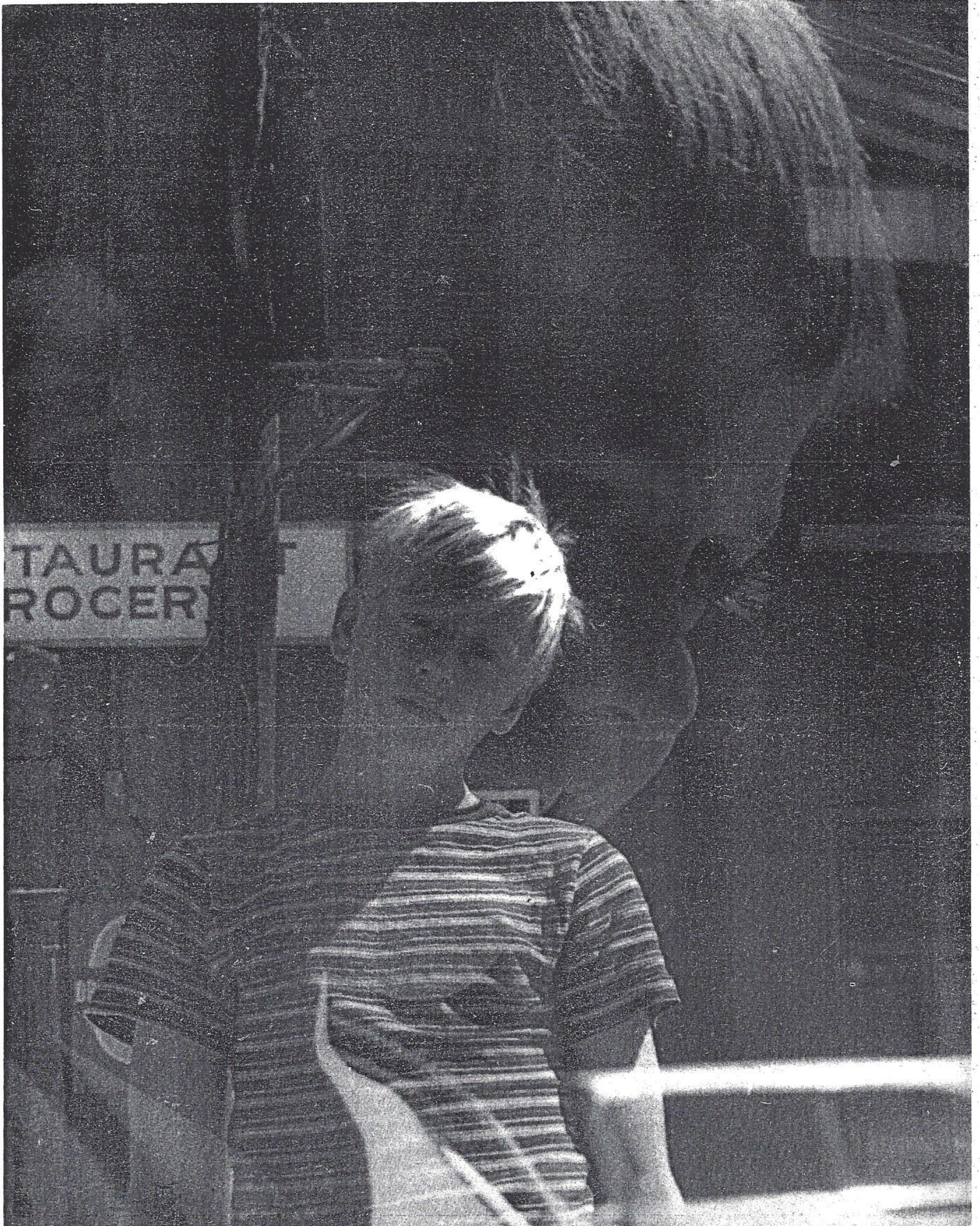
CONTACT #1

October 1968

publication of the mcgill student health organization



CONTACT

Student Health Organizations (SHO-s) in the United States have named their magazines "Yes", "Conception", "Current", "Encounter", and "Borborygmi". We selected "Contact". We felt this best expresses what we do to the people in the community, and what the people do to us.

Moreover, this issue's first aim is to contact you! We feel our activities are worth communicating to all of those who are concerned about health care in our community, both laymen and professionals, both students and practitioners, both French and English speaking.

Our second aim is to provide you with an opportunity to express your opinions. Articles as well as comments in letters to the editor will be accepted for publication in our next issue. Our favourite words include "community-oriented", "interdisciplinary approach", and "total-patient care". Although we select some material on the basis of favourite word content, our interest is not restricted to community medicine, and we welcome political, humorous, literary, and artistic works of our readers.

Nous aimerions aussi des contributions de langue française.

The opinions expressed in this publication are not necessarily those of the Editorial Board. We will print anything within bounds of responsible journalism, which, for us, includes the principle that we do not compromise our effectiveness in providing community health services. For this reason also, we are attempting to keep this publication restricted, and wish to avoid all publicity in the press.

DEADLINE FOR NEXT ISSUE: December 15, 1968.

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Montreal 2, Quebec.

FOUNDING FATHERS OF THE McGILL SHO

Danny Frank MDCM III Director
Alan Bailin Sociology II
Frank Gougeon MDCM III
Charles Larson MDCM II
Stan Spevack MDCM III
Margaret Ward MDCM III

The fathers are aging rapidly. Young blood (MDCM I and II) is desperately needed! If interested, please contact Charles Larson, 3571 Aylmer, Apt. 3 – 288-4052.

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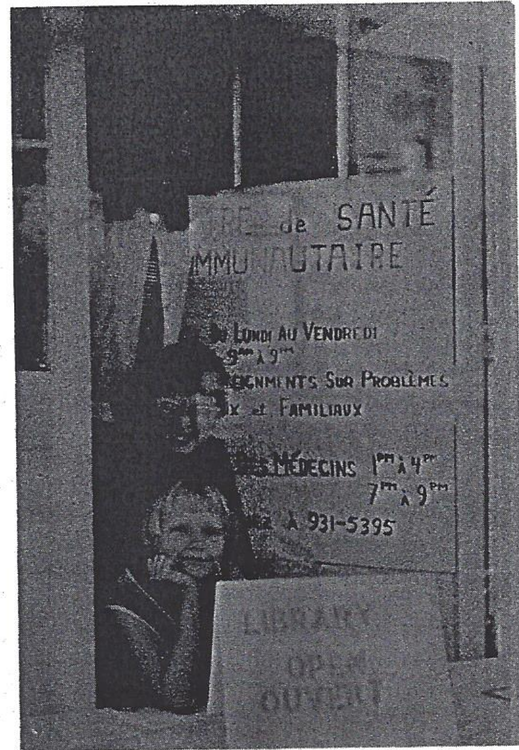

Charles Larson

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foreword

The desire to serve has always been a major factor in the choice of medicine as a career. In the past, this desire was satisfied by the practice of family medicine, whether as a general practioner, internist, pediatrician, or gynecologist. Osler's "Beloved Physician", a title to which the majority of us have consciously aspired, is a role which is increasingly difficult to fulfil. Of the many reasons for this, perhaps the most potent is the vast increase in scientific knowledge that must today be mastered if we are to practise medicine with competence.

Since we cannot main mastery across the whole front of medicine, we increasingly tend to abandon the attempt and aim at proficiency in a more narrowly specialized field. In this way we may recover some degree of mastery of our own chosen specialty but in doing so we lose our competence to treat the whole man. We resign our role, then as a "Patient Doctor", to become a "Heart Doctor" or a "Kidney Doctor" and, in consequence, we can only function as a unit in a health team. Because the health team at present can only function in the hospital, the profession withdraws increasingly from the community.

This trend is, of course, irreversible. However much we deplore his passing, the mutli-disciplinary one-man diagnostic and therapeutic unit, who can carry his complete armamentarium in one black bag cannot long survive the information explosion. The hiatus left by his disappearance must now be filled. The health team must move back to the community. This takes new initiatives and new thinking. The adventure described in the following pages offers a stirring example of how this challenge may be met. I am extremely proud to be a colleague of the "student activists" who not only have realized this need but have devised means for answering it in the middle of their medical training. We of the McGill medical community owe a debt to them, to the Faculty members who work with them, and to the generous donors who have supported them, for the initiative they have taken.

Maurice McGregor M.D.
Dean
Faculty of Medicine

ENIVREZ-VOUS

(Be Always Drunken)

Il faut être toujours ivre. Tout est là: c'est l'unique question. Pour ne pas sentir l'horrible fardeau du temps qui brise vos épaules et vous penche vers la terre il faut vous enivrez sans trève.

Mais de quoi? De vin, de poésie ou de vertu, à votre guise. Mais enivrez-vous.

Et si quelquefois, sur les marches d'un palais, sur l'herbe verte d'un fossé, dans la solitude morne de votre chambre, vous vous réveillez, l'ivresse déjà diminuée ou disparue, demandez au vente, à la vague, à l'étoile, à l'oiseau, à l'horloge, à tout ce qui fuit, à tout ce qui gémit, à tout ce qui roule, à tout ce qui chante, à tout ce qui parle, demandez quelle heure il est; et le vent, la vague, l'étoile, l'oiseau, vous répondront: "Il est l'heure de s'enivrer! Pour n'être pas les esclaves martyrisés du Temps, enivrez-vous; enivrez-vous sans cesse! De vin, de poésie ou de vertu, à votre guise."

Baudelaire
from "Le Spleen de Paris"

The load of to-morrow added to that of yesterday, carried to-day, makes the strongest falter. Shut off the future as tightly as the past. No dreams, no visions, no delicious fantasies, no castles in the air, with which, as the old song so truly says, "hearts are broken, heads are turned". To youth, we are told, belongs the future, but the wretched to-morrow that so plagues some of us has no certainty, except through to-day. Who can tell what a day may bring forth? Though its uncertainty is a proverb, a man may carry its secret in the hollow of his hand, make a pilgrimage to Hades with Ulysses, draw the magic circle, perform the rites, and then ask Tiresias the question. I have had the answer from his own lips. The future is to-day — there is no to-morrow! The day of a man's salvation is now — the life of the present, of to-day, lived earnestly, intently, without a forward-looking thought, is the only insurance for the future.

William Osler
from "A Way of Life"

the mcgill student health organization

INTRODUCTION

In the summer of 1967, a group of medical, nursing and sociology students from McGill University in Montreal met to discuss certain deficiencies in the medical curriculum as could be appreciated from a student's vantage point. As a result of these discussions, a Student Health Organization (SHO) was formed with the initial purpose of establishing a project in community medicine. The activities of the McGill SHO during the summer of 1968 included:

1. The establishment of a community health center which offered total patient care to the community.
2. An alleyway recreation project.
3. A tutorial project involving the local elementary schools.
4. Social animation.

These four aspects of the project have been extended into the winter months and will be described further in this issue.

The raison d'être of the McGill Student Health Organization is to produce a vigorous approach to the problems of urban health care, social welfare, and medical education[1]. As students in the health profession, we are faced with textbooks and long hours of study, and are thus afforded little opportunity to express ourselves in a socially constructive manner. The effects of four years of this experience are well documented[2,3,4]. Until now, there has been little opportunity within the medical curriculum for training and experience in such important fields as community medicine, community psychiatry, family practice, and public health. Further, we are concerned with trends in medicine which involve the study of diseased organs rather than sick people. Large hospital medical care, however essential, involves a highly technological environment where consideration for the individual patient becomes lost in the swirl of hospital efficiency, specialized services and emphasis on sophistication. We are concerned with the set of priorities that permits great energy and finance to be expended in the transplantation of hearts and kidneys when the very community in which the hospital exists has a glaring lack of basic medical care and thus exhibits inferior health standards[5]. Many of the people whom we have met in Pointe St. Charles do not own toothbrushes and are ignorant about their use.

The same iniquities exist within the sphere of education. The children whom we have tutored cannot multiply six times seven, nor can they look up a name in the telephone book. This is after five to seven years of elementary school! How are they to function in high school or compete as adults in an increasingly competitive economic society?

Lastly, we feel that the approach to poverty which involves the sole use of charity is inadequate. It is our opinion that individuals and communities must be directly involved in the improvement of themselves and their social conditions before any lasting beneficial effects may be had. The simple offering of services to a poor community, without that community feeling both responsible for, and justified in their existence, represents in our minds an insufficient effort.

THE COMMUNITY

A brief word about the community in which our project is located. According to the census of Canada, 1961[6], Pointe St. Charles is a low-income district located in southern Montreal between the Lachine Canal and the St. Lawrence River. Of the 25,000 people living there, approximately half speak French, and the other half, English. The average rent paid in the district is between $38 and $50 per month, and the average income for employed males is $3,312 per annum. Large families, crowded dwellings, and lack of sanitation and nutrition are apparent. There are many recipients of public assistance living in the area.

Out of 1,080 school children living in one of the census tracts, 900 were in grade school, 172 in high school, and eight in university. According to several principals, teachers, and a committee of professionals studying education in Montreal's inner-city schools, there is an 80 per cent drop-out rate in high school. Significantly, there is no high school in the district, nor are there any bus service provisions besides public transportation to the distant high schools.

Medically, there are only four general practitioners located in the area, none of whom maintains an active full-time practice, and only one of whom lives in the area. This represents one physician per 6000 people. The Canadian average in 1961 was one physician per 857 people[7]. The signs and symptoms which cause parents to bring themselves or their children to a doctor are more severe than in other neighbourhoods, and diseases such as rickets, tuberculosis, pneumonia, parasitic infections and malnutrition are virtually endemic to the area[8]. The mental health of the community parallels the physical, a known fact in such underprivileged communities[9,10]. The stresses placed upon adolescents and the fathers of households are particularly acute. Finally, there is no hospital located in the area with available medical or social services.

PRESENT STATUS

During its eight-week tenure, the Project in Community Medicine has met with initial enthusiasm and approval on the part of the community, local health workers and educators, and the involved members of Montreal's health professions. We have been asked to sit on the Health Committee of the Montreal Council of Social Agencies, which is the coordinating and policy-forming body for all of the English-speaking health and social welfare agencies in Montreal. Also, we have been asked to present the topic of Community Medicine and our approach to it to the Behavioural Sciences section of the first year medical course at McGill. In addition, the Project has been incorporated by the Faculty into the medical curriculum: under the newly expanded elective programme, medical students may choose the Project in Community Medicine for their ten-week placement in the second, third or senior year. This development will enable us to have the Project staffed with medical students on a year-round basis.

Danny Frank
MDCM III

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GOALS & OBJECTIVES

WE BELIEVE THAT HEALTH CARE IS A BASIC RIGHT, NOT A PRIVILEGE.

EDUCATION

1. To involve doctors and medical and paramedical students in the problems of health care as they are encountered in a medically needy area.

2. To develop a more realistic understanding of the physical and social environment of the underprivileged.

3. To stimulate and help implement curriculum revisions in medical schools so as to include student experiences in community medicine, both during the summer and the academic year.

4. To explore new medical-care rôles for professionals, non-professionals, and health students.

5. To promote the implementation of the multi-disciplinary team approach to health problems and the integration of students into the functioning of neighbouring social agencies.

6. To encourage medical and paramedical students to spend their careers in medically undermanned areas.

7. To inform the medical profession at large of the health and social problems encountered in such a community and of our efforts to deal with them.

COMMUNITY INVOLVEMENT

1. To involve the community in its own medical, social, educational, and recreational problems by the following means:
   - i) Developing an awareness and definition of problems in these areas.
   - ii) Encouraging the development of a community voice in the management of their problems.
   - iii) Providing discussion and exploring possible solutions to these problems.
   - iv) Fostering general medical enlightenment in the community.

2. To encourage the establishment of much needed health, educational, and recreational facilities.

RESEARCH

1. To evaluate and explore the effectiveness of our health centre as a means of providing the patient with community-oriented, non-hospital-based medical care, and as a method of dealing with contemporary urban medical problems.

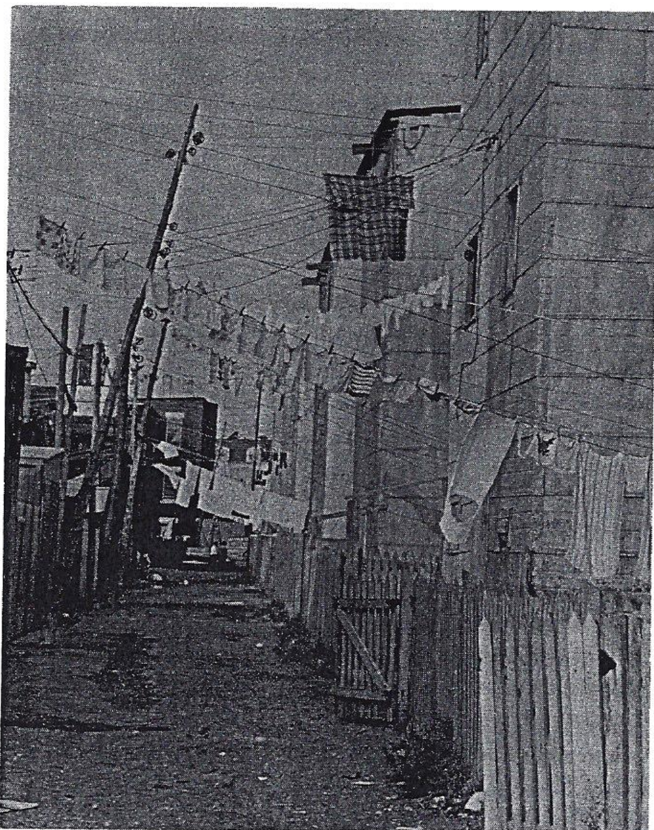
2. To evaluate the usefulness of this type of field experience for teaching concepts of epidemiology and public health to medical students.

3. To evaluate the effect of such a project on attitudes of medical students towards the underprivileged and their health problems.

4. To evaluate the effectiveness of the specific techniques and strategies used in the project to produce community involvement in its own problems.

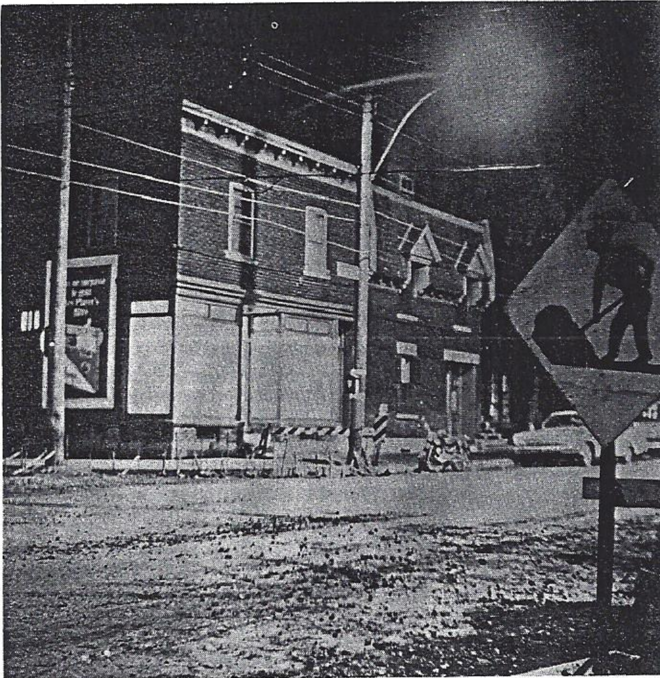
5. To provide essential (and heretofore unavailable) demographic, medical and epidemiological information about such a community.

Bob Allnutt



the storefront medical clinic

On July 2, the Project opened a storefront medical clinic at 0900 Charlevoix Street in Pointe St. Charles. The premises, formerly occupied by a grocery store at a street corner, is located in the midst of a heavily populated district. The three rooms in the back of the store were converted into a laboratory and pharmacy, waiting room and examination room. The front store was retained for an information centre, tutoring classroom and meeting hall.



George Siber

THE CLINIC

The Clinic was staffed in the following way: a general practitioner was hired to work afternoons, Monday to Friday. Staff physicians from the Faculty of Medicine's teaching hospitals (Royal Victoria Hospital, The Montreal General Hospital, and the Montreal Children's Hospital) were approached to donate time in the evenings. The back-up paramedical work (appointment-taking, laboratory work, bandaging, medical history-taking, home follow-up visits, supplies, etc.) was done by two full-time medical students each day and by staff and non-staff medical students and nursing students offering their time in the evenings. The bulk of the medical equipment, supplies, drugs, and technical know-how, was supplied by doctors who have worked with us. A clinic fee of fifty cents was charged each patient who could afford it. The four local doctors were contacted, and, overburdened as they are, were quite happy to refer needy patients to our clinic. In fact, the great majority of our patients were unable to afford a private physician. Approximately 50 per cent came from families whose head was unemployed.

In the first thirty days in which the clinic was open, there were 437 patient-visits and a total number of 363 patients. This number does not include house visits by the afternoon doctor, or the fact that about two-thirds of the patients seen in the evenings were visited at home within the next few days by a medical student to check the course of the illness and the results of therapy. The medical students never took direct medical action and were always under the responsibility and supervision of the doctor who had treated the patient. Many of our patients were children, and common adult problems in the community were of a psychiatric, dermatological, or gynaecological nature.

It is difficult to capture the uniqueness of this community-based health centre. The atmosphere is one of informality and friendliness, owing to the personality of the people in the neighbourhood and to the casual and genuine approach of the physicians, medical and nursing students. The waiting room is plastered with posters about nutrition made by local children and it is cooled by fans donated by a neighbour. The nursing student-receptionists generally engage the patients in conversation, one likely topic being the tutorial or recreation programmes for the children. It is here that the multi-faceted approach of the health centre (medical, educational, and recreational) has made quite apparent the interaction of culture, education and social factors with individual and community health. It has become very clear that it is futile to attempt to alter the pattern of disease in this neighbourhood without a greater effort on the part of health workers at understanding the cultural characteristics of the people with whom they are working. In this respect, the tutorial and recreational programmes in addition to the medical clinic continue to serve as valuable entrées and learning devices.

EXTENDED PLANS THROUGH ROSY GLASSES

In September 1968 the Project in Community Medicine, in conjunction with the community and the Faculty of Medicine with its teaching hospitals, will become a permanent activity. This will involve three full-time workers (secretary, nurse and social animator), a part-time physician, medical students on their elective time (and perhaps social work and nursing students) and the establishment of medical specialty clinics by interested professors and resident physicians from the three teaching hospitals. For example, the Department of Community Psychiatry at the Allan Memorial Institute of the Royal Victoria Hospital will send a team of workers (including a psychiatrist) to our clinic one afternoon per week with the joint purpose of offering a badly needed service to the community and of providing psychiatric training for medical students and resident psychiatrists. In this fashion,

high quality medical personnel will be available to this community. The part-time physician (afternoons, Monday to Friday), nurse, and secretary will form the permanent backbone of the clinic staff. In the evenings, the medical clinic will remain staffed by volunteer phsycians, medical, nursings, and social work students.

In addition to remaining open as a medical clinic, the Project will undertake several measures of public health and epidemiology. The medical students and nurses, in addition to working with the doctor and making home follow-up visits, will be responsible for compiling demographic and epidemiological data on the patients who attend the clinic. Factors of interest are the types and chronicity of diseases encountered, child nutritional indices such as height and weight, employment records, etc. Further, we intend to initiate a programme of complete medical and dental check-ups for the local school children, as well as a school tooth-brushing project (a brush-in!). Lastly, we would like to design and distribute a readable pamphlet concerning all vital medical and social resources available to the community, which will also include basic tips on disease detection, nutrition, and sanitation. In conjunction with this, several law students at McGill are in the process of establishing a legal aid service in the storefront.

Danny Frank
MDCM III

Charles Larson

the alleyway

The alleyway project was created for two reasons: manifestly to provide recreation for children, indirectly to provide closer contact with the community. It proved very helpful in getting the people involved with the health clinic and in starting active groups interested in improving the community.

Four teenagers from the neighbourhood were hired as monitors, an alleyway was blocked off by the police, and the project was started. Approximately 70 children came every day with an average of about 45 at any one time. There were four groups of children, both older and younger, the younger groups encompassing the ages four to eight, and the older, nine to thirteen.

Much of the days' programmes were games such as dodgeball and soccer, but each group planned its own projects in arts and crafts, ranging from mural painting to the making of puppets by the younger girls' group. When the children wanted to, they sang in groups. The older girls planned a dance and the older boys formed a baseball team. Monitors were encouraged to sit down with the children and discuss with them what they wanted to do.

Picnics to the country were held every Wednesday and about 100 children turned up every time. Groups went with their monitors to other parts of Montreal. A majority of the children had never seen these areas before. There was always a great increase in attendance for these trips.

There were many problems. Among the most difficult were the monitors themselves. Not enough time had been allotted, before the project began, to choose and train them as group leaders. No one could be found to be a satisfactory leader for the older boys' group.

While the children were playing, we were busy making contacts with their parents simply by talking to them on their porches or on the street. Many volunteered to help us on the picnics.

Near the end of the summer, we called a meeting of the parents in the area to discuss recreation during the winter. Approximately 40 parents attended. A committee was elected to institute some sort of recreation programme during the winter. Among the difficulties which this committee discussed was the fact that most recreational facilities were too far away for the smaller children and frequently not trusted by parents. In the more distant parts, the monitors spoke only French and they were there only part of the time. Everyone agreed that things had to be changed. All liked the alley project and wanted a similar programme next year. Many expressed interest in the clinic and had attended because they had heard of it from their children or had met the medical students through the alleyway project.

In its totality, the project was a success and proved to be a good method of getting an "in" into the neighbourhood.

Alan Bailin
Sociology II

Community Health Centre

Are Community Health Centre is on the corner of Charlevoix and Knox. The Clinic opens 7:00 for appointments to 10:00. People come in when thier sick or hurt. We have docters come in every night. Some times during the day I go in the Clinic and read books and play game. Sometimes I make posters for the Waitingroom. Some night I stay in the either room and answer the Telephone. We have five rooms. I did posters on Health, teeth, hands, face and either thing. The Community Health Centre open on July 2, 1968.

Sharon Campbell
Age 12

the tutoring project

As we had anticipated when first planning the tutoring project, the children of Pointe St. Charles introduced us to the community. Our first invitations into homes in the neighbourhood came as we met the parents of our students and explained to them our plans for their children. Although our proposals were met with varying degrees of interest, we invariably obtained their approval for the project as well as a friendly contact within the community.

We had many heated discussions on the subject of the priority of objectives within the tutoring project. Were we to teach the children the practical skills of letter writing, using a telephone directory, making change, etc., the results of which could be shown on tests? Or were we to provide motivation for learning through a big brother (or big sister) relationship, the results of which could not be so easily assessed?

To implement the program, forty children from grades five, six, and seven were chosen with the help of the principals and teachers of two local elementary schools. They were chosen on the basis of an average intelligence but low motivation and poor performance in school. These children were subjected to educational and attitude tests, specifically the Stanford Achievement Test (intermediate level for arithmetic, reading, vocabulary, and language skills), the Mooney Problem Check-list, and a form of the Osgood Semantic Differential adopted for school attitudes. From the results of the Stanford Achievement Test, the forty children were divided, by matched scores, into a control and an experimental group. The same tests will be performed again at the end of the project.

Each of the seven staff members assumed responsibility two or three students whom he tutored for two or three ho a week in English or Mathematics and whom he took on ex sions in an around the city. A typical morning at the clinic would find Charlie sequestered behind the portable blackbo in a corner of the storefront enthusiastically teaching 14-ye old Frank that 6^3 means 6 times 6 times 6. In the same ro there would be two or three children playing Monopoly or Scrabble. It was hoped that these games would unobtrusiv improve their basic skills. In the examining room Sharon w be composing a letter to the American Dental Association r questing posters for the waiting room of the clinic. And in waiting room, I would be attempting to ignore the distracti of little boys needing bandaids and the constant ring of tw phones, while teaching Cathy the basics of making change.

The short trips within the city and environs were enjoye all the staff as well as being special treats for the children. some of them, their first trip downtown was a shopping ex sion for the clinic. One little girl has an exciting story to te about being chased by the peacock at Granby Zoo. The m successful trip of the summer was a full day at Upper Cana Village where the biggest attraction was the horse-drawn p ger cars.

The success of the tutoring project was limited by the m problems we encountered, in the children themselves, in th environment, and in ourselves as tutors. Only about ten o original twenty children chosen took part in the program. the other ten, there were some whom we could not intere

even the enticement of the trips could not overcome their antipathy to formal teaching, particularly during their holidays. It became discouraging to have to scour the neighbourhood for the children before each tutoring session. Others lost interest when their curiosity about the new organization had been satisfied. Even among the ten who did come regularly, several attended welfare camp for varying periods of time, breaking the continuity of their programs.

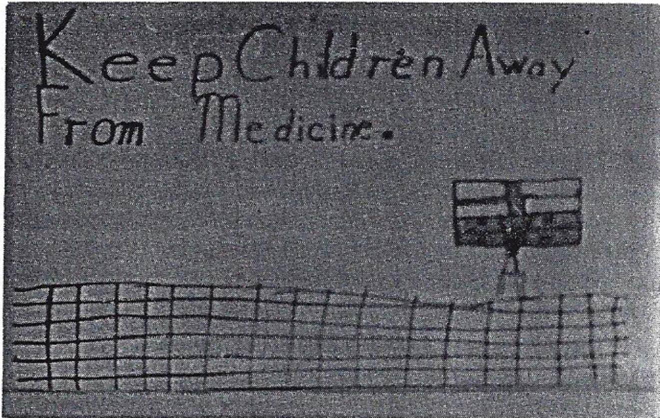
Apart from the lack of participation, another problem was the lack of emphasis placed on education by many of the parents. A large number of the children came from families of up to eleven and twelve children in which the parents simply did not have much time to spend with each individual child. It is usually necessary for a sixteen-year-old to stop school, regardless of his grade, and work in order to help support the rest of the family. The children get little encouragement to read. Even if suitable books were available, there is no privacy or even a quiet corner where a child might be able to concentrate. It was very difficult for us to stimulate any interest in reading in our students, partly because the life of the Bobbsey Twins has little relevance for the children of Pointe St. Charles, some of whom have not been more than a few blocks from home.

Except for the institution of a project of the National Film Board, the school system, which may be adequate for middle class, fails these children. However, this aspect could be the subject of an entire article.

The third major problem we found in ourselves. Although the teaching of mathematics was relatively simple and successful, the teaching of English proved to be neither, with regard to both basic composition and the stimulation of interest in books. We felt that our tutoring abilities were quite inadequate to deal with these chronically understimulated children. Better trained teachers are needed.

Despite our problems and discouragements, we felt that the tutoring program was enough of a success to begin plans for an expanded project during the winter. A full time staff member is in charge, with undergraduate students from McGill offering their time as tutors.

Margaret Ward
MDCM III



Cathy Smith
Age 12

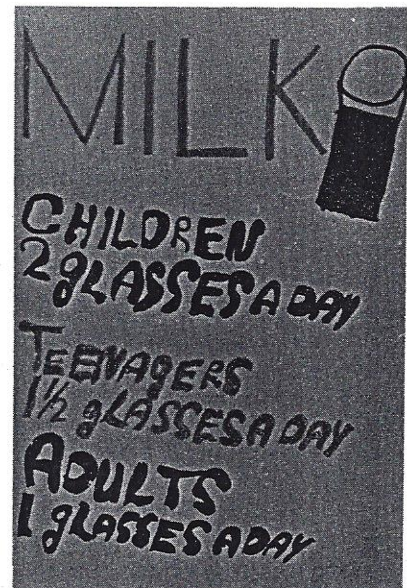
I am a nice nice boy
More than just nice,
Two million times more
The word is ADORABLE.

Martin O'Connor
Age 10
from "Miracles"

A BOY

A boy tried to get killed.
He ran up and down the road
Until a taxi ran over him.
Why?
Because his mother fussed at him.

Benny Graves
Age 6
from "Miracles"



Danny Walters
Age 13

neighbourhood health centres and the OPD what are their rôles?

"Take two of these pills three times a day, lots of fruit juice, and stay in bed if your temperature is not normal".

Such a simple bit of typical doctor's advice to a patient is given dozens of times a day in outpatient clinics all over North America by inexperienced or well trained physicians who must then turn to the next patient. In the neighbourhood health centre one is much more apt to know that this patient will not take these pills because of ignorance, can't afford fruit juice, shares a bed with three others, and has no thermometer. Surely in the neighbourhood centres, we can learn to treat patients appropriately.

Sick people in hospitals and even in outpatient departments are isolated specimens, segregated from their environment, removed from the circumstances from which they became ill, and separated from their families. The more scientific and the more automated hospital centres become, the less emphasis is likely to be placed on teaching doctors the broad aspects of medical practice. Because our institutions attract patients with complex medical problems, the young physician's learning experience often is based primarily on unusual and esoteric cases. Such experience is of course, invaluable for understanding disturbed physiology. It sharpens the physician's powers of observation and develops an inquiring mind, but all of this, in hospitals, is, to quote Dr. John Paul of Yale "done in the proper atmosphere of diagnostic study and careful management on the physician's part, free of outside distractions". It may be trite to point out that these outside distractions are the very thing the modern doctor needs to study as well. It is necessary to bring clinical judgement to bear, not only on the patient, but also on the circumstances under which his illness arose."

The Outpatient Departments of teaching hospitals present a series of interlocking contradictions. These arise from cumulative changes in the economics and organization of modern society and modern medicine. The resulting dilemma confronts all who are concerned with patients and students.

Projections for the decade of 1960-1970, made by the U.S. Public Health Service presage a steady increase in the volume of all types of outpatient care. Holding constant the effect of population growth, the ten year increase is expected to be 79 per cent for emergency facilities, 18 per cent for outpatient services, and only 8 per cent for inpatient services. Yet for the most part outpatient departments are still for the "sick poor", still essentially crisis-oriented, still suffer the stigma of charity and "financial screening", and still stand very far down in the rank of hospital and university hierarchies. The volume of patients and the technical complexity of services have so increased that the financial deficits are no longer manageable by either the local community or the individual hospital.

Is it even very good patient care? No. Traditionally, student of medicine have learned and practised on the "teaching materia in the ambulatory services. This was acceptable because those needing medical care found willing attention, and those needing experience had patients grateful for any medical help. However, with the increasing sophistication of patients, the nature of the highly specialized medical care has not met the full health needs of the clinic clientele, and the fragmentation of delivery of health care in the clinic system has not provided the most appro priate educational model for those in training.

Two possibilities for a solution exist. One is area zoning so that only patients from a particular area can be accepted in a certain ambulatory service. This is extremely difficult to carry out in practice. The other possibility is to provide a screen of neighbourhood health centres, staffed by medical teachers, nurs practitioners, medical students and allied health workers to provide primary care close to the patients' homes, and to refer patients when necessary to the established ambulatory care faciliti in teaching hospitals. Surely this second plan is the most feasib now that ambulatory care facilities have become the first port c call for the public: they are the only 24-hour health facilities available since doctors no longer make house calls and will not live in poverty areas where the 24-hour need is greatest. Satellite neighbourhood health clinics will represent significant improvement in the amount of time and range of professional services available.

Although these neighbourhood health centres are located in urban poverty areas and must be subsidized, their objectives and settings are comparable to those of group practice. The challenge to health professionals in these areas is to define role and allocate tasks so that the patients' needs for personalized unfragmented service can be met with maximum efficiency. Medical students and re idents must be involved in these centr because major goals in medical education should be to promot an understanding of environment-disease interactions and to prepare physicians for the tasks of assessing and redesigning health services.

We must remember that programs to provide better health care to the community must not be run entirely by professio **unless people believe that they can improve their own health, t is little that medicine alone can achieve.** The University and t medical students should be only the catalyst to start such programs. Dr. Haggerty in Rochester recommends an advisory council of representatives from the neighbourhood of the Hea Centre which will ultimately take on the responsibility for ru ning it.

Delivering comprehensive health services to the people in low-income areas is not really a new concept. We have know

MY BRAIN

I have a little brain
Tucked safely in my head
And another little brain
Which is in the air instead
This follows me, and plays with me
And talks to me in bed
The other one confuses me,
The one that's in my head.

Annabel Laurance
Age 10
from 'Miracles"

for some time that services, to be useful, must be accessible. This means that we must bring the traditional services of hospital outpatient departments, health departments, and social agencies closer to the people who need them. Not only must services be more accessible but also more understandable to the people we are trying to reach. The major need in poverty areas are health facilities that are community-oriented and have a reach-out program that will go into homes and provide the motivation to make use of the facilities. The underprivileged characteristically have a marked deficiency in the ability to initiate the search for aid. Poverty and ill health are notorious for close association; poverty provides the situation which helps diseases to flourish; malnutrition, poor sanitation, crowded slum housing. It is easy to see how the traditional outpatient facility designed for the care of moderately well-to-do people does not fit this concept.

Early participation by medical students in community health programs will pave the way for later physician participation. It should be strongly emphasized that there is a need to evaluate results of community health programs to see to what extent they are able to deliver successfully good quality health care to larger numbers of people who now receive sporadic or inadequate care in traditional out-patient departments.

We believe that, for health care to be optimal, the health provisions of all services should be coordinated and extended into many areas outside the medical field, especially into the fields of welfare and education. Moving beyond a hospital's walls into a vital interest in all aspects of a patient's life should not be considered a new departure for physicians, but rather an integral part of their commitment to total health care in its broadest sense. We are ready to try new methods of providing medical care such as the development of a university-sponsored, service-oriented teaching unit located in a serviceable neighbourhood. As the accepted primary purpose, emphasis will be on a preventive, family-centred, service, with a specified educational function rather than on a broad community service. Such a unit should be included in the "Community Medicine" department of a university!

E.S. Hillman, M.D.
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Montreal Children's Hospital

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nursing education and community medicine

Health studies across the country show the rather topsy-turvy nature of the planning of health services, the inadequate and often unimaginative distribution of health personnel, and the difficulties growing out of rising costs including the indignities suffered by a segment of the population which is unable to pay these costs. The emerging idea of community health takes into account the realities of a changing population and the resulting inadequacies of the hierarchical organization for health services. The idea of community health implies a broadly based responsibility for the provision of health services and involves the interests and skills of a whole range of individuals.

As a result of its aims for a high degree of professional competence, professional education can produce a limited vision and a maintenance of the status quo. This has certainly been true of nursing education. Modern nursing, rooted in compassion for the deplorable conditions surrounding the care of ill people, has brought nurses into close proximity with physicians and has tended to concentrate the nurses' energies on the technical aspects of care. Even so, a few nurses have recognized that the effectiveness of their technical responsibilities depended upon an understanding of the people they are caring for, an understanding based on increasingly available knowledge. Despite the firmly held notion that a broader education for nurses is quite unnecessary, a few have persisted in their efforts to benefit from the offerings of general education and university programs have come into being. Such is the story of a developing profession. The object of a broader education for nurses has never been to separate the nurse from the close working relationship with the physician but rather to enhance their cooperative efforts.

Across this country a new pattern of nursing education is taking shape. It is recognized that a great many nurses will be involved in the care of acutely ill persons and will need a high degree of technical skill. This emphasis on skills must not preclude an understanding of people. For the preparation of these nurses two and three-year programs are developing in educational institutions as for example in the new Collège d'Enseignement Général et Professionnel in the Province of Quebec. The success of these programs depends to a large degree on imaginative planning and a sound cooperative arrangement between the educational institution and the health agencies which will play a new and increasingly important part.

The preparation of the nurse in the university does not neglect the importance of the technical skills but places emphasis upon human understanding. Along with basic biological sciences there is a preponderence of behavioural and social sciences. Thus is built the foundation for a creative approach to nursing; for the development of interpersonal skills and for further study and research.

The growth of community health plans will take a variety of shapes and professional workers must be prepared to abandon old patterns and to view health needs from a different perspective. Bold new approaches are being sparked by by "activist" students. The Medical Students' Pointe St. Charles project is an example of such an enterprise. Many of the potential benefits of this imaginative undertaking will be revealed only over time. But one outcome seems certain:- student professionals are learning to work together in a community where the common focus is the "patient".

Miss E. Logan
Director,
School of Graduate Nursing

an approach to social animation

Undoubtedly, the least understood and most precocious undertaking of the McGill SHO in its initial weeks of operation has been its involvement in social animation. The central problems in social animation do not lie in defining its ultimate aim, i.e. **the creation of a live and vigorous community capable of applying social pressures to fulfil its own needs,** but in evolving an effective approach toward achieving this aim.

Prior to embarking on such a project there are several compelling questions to be considered. First, how shall an outsider, be it an individual or an entire organization, become established in a community about which very little is known? Second, are there certain assumptions he can then use for guidelines as he proceeds?

With respect to the former it should be pointed out that animation presently remains in an extremely formulative stage and that many as yet unconsidered avenues of approach must therefore exist. Initially, it was our decision to work with the children and through this contact seek an introduction to the parents. This included the "alley-way" recreation project, trips, and tutoring.

Through our alley-way project we were able to meet over 300 neighbourhood children. The extent to which we were able to provide these children with a stimulating and well supervised program of activities and trips quickly impressed the parents of the community. The newly created enthusiasm of the children soon spread to their parents. Several expressed this by offering their aid whenever needed (which we insured would be **always**). Thus, this project provided one of our first and most readily accepted areas of parent involvement within the community.

The tutoring project involved only a limited number of children. However, it provided us with an opportunity to know these children, and in some cases their families, in greater depth, thus expanding our knowledge of the community.

Come, let us pity those who are better off than we are.
Come, my friend, and remember
that the rich have butlers and no friends,
And we have friends and no butlers.
Come, let us pity the married and the unmarried.

Ezra Pound
from "The Garret"

The wind in the
city it's fertile
it blows the
skirts against
their bodies
wind in the city.

Bob Hackett,
Montreal.

In answer to the second question, it is important from the outset to maintain a flexible outlook. An animator must therefore refrain from formulating certain expectations or accepting untested assumptions. This need not be interpreted as a complete denial of past experiences, but a critical awareness that these are not necessarily applicable to the unique problems of this community. Thus an animator's most beneficial contribution to any group he works among is the constructive consultation he is able to offer. He is there to be **used** by the people. One must avoid being cast into the role of a leader, a position which implies knowledge of their desires or the goals they will eventually define among themselves. This in turn leads to the question of dependence: will a medical student, whose presence is necessarily temporary, jeopardize the continued existence of a community parent's organization when he leaves?

How then should an animator proceed? His approach is characterized by well-timed aggressiveness and opportunism. If the health center, for example, simply replies "We do not provide dental care", to a caller complaining of a toothache, it has lost a valuable opportunity: that this person and others like him, if asked, may be willing to meet and discuss the possibility of establishing a dental clinic within the community.

The relative ease with which the clinic was able to make initial contacts within the community, no doubt, was significantly aided by its ability to provide the community with a badly needed service. As a newly opened health center, we have thus far been exempt from the dominant prejudices of the community, religion, and language. It was, indeed, to the clinic's advantage consciously to avoid aligning itself with any of the community's establishments.

Through this cautious, and yet appropriately aggressive approach, the health centre is presently contributing to the establishment of several community-run projects. Most of these involve small numbers of parents and relatively short-term objectives. These include high school bus transportation, a winter recreation project, legal aid and licensing, and a community library with provisions for a study room and reference books.

In this community of 25,000 as unbelievable and unjustifiable as it may seem, no high school exists. As a consequence the Protestant high schoolers must attend the High School of Montreal eight miles away. This costs the parents over $4.00 per month per child, since no special transportation exists. These teenagers must ride on the normal Montreal public transportation during the early rush hour traffic. It takes them about 45 minutes to reach school. The monthly transportation costs add considerably to the financial burden on their families. These difficulties, to a significant degree, contribute to the 80 per cent high school dropout rate existing in Pointe St. Charles. Initial inquiries to the Montreal Protestant School Board have indicated they have no intentions of providing any sort of transportation, presently or in the future. Given this obvious lack of concern and neglect on the part of the School Board and also the City of Montreal,

the parents of the community are presently attempting to remedy the situation. Emphasis is being placed upon the rude reality that the Protestant School Board reacts most readily to public pressures. Letters to the editors of the city newspapers are being written. Local businesses, much in need of personnel with a high school diploma, are being approached for financial aid and verbal support. The local parents are just beginning to realize that they and their problems will not be noticed or respected until they shout — the louder the better!

Another project of concern to present and future programs is legal aid and licensing. As a newly licensed group these parents are now received more readily by the local businesses and contributions may be given in the name of their non-profit organization.

With the aid of the Montreal Children's Library, another group of parents are attempting to establish a library in the community. No convenient facilities exist at the present time. The library will provide a large study room for children who previously have never had a desk or quiet atmosphere to study in. In combination with this, a separate room will be available for tutoring. Beginning in October, approximately 60 McGill students will be involved in a volunteer tutoring program in Pointe St. Charles.

It is important that the initial projects be relatively small and have a high likelihood of success. The parents of the community must learn gradually to cope with the power structure which has until now largely ignored them. The parents will learn a great deal from their mistakes and gain infinitely in self-confidence from the successes they know they have earned through their own capabilities. Confidence in themselves as a group will do much to erase the fears these parents naturally have. To quote an animator working in conjunction with a local grade school, "Contrary to the opinion that these people have nothing to lose, they will hang on to the little they have hardest of all! " Nevertheless, with the experience these parents are already gaining they will, in the near future, be qualified to meet the more fundamental problems of the community. This includes educational reforms, housing improvements, and social services.

Although the projects have led to some degree of optimism, in many respects our overall aims within Pointe St. Charles have not nearly been met. As yet, we have not successfully established a working relationship with the French-speaking sector which comprises 50 per cent of the community's population. In addition, there has been a tendency on our part to rely too much on the few parents who have shown exceptional interest and capability. More time must be spent in encouraging these people to delegate responsibilities to the reluctant majority.

In this way, we hope, new leaders will eventually evolve and an active self-sustaining interest will develop within the community.

Charles Larson
MDCM II

. . . and O that awful
deepdown torrent O and
the sea the sea crimson
sometimes like fire and
the glorious sunsets and
the figtrees in the alamada
gardens yes and all the
queer little streets and
pink and blue and yellow
houses and the rosegardens
and the jessamine and
geraniums and cactuses
and Gibraltar as a girl
where I was a Flower of
the mountain yes when I
put the rose in my hair
like the Andalusian girls
used or shall I wear a red
yes and how he kissed me
under the Moorish wall and
and I thought well as well
him as another and then I
asked him with my eyes to
ask again yes and then he
asked me would I yes to say
yes my mountain flower and
first I put my arms around
him yes and drew him down
to me so he could feel my
breasts all perfume yes
and his heart was going
like mad and yes I said
yes I will Yes.

— Joyce

jamaica - summer 1968

"And round about there is a rabble
Of the filthy, sturdy, unkillable infants
of the very poor.
They shall inherit the earth."

— Ezra Pound, in "The Garden"

There's an inescapable attrition going on along Spanish Town Road. Back aways from the old jalopy taxi cabs speeding towards Mandeville and the banana-basketed donkets edging towards downtown Kingston were the "yards" like those of Delacree Lane where several mothers share adjacent sheet-metal shanties which abut on dried-up, dust-filled lots. Chicken pox just moved through the yard three weeks ago and a few faces playing outside show the evidence of past and present varicella. A little brother lies at home with a fever and vesicular rash. Rachel Hunter cares deeply for her child and so she soaks her son's forehead with a rag which she occasionally dips and wrings into a small basin of cool water with baking soda. She powders his body with talcum and hums a gentle Caribbean melody. Earlier this year Millicent, Rachel's 8-month-old daughter, had died in the night with an acute respiratory infection. She had cried for two days before accepting the child's death.

Rachel was one of more than three hundred mothers to whom we spoke this August during a 12-day clinic visit sponsored by CAMSI, the Canadian Association of Medical Students and Interns, and the Jamaican Save the Children Fund (JSTCF). Seventy students and interns from all across Canada participated through CAMSI variously in hospital ward rounds, field hospitals, maternity delivery rooms, family planning clinics, or emergency room treatment.

The JSTCF was the project with the least formal teaching but the most exciting learning. It was far more routine than its melodramatic name implies. The JSTCF sponsored screening clinics for pre-school children in less privileged neighbourhoods in and around Kingston. Mothers were told in advance by mail that a group of medical people would be in the neighbourhood schoolhouse on certain days. Examinations would be given to as many children who attended pre-school classes in that neighbourhood as possible. Rumor had it that no one would show up; we hoped for a 20 per cent turnout. The 500 per cent turnout was our surprise but we welcomed that kind of excitement. Our "total physical" consisted of indicator urinalysis, a hemoglobin, and a top-to-bottom exam on a bare kitchen table.

The 10 students with the JSTCF recruited from other CAMSI projects. Our ranks swelled to 15 and we completed well over 2,000 examinations. It was sort of crazy. Every mother brought every child for this routine exam. Pre-schoolers were no more frequent than other aged children. We looked at kids from 16 days to 16 years of age.

Two of us had finished only two years of medicine. Our confidence crumbled but it was quickly rebuilt by our older comrades who taught us as we worked. For example, although Gilbert's (zheel-bear's) English occasionally faltered in the face of the Jamaican patois, nous avons traduit pour lui, and, in exchange, he taught us how to hear the soft diastolic murmurs above wailing infants, how to recognize and cleanse the sores of impetigo, and how to know which umbilical hernias would eventually reduce. Our ideas of normals quickly changed as we watched children with – hemoglobins of 8 or below stick out bright red tongues and show no paling of their conjunctiva. Feet that had never worn shoes had callouses that made Babinskis impossible.

Our proudest breakthroughs were the minor ones. Music and language were conquered in about a week. Learning "ABC Rock Steady", a nursery rhyme turned popular song, earned us instant rapport both with the Jamaican mothers and their kids.

Think ah nevah see ya
When ya go ovah the wall.
Think ah nevah see ya
When ya accidently fall.

A It Mek; ya accidently fall.
A It Mek; ya pop ya bittah gall.
Hear she cryin out for ice water.
Ah, ha, ha, ha...

The lingo of the clinic ripened after a week of experimentation. "Long out your tongue, man," brought those bulging tonsils into view. "Blow hard," translated to "Take a deep breath," so that we could feel a big liver and spleen in a 3-year-old with a hemoglobin of 7.8 mg% and possible early signs of sickle cell trait. The "runny belly" (diarrhea) in 2½-year-old Amos Beckwith fit well with his reddish-brown, brittle hair, with his retarded growth, and with his apathy and pale skin. Amos was referred to the University of the West Indies hospital pediatrics department for investigation and treatment for kwashiorkor. "He blow short in the yard," said the mother of the child with the murmur of ASD, explaining his shortness of breath.

Jamaica's infant mortality rate is one-and-a-half times that of Canada. In the slums we visited, like Trench Town where Rachel Hunter's child died, the rate is 73 deaths per 1,000 live births, twice that of the rest of Jamaica. Recent estimates show that this figure will have to be revised upwards to conform with W.H.O. definitions because of a failure by midwives to report all deaths during the first five hours of life as live births.

What we did, of course, was a scratch. In a few cases we know the scratching helped. Toothpaste and toothbrushes, rewards for braving a pinprick hemoglobin test, now are scattered throughout Trench Town (although the former is now probably gone). In terms of health, the Jamaican children are remarkably handsome and strong. Fortunately for them their problems are far simpler than those of children in Borneo, Bolivia, or Biafra. Many of their "rising expectations" will indeed be met.

David B. Spring,
MDCM III

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