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promotion remains an obvious feature of office practice. Patients may be anxious as to what will happen if they *do* seek care as well as if they *don't*.

Organizational features, such as appointment hours limited to times that conflict with work or home duties, may also be significant. Revising such features may be more effective if allowance is made for patient attitudes and circumstances. Assessing timeliness helps provide feedback on the effectiveness of efforts to wipe out delay.

However, the providers' evaluation has shortcomings. It does not really see "need" as the patient sees it. The predicted medical effects of timing have to be validated after an appropriate lapse of time (longer than one week).* Furthermore, the totality of the system must be taken into consideration. Timeliness in regular departments is not independent of walk-in opportunities in the same facility, telephone arrangements, etc.**

*Measurement of this type would require careful sorting of patients by multiple system disease, severity and other medical and social/psychological characteristics.

**Access as perceived by patients has dimensions that may not be encompassed in having a regular source of care.

The analysis of timing of care reported in this issue of the Journal[1] is based on a white population with above-average income. Do other population groups interact with health care systems in the same way and for the same reasons? It is time to find out, and to use the findings to improve health care delivery.

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The Environmentalist's Challenge

It is barely 16 years since Rachel Carson's *Silent Spring*[1] initiated a serious concern for the environmental impact of our commercial and industrial activities. The immediate response in most quarters was that this book overstated a relatively small problem. We have come to learn, however, that the warning was correct. The late 1960s saw the development of a popular national effort, culminating in Earth Day, which called attention to the need for a public commitment to a safe and healthy environment. Althought some saw this as a passing phase, the reemergence of popular protest against nuclear power and even high power transmission lines has gained a growing coalition of young and old, liberal and conservative calling for the preservation of the environment.

One of the benefactors of these developments has been the environmental scientist. New federal and private monies have been committed to support teaching programs and innovative approaches to problem solving. Much regulatory legislation has been passed. Some is directed to the control of existing sources of pollution; some is designed to prevent the introduction of new sources.

Observing these developments, people interested in environmental quality have been pleased by the emphasis on the preparation and consideration of environmental impact statements before the launching of new governmental programs. They have watched with some satisfaction the reduction in automobile and industrial pollution, even if the process has been frustratingly slow. They have even been surprised to see the development of evidence which suggests that increased pollution control may on balance create new jobs or save money, thus at times countering spurious economic arguments propounded by some polluters.

But scientists addressing environmental problems are being faced with second-order problems they may have hoped to avoid. For example, it seemed eminently reasonable to prevent atmospheric lead pollution by phasing out tetraethyl lead as a component of gasolone. The fight was a long one but eventually a successful one—phasing out has begun. Part of the problem, however, continues, as presented in the article in this issue by Joselow, et al.[2] The authors report that one of the replacements for organic lead has been organic manganese. Using methods similar to those characterizing pollution by lead from automobiles and its absorption by human beings, the investigation suggests a new problem. Manganese appears to be distributed in a manner similar to lead and in direct relation to traffic density. Unfortunately, the health effects of manganese are relatively poorly understood. Levels encountered in certain industrial settings are known to result in alterations in psychological and neurological function. But no data are available on low level, long-term exposure, especially in the general population.

The hazards of substitution are not new to environmental scientists. Inevitably judgments based on imperfect infor-

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mation must be made. But just as they understand the interdependence of all life systems, environmentalists must come to understand the interdependence of scientific and social or political decisions. In the case of lead additives, significant reduction in environmental lead may be accomplished by replacing lead with organic manganese, or by replacing autos with mass transportation. The former solution is largely a technical one which inevitably has its technical consequences. The latter solution is primarily social and political with social and political consequences. Utimately, there are no scientific answers to political questions. Perhaps the most important help scientists interested in the environment can offer will be to provide the background material to make unpopular social or political decisions; decisions which may require sacrifices we would otherwise not be willing to make.

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Limitations of Community Control of Health Facilities and Services

Within the last ten years a considerable literature has emerged on the subject of community participation in the control of the operations of health care services and facilities in the United States. A great deal of this literature has concerned experiences arising from the Neighborhood Health Center movement, which received its principal stimulus from the Federal Office of Economic Opportunity. In this issue of the Journal, Warren Paap has drawn upon that literature as well as his own experience to present us with some of the "structural problems" consumer-based boards of health centers have "in achieving effective control" of them.[1] Among the major problems observed by Dr. Paap are the following:

- Institutional structuring of information and the problems of health care delivery system language for nonprofessionals;
- Institutional structuring of time, and the limitations that time constraints impose upon consumer participation;
- Structural basis of contacts and careers which give many professionals inherent advantages in decision-making powers over consumers, especially working-class ones;
- The lack of political power bases in the community for most community representatives; and,
- "Organizational imperatives" which may make significant consumer involvement dysfunctional to program operations.

Dr. Paap concludes that it may not be possible to overcome these problems and produce more "consumer control" by educating consumers either about their roles or about the health care delivery system. He proposes instead to stress the building up of the influence of consumers at all levels of the health care delivery system rather than just at the local level as has been stressed to date. This development would serve to create consumer information, communication, and influence networks, distinct from the professional networks which, in Dr. Paap's view, provide professionals with so much of their power.

Some time ago, I took a look at the problems of "community control" in health services facilities.[2] I concluded then, and still believe, that the principal obstacle to community control in the health care delivery system is the fact that control over the system's basic *building blocks* (expense budget, capital budget, and quantity and quality of staff) does not lie within the realm of a local community board or of a local program administrator. Because of the nature of the medical licensing and fee-for-service private entrepreneurial medical practice systems, a great deal of the medical program decision-making in the system is undertaken by one group—the physicians—who are essentially beyond the control of anyone.

The health care delivery system in the United States, more properly called the disease care delivery system, is oriented toward the diagnosis and treatment of acute illness. Because prevention is generally ignored, diagnosis and treatment are in fact the system's centerpieces. The medical license gives the physician essential control over diagnosis and treatment, and thus over the system's centerpiece. One could, of course, reason the other way: that because the license gives the physician the powers of diagnosis and treatment, *they become* the system's centerpiece. The functional outcome is the same. Physicians independently make the decisions concerning the allocation of 60 to 70 per cent of the resources expended by the system, a powerful position indeed. About 80 per cent of all physicians in active practice, other than house-staff, are in private fee-for-service practice.[3] Control of the system's centerpiece is thus exercised

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