

On Fitzhugh Mullan's: *White Coat, Clenched Fist*

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In the late 1960s to early 1970s, Lincoln Hospital in the South Bronx became a central site to a vigorous urban movement around health care. Two dramatic events set the stage. Event one: in May 1968, community health workers at Lincoln Hospital's Mental Health Services (LHMHS) protested what they perceived as the increasingly hierarchical administration of Harris Peck, Seymour Kaplan, and Melvin Roman. At its outset, LHMHS had hired more than 300 African-American and Puerto Rican community health workers, most of them residents of the surrounding community themselves, to staff three storefront "neighborhood service centers" in the heart of the South Bronx. They provided language translations from patient to doctor, encouraged apprehensive South Bronx patients to use services, and collected survey data from residents. Administrators had promised these "paraprofessionals" more community input into LHMHS's operation and career mobility through job training programs. Increasingly frustrated by the failure of the administration to follow through on these promises, the workers "revolted" in May 8-10 of 1968, staging a sit-in and a work stoppage that kept LHMHS closed for three days. A year later, in March 1969, a far more sustained and organized action occurred that led to the physical ejection of the three administrators and a standoff that lasted for a few weeks, during which participating workers slept in the facility and ran it by themselves under the leadership of Aubrey Dawkins and Richard Weeks. More than 100 workers and 21 sympathetic physicians took part, ensuring minimal disruption of care. About a

month later, most of the workers returned to their jobs, many with suspensions without pay, having secured some promises about comprehensive job training and the removal of Drs. Peck, Kaplan, and Roman.

Event two: in July 1970, some workers from the 1968-1969 events, along with members of the Young Lords Organization, a Puerto Rican nationalist group that had made health care one of its central demands, began plotting a one-day takeover of Lincoln Hospital's Nurses' Residence. At 10 a.m. on July 14, they issued demands that included immediate funds to build a new Lincoln Hospital, long promised and delayed by the city, no personnel cutbacks, door-to-door health services "for preventive care, emphasizing environment and sanitation control, nutrition, drug addiction, maternal and child care, and senior citizen services," a permanent 24-hour grievance table, a \$140/week minimum wage, and a day care center for the community and hospital workers. The final demand invoked the then pervasive rhetoric of anti-imperialism and "community control," calling for "total self-determination of all health services through a community worker board to operate Lincoln Hospital." The takeover succeeded in bringing public attention to grievances about the hospital, along with public embarrassment of the administrators deemed responsible.

Yet dramatic as these events were, there still exists only one detailed chronicling of them and day-to-day life in between. The re-publication of Fitzhugh Mullan's *White Coat, Clenched Fist*, therefore, is quite welcome. Mullan's memoir of his years as a politicized medical student, intern, and resident is a departure from most produced about the period – refreshingly free from romanticization or self-servingness, full of candor about its author's own ambivalence and internal confusion at the time period. It is must reading for

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anyone with an interest in urban health and the historical attempts, successful and otherwise, to improve it.

As he relates in the excerpted chapter, Mullan began work as a resident at Lincoln Hospital in July 1970 amidst the energy of the first two events. (Indeed, the second one occurred just a scant couple weeks after his arrival.) But he was far from a political neophyte. Just a year before, Mullan and two other fellow interns at the North Bronx's Jacobi Hospital, Marty Stein and Barbara Blase, organized a "billing action," during which patients were encouraged to withhold payments to protest a new fee increase and cutbacks in Medicaid. And Mullan and Stein went back even further as early and important members of the Student Health Organizations (SHO). Familiarity with the trajectory of SHO, therefore, is key to understanding the Lincoln events that Mullan later relates.

Founded in 1965 by two University of Southern California medical students, William Bronston and Michael McGarvey, SHO quickly spread to major medical school campuses across the country. Among other activities, its chapters hosted prominent speakers, pushed for curricular reform and social medicine programs (ultimately perhaps its most important legacy), and published magazines that examined the social, political, and economic dimensions of health and health education. One can see SHO as the byproduct of both the general political foment of the time period but also the malaise of medical education felt by many medical students then. As Mullan recalls early in *White Coat*:

Our examinations reflected the blind, anti-intellectual quality of our work. We all assembled outside the door of the anatomy lab at the appointed time... The door opened and we bustled in and took up positions in front of a cadaver, any cadaver. At the signal we were to study the organ, nerve, or vessel marked with a colored pin.... Then the exam was over and, supposedly, we were one small step closer to being doctors of medicine, physicians to the human being.

SHO's most notable activities were its Summer Health Projects (SHPs), eventually

organized in cities across the country and funded by the newly formed Office of Economic Opportunity, the federal agency chiefly responsible for distributing War on Poverty funds. The first SHP, in the summer of 1966, provided funds for "90 medical, dental, nursing and social work students from 40 institutions in 11 states" to work across California in the state's poorest areas, providing free basic screenings, birth control information, referral services, and dental work at free clinics, migrant farm worker camps, and public hospitals. The project resulted in the evolution of participants' political consciousness. At a Stanford conference where some shared their experiences, Margaret Sharfstein, who had come to California from New York City to work in the Los Angeles General Hospital, remarked: "Nurses and social workers go into the community. Why shouldn't doctors? That patient is a whole human being, with a home and a social interaction all of his own... To look at the patient as a disease alone seems inconsistent to me for the 'healing professions.'" A favorable *Los Angeles Times* article labeled these students a "new breed," as they recounted interacting with poor patients who often delayed or simply did not seek health care because of the inefficiency or patronization they encountered within health facilities. SHO co-founder McGarvey commented: "The idea that health care is everybody's right and not merely a privilege doesn't seem to have been absorbed into the bones and marrow of most people in the health professions. They act as if they are doing patients a favor. That's why they act so condescendingly."

But as the SHP's spread, so did some doubts about the projects and SHO in general. While participants found them educational, others qualified the praise with criticism of the projects' ephemeral nature. One participant in the New York project, for example, wrote of the experience in an evaluation:

According to the project fellows and SHO literature, the main goal was "sensitization" of white, middle-class, medical students. A perfectly rational idea – from the white student's viewpoint. But from the moral point of view, this is a horrendous injustice to the community! How can SHP invade a ghetto (to "help," of course) with an army of white

medical students, and for ten weeks perform acts of charity and fellowship, but simultaneously have the anguish of the ghetto as a secondary reason for justifying the existence of SHP? The makeup and foundation of SHP must be changed.

The program cover at the 1968 SHO convention asked: “WHERE ARE YOU GOING, SHO?” And in the same year, the chairman of Cincinnati SHO declared in his chapter’s publication that “the Student Health Organization was evolving through an identity crisis.” He cast the hallmark student projects as “temporary, project-oriented solutions” that “though educational, are destined to eventual failure because they don’t attack the roots of the problem.” *Catalyst*, Boston SHO’s publication, tackled the issue of overwhelmingly white health students’ interacting with predominantly poor and non-white patients, suggesting it was exploitative with a cover drawing of a light-skinned hand reaching down towards a dark-skinned one with visible skeletal structure beneath it. The following year, quotes and drawings of Mao Tse-tung, Ho Chih Minh and Che Guevara dotted SHO’s national publication, *Encounter*, with the latter appearing on the cover above the headline: “Che Guevara, M.D.: The People’s Doctor.” That same issue declared: “SHO is a liberal organization. Originally conceived as a refuge for all well-meaning and concerned, left-of-center health student activists, it has long outlived that usefulness.”

Indeed, in all its activities, SHO had defined its programs only in terms of the students and their academic and government patrons. Actual people living in poor communities and non-professional health workers had not played major roles in the planning of programs designed supposedly to help them. The projects may have transformed the *students* and built consciousness. But were SHO members taking from poor patients without leaving much permanent behind? What might they do to attain more structural improvements that lasted longer than the duration of the projects themselves? What next and what more, in short?

These sorts of questions circulated vigorously within SHO as Mullan ended his career as a University of Chicago medical student and one of the organization’s most prominent members. Mullan himself never adopted the corrosive rhetoric or revolutionary political disposition of some others in SHO’s latter days. A couple years ago, he half-jokingly remarked to me that he always considered himself the “right wing member of a left wing group,” the Lincoln Collective, the political formation he helped build shortly before his arrival at Lincoln Hospital.

In the three decades since, much lore in medical and public health circles has arisen about the Lincoln Collective, ranging from who was actually in it to what it in fact actually did. In a subsequent chapter, Mullan writes in detail about the ambiguities coloring the project from the start. “We all arrived at Lincoln,” he recalls, “with many preconceptions about what the Collective would become.” These “many preconceptions” contributed to internal tension within the group from its outset.

As Mullan recalls, the Collective began when he and two fellow Jacobi interns, Stein and Barbara Blase, conceived of gathering a critical mass of politically active interns and residents at one central location: Lincoln. They proposed a concerted house staff recruitment effort coupled with an overhauling of the pediatrics program to reflect the Collective’s political thrust. With their idea, they approached two others, Dave Stead and Charlotte Phillips, already in Lincoln internships. The only two US-trained house staff, Stead and Phillips had chosen Lincoln on political principle. (Phillips brought considerable organizing experience with her. She had helped organize Cleveland-area SHO summer health projects and SDS’s Economic Research and Action Projects, which sent students to poor communities to organize workers.) The group approached Henry Barnett and Lewis Fraad, chair and assistant chairs of Einstein College of Medicine’s Department of Pediatrics, which ultimately oversaw Lincoln’s department. Although Fraad approved the group’s plan, final authority rested with Arnold Einhorn, Lincoln’s pediatrics chair, whom many community people and hospital workers viewed as insulated and autocratic. But Einhorn surprised the group with his approval, though Mullan suspected

that the prospect of recruiting thirty US-trained house staff probably motivated him as well.

The program's creation under these official auspices reflected a tension between liberal-reformism and radicalism, and so did the actual proposed activities. Much rhetoric in its four-page recruitment pamphlet resembled that of the SHO summer projects. The pamphlet spoke of interns and residents who had "become isolated and unable to act in socially effective ways with respect to their work situations." Promises of "dissemination of knowledge from the hospital to the community, and the initiation of concurrent efforts to combat social as well as physical disease" seemed familiar. Other sections, however, suggested significant departures from the SHO days. Most obvious was a quote from the revolutionary anti-colonial theorist Franz Fanon on the front cover. In an essay on Algeria under French rule, Fanon charged doctors with complicity in the imperialist project and wrote:

In the colonial situation, going to see the doctor, the administrator, the constable, or the mayor, are identical moves. The sense of alienation from colonial society and the mistrust of its authority are always accompanied by an almost mechanical sense of detachment and mistrust of even the things which are most positive and most profitable to the population.

The Collective organizers declared that they needed "to become part of the solution rather than part of the problem" and "affirm[ed] that we are in training to serve the community, and that we are committed to dealing with the problems of the urban ghetto community in a long-run way." These new sentiments seemed a product of reflection about the summer projects and their short-term nature. The Lincoln program, by its year-round existence alone, moved significantly beyond the SHO summer project. It promised structural changes within the department, too, including continuity of care, where the patient saw the same physician on each visit and through to the outpatient clinic each time. The program also offered "clinical training which emphasizes generalism, not specialism, a reaction to the trend towards narrow specialization in medicine. A new

"community elective" required participants to spend time outside the hospital disseminating health information. Though it carried some SHO overtones, the difference in outlook becomes apparent after a closer comparison of rhetoric. SHO summer project pamphlets contained lines such as: "A major goal of these projects is to *provide us as students* with direct experience in dealing with these problems," which focused on the benefits participation would have to the medical students and their political consciousness. By contrast, the Lincoln proposal emphasized "a shared commitment to the community" and "transferring technical knowledge to the people."

With a new staff rotation, the Lincoln Collective began its work in July 1970. But as Mullan recalls, from the outset, the Collective's plans were swept up in the ongoing political agitation around the hospital. For months, a community group called the Think Lincoln Committee had operated a complaint table in the hospital lobby, partly to symbolize the perceived lack of accountability at the hospital. Some of the community health workers from the 1969 LHMHS takeover, meanwhile, had formed the Health Revolutionary Union Movement (HRUM), a group closely allied with the Young Lords. And just days after the one-day takeover, another dramatic event occurred, involving the death of a young Puerto Rican patient, Carmen Rodriguez, who had received a saline-induced abortion, a procedure particularly risky for women with heart conditions. Lincoln resident (and sometimes Collective member) Michael Smith soon learned from consulting Rodriguez's medical records that she had begun wheezing after the procedure and been given asthmatic treatments that may have exasperated her condition. The doctors who had overseen and performed Rodriguez's abortion, he concluded, seemed unaware of Rodriguez's heart condition, either through unavailability of her medical records or not taking a thorough medical history prior to her entrance.

The fall-out from the revelations came rapidly. Forced by community anger, the doctors of the obstetrics department held a public clinical pathology conference (CPC), generally a private process used by doctors to identify reasons for a failed medical procedure. At the public CPC, named a "people's CPC" by some Collective

members, OB/GYN doctors attempted to explain Rodriguez's death. Most in attendance, including Mullan, found the presentation obfuscatory at best. Led by HRUM, agitation around the head of the department, Joseph J. Smith, lasted for several more months. The protests reached a peak on August 24, 1970, when around 30 HRUM members and the Young Lords occupied Smith's office and walked him to his car, ordering him not to return.

The eventual exit of Arnold Einhorn, who had approved of the Collective's program in the first place, capped the tumultuous summer. The Collective's statements of general support for HRUM and the Young Lords – and a few Collective members' participation in their leafleting -- had increased Einhorn's animosity. In late July, twelve non-Collective pediatrics staff walked off their jobs, citing the political atmosphere of the Hospital. By the end of the year, Einhorn's animosity towards the Collective had created an unworkable relationship, and he stopped providing academic presentations altogether. But to his surprise, Barnett and Fraad decided to move him away from Lincoln Hospital to Jacobi Hospital rather than oust the Collective. Although allowed to stay at Lincoln, many of the Collective's members, for a variety of reasons, also began to question HRUM and the Young Lords' tactics, an ambivalence that became a central issue during the Collective's remaining time at Lincoln.

Mullan's analysis of this ambivalence forms the last – and perhaps most compelling – third of *White Coat, Clenched Fist*. Politically, the Collective, which consisted of about 30 members during its first year, was a pastiche in terms of programmatic goals, demeanor, and ideology. Mullan considered himself a member of its more moderate wing. But others wanted to accelerate the Collective's commitments to "Third World" groups, in particular HRUM. Soon, a "Heavy Action Committee," whose members saw themselves as more politically advanced than others, met separately over a weekend to map out relations with such groups. In December 1970, one new major relationship between the Collective and

surrounding groups that claimed to speak for workers and the community emerged: monetary. By February 1971, the Collective was regularly committing \$150-250 per month to the so-called "Third World" groups: the Black Panthers, Young Lords, and the Spirit of Logos (a Bronx drug recovery clinic), and HRUM, with each member contributing roughly \$50 a month to the Collective's budget. There were indications, however, that many in the Collective felt ambivalence towards these groups. In May 1971, towards the end of its first year in existence, its members were 3-4 months behind in dues and scrambled to make back payments after a Young Lord requested bail money, for which the Collective allotted an additional \$1000. Similar episodes occurred during its entire existence – fluctuation between feelings of ambivalence and of obligation toward outside groups. For example, Peter Schnall, known as one of the most radical members of SHO, nevertheless felt that the demands of outside groups increasingly amounted to "guilt tripping" of the Collective's all-white membership. In *White Coat*, Mullan wrestles over this issue repeatedly, at one point writing: "Obviously, we wanted to behave differently, with the result that we bent over backward not to assert ourselves but to accept the leadership of indigenous groups."

Still, even as the Collective struggled with these political questions, it made a number of early institutional changes within Lincoln to improve patient care. The changes were made largely because of new pediatrics head Helen Rodriguez's willingness to work with the Collective and the power she actually held to implement them. One of these was continuity of care. At an academic conference, Rodriguez explained the policy as follows:

Continuity clinics are a very important part of the program because we hope through them to train the young physicians in ongoing responsibility for the care of patients. This policy discourages those anonymous, casual contacts the staff usually has with patients in poor populations and in governmental institutions. The physician is encouraged to take the same responsibility for a patient as if he were the family's private

physician; patients have the phone numbers of the physician and can call them at home.

The other major medical change the Collective successfully pushed for was the Weed System of “problem-oriented record keeping.” Formalized in the late 1960s by Lawrence Weed, then a professor at the University of Vermont, over the next decade it slowly replaced a system of patient charts in which doctors haphazardly recorded symptoms without indication of their dates of origin or whether and when they were resolved resolutions. The Weed System, by contrast, required doctors to list meticulously these details, thus providing a far more comprehensive medical portrait. Lincoln was one of the first hospitals to implement it, eventually across most of the facility. Weed also closely associated his system with continuity of care, for he felt that if the same doctor filled out such a chart for as long as possible, it would more likely be done properly and thoroughly.

Introspection (and infighting) persisted throughout the first year, however, over the Collective’s exact relationship with hospitals workers and the community. Shortly before a new staff rotation in July 1971, for example, Hank Abrons hosted a hastily arranged Collective party at his mother’s Connecticut home. But of all the attendees, only one was a hospital worker, Denise Bertrand, who frequently came to Collective meetings. The remaining guests had been white Collective doctors who, after a quick planning meeting, concluded that notifying workers would require too much time on too little notice. At an emotionally charged meeting after the party, however, members concluded that “the racism of the decision slipped by the people in the last meeting.” The meeting’s note-taker summarized: “Everyone knew they were exercising class privilege but were not talking about it.” By late August of 1971, the house staff rotation and the departure of half the Collective, including some founding members, had occurred. Continuing the anxiety of early summer, many Collective members expressed frustration with the lack of appreciable political progress. A note-taker at the August 10, 1971 meeting recorded “feelings of ‘something missing’ from the collective this year – of dissatisfaction and frustration, of hopes unmet

and actions not carried through. Of the ‘collective’ being an elusive and perhaps illusive concept...” “Who are we / What are we / What are we doing / What are we doing here... Do we follow/ Do we lead... Are we philosopher-kings or workers, actors or acters? ... A consensus was reached to try again,” ended the log.

Two weeks later, HRUM and Collective members met to discuss their future. In their presentation to the Collective, HRUM members “apologized for their failure to provide more leadership stating that there has been an acute shortage of people power for the last several months...” At the same time, they insisted that they would “give leadership” to the Collective. As one member summarized:

They pointed out that doctors are limited by their class position, especially in attempting to work in a third world hospital. The fact that we are members of the ruling class with special privileges separates us from other workers in the hospital. They felt we were often guilty of having a colonizer attitude.

But far from “going home,” HRUM argued, the Collective needed to stay, for it possessed essential skills and technology that few had the knowledge to operate – all necessary for true “worker-community control’s” eventual implementation. Although most Collective members went along, many like Mullan also felt doubts towards the notion of “taking leadership” from another group, particularly with their experiences as leaders in a vibrant student health movement just a few years earlier.

These doubts grew as HRUM increasingly imposed its amalgam of anti-imperialist and Marxist-Leninist-Maoist politics on the Collective. In January 1972, it removed its white members, placed them instead in the Health Revolutionary Alliance (HRA), which would include the Collective’s most radical members in their eyes. HRA sent the Collective’s Hal Osborn to sell HRUM and the Young Lords’s newspaper at Greenpoint Hospital in Brooklyn and other hospitals in working-class white neighborhoods as part of “develop[ing] working class and proletariat ideas,” which to some Collective members took away personnel from problems at Lincoln,

particularly given the downsizing of the house staff. (When I spoke to Osborn recently, he recalled that he began to have doubts about the task.) At a March 1971 Collective meeting, members raised questions about whether “tension” existed between the Third World groups and the Collective. A debate involving whether to help raise \$6,000 bail money for three jailed Young Lords reflected growing uncertainty among some Collective members over relationships with outside groups. It also showcased lack of uniform political opinion that had plagued decision-making from the beginning and made difficult an agreement on common purpose within the Collective. Members attacked frequently for “individualism” or political moderation, like Mullan, would sometimes nevertheless ardently support the outside demands. On the question of bail money, for instance, Mullan demanded the Collective “stop shitting around” and that every member “should be made to pay.”

Eventually, the relationship with HRUM withered for a variety of reasons. First, HRUM and the Young Lords underwent internal disagreements and moves of key leaders. Its “worker-community control” demand, meanwhile, turned out to be much less clear in practice. Despite the events of 1969-1970, the “community” did not continue mobilizing in as militant and persistent a manner as might have been anticipated, perhaps because hospitals were not institutions with which community members interacted on a day-to-day and regular a basis, unlike schools. Moreover, it was always unclear what exactly “the community” was, anyway, beyond an opportune construction invoked by groups purporting to speak for it. Interpersonal relations within the Collective worsened as these political questions went largely unresolved. Those deemed overly moderate were accused of “individualism,” among other characterizations. More radical members were increasingly viewed by others as overly deferent to HRUM/HRA at the expense of the Collective. This dichotomy, of course, was hardly rigid, and while Collective members may have leaned one direction or the other, they also occasionally felt torn between both.

As for the “worker-community control” concept, for all its ambiguities, it was far from a

completely unrealized pipe dream. Towards the end of its first year, the Collective began a Pediatrics Parents Association within the pediatrics department, which would learn about children’s problems, take occasional part in rounds, and most importantly, have input into the house staff selection. During staff selection, parents were allowed to ask candidates questions, and at one point, a 10-year-old and an 11-year-old also participated in interviews. Governing committees within the department were also restructured, and parents, nurses, and workers were encouraged to attend and allowed to level complaints against doctors during “criticism self criticism” sessions. For example, in one such meeting, nurses complained that “some doctors [had] a poor attitude and [were] hard to locate.” Others complained about doctors’ tendency to admit patients for stays even if they did not seem ill. Meetings in which nurses and health workers could openly attack their physician supervisors without fear of reprisal represented an attempt to level historic status differences between health personnel. It was some attempt to “ignore professional hierarchies,” as stated in the first Collective recruitment pamphlet.

Even as the Collective began to peter out by 1975, most who had spent time in it – Mullan would leave in 1972 -- developed new political consciousness during their time there. They gained new insights into the privileges that came with being white physicians in a municipal hospital, and had been exposed to the grim, even deadly, effects of institutionalized racism’s effects on health. Along the way, they succeeded in making both modest and major changes in Lincoln’s medical operation, which increased patient accountability and participation of those who used the hospital. In one year, the Pediatrics department received a city rating of nearly 30 points higher than the average. Still, there was no denying that the overall condition of Lincoln hospital remained in dire shape, much of it outside the Collective’s control. Mandatory reductions in the number of patients to a ward regularly occurred throughout its presence, as did annual budget cuts against the backdrop of a looming urban fiscal crisis that would take a devastating toll on the overall public health of New York City. In mid-1973, Peter Schnall and Al Ross wrote to Lincoln’s new

executive director, J.C. Galarce, with a list of more than forty hospital inadequacies. “The list is by no means all inclusive and far from excessive or lavish,” wrote Schnall and Ross. “It seems to be, however, a bare outline of what most people feel is necessary to provide acceptable working conditions and patient care.” In late 1974, Lincoln briefly lost its accreditation after an inspection by the Joint Commission on Accreditation of Hospitals. Reasons cited were the dilapidated facility and overcrowding.

Two statements by Collective members raised provocative questions about the group’s success and failure of the Collective. The first came from Ellie Graham during an argument around meal tickets. She explained how she failed to see the relationship between “personal revolutionizing and world revolution...” Graham’s question was not new. A variant of it had surfaced back in the days of summer projects, when students asked whether it was sufficient merely for internal, personal political development to occur within them even as the long-term state of health care remained poor. The question was equally applicable to Lincoln, given its overall shape even after some internal improvements. Was the greatest consequence of the Collective in fact not change to Lincoln or the broader health-care sector but personal transformation? And was that good enough?

The second statement, from Mike Steinberg, came from an article in *The Sciences* on Lincoln. Steinberg remarked:

It is not enough to change just one hospital or just the medical system. To meet the health and living needs of all the people in the country, we need a more fundamental change of government in society. It would be a token to have community-worker control of this hospital and provide good services if people are going to live in miserable housing, if they don't have jobs, if they are forced to be on welfare.

Steinberg asked not only whether organizing within a single institution was enough but also whether it was sufficient to alter the health-care sector alone. Was it possible to discuss separately the overhaul of the health-care sector without discussing an overhaul of the broader society in which it existed?

These two quotes, I think, capture the essence of Mullan’s work. One gets the sense after closing it that he continues to ask himself these questions and that the answers keep changing. The book, to its credit, avoids simplistic moral declarations about the politics of Mullan’s era, the events he experienced, and the people he encountered. One finds instead an enormously introspective and self-critical narrator whose nuanced voice ought to be read inside and outside the health sector. With its republication by the University of Michigan Press and *Social Medicine*, I hope more generations will be able to discover and debate the important issues it raises

