less than the forging of these three links could create the conditions that would make possible the desired result—enabling individuals to experientially understand that it is both their responsibility and potentially within their power to become the agents of the construction of their own future.

In this regard we would be remiss in not placing some of the onus for this state of affairs on Health/PAC, whose BULLETIN more than any other intellectual journal fostered the idealization of these struggles. This posture sprung from the felt need, conveyed in dozens of ways by movement groups during these uncritical years, of presenting a positive image of the possibilities of social change so as to encourage the growth of the movement. The end result of such unreflective and unwarranted positivity was epidemic disillusionment, divorce from reality and fostering of false premises, all of which were without doubt self-defeating. Finally, this intellectual euphoria depleted groups such as Health/PAC of their ability to delve deeper into an analysis of the health system and its...
oppressiveness to workers and consumers, which analysis alone can ultimately form the foundation of a movement for social change.

**Factions: The National Office**

The national office faction consisted of Quentin Young, Frank Goldsmith and Pat Murchie, the editors of *Health Rights News* and the leaders of both the Third World caucus and the Occupational Health Task Force. Although later events would reveal the fragility of this coalition, to the dissidents this group at the time seemed monolithic, if not conspiratorial as well.

Fueling the dissidents' readiness to see a conspiracy were the facts that several people in the national office faction were open or reputed members of the Communist Party and that the national office faction could depend on support from groups and/or individuals in New York and the South that had long been associated with the Party. Whether or not particular individuals were actual Party members and whether or not the Party made a conscious policy of putting forth its line in the organization, there is no question that many aspects of the national office leadership were reminiscent of the Old Left, including its united-front approach to constituency, its mass-line, least-common-denominator approach to the program, its bureaucratic style, its opportunistic use of issues and its centralist orientation, with its intolerance of differences or criticisms from within the organization.

The national office felt that the success of its political leadership was confirmed by the large numbers of new people turning out to MCHR functions. Because it was better organized and shared more political unity than anyone else, it felt no need to discuss political directions or develop a program for the organization. Instead, it felt threatened when others wished to do so, because this felt need in itself represented criticism, and because such discussion could not but weaken its position. Indeed, before long the energy expended by the national office at thwarting criticism and fending off dissent almost came to define its entire operation.

**Keeping Dissent at Bay**

It was in the end the unwillingness of either faction to back off and the repressive tactics stemming from the centralist stance of the national office that led MCHR down the road to factionalism and demise. The national office honed a set of tools with which it attempted to discredit, silence and eventually expel dissenters. Questions probing the content or meaning of the numbers, the claims or the style of the national office were taken as hostile attacks. From a disturbingly early stage in the new regime, people were seen as either friends or enemies and there was little in between. New activities were warmly embraced and solicited by officers and staff until the first time they expressed doubts or criticism, whereupon they became pariahs. Old friends who dissented were at first ignored or dismissed out of hand and later branded as negative, destructive, localist and ultra-Leftist.

**Structuring Out Dissent**

The most subtle of these tools for repressing dissent was the structuring of MCHR gatherings so that it was difficult if not impossible for dissidents to meet or talk. This tactic involved rigidly tight scheduling and the use of constant fragmentation into small groups, all for the purpose of precluding any occasion for a broad discussion of overall politics. At the 1972 convention in Chicago, for example, the leadership scheduled some 40 workshops and 15 constituency caucuses. As a result, the four-day convention provided only a short Sunday morning plenary session as a forum for organizational business. Older members were both frustrated by this maneuver and resentful of the fact that every MCHR gathering was geared to the recruitment and needs of new people, who were invariably neither interested in nor experienced with MCHR internal affairs, rather than to the needs of those for whom those internal affairs were of paramount concern.

When older members began to organize occasions compatible with their needs, they were slashingly criticized by the national of-
One such occasion came when leaders of the Northeast Region, out of dissatisfaction with the organization of the Chicago convention, organized a largely unstructured retreat to soberly analyze the organization's directions and viability. The national organizer, when informed of the meeting, threw a virtual tantrum, branding the members involved as elitist, exclusionary and racist, and castigating them for having "No Workshops!... No Caucuses!... No Women's Caucuses!... Task Force and Constituency Organizing Completely By-Passed!"

Dirty Names

The national office wrapped itself in the cloak of a united-front constituency and bureaucratic structural solutions to MCHR's problems of racism, sexism and elitism in an attempt to immunize itself from criticism. It then used these concerns as epithets to be hurled at its critics. Those who wanted a focused constituency were dubbed exclusionary and elitist, anticonsumer and anti-worker. Those who felt frustrated by the constant fragmentation into special-interest caucuses were dubbed sexist and racist.

Using this kind of ammunition, Goldsmith opened a frontal assault on the big city chapters by the fall of 1972. (It was no accident that MCHR had meanwhile discovered the virtues of rural organizing.) Goldsmith drew up an organizational report purporting to evaluate chapters by a list of criteria including racism, professional dominance and sexism, which found the big city chapters guilty on every count. To sustain his charge of racism, for example, Goldsmith maintained that the anticonsumer bias of the older, larger chapters was nothing but a ruse to exclude Third World people from participation. What he did not mention was the fact that Third World people everywhere constituted but a small fraction of the MCHR membership.

Dirty Tricks

By this time MCHR was well down the road to factional demise, but one weapon, the most extreme, remained: outright expulsion of the critics. The national office first attempted to pave the way for this tactic through a seemingly innocuous and legalistic maneuver to revise the MCHR constitution, which was generated in Chicago and presented at the 1972 Chicago national convention. A close look, however, showed that virtually every change proposed was designed to create a greater centralization of power and to give the chairperson's power by instilling a longer term and by allowing the chairperson to appoint a new director, thereby weakening the opposition. Specifically, the revisions would have increased the chairperson's power by instituting a longer term and by allowing the chairperson to appoint a new director, thereby weakening the opposition. Specifically, the revisions would have increased the chairperson's power by instituting a longer term and by allowing the chairperson to appoint a new director, thereby weakening the opposition. Specifically, the revisions would have increased the chairperson's power by instituting a longer term and by allowing the chairperson to appoint a new director, thereby weakening the opposition.

Selection of Delegates for an MCHR Trip to China

The selection of delegates for an MCHR trip to China was a classic illustration of the manipulative use of the charge of racism. The national office, in their attempts to control the trip and manipulate the decision-making process, nominated a candidate for the trip. When the New York chapter objected and asked for justification, it was informed by the Selection Committee that none was necessary since the candidate (who is Black) had been endorsed by the Third World Caucus, a factor that apparently overrode the previously announced guidelines. When the New York chapter protested further, it was scathingly denounced as racist by Ann Garland, former national treasurer and leader of the Third World Caucus. It was clear that in this instance the issue of race was used only as an afterthought and as a means of intimidating anyone critical of the national office.
chairperson to act independently on a number of issues (such as hiring staff) rather than having to consult with representatives of the NEC. More importantly, they would have allowed the NEC to remove its own members and would have diluted the impact of big city chapters.

The proposed constitutional revisions were resoundingly defeated and their actual impact was to expose the intentions of the national office faction and to increase polarization. Yet the national office was undaunted. At the following meeting of the NEC, Goldsmith presented a proposal for permitting the NEC, after an investigation, to expel chapters. (Grounds for expulsion were unspecified.) In special cases, which presumably could not await investigation, the proposal provided for immediate “temporary disaffiliation.”

These attempts to set the stage for expelling critics, the final and most extreme attempt to tighten the centralization of the national organization, were doomed to failure. They were premature, to say the least, and it is doubtful they could ever have worked. For the national office had to rely for support on the ranks of new recruits, most of whom were only in the process of walking through MCHR’s revolving door. Those who stayed around were either repulsed by such tactics or simply felt themselves too new to take a stand on such a controversial and seemingly internecine issue. Meanwhile, mounting criticism eroded the unity of the national office. Shortly after his reelection at the April, 1972 convention, Quentin Young—to the sharp displeasure of others in the national office—accepted the position of Chief of Medicine at Cook County Hospital, a job too consuming to allow him to continue to play a strong role in MCHR.

At that point the polarization was so great that both sides felt too frustrated, even paralyzed, to have the stomach for the investment of energy that fund-raising and other vital leadership functions required. Consequently by the summer of 1972 MCHR’s financial state became critical. The organization had spent over $160,000 since the April, 1971 convention. Quentin Young had been the only person to do substantial fund-raising and that activity had ceased by the end of his first term. The clash of the two factions reached a head when, in spite of MCHR’s financial condition, Pat Murchie and Frank
Goldsmith at the fall NEC meeting asked for a cost-of-living salary increase from $10,000 to $11,000. The NEC, having just severely challenged Goldsmith for his attack on big city chapters, denied salary increases and proceeded to pack the real wallop to Goldsmith as it voted on financial priorities. When the inevitable crunch came, the NEC voted that funds for the executive secretary would have first priority, travel funds for the NEC second and funds for the national organizer third. With that, both Goldsmith and Murchie quit.

The Aftermath

With the national staff gone, the chairman consumed in his new job, the treasury bankrupt and the organization exhausted from factionalism, MCHR sank to an all-time low. True, national MCHR still holds annual conventions, its NEC still meets from time to time and it still maintains a national office in Pittsburgh. Publication of Health Rights News has recently been suspended for lack of resources and participation. MCHR's most visible national activities of late have been its presence at the annual conventions of the American Public Health Association and the formulation of the old MCHR national health plan into a bill to be introduced into Congress by Rep. Ronald Dellums of California.

In the aftermath of the fall 1972 NEC meeting the national office once more shrank to a vestige and in the next year was moved to Pittsburgh. Unlike the immediate post-civil-rights period, this time there were few local chapters for the organization to fall back on. Many had barely existed to begin with except in the body count of the national office; some, such as Chicago, had undergone political splits that spelled their demise; but most simply reaped the harvest of bitter seeds planted in other movements.

With the anti-War years over, the larger movement was in disarray. SDS and the Black Panthers had split, been repressed and faded from the national scene; many local community struggles had faded as well. With the fall of the larger movement rose the star of the Left sectarian groups, whose attraction to activists was their simple, complete and prepackaged sets of answers to the thorny issues facing the American Left and—probably more importantly—their apparent sense of purpose and community, a welcome contrast to the confusion, fragmentation and isolation that now characterized the independent Left. Political parlance came to be studded with talk of the Progressive Labor Party, the Communist Party, the October League, the Revolutionary Union and the National Caucus of Labor Committees, to mention only the most prominent.

MCHR had never anticipated the demise of the many groups that had lent it its raison d'etre. More than that, its residual reputation and appeal to new recruits, its breadth of politics and its lack of self-definition made it a perfect breeding ground for sectarian groups. Once entrenched, such groups added still another obstacle to MCHR's addressing the critical issues, since it is then put in the reactive position of having constantly to respond to the initiatives of better organized outside forces. The New York and Boston chapters withstood the onslaughts of the Progressive Labor Party only to have the Revolutionary Union rise to take its place there and in other Eastern cities. At the national level, the Communist Party began to function more overtly, and in the following years MCHR members closely associated with the Party were elected as officers and served as staff.

In spite of these setbacks and obstacles, there still exist in many cities small numbers of long-standing independent MCHR activists who are guardedly confident that MCHR can be rebuilt. They point to the ability of MCHR's name and reputation to draw new people into its orbit through low-keyed conferences, forums, projects and the like. And given the absence of any other organization to fill the bill, many activists see little alternative.

Whatever the good faith and good intentions of such individuals, however, there remains a fundamental obstacle to the realization of their hopes: Those factors that have led MCHR to the brink of total demise—its latter-
day contempt of democratic dissent, its disdain for theoretical perspective, its unwillingness to concretely analyze its activities and its impatience with the slow task of building bases—have as yet barely been articulated, let alone addressed.

Epilogue

For the decade between 1964 and 1974 MCHR was the standard bearer for the health left. Though often standing in quicksand, it still has claims to success.

MCHR was an important, frequently effective ally of the civil rights movement. More than any other organization it alerted the health community to the truth about the War in Southeast Asia. It acquitted itself well throughout by allying itself with the weakest, most oppressed and despised members of American society. More often than not its heart and muscle were on the right side at the right time.

Internally, for all its faults, MCHR can boast of accomplishments that no other health organization can claim. Even in its days of greatest doctor domination, it opened itself to other health workers and to those outside the health system altogether. It issued an early challenge to a racist health system both in terms of its delivery of health care and in terms of the treatment afforded minorities within it. Almost alone of all health organizations, MCHR saw the sexism within the health community and strove to banish it from within the organization.

Finally, MCHR was hardly alone among organizations, either in the health movement or in the movement generally, in its inability to come to terms with the two critical questions: who was to be its constituency and what was to be its strategic thrust? The long MCHR experience, in both its positive and negative aspects, has brought many MCHR activists to understand the importance of focussing their energies on a limited constituency of middle level and upper level health workers in the setting of those growing bastions of power and resources—America's health institutions.

What the MCHR experience has not done is to point the way past this most elemental step in understanding toward a strategic path which might lead to the objective of a health system humane to both its workers and its patients. To do this, we believe, will require at least two tasks, both analytical
and to some extent abstract in their nature and both, we fear, going against the grain of the impatient, action-oriented movement of the '60s and '70s. The first task is that of concretely analyzing and understanding the health system, including both an overview of its political economy, and an analysis of how it more immediately shapes the values, perceptions and relationships of the workers and patients upon whom it impinges. At the level of an overview, it is hard for us to imagine a successful movement which has not addressed such questions as: By what forces or combinations of forces is the health system controlled? Is it by doctors? . . . by administrators? . . . by banks? . . . by insurance companies? For what purposes is it controlled? . . . profit? . . . social control? . . . empire building? What is the relationship of the health system to other controlling interests in American society, for example, to multinational corporations? . . . to finance capital? . . . to labor unions? What roles does the government play? Is it simply a handmaiden of the controlling interests? . . . a mediator of them? . . . an independent force? Clearly these questions are only suggestive.

Likewise, at a more immediate level, it is hard for us to imagine a health movement serious about health workers and institutional change which does not have a firm understanding of such questions as: How has increased technology, specialization and corporatization affected the role definitions, the self perceptions, and the felt needs of health workers? Is their course, and with it the course of increased fragmentation and alienation of the workforce, unalterable? What forms of resistance and rebellion have different workers groups taken and what are the implications for the workforce as a whole and for patients? Can trade unions deal with such wide-ranging issues? Are they necessarily limited vehicles for worker defense? Or contrariwise, do they serve to regulate the workforce and integrate it into the designs of management? To what extent can worker concerns mesh with those of patients and to what extent do they conflict with them?

Finally, the success of the health movement as well as of the movement at large rests on one last and possibly more difficult analytical task. We believe that the movement must apply equal intellectual and analytical rigor to itself—its own forms, styles and modes of organizing. For it is only in doing this that the movement can effectively focus and conserve its precious energies and resources, and not squander them in impulsive reaction, outmoded models and acting out unconscious needs.

But at least three serious obstacles stand in the way of accomplishing these tasks, particularly the latter. The first is that, needless to say, activists obviously have large
personal stakes in the struggles and organizations of the ’60’s and ’70’s which, much rhetoric notwithstanding, inhibits candid criticism of political practice. Indeed, not unlike the establishment, movement organizations structure themselves to ward off criticism.

But an even more serious obstacle, we think, is an anti-intellectualism woven into the very fabric of the movement, stemming from a paradoxical and often unconscious amalgam of American pragmatism and Marxist historical determinism. From American pragmatism comes an ethos of “nothing succeeds like success” and “what works, works.” Moreover, this philosophy dictates that what “works” will be found in action, not words, although in practice the action more nearly resembles trial-and-error. From Marxist historical determinism comes the assumption that socialism will emerge inexorably from the contradictions of capitalism and that individuals can only hasten or hinder the course of history, not alter it. Thus they are also relieved from the responsibility of determining it. Together these two traditions undergird the tendency for the movement to mindlessly laud any and every activity, project and organization as signifying success by their very existence and hence bringing the movement that much nearer to final victory. Likewise, they underlie the tendency of the movement to recoil from sober evaluation of its activities in the context of larger directions. Indeed, not to accept the very existence of these activities as signifying success, to even press the need for sober evaluation, is likely to cast the critic as a defeatist when, in fact, he is like the proverbial messenger who must suffer the consequences of the message he brings.

The final obstacle is the absence of an intellectual tradition in the American Left which, when activists finally recognize the need for theory and analysis, makes them susceptible to the formalistic and outdated answers lifted from the Marxist classics and mechanically applied out of time and context to 20th Century America.

Not to address and overcome the anti-intellectual and unreflective undercurrents described above guarantees a future resembling the past, where the movement responds to rather than directs the course of history. Indeed, it is as if activists have stood attempting to discern the first swell of a wave, have leapt on and ridden it as long as possible, and then have been cast on the shore to have the process repeat itself. And at any point in time, success has been measured by the height, splash and roar of the waves. Rather, we would suggest, it is the responsibility of activists to take account of the waves, but to turn their attention to navigating the tide on the way to their chosen goal.

—Ronda Kotelchuck
Howard Levy
Vital Signs

Finding Masses En Massee

"Do it our way or not at all," the New York Cancer Society has ordered the Concerned Citizens of Canarsie, a Brooklyn group sponsoring a five-day breast cancer screening program. The source of the dispute is the community demand that women be pre-registered and appointments be made to avoid "herding them like cattle." "If we can serve only 140 women a day, there's no reason to have 100,000 people in line. We'd rather do it with decorum and make the women feel like people, not cattle," stated the chairman of the Canarsie group.

To the Cancer Society this was an "excessive demand." "We have the expertise, we know the logistics. It's national policy to screen as many people as possible and have the program open to the public," said the Brooklyn Field Representative. "As far as I'm concerned, Canarsie has already been cancelled."

50-Yard Line: New Frontiers of Medicine

The latest breakthrough in health care delivery has been pioneered by Harvard Medical School, where no one can say that medical care is inaccessible or unresponsive to at least some human needs. Harvard now stations two emergency coronary care units, manned by a four-person health team, including one doctor, on the 40-yard line during every Harvard University home game. A fatal heart attack strikes a spectator once every 2.5 home games at Harvard, and the new units have reduced the time required to get medical assistance from 10 minutes to a minute and a half.

Patient's Rights On Video

The Berkeley Community Health Project has produced a half-hour videotape entitled "Patients' Rights, or How to Talk Back to Your Doctor." Through scenes of doctor-patient encounters accompanied by commentary, the videotape deals with the right to know, the right to dignity, the right to confidentiality and the politics of the health system. The Project hopes that community health groups will find it useful as a focal point for discussion of and organization around patients' rights issues. Those who would like information on buying or renting the videotape should contact the Project at 2339 Durant Avenue, Berkeley, California 94704. (415) 548-2570.

Hamburger Hazards

A dermatologist in Beechwood, Ohio has tentatively identified a new skin condition he calls McDonald's acne. It frequently appears during the summer months (when acne ordinarily improves) among teen-agers working at fast-food restaurants, where their job brings them into frequent contact with hot cooking oils and greases. When the patient leaves the job (typically in the fall, to return to school), the acne dramatically disappears, frequently without the aid of medication. As the dermatologist notes (in a letter to the editor of Archives of Dermatology), the condition should be compensable under workmen's compensation laws.
Dear Health/PAC:

It was, of course, with great interest that I read your article "Fit To Be Tied" in the current [January/February] BULLETIN, which did present a good review of the current status of sterilization. I was pleased to participate in the background gathering and would like to reinforce the thrust of the piece. That is the role of using selective patients as so-called "teaching cases" for resident training, a practice which is the mainstay of teaching hospitals. Under our present system, it seems to me that a wiser distribution of house staff can be made so that adequate teaching is provided on indicated pathology rather than "create" quasi-indications for the sole benefit of education. No such risk to a human can ever be justified for that purpose.

As director of the section of psychosomatics of the Department of Obstetrics & Gynecology at the New York Medical College-Metropolitan Hospital, I have certainly seen this change downward in requests for tubal ligations. There are those who are active in having these prospective patients seen and counselled before the final decision is made.

However, there is one point I would like to make that is from the other side of the coin. It makes this problem of tubal ligation somewhat ambivalent in my thinking (in contrast to hysterilization, for which there is no place). I refer to the basis for much of the thinking behind the placing of women either in or out of the operating room depending on the desire, whim, or need of the surgeon rather than that of the patient. I am concerned that the other extreme is to deny the individual woman the right to decide whether she wants the procedure or not. Adequate counselling—yes. Decision making—no. The proper role of the surgeon is to give the patient the benefit of the art when the patient requests it. The doctor should give a fair, honest, and complete account of the pros and cons of any operative procedure. The ultimate decision must be that of the patient. That is what is missing—the giving up of the control in which the surgeon has such great investment. Or better expressed—the deglorification, the demystification, and the depersonalization of the medical profession.

There's the ambivalence. On one side is not placing the social-economic deprivation of the patient and thus the patient in a position of being denied so as not to persecute. The other is leaving it up to them as individuals. It all boils down to the same basic question that always is at the "bottom line"—that being poor means being second class. Poverty is our only disease state.

Again, thank you to Ms. Caress. Her survey was excellent and well-appreciated.

—Don Sloan, M.D.

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