CONTACT #3

publication of the montreal student health organization

contact

CONTACT is the publication of the Montreal Student Health Organization (SHO), a multidisciplinary group of students from the health and social sciences, with a common interest in evolving an effective approach to community problems.

CONTACT is designed to

– keep others concerned with these issues informed of our current activities and the philosophy behind them.

– serve as a forum for the interchange of ideas on a wide variety of contemporary problems including those of education, ethics, and politics.

– provide a medium for the publication of humorous, literary and artistics works of our readers.

All contributions are welcome – on any topic – in French or English. Comments in letters to the Editor will be accepted.

Although we are not intending a subscription charge for this publication, we suggest a donation of $3.00 per year from each of our readers able to contribute this sum. (For organizations requiring over 10 copies, $1.50 per subscription would cover our printing and mailing costs.) Donations of any size will of course be ecstatically received. Cheques should be made payable to "The Montreal Student Health Organization".

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poetry and things

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. . . I could

upstage this

whole show . . .

ARTICLES

Asclepius' Advice

So you wish to become a physician, my son?

'Tis an aspiration of a generous heart and a spirit craving for science.

You want that men should hold you for a god who relieves their ills and scatters their fears.

Have you thought well about what your life will be like?

Your private life is forfeited. Don't expect that this difficult work will make you rich. I have told you: it is a priesthood, and it would not be decent if it brought you profit like that gained by the merchant in oils or in woollens.

Your life will run in the shadow of death, among the pain of bodies and souls, and among the hypocrisy that waits, calculating, at the bed of the agonal.

You will find it difficult to preserve a consoling view of the world. You will find so much ugliness under the most beautiful appearances that your confidence in life will crumble, and every enjoyment will be spoiled. The human race is a prometheus being torn apart by vultures.

You will find yourself alone in your sorrow and in your studies, alone in the midst of human egotism. Not even among physicians will you find comfort, as they blindly fight each other for either self-interest, or pride.

When after much effort you have prolonged the existence of a few old men, or of some crippled children, then there will come a war to destroy the healthiest and stoutest in the city. And you will be charged with separating the weak from the strong, so as to save the weak and send the strong to their death.

Think it over, my son, while there is still time . . .

Translated from Spanish by Nic Steinmetz

And Death Shall Have No Dominion

And death shall have no dominion.
Dead men naked they shall be one
With the man in the wind and the west moon;
When their bones are picked clean and the clean bones gone,
They shall have stars at elbow and foot;
Though they go mad they shall be sane,
Though they sink through the sea they shall rise again;
Though lovers be lost love shall not;
And death shall have no dominion.

And death shall have no dominion.
Under the windings of the sea
They lying long shall not die windily;
Twisting on racks when sinews give way,
Strapped to a wheel, yet they shall not break;
Faith in their hands shall snap in two,
And the unicorn evils run them through;
Split all ends up they shan't crack;
And death shall have no dominion.

And death shall have no dominion.
No more may gulls cry at their ears
Or waves break loud on the seashores;
Where blew a flower may a flower no more
Lift its head to the blows of the rain;
Though they be mad and dead as nails,
Heads of the characters hammer through daisies;
Break in the sun till the sun breaks down,
And death shall have no dominion.

Dylan Thomas (1942)

plans for the spring and summer of 1969

What's happening at the health center? It seems our last issue of CONTACT left a number of readers rather puzzled about our present activities and questioning our future plans. To bring things up to date and to permit a better understanding of the priorities we have decided upon after our first year of operation, this article shall simultaneously take a critical look at what has been attempted in the past, try to explain (where possible) some of our errors and cite our plans for change.

A. Bilingual and Bicultural Medical Care

The French and English populations in Pointe St. Charles are approximately equal. However, in the initial months of operation the health center found itself working predominantly with the English sectors of the community. In both our tutoring and our alleyway recreation project we worked mostly with English-speaking children. Efforts to avoid branding ourselves as an English service were largely unsuccessful and understandably so. For example, of the original medical students involved, only one was a French Canadian and the only truly bilingual member of our group. The evening volunteer doctors were drawn mainly from English teaching hospitals, and although most could communicate in French, only a few were French Canadian. Yet in the past two months we find ourselves handling a 60% French-40% English patient ratio. This welcome balance is in part due to the hiring of a bilingual staff last fall; including a fulltime public health nurse and part-time pediatrician. But much of the credit goes to our French Canadian receptionist for the evening clinics, hired in February. She is a local resident, bilingual and respected within the community. This is a clear indication of how successful the employment of a staff representative of the entire community can be – a lesson for us which was fortunately not too late to remedy.

Of more significance for the future is the consolidation of the McGill SHO with its recently established counterpart at l'Université de Montréal into one organisation – the Montreal SHO. With our joint participation an effective bicultural approach to the defining and handling of the fundamental health problems of Montreal will hopefully evolve. This is an extremely proud moment for us and represents an initial tearing down of those traditional barriers which have kept the two medical societies in nearly complete isolation. Efficient solutions to a rising social challenge for better medical care and projects which shall distribute services fairly in the heterogeneous urban populations of Montreal can and, we feel, will succeed with joint French-English cooperation and unified action.

B. Community Direction

It has always been our hope that ultimately the citizens of Pointe St. Charles would take over the administration of our health center. However, to date we have been only partially successful in our attempts to instill the attitude that the health center does belong to the community. In truth, as the health center has functioned, in many ways it is not theirs. The question of how to approach a community when establishing a health center has been only partially answered. However, certain positive steps have been taken. Others are contemplated. Six local residents are presently being trained as our regular receptionist-secretaries during day-time operation. They are familiar with the basic operating procedures and are already recommending helpful changes. In addition they provide a familiar face which puts the patients at ease, but more importantly they are the first tangible evidence within our clinic that this will, indeed, become the COMMUNITY's health center.

This spring a fulltime social animator will join our staff. His activities are impossible to forecast at this stage, but they will involve problems of common concern within the community – only some of which involve health care. It is our objective, through his DIRECT work with local residents, to ensure that the community plays a leading role in establishing an interdisciplinary approach to services functioning in the community. Concerning our activities in the health center, we shall explain to the local citizens what we are doing in Pointe St. Charles and why. If a second clinic is to be opened in this community, it will hopefully start with demands from within – not from the outside. The disadvantages of the "top-down" approach have become clearly evident to us.

C. Professional Staff

To date we have not been completely successful in our aims to provide adequate and consistent professional health care. The physical set-up exists and several significant improvements have been made since last summer; however, a few areas do demand more attention. Our evening clinics are staffed by volunteer doctors in an irregular manner. In the future, with a limited number of doctors and hopefully regular scheduling, the center should be providing the patients with the feeling they are seeing their own doctor – "a real doctor". We plan in addition to employ a fulltime physician for the day clinic beginning in late June. This spring an OB-GYN team from the RVH will initiate a weekly clinic. This will provide pre- and post-natal care, personal counseling for mothers and advice on family planning. All the clinics will be coordinated with the medical students who will conduct regular follow-up visits in the homes.

This May marked the beginning of a ten-week elective for seven second-year McGill medical students, and most will carry on through the summer with individual projects. These students have been active in the clinic over the winter, are familiar with the clinic operations and the local residents. Specific projects to be initiated by these students include: 1) dental care, 2) legal aid, 3) health education in homes and schools, 4) OB-GYN clinic, 5) community pediatrics, and 6) discussions with local, provincial and federal authorities concerning health care in urban environments. In the summer these students will be joined by first-year medical students as well as students from l'Université de Montréal. The first-year students are planning to establish (in conjunction with volunteer nurses) a comprehensive program in preventive medicine. Students of l'Université de Montréal, headed by Pierre Montpetit, have completed preliminary preparations for the opening of a health center in the neighbouring district of St. Jacques. A similar approach to that implemented in Pointe St. Charles will be attempted in the second clinic.

A follow-up article next September will no doubt show additional areas requiring reform, but hopefully some of our projects will prove successful in terms of adequate provision of health care in an urban setting.■

by Charles Larson, Med. II
Co-director
Montreal Student Health Organization

Letter(s)*

Dear Sir,

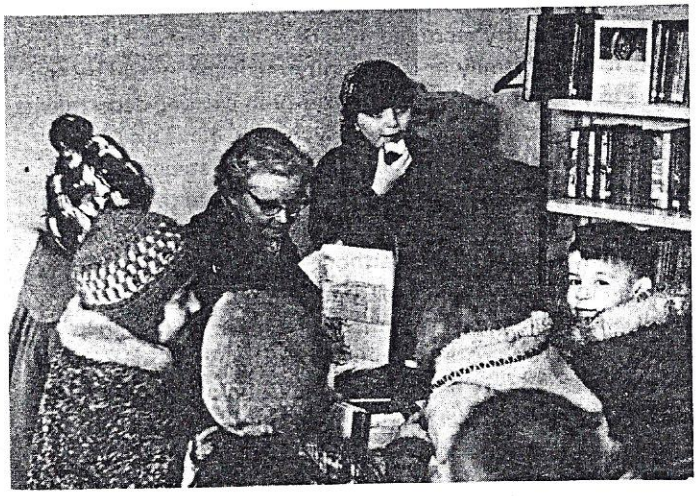
In your article, "B. and B. in Medical School", (Contact No. 2) you decry the lack of communication between the French and English systems of medical education in Montreal. Having been born and trained in Montreal, and at McGill, my initial response was to agree wholeheartedly with the article. However, since arriving in Vancouver, I have come to realize that the language barrier is only one facet of the problems in communications. It would seem to me, that in Montreal, language differences only make the justification of lack of communications easier. The similarities in the communications problems of Vancouver and Montreal, or of British Columbia and Quebec, are indeed impressive.

In our concern for French-English communications, we should not be blinded to the very real problems in English-English communications. In short, I feel that students everywhere should not lose sight of the essential nature of our communications difficulties. Concern for French-English communications is only a beginning.

R. Tonkin, M.D., C.M., F.R.C.P (C)
Department of Pediatrics
University of British Columbia

*Since its inception, a gratifying number of letters expressing enthusiasm with the general idea of CONTACT has been received. We feel their publication would serve no useful purpose, but continue to ask for specific criticisms and comments. There is much room for expansion of the "letters" column!

Editor



David Rahn

The CAPS Library . . .
no money for heat.

David Rahn

At the clinic . . .
Barbara with lunchtime friend

lunch

My Favorite subject is lunch. What's school without lunch. Maybe we don't have a lot of time for it but its eating.

Lunch is a break between subjects to eat, sleep, play, and do homework.

Lunch is a break to settle problems with your friend. Lunch is chasing people, watching television or leasoning to the radio.

Lunch is buying and selling, horsing and yelling. I love lunch and without it I'll die. And whoever don't like lunch isn't eating.

At 12 o'clock while others play ball, I eat lunch. While others yell and scream, I eat lunch. And now I can't wait til tomorrow to eat lunch. And before you know it, its the 6 period again.

Richard F **Age 15**
from "the me nobody knows"

the training of physicians - society's dilemma

by John C. Beck, M.D.
Physician-in-Chief,
Royal Victoria Hospital

The medical profession and medical educators have been engaged in continuous dialogue about the training of physicians over the past twenty-five years. In some areas, such as the training of physician-scientists, agreement has been reached but in others there is still no consensus.

This is particularly true concerning the question of the future training of the general practitioner-primary physician or first contact physician, and it is upon this subject that I wish to make some comments. The intense disagreement in this particular sphere has been accentuated by the appearance of the Millis and Willard Commission Reports[1, 2], statements by the American Academy of General Practice[3], and views emanating from the meeting of the College of General Practice of Canada held at the University of Western Ontario in 1968[4].

Proposals put forward by the Family Practice Group in North America certainly represent an important effort to improve the standards of family practice and I feel this deserves support. They appear, however, to be too closely stereotyped along the lines of the family physician of twenty-five to fifty years ago and do not seem to be in keeping with the increasingly rapid changes in medical science and in methods of communication within the North American community.

It is my contention that until a basic decision is made concerning the method of delivery of health services in the future, there can be little constructive development in training programmes for the personnel who will man these services. We are caught in the proverbial "cart before the horse" situation and are suggesting new models of health personnel with a view to building a health care delivery system about them.

I recognize that one of the motivating factors behind these various reports is the desire of the general practitioner groups to achieve economic, academic, psychologic, and social recognition, and I have no disagreement with this objective. However, there is also an increasing need for a searching evaluation of the current methods of delivering medical care to the public. I believe the latter to be one of the major challenges facing us today. That there is a real need for increased numbers of better qualified first contact physicians cannot be disputed. The statements which have been made regarding the role of such physicians in integrating specialized care provided by other physicians and in assuming community and comprehensiveness of medical care would also seem to be valid. One of the main problems in planning the more efficient delivery of medical services lies in deciding whether the solution in most areas involves the development of a new form of medical practitioner or rather a workable arrangement of existing facilities to complement those that will develop in the future. The observations which have been made in these various studies are that general practice as it exists today is unsatisfying and unattractive to the majority of young physicians. This really is self-evident, and one of the major reasons, in my view, is that it is impossible for one individual to encompass and apply effectively the vast and rapidly increasing scientific knowledge necessary for competent medical practice.

At the same time, the general public is relatively ignorant of the complexities involved. Many people continue to desire home calls by physicians for acute illnesses, often an ineffective means of dealing with such cases. The public is not as yet geared to the effective use of modern medical facilities, such as physicians' offices, group clinics, ambulatory care developments, and emergency rooms at hospitals. There is no question that there are wide regional differences in both public education and the role of present specialists in internal medicine in delivering primary contact care. This makes the problem even more difficult to resolve.

The solution put forward by many individuals, that of setting up departments of community medicine in our medical schools with a separate faculty, budget, and beds for the carrying out of model family practice on a well-defined population group seems unacceptable to me. I believe that this objective could be met within the present format of most medical schools. My point of view, however, would not preclude certain institutions which feel that separate programmes are necessary from initiating them, provided that methods of carefully evaluating the changes effected are also incorporated in the general programme. However, if institutions decide to embark on such programmes, it is imperative that they be planned by teachers of equal stature and ability to those now found in most academic departments in North America. An alternative would be to set up a separate division within the traditional departments of medicine. This division of community medicine would train and interest medical students in family practice and would conduct a training programme of about a year's duration, leading to some form of certification in primary delivery of medical care.

As one reviews these recommendations there are obvious difficulties and perhaps the greatest involves the problem of quality control of the programme as well as of its professional product. Any faculty recruited now or in the foreseeable future with its focus on family or community medicine, would by and large be of inferior quality to the faculty in existing departments of medicine, paediatrics, surgery, psychiatry, etc. This could only be accompanied at the moment by lower standards in patient care and undergraduate and postgraduate training. The products of such training programmes would have only limited ability in any particular field, although they would probably possess an increased breadth of knowledge compared to the present output from medical schools in university hospital systems. I believe the primary physicians' training programme cited earlier could very easily lead to dilution of knowledge in specific areas. There is certainly a question as to how well this new breed of health personnel would recognize an obscure disease. The suggestion that consultation and referral of such problems would be a solution to any dilution of knowledge is questionable; it is only too evident in the practice of medicine that without proper suspicion or identification of illness, referral or consultation either never occurs at all or occurs much later than need be.

I have serious doubts that the proposed programme for education and training in family practice would attract students and house staff of adequate calibre. The risk that the faculty in family or comprehensive medicine would be outshone by their clinical colleagues in the classical departments of medicine is a very real one. The research programmes which have been outlined are unimaginative compared with programmes in many academic departments of medicine and would probably not appeal to many students. I also believe that the status provided by some specialty recognition of family practice would not prove very meaningful except in terms of economic advantages.

The arguments which have been brought forward in advocating family practice as a finite specialty are vague and unrealistic. Family practice is admitted to be an organisation of practice by **function** rather than by **content** of knowledge of a discipline. The area defined is far from self-sufficient or self-encompassing, in that the resources of other departments must be heavily involved. These departments must not only be utilized in the proposed training programmes but also in the development of the specialty certification. I believe that any undergraduate and graduate education programme in clinical departments must exploit the latent ability of most students to provide comprehensive medical care within the bounds of one of the specialties in collaboration with their colleagues.

There seems no question that with the present rapid increase in new medical knowledge, specialization will increase and it will become progressively more difficult to maintain and train physicians with a wide breadth of knowledge. Consequently, it will become increasingly difficult to practise medicine with a wide scope and individuals with this kind of training may become progressively more ineffective.

These formidable difficulties in organizing effective training and practice programmes in family practice immediately raise the question of alternatives. One alternative, which has already been tested and which appeals to many, is to promote the rearrangement of practice into effective groups of specialists. This is an increasingly popular and effective mode of practice in areas of rapid population growth and the physicians in groups, both individually and collectively, serve as first contact physicians, but in so doing assure comprehensiveness and continuity of clinical care. They are also able to be more concerned with the socio-economic aspects of their patients and are able to make a greater use of personnel, such as social workers, visiting nurses, and physicians' assistants. It is my opinion that such an organization, with proper attention to the multiple factors involved in illness and with the increasing use of paramedical personnel, would be more in step with the goals of modern medical education and the scientific advances in medicine than the proposals which are being generally made by members of the profession, social scientists, and certain politicians. Strong support should be given to the newly emerging programmes for the training of physician-assistants or clinical associates since these individuals are clearly capable of forming an important link in future health care delivery systems. (See article on "the nurse-practioner" in this issue – Ed.)

As I have already inferred, it seems impossible to discuss realistically the requirements for future training programmes without correlation with what appears to be the future of the practice of medicine. My suggestion clearly implies rearrangement of the present facilities for delivery of health care. I suggest that most smaller hospitals will disappear and be replaced by ambulatory care centres staffed by qualified medical and paramedical personnel. Regionalization of other health facilities would accompany this change. As my colleague, Dr. Jacques Genest[5], and I have frequently discussed, the university medical centre in this context would be a true centre for consultations, undergraduate teaching, residency training and research. These hospitals have all possible modern facilities for the training of medical personnel in all specialties and sub-specialties; they possess well-developed and automated laboratories, x-ray departments, physiological laboratories, and greatly improved centralized facilities for clinical research. In addition, it would be their role to develop models within their own regional areas of responsibility for the delivery of health services which, if proved valuable, could be "transported" to the community at large.

These university medical centres would be linked, and I believe this is crucial, by much more effective systems for the rapid and efficient transport of patients from primary regional hospitals and ambulatory care centres. These primary regional hospitals might care for populations of 50,000 or more people and would integrate the ambulatory care health centres, other group medical practices, and the paramedical personnel. These regional organizations would deal with primary care patients, and be equipped with well-developed laboratory and x-ray departments; however, they would not be in a position to offer more advanced and complicated forms of diagnostic and therapeutic techniques. Such university health centres and primary regional hospitals attached to them should be supplemented by groups or centres for rehabilitation, convalescence, and the prolonged care of patients with chronic disease.

The problems which confront society today with respect to the delivery of health services are complex and I would plead that the solutions eventually arrived at should be developed logically, tested early for effectiveness, and then distributed more widely to the community at large. ■

References:

1. Millis and Willard Commission Reports
2. Millis and Willard Commission Reports
3. The American Academy of General Practice report of the Annual Meeting (1968)
4. C.M.A.J. 1968, 99, August 3rd, pp. 237-238
5. "The Hospital Situation in Quebec" by Dr. Jacques Genest (in press)

youth and social action

Helping "the poor" –whose needs are being met?

Betty Ann Affleck*

There have been numerous definitions of poverty and who "the poor" are, usually based on economic definitions of need or a categorical approach to a segment of our population who are economically poor and therefore labelled "they" as opposed to "we"; often even categorized as belonging to a different culture, based on, I feel, a misleading middle class notion that there actually exists a definable "culture of poverty". Many social critics now take exception to these narrow classifications, feeling that they are not viable as "The very concept of poverty must be broadened. There is economic poverty. But there is also the poverty of hope, the poverty of opportunity, the poverty of knowledge, and the poverty of relationship"[1] which cut across all of society and know no defined boundaries of culture or class.

It is a truism to state that nobody helps others without being self-motivated. To pretend that one's own needs are not involved is a shallow pretentiousness and a dangerous posture. Self-motivations and outward motivations can and have to overlap. Every creative person intuitively understands this – that to be effective in any endeavour one has to be self-motivated or as Christianity has stated, "Love Thy Neighbour as **Thyself**". The "bleeding heart", or "I'm only trying to help you" approach is generally felt to be insincere and is often exposed as sham particularly by people who are in a vulnerable or powerless position. This latter approach is still very much with us and for some people involved in the helping relationship, is only a cover up for "... the helper to bring with him a need to feel superior, in economic or social status. He has a need to be different. He hides his similarities such as professional or personal frustrations, his own sense of alienation... , his sense of powerlessness in great odds, and perhaps his reluctance to ask himself who he is".[2]

Both Wilcox and Warren have made the observation that "helping" professionals and social agencies need poverty, social problems and human misery to define their roles as that of "helper". Wilcox elaborates on this observation that helping professionals may even require of "the poor" "... that they engage in a public striptease in order to receive services. They completely and consistently overlook their strengths."[3]

As an individual or group entering the field of social animation or community organization, the above approach or set of needs would automatically and immediately place any animation programme in jeopardy "... because the organizers' mere presence in the community is a tacit insult"[4] to start with, and "the poor" may easily interpret his presence to be that of an outsider saying to them "You are so dumb that you need me to think your way out of this mess you are in".[5]

The question, whose needs are being met when individuals or agencies help organize or provide service to "the poor" does not, however, have a simple either–or answer.

To be effective in this new embryonic method of intervention with "the poor" and to avoid the situation often experienced by the poor of having "met only professionals and bureaucrats anxious to **manage** them,"[6] I would like to suggest a forgotten role of the social animator. Throughout the literature I have read, it strikes me as paradoxical that the organizer is always cast in the authoritarian role of educator, instructor, interpreter, etc.[7] ... but never in the more equalitarian role as "**learner**" juxtaposed to the role of his client as "**teacher**". Usually the innuendo is the reverse. The obvious reason for this role reversal is the fact that the organizer, particularly when he is an outsider, cannot possibly know or sense his clients' needs, wants, or aspirations in the same existential fashion as the people themselves experience them. The animator must be, therefore, a constant student who must listen, sense, and learn from his clients. The goals that the people aim for can only be accomplished, I feel, within a flexible process-oriented structure that can remain open to constant experimentation, exploration, and, yes, uncertainty.

Provision for new modes of participation by "the poor" in their own affairs will, of course, threaten and come in conflict with traditional helping groups, but may prove to be a long overdue corrective.

Furthermore, the detached bureaucratic model of "helping the poor" has largely proved a failure. Insistance on paternalistic management control or detachment (really meaning non-involvement) is simply "... an attempt to impose order on an instable situation, a device to overcome the anxiety which arises from his inability to bring everything under human control. It is the modern substitute for prayer and primitive magic."[8]

If such be the case, the new approaches to organizing "the poor" must be given careful sensitive scrutiny to avoid the pitfalls of forms of organization that would grind up human beings and often viable human systems in the guise of "helping". Service must become holistic but fragmentary in nature and those animators who are involved must realize that "the problem is to develop an approach to change which takes into account both social structure **and** human nature."[9]

youth involvement

One group in our society who is deeply affected and sensitive to the self-alienating depersonalizing forces within society is youth. Generally speaking, unless they subscribe to the values inherent in the competitive success ethic (or at least pay these values lip service) and remain, for an increasing number of years within educational institutions, they cannot generally gain access to meaningful roles or opportunities for self-realization.

> "Society is turning toward the reduction of the number of channels of ascent, the channels of occupational mobility? Increasingly education becomes the siphon as well as the distributor of talent in our society."[10]

*Betty Ann Affleck is a student in 2nd year at the McGill School of Social Work who worked "out of" the Medical Clinic as a social animator for six months during last fall and winter. She is married and has five children.

Amongst the results of this phenomenon are the progressive postponement of emotional, social, and economic maturation as well as the atrophy of the humanizing function of education in contrast to its function as "the way to get ahead in the world". The phenomena of the student activist and the dropout both represent a response by young people to the current state of the educational assembly-line. Paul Goodman has written of this phenomenon: – "Nor are these young people properly called 'youth'. The exigencies of the American system have kept them in tutelage, doing lessons, till 23 or 24 years of age, when years past young industrial workers used to walk union picket-lines or when farmers carried angry pitch forks, or soldiers are now drafted into the army. Another cause of their shared resentment is the foolish attempt to arrest their maturation and regulate their social, sexual, and political activity."[11]

Hence arises conflict between youth who sense a lack of personal freedom and self-realization and their elders who are enmeshed in the corporate complexities of society.

> "The conflict of generations is analyzed by liberal psychologists and sociologists as the result of moral and personal problems of young people. However, examination of the kind of work that young people are forced to do makes clear that their 'problems' are those of their social situation not of their individual psyches and that they will not be solved until their labour is no longer expended in activity lacking in human meaning."[12]

Youth are often powerless regarding crucial decisions affecting themselves and their environment. In this respect they have common cause with "the poor".

An alternative course offered by social critics such as Robert Theobald and Paul Goodman, is that society must concentrate on offering youth meaningful choices between various alternative life styles and roles. This, the educational system is hardly beginning to explore. In the meantime, some youth cannot wait for the educational system to respond to their needs, and hence are proceeding on their own initiating, either within or without the University system, to broaden their possibilities for participation in society and "... learn about life from life itself."[13]

What, then, motivates some students and dropouts to become involved with helping "the poor"? Maybe an attempt to escape alienation from their environment and alienation from themselves. Often they see their elders' lives as hypocritical and shallow, and the institutions these adults inhabit as impersonal and coercive. Maybe, as has been suggested by Jerome H. Skolnick, "... their parents adopted a style of private attack and public prudence, of private animosity and public acceptance – a style vulnerable to the charge of hypocrisy."[14]

"The truth, the central stupendous truth, about developed countries today is that they can have – in anything but the shortest run – the kind and scale of resources they decide to have . . . It is no longer resources that limit decisions. It is the decision that makes the resources. This is the fundamental revolutionary change – perhaps the most revolutionary mankind has ever known."

U Thant, Secretary General
The United Nations

Some of the dropout youth are experimenting with new life styles, with strong religious overtones, in an attempt to recapture an elusive personal authenticity and identity that they find wanting in the so-called "straight world". Many youth appear to share architect John Eberhard's concern that society is suffering from "... a dwindling capacity to feel", or a "psychic poverty". He goes on to explain his concern.

> "I have the uneasy and unhappy feeling that we have lost, or are losing, our capacity for emotional involvement, our ability to realize emotionally what we know intellectually."[15]

The McGill students who founded the storefront medical clinic at Pointe St. Charles are one example of a number of groups concerned with the lack of human encounter when the helping professions deal with "the poor" Many of the citizens I have met in Pointe St. Charles who come to the McGill Student Health Clinic refuse to go to the established institutions. They fear stigmatization and humiliation at the hands of "outsiders", who do not share their values; in social agencies, welfare offices, hospital clinics, etc. They feel lost in red tape and alienated outside their own familiar community. They can often not afford the hours of waiting, travelling, or cost of travelling entailed in obtaining help. The student founders of the medical clinic are also concerned with the depersonalizing aspects of help within large hospitals, especially the "...study of diseased organs rather than sick people... in an environment where consideration for the individual patient is lost in a swirl of hospital efficiency."[16]

The youth who operate the medical clinic are concerned with the environment, the "sense of place", in which they have locatec their services. It is difficult to communicate, in a literary medium the quality of the environment at the storefront medical clinic. However, one can list a few characteristics that apparently make interaction with this environment more acceptable (than the conventional institutions); lack of red tape, such as lengthy forms to fill out and too many questions being asked; stress laid on personal service with lack of formalistic professional barriers (i.e., white coats for doctors are taboo at the medical clinic); the proximity to the community served; the relaxed informality of the environment with no pretentions, furniture or decoration; the immediacy of response to needs; constant communication with the indigenous leadership within the community; a non-fragmentary approach to clients' problems; a concern for development of trust and understanding on a personal basis; and a direct involvement of recipients of service in the organization whenever possible.

One aspect of this trend away from the confines of educational and other institutionalized institutions into the wider community is the effort to work with or join the ranks of "the poor" (as in the case of so-called "hippies") "... by creating new small enterprises to fulfill needs that big organizations neglect or only pretend to fulfill."[17] This move on the part of youth to create new or paralleled organizations or places of decentralized service to disadvantaged communities is commendable, for:

> "There is good hope for bringing to life many of our institutions by surrounding them with human enterprises, like a cambium or growing layer. The most telling criticism of an overgrown institution is a simpler one that works better."

Insofar as youth's motivation is concerned, we seem to have come full circle, for their move into the community to help the

disadvantaged is reminiscent of the early days of Toynbee Hall and Hull House. Jane Adams, in her day, condemned the educational system for catching the young in what Tolstoy called "the snare of preparation" by being

> "... given over too exclusively to study and thus entangling them in a curious inactivity at the very period of their lives when they are longing to construct the world anew and to conform it to their own ideals." [19]

"This motivation to help "the poor" is often accompanied by dissatisfaction with traditional academic curricula. Both these attitudes are found among the group of McGill medical students who began the Community Health Clinic in Pointe St. Charles last summer. In their progress report of October 1968 they stated:

> "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." [20]

There is also dissatisfaction amongst some youth (which they share with "the poor") with traditional modes of rendering service to people generally, and people in disadvantaged areas in particular. Therefore another strong motivation amongst youth in effectively organizing or helping "the poor" is to experiment with new modes or organization outside the interlocking corporate bureaucracy of services in an attempt to bring more vitality, self-determination, spontaneity, and flexibility into practice in providing a more personalized service to those groups of citizens with whom they work. The organizational structure of the storefront clinic is almost anti-organizational in character – an attempt to create an atmosphere, not only to accommodate change, but an almost creative chaos where "things can happen" that have not been pre-planned or foreseen. In this sense, the students at the storefront clinic practise an organizational style that is more process-oriented than goal-oriented. They attempt to solve problems as they arise in "ad hoc" sessions, generally steering clear of regular meetings, as they see this form of activity as being over-structured and using up time better spent in action.

In the opinion of the writer, youth groups who are involved in grass roots work are less alienated because they are less repressed, more committed to innovative change, and get closer to "the poor" with whom they are working than many established agencies. The latter's role tends generally to be more focused on "keeping the lid off", by remaining detached.

Youth's service is often suspect, however, by both the recipients of their help, and the established institutions within the community, because they initially lack legitimization from both quarters. Even when they have won legitimization from their clients, they may continue to suffer territorial rivalry and suspicion on the part of the older institutions. Although society idealizes youth in many ways, suspicion about youth's responsibilities and experience continues to interfere with their role as helper.

The medical clinic, however, was fortunate in this respect. Although initially suspect from the medical profession and then envied by some of the established social agencies in the community, it gained legitimization from citizens in Pointe St. Charles, and funds from a large New York foundation, quickly. Even established institutions cannot deny the effectiveness of the operation, because the clinic is providing a visible, badly needed, and highly acceptable service in its medical aspects. Social animation can glide more legitimately into the programme as a result. Also, unlike some other youth groups, the medical students are perceived as more responsible, respectable youth who have remained "within the system" and are preparing themselves, in their roles at the clinic, for entry into highly respectable professions in society.

Youth organizations are frequently accused of "using the poor" to work out their own problems – whether it be in helping alienated youth with drug problems to relieve their own guilt at having once been through the drug experience themselves; to use "the poor" to learn their roles as future doctors, lawyers, architects, social workers, sociologists, etc.; to unload pent-up hatred at "the system" by using "the poor" to practice an ideology foreign to "the poor", such as the Kingston SUPA group; or simply to use "the poor" to seek their own elusive identity. I cannot see these criticisms of youth organizations in such black and white terms, nor do I believe that "the poor" are so inert that they will not reject any implant that is a foreign body. I have a great faith in the intuition of the poor in this regard – and their sensitivity to "outsiders". Surely the organization will die out or become ineffectual as in the case of the SUPA group if not found acceptable by the disadvantaged community it serves.

The problems posed by youth organizations, who do involve themselves in helping to organize the poor, are certainly not lack of moral commitment or "lack of training", but rather problems involved in idealistically seeking quick results for their endeavours (as in the case of the SUPA Kingston Project) and the problems posed by the turnover and therefore lack of continuity of personnel working in any given project, as well as the major problem of funding.

They are sensitive to the fact that the scarcity society is at an end, unlike many of their elders, who continue cautious delaying actions as if the great depression was still upon us. The fact that these youth realize economic scarcity need no longer exist, and that our society has the ability (if not the wisdom) to end economic poverty, provides many youth with an optimistic initiative in both taking risks and even living in voluntary poverty themselves, knowing some solution will hopefully be found in dilemmas. Also they aggressively approach sources for money, almost as a right. This optimistic attitude percolates through to the disadvantaged with whom they work, and dismays the traditionalists in the field, who cannot act or project optimism, as they continue to perceive the world through the blinkers of a competitive scarcity economy.

Finally, youth in the field of social animation, tend to understand better the changes taking place in society from production-orientation to service-orientation. As a corollary, they are able to sense and actualize tentative alternatives to the industrial society and the Protestant Ethic. They understand that the prototype of "the honest working man" is no longer in accord with what's happening, nor is it a solid basis for judging a man's worth. This realization, of youth's part (often related to their own inability to find meaningful roles within the social system), frees them from judgmental attitudes concerning "the poor" and protects "the poor" from stigmatization and prejudicial treatment (so often meted our by established agencies, where policies are still linked to the "work ethic").

The youth I have worked with apply many social work values – that within the established social agencies are merely paid lip service.

"It is as if, having smelled the hypocrisy in some past pronouncements, they have decided to proceed by individual acts that bear witness to beliefs. They don't talk about the dignity of man. They seek it . . . . They are tired of standpatism dressed in the guise of maturity and reason." [21]

Kropot Kin, in his book "Mutual Aid" stated that there was an instinct in animal and man to aid others – as deep an instinct as ones we normally accept, such as the Freudian notion of aggression. Within the framework of our society, this basic drive is often frustrated. Nevertheless, a cause for optimism in this regard is the ability shown by some of the more concerned youth to provide help and understanding for disadvantaged groups in our society outside the familiar bureaucratic structure, using fresh and innovative methods of service.

"If we seriously and effectively tackled the problems of anomie, alienation, riot, pollution, congestion, urban blight, degenerative and mental disease, etc., we would find ourselves paying more particular attention to persons and neighbourhoods, rather than treating them like standard items; we would have a quite different engineering and social science; and we would need **all** the human resources available." [22] ■

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"I said to you the other time, I've tried there. It's like at City Hall, you wait and wait, and they pushes you and shove you and call your name, only to tell you to wait some more, and if you tell them you can't stay there all day, they'll say 'lady, go home, then'. You get sick just trying to get there. You have to give your children over to people or take them all with you; and the carfare is expensive. Why if we had a doctor around here, I could almost pay him with the carfare it takes to get there and back for all of us. And you know, they keep on having you come back and back, and they don't know what each other says. Each time they starts from scratch."

Robert Coles
from "Like it is in the Alley"

"The new emphasis on community mental health care is part of a larger current, moving away from the view that man's need for help, and the human conditions that we call social problems, are unusual special cases affecting a series of individuals. Rather we are now moving toward the view that social problems reflect flaws and inequities in the social order that must be dealt with as problems of the total community requiring social change, not merely the repair of individuals. . .

"To explain our failure to provide help to the poor, to the blue collar worker and to the exploited minorities, we have too often fallen into the error of blaming the victim! "

William Ryan, PhD,
Director, Community Activities Division
Connecticut Mental Health Center

It is fruitless for medical schools to experiment with curriculum changes designed to produce general physicians unless they are willing to identify and study objectively the faults of the system of medical care which we now provide. Further, they cannot hope to develop a rational system of medical education until some models are created that demonstrate how care may be provided in the future . . .

The mandate to the university is perhaps the most difficult it has ever faced in the field of education, for it must not only redesign an educational system, it must simultaneously re-examine the medical-care system itself. It must experiment with the delivery of health care with the same objectivity that it approaches biological problems and it must redesign the training of the physician (as well as the nurse, the social worker, the pharmacist, and other health professionals) on the basis of function in the modern world and not wishful thinking about the past.

Robert H. Ebert: Medical education and the university in Views of Medical Education and Medical Care, edited by John H. Knowles, M.D., Harvard University Press, Cambridge, 1968, pp. 132, 137.

the nurse-practitioner

by Marjorie E. Shaw, B.Scn.
Nursing Coordinator
Home Care Programme
Montreal Children's Hospital

The problems — 1. Methods of improving standard of health in community.
2. Marked increase in demands for ambulatory patient care.
3. Changing the definition of nursing.
4. Shortage of medical and paramedical personnel.

One solution — the nurse-practitioner.

I do not suggest that this is the only solution, or that one solution will solve all the problems. But it does seem to be a step in the right direction. What is a nurse-practitioner? It is a nurse who after a selected period of graduate education and supervised experience, becomes more actively involved in the delivery of comprehensive medical care to the community. Since my field of interest is paediatrics, my comments will be paediatric oriented, but I should like to emphasize that the principles of paediatric nurse-practitioners could readily be adapted to other age groups.

The paediatric nurse-practitioner courses currently offered* are designed to prepare nurses to work in two major fields: the paediatrician's office and areas where health care and supervision are presently inadequate. The courses consist of formal lectures and practical experience, encompassing all aspects of child health and disease. The nurse delves more thoroughly into normal growth and development, she is taught and supervised in the techniques of interviewing and counselling, and she learns the multifacetted aspects of the basic family unit, its effect on an individual member and a member's effect on the unit as a whole. In the area of health preservation, emphasis is placed on immunization, accident prevention, requirements of good nutrition, dental health, and the nurse-practitioner is able to supervise these areas of comprehensive care knowledgeably and effectively.

Diagnosis and treatment of disease is a relatively new adventure to many nurses. In order to give the nurse-practitioner the competence to work effectively and responsibly in this area, she spends much time, both in formal lectures and practical experience, learning about methods of diagnosis and treatment. She learns the use of stethoscope and otoscope, the techniques of history-taking and physical examination. She attends the clinics and emergency department, actively participates in the diagnosis and treatment of ill children, joins the medical staff discussions on evaluation and management of children with a variety of diseases. Throughout this period of active medical experience she learns to detect the normal from the abnormal, the management of common childhood diseases, and the methods of obtaining certain diagnostic specimens such as throat swabs, haemograms, as well as interpreting the results. The nurse-practitioner becomes competent in various screening tests. She learns the fundamentals of neurological testing, developmental tests, hearing, speech and visual tests, and is supervised in performing these procedures.

Once the period of "formal" education is completed, or concurrent to it, the nurse-practitioner spends a specified time actively working in her new field, under the supervision of a paediatrician in his office, and in community clinics under the supervision of the attending or responsible paediatricians. When she has completed her graduate training, the paediatric nurse-practitioner is equipped to supervise family health care, run child health nursing clinics, and assist in the paediatrician's office. She can diagnose and treat certain paediatric illnesses including many skin diseases, contagious diseases, otitis media and croup. She screens and appropriately refers children with disabilities in the fields of orthopaedics, hearing, speech. She refers to medical facilities children with diseases beyond her management capabilities. In her training considerable emphasis is thus placed on her ability to distinguish the minor disorders which she can handle herself from the more serious ones which she must refer.

When a paediatric nurse-practitioner is employed in a private sphere, she works closely and continuously with the paediatrician, practising her skills and treating his patients under his supervision and guidance. Since the role of nurse-practitioner in the community clinic is more diverse, I would like to direct my remarks to this area.

We all recognise the deficiencies existing in public medicine today. The problem of insufficient medical personnel to meet the demands, lack of continuity of care, inadequate or non-existing programs of disease prevention are subjects widely discussed. The concept of the nurse-practitioner does not solve the problem of insufficient personnel. However, it does provide the one consistent person in the clinic with greater tools and skills to perform a more complete function. Frequently, community child health clinics are attended by physicians and residents on a rotation (sometimes on a catch-as-catch-can) basis, and no real provision is made for continuity. If the nurse is equipped to expand her role in medical care, she can successfully provide much of the continuity which is now lacking. The problem of disease prevention, as those preceding, is not readily solved, but it does seem logical if one responsible person is able to follow a group of families consistently, be available for routine care as well as crisis situations, and is well-schooled in all aspects of family needs, then preventive care will be included as an important aspect of her job. It is impossible to discuss immunization with a mother when her child's temperature is 104°F., accident prevention when the child's face is covered with impetigo, dental care when he presents at Emergency with a fractured leg. But if consistent medical care is readily available on a day-to-day basis, the mother has a chance to establish an agreeable

*Two full-scale programs are presently in operation in the U.S.A. — at the University of Colorado Medical Center, Denver and at the Massachusetts General Hospital, Boston. One nurse-practitioner is presently being trained on an experimental basis at the Montreal Children's Hospital under the direction of Dr. Elizabeth Hillman.

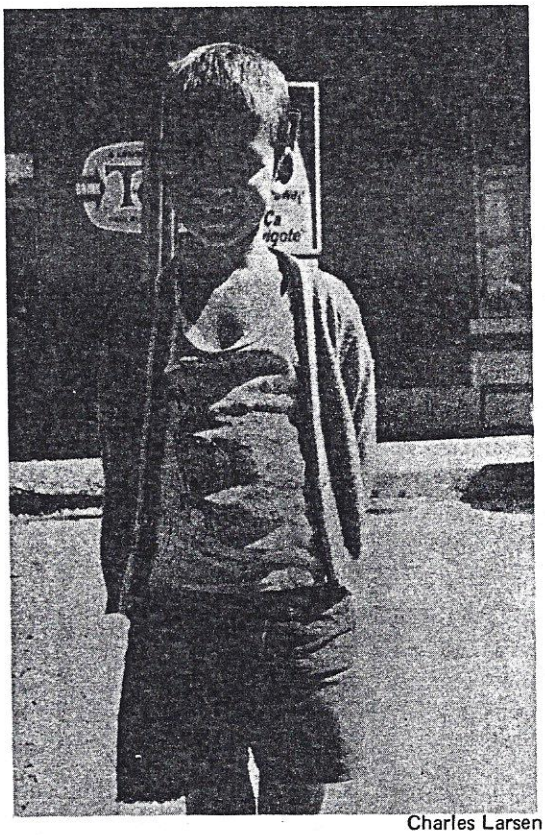
relationship with the nurse-practitioner, is not forever receiving conflicting advice and opinions, and thus develops faith in this person's ability to direct and guide her in medical matters.

In a nurse-practitioner clinic, the nurse is able to handle about 75% of the daily problems that cross the threshold. She is working under the direction of a physician and more skilled and complex medical services are readily available to her. Even in the case where a physician attends the clinic only once or twice weekly to see special problems, the nurse is sufficiently skilled and confident to carry the clinic alone, knowing her limitations and capabilities.

Contrary to some opinions, the nurse clinic does not deliver second-class medicine to medically indigent patients. The nurses selected for this field are carefully screened and hand-picked, have the capabilities and initiative as well as the maturity to do the job. Many nurses are now fulfilling even more responsible positions, such as those working in the Arctic or northern outposts, and have not had the advantage of nurse-practitioner training.

I have one last topic to cope with: the changing role of the nurse. Everyone must accept, sooner or later, that the image of Florence Nightingale with the lamp is somewhat outdated. The science of nursing must advance with the science of medicine. An obvious remark you may say, but to some it is not so obvious. There is as much talk about returning to the bedside as there is about expanding the nurse's role to take on what were,

David Rahn



Charles Larsen

heretofore, physician's responsibilities. Today's nurse has completed four or five years high school education, many have university degrees, some have completed a Master's course. This alone separates her notably from the Nightingale "ladies". Surely this nurse of today is intelligent enough, responsible enough to learn the difference between measles and smallpox, and act accordingly. Surely she can be trusted to seek help when necessary, realizing she doesn't have all the solutions to all the problems. I am not recommending this field of nursing for all nurses, but the opportunity of being a nurse-practitioner should be available to those who are interested and able.

Most children are taken to medical resources by their mothers. Most mothers relate well to nurses, but still regard "the doctor" wit with awe, and some fear, and have difficulty expressing their thoughts or feelings to him. But these thoughts and feelings are often pertinent to the execution of good medical care. A paediatric nurse-practitioner knowledgeable in medical matters, able to utilize effectively the community resources, interested in maintaining continuity of care for her families, may well deliver better ambulatory medical care to the children in the community than a skilled, well-trained, harassed, overworked paediatrician (HERESY!

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my block

I wish that I could have a better block than I have Now. My landlord said that He was going to put Swings in my back yard. how can He do that When the backyard is junky I do not like people throw junk and I demand a Pretty good houses and more food to eat thats What I demand and I better get it.

Rhonda Age 7

I wish they will stop killing people around My block and Rhonda's block. I keep dreaming that I will get hurt. But that is not true. I keep saying to my mother I don't want to go out. But my mother says it is sunny out. I said that is not what's wrong. I'm scared that someone will hurt me.

Lorraine Age 7

A round my block There is a lat of glass and food and paper and people fight all the time. I like people love each other.

Carlos Age 7

parents

My parents hardly never understand my problems because sometimes i will get in trouble like on April fool day. i would tell a teacher her toes are bleeding and then i'll get in trouble, when i would be only fooling around and then my mother would have to come to school and then I'll get a beating, and i'll try to make her understand it was a Joke like anyone would do.

One of the teaches in this school he's a man. When he be walking in the halls he would tap me on my shoulder and when i was in the 7th grade two years from now i tapped this teacher on the shoulder. I was just playing and he went down to the principal and tell them i gave him a CARATE Chop Chop and then i got in trouble right then.

My mother had to come to school and a lot of crap. And i tried to explain to her i was just playing with teacher. But she just didn't believe me. She think that i can't do nothing by myself.

Like another time Foster was at my house. He eats like a dog. One time i had to throw him out because he went in my ice box and ate a half a cake.

Ronald C Age 16

My best friend is my mother. She understands each subject I learn in school and helps me in each one.

She never slaps us. First she gets all the facts together. She asks questions, then puts the answers together and starts yelling. She understands about the way we do in school. She's very patient if she's in a good mood, but if she isn't, oh boy, will someone get hurt!

She's sweet, she plays like one of us, she's a good cook and keeps a swell house. Most of all we love her.

Annette C Age 15

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*The above selections were written by children in New York City Public Schools and published in "The Me Nobody Knows", ed. Stephen Joseph, Avon Printing, N.Y., 1969.

my friends

M. BAILY AND L. HATCH

M. Baily and L. Hatch I like. Baily he is a nut and why I like Hatch is he a little devil. L. Hatch is always fight somebody he is devil. M. Baily is a little nut who wear glasses. He is 4 eye Cannon hard and he look like a worm.

Larry Green Age 16

ROBERT THOMAS

Robert Thomas is a boy who slants when he stands. When he walks, he walks with a bouncing effect. He is thin and wears glasses most of the time. He also wears braces on his teeth. His face is sort of thin and straight, his ears stick out from his head, but not all the way.

Robert carries a knapsack to school with his books in it. He talks with a sissing sound and sometimes stutters. He also blinks rapidly.

Alvin Robbins Age 15

ALVIN ROBBINS

Alvin's eyes are black and his hair is blacker than black. He walks like a roach. He fights like an ant. He walks like a person who hasn't sobered up yet. His house is broken down.

Robert Thomas Age 15

The way I feel

Walking alone around the park is just like forgetting everything. You see the free children playing. I remember when I was a kid and I always was playing and dancing with the other kids. Life is easier when you are small. The parents they care for you more and always gives you what you want. I wish I could be a kid again. They hug you and carry you. When they kiss you goodnight or sing a song to you. You get so sleepy.

Unsigned Age 14

GRIEF

Grief is a gigantic snake ever squeezing until there is nothing, nothing at all left for your very soul to grasp onto. You lose track of everything that means something to you, you just know that you want to escape, escape into reality which in reality is not reality, your whole world revolves around it, it is a terrible experience, the only escape is to do something far beyond the comprehension of a normal person, it's like a drug, an awful terrible drug, your mind screaming with fear, screaming out for guidance out of the vast limbo, it's like heaven and hell, you're on top of the world yet your mind has a great burden.

The only escape is to do something to yourself, something that will hurt not only you but someone else as well, you must, it's the only way to find guidance out of this unreal world, this world of your own, and you emerge, you emerge ready for the world, you're a whole new Person, you're free, the world awaits you.

Paul Parker Age 15

David Rahn

what's wrong with health care in Canada?*

the honourable John Munro
Minister of National Health
& Welfare

There are many departmental programs I could talk about – anti-smoking for example, or air pollution control. The Health Department is big enough and diversified enough that it would also be within my sphere of incluence to discuss drugs and drug quality control, or the provision of health services to Indians and Eskimos.

However, I would prefer to delve into a topic which, while not directly within the scope of government programs, is nevertheless at the root of the challenges, the successes and failures, of our national health picture. I refer to the structure of health and medical treatment in Canada.

I am pointing at the broad scene. There are many components – medical education, doctors' specialization, the structure of allied health professions, the nature and role of health facilities, public health and public attitudes – which go to make the total perspective of dealing with sickness in this country.

Two central problems are always cited as being the cause of any difficulties in obtaining treatment today – a shortage of doctors and a shortage of hospitals and hospital beds.

These two alleged problems are largely myths.

I am tired of hearing that the government is allowing our people to go unattended because they aren't doing enough about building health education centres, plus more and plushier hospitals. Sometimes I hear it stated that one of the reasons we should delay Medicare is because the present shortage of personnel and facilities will be exacerbated further with the increased demand.

Pardon me if I fail to strike my chest and shout out "Mea culpa". But on the question of doctor supply, I think two very salient facts must first be observed. First, we have more doctors in Canada than we have ever had. Second, the ratio of doctors to population is getting steadily better and better.

This might surprise you. It does surprise a lot of people. Yet, since the estimates of the Hall Commission, the doctors' situation has considerably brightened. For instance, in the last couple of years, or in other words, approximately since the announcement of the Medicare program, enrolment has increased 10% in medical schools each year. It looks like the same thing coming up next year too. This is after a long period of static registration figures, which barely kept pace with the population.

Another statistic. The rate immigration of doctors to Canada has accelerated enormously in the last few years. The expected level was projected at about 350-400 annually. Instead the actual figure has been running at about 1,200 doctors coming to this country every year. It is noteworthy that this three-fold increase, just as with the increase in Canadian medical school enrolment, has come at the same time as we have started implementing national Medicare. We should also keep in mind that the drain of qualified doctors to the United States has slackened since the period of extreme gloom and doom forecasting that Medicare would scare people away from the Canadian medical profession.

Well then, the Canadian public is perfectly entitled to inquire now as to why, with all these improved numbers, it becomes more and more of an effort to see a doctor in the flesh without having an appointment arranged at least three years in advance. We use a rough rule of thumb on this – of 1,000 people who get sick, less than 300 see a doctor. There are also vast regional and geographic differences. If you live in Vancouver, a cough is likely to bring five specialists in internal medicine springing out of their offices. Yet a very real and a very serious shortage does exist in our Atlantic provinces.

This in turn points up another differential in doctor distribution. Somehow there are always far more doctors available to serve middle class and upper class citizens than there are in urban and rural poverty districts. This is notwithstanding the fact that illness and disease levels are higher in poverty areas.

So there are real problems in getting treatment. Then what is the cause?

The numbers game breaks down when we analyze what our doctors are doing. They are becoming specialists. And unfortunately, in an ever escalating number of instances, they are even becoming specialized specialists. Now we know that we do need a certain percentage of particularized practioners, capable of dealing with the unusual, the immensely complex treatment of certain difficult types of disease, such as heart disease. But, the more specialized a doctor becomes, the more remote from the general public he becomes. He is isolated by his increasingly technical education as surely as by any prison bars. The more specialized his calling, the fewer people he tends to see. Moreover, he sees only those who are sent to him.

This is the trend. Just after World War II, the general practitioner or G.P. formed 70 to 80 per cent of the physician population. Twenty years later, the percentage was 50 per cent and has continued to drop since. To look at it another way, in the ten year period since 1955-65, with a general population increase of 25%, there was a 90% increase in medical specialists, but only a 4% increase in G.P.'s.

Of course, this is not that difficult to understand. All the pressures favour the specialist. Medical education provides greater exposure to trained specialists, both in the classroom and on rounds. The doctor-in-training is actively encouraged, once he has his primary degree, to take post-graduate work in some refinement of whatever specialty he is heading towards. When he goes out into practice, he finds that fee schedules and private insurance plan payments vastly favour specialists; they can get more money while working regularized hours. Hospital privileges show the same professional bias.

Of course, Medicare can put the brakes on these special privileges in the doctor's economic field. Through universal coverage, deductible features and co-insurance fees should diminish.

*Speech delivered by the author to the Hamilton Health Association, released March 12, 1969. Title supplied by editor.

Compare Saskatchewan with Medicare to Quebec without any government plan. At least prior to the introduction of the utilization fee the best paid G.P.'s in Canada lived in Saskatchewan, and 70% of Saskatchewan docters were general practitioners. Yet in Quebec, with 37% of the population having no medical protection, and with little first dollar coverage in private plans, 60% of the doctors are specialists. Moreover, not only has the percentage of G.P.'s declined, but the absolute numbers of such essential physicians has dropped as well.

To appreciate the dimensions of this changing relationship, consider the change in medical terminology. The name "general practitioner" implies a Jack-of-all-trades, master of none. The new term has therefore become family care or community care physician.

Yet why is only one type of doctor associated with the family or the community? Isn't it supposed to be the duty of all doctors to treat the community at large? Doesn't the Hippocratic oath have a section about entering every home?

Doctors belong among people. Not everyone who is sick realizes when his illness is serious enough to see a doctor. There has to be general case finding – identifying the health deficiencies of communities and their inhabitants. This ought to include all sorts of communities – tenements as well as town houses, slums as well as suburbia.

Yet the point is often quite validly made that the doctor who seeks to serve the broad population has to spend an inordinate amount of time on routine tasks, which do not require his medical skills at any but a minor mechanical level. The same thing goes for doctors in clinics – even outpatient clinics in hospitals.

Thus we must turn our inspection to the structure of health professions in their full range. The immediate item that should strike us is that there is a personnel gap between the doctor, who averages ten to twelve years of education, and the nurse, who averages two to three years. Yet if this looks like a lack of organization, the existence of over fifty health professions, on the other hand, might lead us to think that there is too much organization – a surfeit of structure.

Still, must doctors be the only ones to conduct preliminary medical examinations? Or to do suturing and to apply dressings? Or to treat coughs, colds, and other simple aches and pains?

Some say we need a new category of health worker – some form of para-medic who can relieve the simple detailed work from a community care physician, and leave him free for diagnosis and prescription of more complex treatment. Alternately, we might upgrade a senior category of nurse to fill this need. Not being an experienced medical analyst, I cannot say what the answer is, any more than I can outline the proper mixture of specialists to community care doctors. However, I think that on the basis of the evidence, I can suggest that, before we continue to accelerate the amount of medical concentration, and before we continue to widen the gap between physicians' education and other medical education, we ought to have a pretty intensive study of what directions we should be taking, and what goals we are seeking in the health professions generally.

The other objection to the family or community care doctor, as presently trained, is that his solo practice creates the immense difficulty of his remaining on call all of the time. Any time he is away or engaged, a gap in medical service develops. This raises serious problems in the continuity of care. The continuity is also affected when the G.P. comes upon a complex case in need of special treatment. He must refer the case to some specialist whom he may not know personally in a hospital with which he, the G.P., may have no continuing contact, thus breaking the link between doctor and patient, and tending to depersonalize totally the relationship between them.

Must this be the pattern? Must the health delivery system be composed exclusively of solo practice G.P.'s in the community and specialists in the hospitals, existing in semi-segregation from each other? The answer to this dilemma seems to me to involve integrally the social role of the modern hospital. If I appear to be jumping topics, I assure you that I am not. Allow me to continue that treatment breakdown I started earlier. I said that, of every 1,000 people who get sick, less than 300 see a doctor. Of those 300, our estimate is that only 10 go to hospital. Of the 10, only one goes to the queen and the flag ship of the medical system, namely the large modern hospital with sufficient facilities to be a teaching hospital.

To get to the core of the problem, I do not believe that our Canadian hospital system as a whole, together with the élite specialists who staff them, is sufficiently involved with the general health and health care of the total Canadian public they are supposed to serve.

Ideally, should not hospitals be like parish churches, serving the complete medical needs of a specific community? A hospital contains the personnel and the facilities to back up and complement the forces of family-care doctors in the field. Yet all too often, other more prestigious projects seem to deflect a lion's share of their energy.

For example, why can a master plan not be developed on a regional or provincial basis for hospital development, so that you do not have anomalies like a number of open-heart surgery theatres in a metropolitan centre which should logically, according to patient volume, have only one? Furthermore, hospitals should not be vying with one another as to who has the most elaborate paediatric ward, or the most exotic of surgical facilities. Competition may be healthy when you are selling soap, but is it necessarily the same effective method when you're dealing with human life?

Teaching hospitals are perhaps major sinners as well. How many can say that they are exposing their students to the variety of the human health condition, in all its native environments? Too often accusations can be leveled that students are being shown and guided towards only the high paying specialty treatment disciplines.

Another disturbing facet of teaching hospitals is one of the same aspects that has fostered student revolt on general campuses – a growing lack of attention to teaching and to students on the part of faculty members absorbed in the pursuits of academic glory. I am not about to launch an attack on medical research. Everyone can appreciate the value of continuous investigation in medicine, and the enormous breakthrough it has meant in the conquest of disease. Still, the remark is frequently heard

that the "publish or perish" syndrome is spreading to our teaching hospitals.

Yet surely now more than ever the quality of instruction is of prime importance. The need to diagnose actively and to treat larger sections of our population is growing. For instance, we are beginning to wake up to the ravages still made on the individual state of health by inadequate diet, and even malnutrition, in many of our poverty areas. Up until a little while ago, everybody was assuming that if anything was certain, it was that all Canadians were well fed. Now we are not so sure anymore.

If some of our suspicions turn out to be right, then good doctors will be needed to cope with an increasing medical dimension. We are not at the stage where we can assume that this is the best of all possible health worlds, and everyone can retire to the laboratory.

What can be done to meet the new challenge? Well, hospitals can relate to their communities much more, instead of showing signs of becoming, as Jonathan Swift's mythical island of Laputa, a comfortable haven for the intellectual élite floating high in the sky above the general run of men. Outpatient clinics, for example, can develop mobility. Hospital doctors can establish team practices in communities working hand in hand with community and family care physicians. Roving investigations of neighbourhood health standards can be carried out, and remedial action, such as part-time local specialists clinics, can be undertaken by entire hospitals.

I was struck a little while ago by an exciting venture launched by some medical students of McGill University. They set up a storefront clinic in a poverty area of Montreal which they undertook to keep staffed on a regular basis. Not only did they contribute their own efforts, but they worked to recruit senior doctors to contribute their expert knowledge. I might add that they also found time to run an alleyway recreation project and a remedial education program as well as other community-oriented social work. They publish a magazine called **CONTACT** describing their activities. I strongly recommend this magazine to every hospital administrator and health educator in Canada.

Perhaps this shows that there is a favourable side to the generation gap. Here's a case of young people not willing to limit themselves to pursuing the most lucrative career possible. It is my hope that the McGill project is not an isolated instance, but rather represents a new breed of medical student.

I ought to stress at this point that such active community health work, particularly in regard to diagnosis and early treatment of potential dangers, fits in with the old adage about an ounce of prevention being worth a pound of cure. Better community health is just another form of preventive medicine. Such public health programs, in the long run, cut the enormous amounts of money needed for active treatment. This is essential if we are to get the best value for our health dollars. As it is, if we continue at the present rates, we will spend ten times as much for curative medicine as for preventive medicine over the next ten years. I do not think this situation should continue.

This is part of our challenge. That's why the Federal-Provincial Conference of Ministers of Health appointed various Task Forces to go into the total question of health costs and the health delivery system in Canada, with a view, not to cutting corners on service, but to improving the efficiency of funds now spent in this field.

Take hospitals and hospital beds. You often hear of terrible shortages in these facilities. But how real are they? Shortages can be caused by a number of factors. Owing to the competition for status that I mentioned earlier, there can be a shortage of general beds but a surplus of special care beds. Through lack of sufficient regional planning, there can be inadequate general care beds but an excess of obstetrical beds and new-born nurseries. Deficiencies in overall provincial planning can result in a feast in one area and a famine in another. Also, over-concentration in one type of hospital – the active treatment hospital – can result in needed beds being tied up by people who could otherwise be fully looked after in convalescent or chronic care institutions at a fraction of the cost.

The need of complete planning cannot be overstressed. Hospitals should not be looked upon as municipal showcases. We should not arrive at the same situation they have in Ireland, where, after years of Irish Hospital Sweepstakes, they say that if you sneeze in County Killarney they automatically build a hospital around you.

In essence, then, the message I am preaching is that we must take a good hard look at the system of health care and medical treatment in Canada. We cannot afford to live and plan and operate on a basis of a status quo founded in myths of outdated assumptions. Production, whether of personnel or of facilities, is not the sole answer to the health problems of Canadians. It may not even be the major answer. Distribution, as the U.S. Presidential Commission on Health Manpower pointed out, is of equal or greater importance.

I do know that the contradiction of a high ratio of doctors in hospitals per population, co-existing together with serious health problems as the rule rather than the exception for that substantial proportion of Canadians living in poverty or on its borderline, should not be allowed to continue. National health is more than a medical question; it's a social question as well.

Therefore the only conclusion to make is that our doctors, our nurses, our hospital administrators, our medical professors, and all others involved in the Canadian health delivery system have got to involve themselves as much with its social aspects and its human dimension as with its medical aspects.■

"My feeling is that the tendency to carry youthful characteristics into adult life, which renders man perpetually immature and unfinished, is at the root of his uniqueness in the universe, and is particularly pronounced in the creative individual. Youth has been called a perishable talent, but perhaps talent and originality are always aspects of youth, and the creative individual is an imperishable juvenile . . . "

Eric Hoffer
"The Ordeal of Change"

3 poems*

Michael Ondaatje

The Sows

Only a few survive the day – pink.
The dust's too luscious and cool
to even compete with beauty.
Lunch clangs
and scuffs to a halt.
They gyrate a hole,
overcome gargantuan sighs
and close albino eyes to sleep
– an eyelid trembling in the air.

And there are ways of sleeping too:
dust collects on your wet snout
if you face wind,
and there's the sun
streaming through barbed wire
to worry about.
But it's cool in the dust
and flies don't like your pine hard hair.

So chinless duchesses
sniff out the day,
gauging their loves with a seasoned eye.
On spread thighs, and immobile,
they categorize the flux around them,
watching the rain melting the dust,
or the sun
fingersnapping out the dying summer.

Application for a Driving License

Two birds loved
in a flurry of red feathers
like a burst cottonball,
continuing while I drove over them.

I am a good driver, nothing shocks me.

Henri Rousseau and Friends

for Bill Muysson

In his clean vegetation
the parrot, judicious,
poses on a branch.
The narrator of the scene,
aware of the perfect fruits,
the white and blue flowers,
the snake with an ear for music;
he presides.

The apes
hold their oranges like skulls,
like chalices.
They are below the parrot
above the oranges –
a jungle serfdom which
with this order
reposes.

They are the ideals of dreams.
Among the exactness,
the symmetrical petals,
the efficiently flying angels,
there is complete liberation.
The parrot is interchangeable;
tomorrow in its place
a waltzing man and tiger,
brash legs of a bird.

Greatness achieved
they loll among textbook flowers

and in this pose hang
scattered like pearls
in just as intense a society.
On Miss Adelaide Milton de Groot's walls,
with Lillie P. Bliss in New York.

And there too
in spangled wrists and elbows
and grand façades of cocktails
are vulgarly beautiful parrots, appalled lions,
the beautiful and the forceful locked in suns,
and the slight, careful stepping birds.

Michael Ondaatje

*These poems appeared in "The Dainty Monsters" (The Coach House Press, Toronto, 1967), Mr. Ondaatje's first book of poetry, and are reprinted with his permission.

2 student projects in Vancouver

THE INFORMATION CENTRE

Although as of this moment, U.B.C. has no SHO in a formal sense, U.B.C. health science students have been active for the past two years in community action programs.

In the summer of 1967, as in Montreal, a group of interested medical, nursing, and social work students from U.B.C. met to consider ways of remedying the shared deficiency in community involvement in the formal curricula of the various schools. The goals of the project they chose were modelled on those of the SHO as outlined in Contact No. 1, page 5. They decided to select an area of Vancouver and to talk to enough citizens of the area to permit them to develop a project in response to stated needs. In this way, the project would not impose what the university students saw as important, but rather would fulfill an existing need in the minds of the area's inhabitants.

The area chosen was Woodland Park, a low income district in East Vancouver with a large population of Italian-speaking new Canadians. The community includes single-family dwellings as well as a low rental housing project. The major problem defined by the group who initiated contact with the community was not strictly medical. In fact, it soon became evident that many of the services wanted by the local people were already available, including medical care, close at hand. What was needed was a way of getting across the fact that these facilities were available and the ways in which each service should be approached. In some cases, it became evident that fear of "the organization" and the complexity of a new language were keeping people from seeking the help they needed, be it registering for Health Insurance or getting legal aid.

Consequently the group set up a community advice bureau in a rented storefront called, unpretentiously, 1112 CENTRE. Few guidelines were set — the plan was to develop a program as needed. The staff consisted of medical, nursing, social work, law, architecture, and sociology students plus several interested community members. The community members were most important as it was recognized that students could only be involved on a short-term basis and the project seemed to be needed on a long-term basis. An old stove, chairs and tables were donated by local merchants, curtains were sewn and signs and brochures were distributed announcing the opening of the Bureau.

Business increased gradually, primarily consisting of old age pensioners at first, who wanted answers to questions ranging from marital problems to how to fight city hall. The students' approach was "If we don't know, we know someone who does". To this end, a master list of sources in the general community was developed, doctors, lawyers, aldermen, city social service workers, etc., who were prepared to be called upon for advice, day or night. As the same questions began to be asked repeatedly, it was realized that the students would know the answers to more and more of them. Both advisers and advised were learning the ins and outs of the organized services of Vancouver.

The Centre also served as a focal point for a community action group which drew up a brief during the Great Freeway Debate of 1968. A freeway route was being planned to go through a heavily populated area of Woodland Park. Through this action the local ratepayers gained new strength and support, and the freeway was successfully blocked.

The Centre became a place where young people could gather, where discussion groups could be organized, where what was needed could be looked for. From the original two days and evenings, the Centre began to stay open more and more days and nights of the week, as more people became interested.

At the present time, a new group of students and a large number of community people are operating the Centre, strongly supported by the United Community Services, who recognized how useful a project like this could be. New programs are developing as interested people request them. And the Centre shows every sign of continuing for many years.■

Carol Herbert
U.B.C. Med. IV

COOL AID

Last summer in Vancouver, two medical students and two nursing students set up a medical clinic under Cool Aid, Vancouver's feeding, housing, lost and found, job-finding "hip benevolent society". They joined forces with several individual doctors, and a group, the Christian Medical Society who were already providing some help, and worked closely with community agencies such as the hospital Outpatient Departments, Family Planning Clinics, and the provincial Division of VD Control.

Operations began in the washroom of a local psychedelic nightclub one night a week and later expanded to a nightly service in a room equipped with donated drugs and examining tables in a house acquired by Cool Aid. Easily treated problems such as upper respiratory infections, abrasions and gonorrhea were handled in the clinic and bigger problems such as pregnancy, hepatitis and kidney infections were referred to a local hospital. A dentist and several psychiatrists donated their time generously. The clinic was run most nights by a medical and a nursing student with the provision of telephone contact to several doctors for advice and prescriptions. One evening a week, one or more doctors were present at the clinic. On this night, besides the other business, we did pelvic examinations and gave out birth control pills.

Since the summer, the clinic has continued to operate with a variety of medical and nursing students. The clinic has proved to be a good practical training ground for the interdisciplinary approach to problems. Now students in related professions such as Rehabilitation Medicine, Pharmacy, and Dentistry are becoming interested in taking part.

Perhaps the greatest benefit of the summer was that it increased our appreciation for all types of people, and deepened our understanding of their needs.■

Cathy McCallum
U.B.C. Med. 1V

a student manifesto

*In Search of a Real and Human Educational Alternative**

by David Zirnhelt
President, Alma Mater
Society, U.B.C.

Today we as students are witnessing a deepening crisis within our society. We are intensely aware, in a way perhaps not possible for the older generation, that humanity stands on the edge of a new era. Because we are young, we have insights into the present and visions of the future that our parents do not have. Tasks of immense gravity await solution in our generation. We have inherited these tasks from our parents. We do not blame them so much for that, but we do blame them for being unwilling to admit that there are problems or for saying that it is we who have visited these problems on ourselves because of our perversity, ungratefulness and unwillingness to listen to "reason".

Much of the burden of solving the problems of the new era rests on the university. We have been taught to look to it for leadership. While we know that part of the reason for the university is to render direct services to the community, we are alarmed at its servility to industry and government as to what and how it teaches. We are scandalized that the university fails to realize its role in renewing and vivifying those intellectual and moral energies necessary to create a new society — one in which a sense of personal dignity and human community can be preserved. We are scandalized that the university, implicitly if not always directly, in the form and content of education continues to teach and inculcate in its students precisely those values in our society which if persisted in can only lead to a deepening of the present crisis and the eventual loss of human dignity and freedom.

Our trust and confidence in the universities and our school system is further weakened when we see the simplistic reactions of both faculty and students in this time of stress. It is evident that our schools and universities have produced a state of mind bordering on insanity in both students and faculty. Driven by these attitudes students sometimes issue unreasonable and impossible demands and they often resort to a direct confrontation in their need to be heard. The administration and even some faculty and students feel required to offer total resistance and the determination to defend the university, as they know it, with violence. We reject as unworthy of our dignity and capacity as human beings to be driven to either extreme — to defend the **status quo** by violence or to meet it with violent confrontation...

We strongly believe the university is in need of reform and we will not have the thrust of our intention blunted by university authorities who accept reforms only so long as the university continues to run in the old way. We also condemn this attitude as a form of insanity which can lead only to further decay in the university.

What we are seeking as a matter of principle is what any human being seeks.

1. We seek a form of education in our university which gives the student freedom of choice in what he should study.

2. We seek the political rights of free human beings to have a say in those decisions that affect them.

3. We seek the right to question whether we should be educated in the traditional manner or educated at all.

We declare that except in theory and in a few courses in the university that teach **about** freedom, these ordinary rights have all but disappeared in our universities. Our freedom in these matters is jeopardized by both reactionaries and extremists on the left. That is, by:

Those who claim that we now have a democratic society and that each person should have the right insofar as he can to participate in those decisions which affect him and yet deny him that right in practice.

Those who say that the pursuit of knowledge should be free and that this is the glory of our universities, yet in practice give only the opportunity to learn certain things.

Those who say in our universities and society that the pursuit of knowledge in the arts, philosophy and the end of man is better than pursuit of material things for their own sake, yet insist in practice that our educational requirement be determined in most instances by the demands of our economy along the lines of efficiency and almost exclusively designed to fill the expectations of jobs in our industrial society.

Those in the university who seek to legislate our morality and continue to ignore the problem of the immoral use of knowledge in our society.

Those others who in opposition to the "establishment" preach freedom and love, and in practice would impose another form of control and conformity in ideas, and in their turn deny others their basic rights.

Those who in the name of democracy seek a democratic use of power, but in the end only seek power for themselves.

Those who decry the secrecy and depersonalization of structure in society, yet themselves meet in secret and use organizations to obtain power.

When it comes to the preservation of freedom and political rights in university life we are concerned with the role of the students and faculty in decision making, and the role of the university **in loco parentis** . . . Although we are generally in favour of the idea of parenthood, we are impatient with the idea that universities think they can assume the responsibilities of being parents when even parents are confused about being parents. It surprises us when the university insists upon being regulator of our morals, when the university will not subject itself to a moral scrutiny of its purpose and structure.

*This document was drawn up under the auspices of the Alma Mater Society at the University of British Columbia in June, 1968. It was accepted by the whole of the student council as policy and presented to the university.

The threats to freedom in our age do not only come from physical violence and coercion. This is also an age of intellectual violence. The two cannot be separated; where one exists, so must the other. We will not be coerced by what has come to be the equivalent of university education by compulsion. To say there are alternatives and we are free to choose them is simply not true. One needs "the ticket" to make his way in society. We decry this false set of values placed on university education by society, especially when the utility of the degree in government and industry is given as their most meaningful criteria. These values are often reflected in the students themselves. In a recent student publication the editor wrote:

> . . . he (the student) spent five years at university and fulfilled all the faculty requirements, thus proving he has the ability to learn. He has the ability to learn the requirements of his job and he has the guts and stamina to persevere where the person without a degree will give up and fail.

The university has all but entirely submitted to industry and government and the need to advance our economy, not only in the purpose for which it exists but also in the system of rewards and punishments it imposes in the form of grades, and in the criteria it establishes for excellence. As free individuals seeking and education for **our** purposes and for a truly free society, we will not subject ourselves to the compulsion which says in effect that you cannot have a degree or attend this university unless you follow this precise set of rules regarding your education and fulfil these obligations.

The first unwritten and unexpressed rule given to us by the university is that students and faculty shall not question (except in a hypothetical way) the rules which are given, their moral implications or the purpose of the university. If you as students question this first rule in any practical way you shall be declared undemocratic, communist, anarchist, sick, ungrateful to the bountiful society which supports you or, worst of all, a drop out. In fact, we shall ostracize you, for if you do not follow this rule we shall declare you intellectually inadequate. We may be atheists, agnostics, Christians or whatever, but we are not prepared to worship at the altar of this, the foremost of the modern idols.

There is no doubt a tendency on our part to overgeneralize about the inadequacies of the universities. In the same way, the older generation overcompensates in its criticism of the student demands by saying they are impractical and in this way attempts to avoid the real issues. It is said that we do not take into account the obstacles to reform, that is, the need for trained people in society, the problems of overcrowding, budget problems, the presence in some cases of inadequate and uninterested faculty, the human problems of jealousy and power seeking within the university and — given these problems — the need for some systematic way of ordering activity in the university. We do recognize these difficulties and admit we lack experience in dealing with some of them. However, we will not allow these difficulties to be used against us as excuses for so-called "moderate" reform or as a technique of absorbing and blunting our criticism or not doing anything at all.

Professional schools and training must exist, and they must have some means of regulating their standards. This is obvious enough. We do not, however, think that the criteria of professionalism and the specious scholarship that often accompanies

For What It's Worth

There's something happenin' here,
What it is ain't exactly clear.
There's a man with a gun over there,
Tellin' me I've got to beware.
It's time we stop, children,
What's that sound?
Everybody look what's goin' down.

There's battle lines bein' drawn,
Nobody's right if everybody's wrong.
Young people speakin' their minds,
Gettin' so much resistance from behind.
It's time we stop, children,
What's that sound?
Everybody look what's goin' down.

What a field day for the heat.
A thousand people in the street,
Singin' songs and carryin' signs.
Mostly saying, "Hooray for our side."
It's time we stop, children,
What's that sound?
Everybody look what's goin' down.

Paranoia strikes deep,
Into your life it will creep.
It starts when you're always afraid,
Step out of line, the Man come
And take you away,
You better stop, hey,
What's that sound?
Everybody look what's goin' down.

Stephen Stills
(for The Buffalo Springfield)

WHAT IS MAN?

"A self-balancing, 28-jointed adapter-base biped; an electro-chemical reduction plant, integral with segregated stowages of special energy extracts in storage batteries for subsequent actuation of thousands of hydraulic and pneumatic pumps with motors attached; 62,000 miles of capillaries. . .

"The whole, extraordinary complex mechanism guided with exquisite precision from a turret in which are located telescopic and microscopic self-registering and recording range finders, a spectroscope, etc.; the turret control being closely allied with an air-conditioning intake-and-exhaust, and a main fuel intake. . ."

R. Buckminster Fuller
"Nine Chains to the Moon"

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it should be the basis of all education in the university. When this is the case, teaching is reduced to training to meet the standards of professionalism and research becomes in many cases a means of maintaining professional standing and advancement within the university. The students (to say nothing of the faculty) suffer under such a régime. Such a system induces passivity on the part of the student and an unthinking obedience to his teacher.

We have become dissatisfied with the quality of university education and the slowness and apparent lack of interest of the university to make these changes. Most of the changes we insist upon have little to do with budgeting. We are becoming increasingly discontented with the criteria, range and meaning of course marks. We question the educational value of competition for marks, written examinations as a basis for grades and ultimately the utility of any grading system. There is increasing unrest over courses which are often restrictive, often biased and usually irrelevant. We recognize the need for scholarship and discipline in studies. This is not incompatible with freedom of choice. We wish more freedom to study what we want to study and how we want to study it, without being forced to accept certain models or biases in order to obtain satisfactory grades.

We are becoming increasingly impatient with dry, uninteresting lectures and with those which emerge almost completely from a text book. If this type of instruction continues, we will not continue to attend classes. We still protest the impersonality of the university to a point where the statement appears trite. Yet with some exceptions we have not seen any improvement in this direction. While budgetary limitations are recognized, we believe that imagination and a demonstrated willingness on the part of most — not just some — faculty to overcome this problem would do much to improve the learning situation.■

Outside of a Small Circle of Friends

Look outside the window, there's a woman being grabbed.
They dragged her to the bushes and now she's being stabbed.
Maybe we should call the cops and try to stop the pain,
But Monopoly is so much fun, I'd hate to blow the game.
And I'm sure it wouldn't interest anybody
Outside of a small circle of friends.

Riding down the highway, yes my back is getting stiff,
Thirteen cars have piled up, they're hanging on a cliff.
Maybe we should pull them back with our towing-chain,
But we gotta move and we might get sued and it looks like
it's gonna rain.
And I'm sure it wouldn't interest anybody
Outside of a small circle of friends.

Sweating in the ghetto with the colored and the poor.
The rats have joined the babies who are sleeping on the floor.
Now wouldn't it be a riot if they really blew their tops,
But they got too much already and besides we got the cops.
And I'm sure it wouldn't interest anybody
Outside of a small circle of friends.

There's a dirty paper using sex to make a sale.
The Supreme Court was so upset they sent him off to jail.
Maybe we should help the fiend and take away his fine,
But we're busy reading Playboy and the Sunday New York Times.
And I'm sure it wouldn't interest anybody
Outside of a small circle of friends.

Smoking marijuana is more fun than drinking beer.
But a friend of ours was captured and they gave him thirty years.
Maybe we should raise our voices, ask somebody why,
But demonstrations are a drag; besides, we're much too high.
And I'm sure it wouldn't interest anybody
Outside of a small circle of friends.

Phil Ochs

. . . Then I said, "All right. What do they do, the fish and all, when that whole little lake's a solid block of ice, people skating on it and all? "

Old Horwitz turned around again. "What the hellaya mean what do they do? " he yelled at me. "They stay right where they are, for Chrissake".

"They can't just ignore the ice. They can't just ignore it."

"Who's ignoring it? Nobody's ignoring it! " Horwitz said. He got so damn excited and all, I was afraid he was going to drive the cab right into a lamppost or something. "They live right in the goddam ice. It's their nature, for Chrissake. They get frozen right in one position for the whole winter."

"Yeah? What do they eat, then? I mean if they're frozen solid, they can't swim around looking for food and all."

"Their bodies, for Chrissake — what'sa matter with ya? Their bodies take in nutrition and all right through the goddam seaweed and crap that's in the ice. They got their pores open the whole time. That's their nature, for Chrissake. See what I mean? " He turned way the hell around again to look at me.

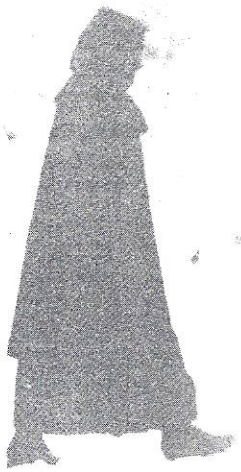
"Oh," I said. I let it drop. I was afraid he was going to crack the damn taxi up or something. Besides, he was such a touchy guy, it wasn't any pleasure discussing anything with him. . .

. . . When I got out in front of Ernie's and paid the fare, old Horwitz brought up the fish again. He certainly had it on his mind. "Listen," he said. "If you was a fish, Mother Nature'd take care of you, wouldn't she? Right? You don't think them fish just die when it gets to be winter, do ya? "

"No, but —"

"You're goddam right they don't," Horwitz said, and drove off like a bat out of hell. He was about the touchiest guy I ever met. Everything you said made him sore.

J.D. Salinger
from "The Catcher in the Rye"



More specifically, this has two side-effects of immediate impact on students: (i) The type of research a professor pursues helps determine the courses he is interested in teaching, the approach or orientation towards the courses he agrees to teach, and the interest he brings to them.

(ii) The second side-effect especially concerns post-graduate students. Since a post-graduate student needs a research director under whose supervision he does his research, it is quite likely that he will choose his research in areas where the department's professors are able to offer guidance, and assimilate the orientation or approach of the professor. Since the post-graduates become the next wave of professors the system can be viewed as (perniciously) self-perpetuating.

The two above "side-effects" constitute ways in which both undergraduates and post-graduates are directly affected by the areas or nature of research done by faculty. With respect to the second effect an undergraduate intending to go into post-graduate studies and research has the same legitimate interests as the post-graduate already there. Those who maintain that students can go elsewhere where the fields of study or approach are different overlook that students, and more specifically undergraduates, are not nearly so mobile as their more affluent professors, and often have to live with their parents, or in the same city; and second that they do not generally know the specific orientations and fields of study in other universities. Moreover certain areas of concentration in the major Faculties of the university are pervasive to a remarkable degree throughout North America. Within this context, mobility is somewhat meaningless.

5. Finally any faculty addition to a department shifts its overall balance. Inasmuch as he takes part in departmental meetings, is in effect a "legislator" for the department like all other members of faculty, and influences the development of curriculum, the selection of new staff, etc., his area of interest and his view towards his discipline and its potentialities are of legitimate concern to students since the latter, as part of the same department, are thereby affected.

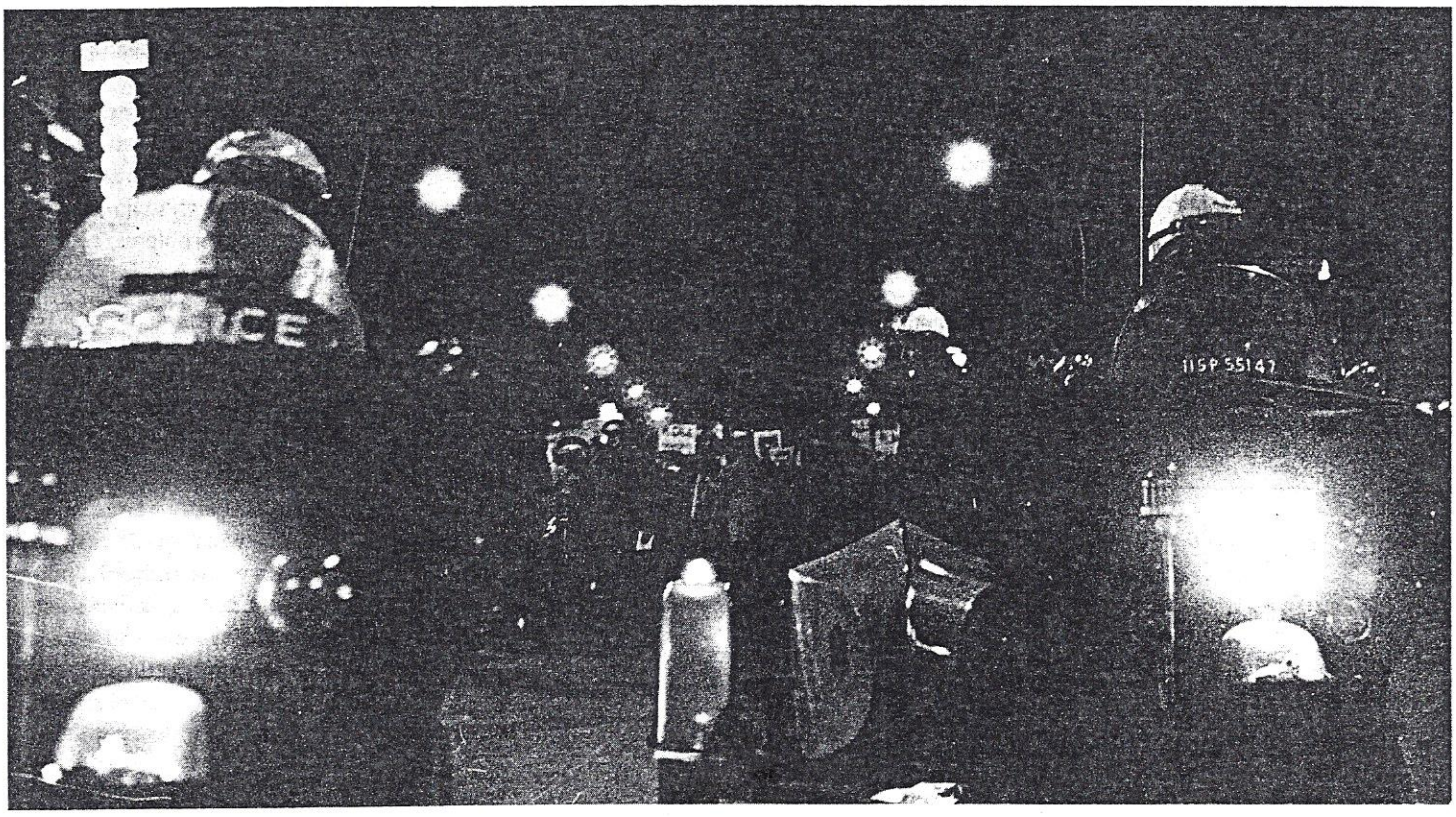
The Question of Competence

The main objection made explicit by faculty to student participation in the selection and promotion of academic staff is that they lack the competence to do so intelligently. This objection merits a more thorough analysis.

The fight for democratisation originates with those students most dissatisfied with their present education and the university's other activities. This does not imply that other students would not support those in the forefront, but simply that they would not initiate demands by themselves.

This relationship is not accidental. Not only is democratisation inherently desirable inasmuch as it provides a progressive model for all sectors of society (within the immediate context of the university) but more importantly it should be viewed as a practical strategy for change. The desire for change presupposes knowledge of and conscious dissatisfaction with the status quo, and the perception or development of alternatives in large part derived from that knowledge and dissatisfaction. This brings us to the question of competence.

Bob Allnutt



"Even if we're on the right track, we'll get run over if we're sitting down."

For a member of a selection or promotions committee competence depends primarily on the ability to **obtain** and **evaluate** information. Information can always be **obtained** concerning a prospective new appointee's university education including his research thesis, his research and publication interests and record, evaluation of his teaching ability (presuming a Course or Teacher Evaluation Guide exists) and his general area of interest within his discipline. Written references and a personal interview can fill in the remaining gaps. In the case of a faculty member presently employed in the department whose re-appointment and promotion are being considered it is quite likely that the other faculty members are more aware of his research activities than are the students. But it is also true that the students are more knowledgeable as to his approach and orientation towards the courses he teaches and the quality of his teaching. In fact faculty may have little or no idea of these factors since they do not take courses from each other, which is one of the reasons why at present they give them correspondingly little weight in considering promotions.

The students in a specific department or Faculty who, through their own effort, achieve democratisation at their level, including participation in determining new appointments and promotions, are able to **evaluate** the necessary information. Once students become fully aware of the importance, or what is equivalent the uses, of this form of participation they will be able to exercise the resulting influence intelligently and effectively. Thus, the condition which leads to the demand for democratisation in this area enables one to practise it — namely the development of consciousness; and this applies to faculty as well as students.

It is for this reason that there should be no university-wide rule concerning student participation in the selection and promotion of academic personnel. On the one hand legislation preventing this form of participation would in general be blatantly repressive and in particular would violate the integrity of several agreements concluded between students and faculty in individual departments. On the other hand a ruling enforcing this would impose an artificial sense of participation on sectors of students who felt, at least on a conscious level, no particular need for it, and were not sure what they wished to accomplish with it. Agreements should be reached on an individual departmental or Faculty basis. Senate's only role is to approve the concept in principle, and to encourage or ask departments and Faculties to accede to the legitimate requests from the students within them for this form of participation.

People are walking
To work they are going
Money money ha

Michael Benward Age 13
from "the me nobody knows"

Another possible charge that could be brought against students is that of **false consciousness**: viz. "they may think they know what they want, in fact are able to articulate it in fairly precise terms; but this does not mean that they are right, and furthermore considering their lack of experience they are quite probably wrong, or at least misguided." The trouble with this charge is that it could also be brought against faculty, with the difference that "lack of experience" is replaced by "excessive degree of socialization". In neither case could such a statement be proved, and furthermore it it was arbitrarily presupposed in either it would undermine any basis whatsoever in believing in a democratic process as applied to the university.

The only solution is to allow both groups to participate in the determination of staff and should the charge in either case be correct this will be revealed. Conversely if the charge is being used consciously or unconsciously by the faculty to mask a real division of interest existent at the university and so suppress the students from achieving a degree of power, this will also be revealed. The alternative is continued alienation for those students who cannot give effect to their conscious aims.

It is an interesting comment on the competence argument that the present statutes give the Board of Governors, a body of laymen, final authority over appointments and promotions; that they place on statutory selection committees faculty who are completely outside the discipline for which a professor is being appointed, and who probably know less of the requirements of that discipline than do senior undergraduates within it; and that in general the statutes do not give to faculty, with the exception of departmental chairmen and Deans, the **explicit** right of suggesting new appointments and promotions.

A further aspect of the competence argument alluded to above is that students lack the experience that faculty members have acquired to participate intelligently in the selection process — i.e. that faculty have experienced the learning, teaching and research aspect of university life whereas students have not. Against this it could be quite legitimately charged that what has happened in fact is that faculty, especially those in senior ranks, have become socialized to conducting research in a narrow discipline-oriented system dealing with minute problems, of interest primarily to their discipline, or to those who presently control corporations and governments; that they have become socialized to the status quo as a whole, have profited from it to the extent that they have little desire to change it fundamentally, and in general are biased by and in support of it.

The faculty have forgotten the subjective experience of being a member of the student mass — the "lumpenproletariat" of the university. Moreover, objective conditions have changed in that universities were nowhere as big when the faculty were students as they are now. The faculty's world outlook and values, moulded in former periods and under different social circumstances, may in many cases, no longer be valid for present conditions. The "experience" argument is ultimately little more than a conservative plea for the effective furtherance of the status quo.■

THE TYRANNY OF GOODS

"One has only to look at the ads showing the American consumer in his leisure time to see this; he is surrounded by a multitude of goods and gadgets which subject him to the burden of their consumption. Even today, before we have reached a completely automated abundance, we are enslaved by the tyranny of goods, which direct the use of our leisure. The producers and advertisers are not only luring us into buying a multitude of goods; they also dictate to us in this way how to use our leisure. Freedom from necessity would also require freedom from consumption of certain types of goods.

"The more there will be produced, the more goods will be turned out by robots, the greater will be the time-and-energy consuming burden of consumption, and the more will our freedom be restricted. The time and energy used in the consumption of goods and gadgets will be taken away from the time and energy available for the satisfaction of non-economic needs.

"Not enough time and energy will then be available for love and friendship, for the enjoyment of nature, the contemplation of beauty and truth, for artistic expression and non-purposive behavior."

Walter A. Weisskopf
"Brief on the Economics and Psychology of Abundance"

"Your plane is not in from Seattle yet, sir," she said. "There will be a slight delay."

"I happen to have information on that flight," I said. "The plane is actually at this moment still circling Moose Jaw while the pilots study a 1938 Texaco road map. They've been lost for an hour and are running dangerously low on sugar coated gum tablets and little dry sandwiches."

"But in a larger sense," said Nancy, "aren't we all still circling Moose Jaw?"

from "Still Circling Moose Jaw"
by Richard Bissell

The face of change is a young one – and it comes in many colors. All previous revolutions had, as their goal, the attainment of some new state of equilibrium. What we are seeing in our time is a new order of revolution, whose goal is not a new equilibrium, but social disorder itself. It is the first social recognition that continuous change itself is a form of equilibrium – and that it is only in disorder that we find order. These kids are "surfing" and it is the essence of surfing that one should ride the turbulence without succumbing to it. You cannot have fun surfing on a slow wave – and you cannot surf at all on a frozen one.

Don Fabun
"The Dynamics of Change"

The Times They are A'Changin'

Come gather 'round people wherever you roam,
And admit that the waters around you have grown,
And accept it that soon you'll be drenched to the bone.
If your time to you is worth savin',
Then you better start swimming or you'll sink like a stone,
For the times they are a'changin'.

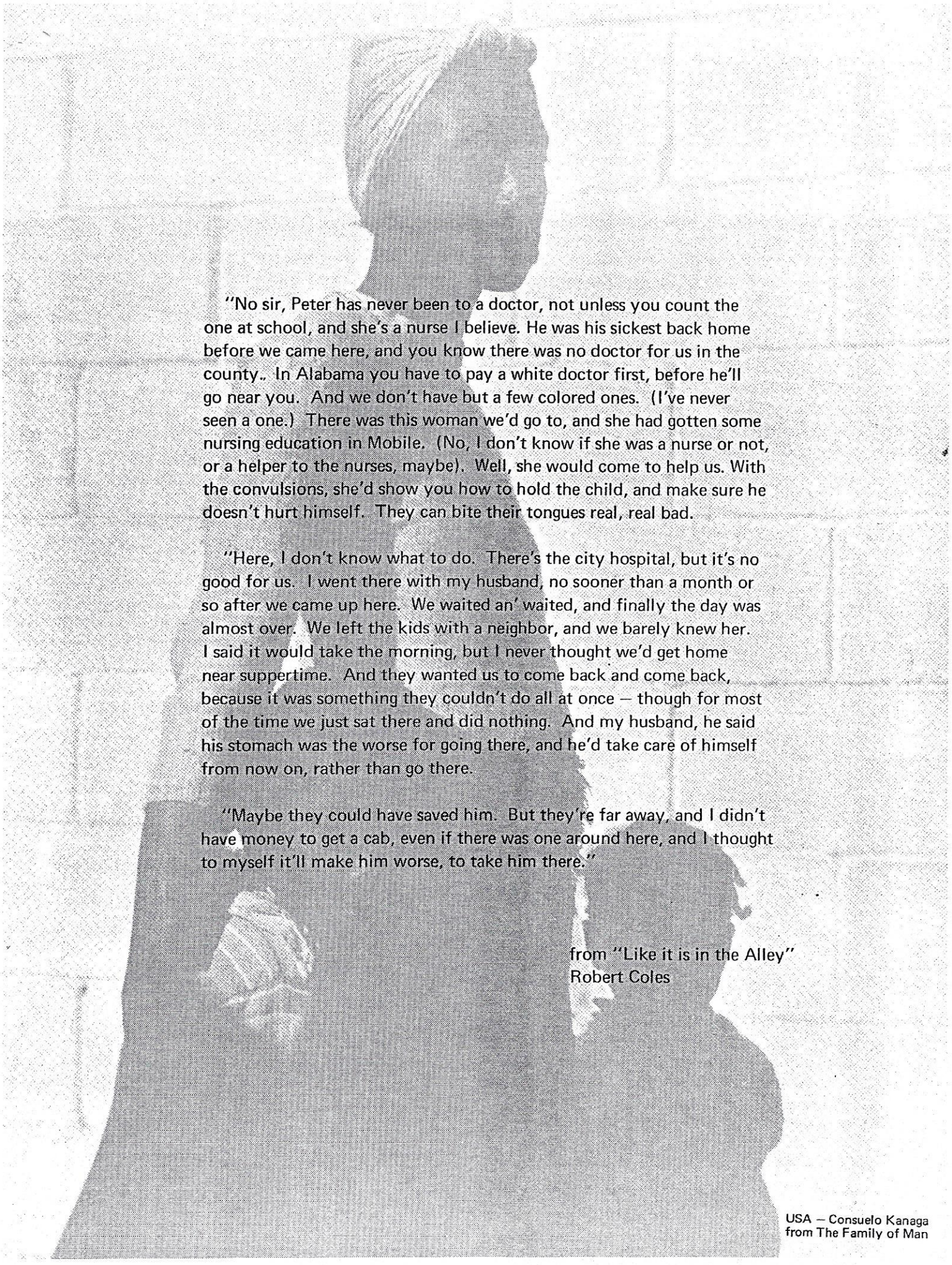
Come writers and critics who prophesize with your pen,
And keep your eyes wide, the chance won't come again,
And don't speak too soon for the wheel's still in spin,
And there's no tellin' who that it's namin',
For the loser now will be later to win,
For the times they are a'changin'.

Come senators, congressman, please heed the call,
Don't stand in the doorway, don't lock up the hall,
For he that gets hurt will be he who has stalled,
With battle outside ragin'.
We'll soon shake your windows and rattle your walls,
For the times they are a'changin'.

Come mothers and fathers throughout the land,
And don't criticize what you can't understand.
Your sons and your daughters have yawned your command,
Your old road is rapidly agein'.
Please get out a new one if you can't lend a hand,
For the times they are a'changin'.

The line it is drawn, the curse it is cast.
The slow one now will later be fast,
As the present now will later be past,
The order is rapidly fadin',
And the first one now will later be last,
For the times they are a'changin'.

Bob Dylan



"No sir, Peter has never been to a doctor, not unless you count the one at school, and she's a nurse I believe. He was his sickest back home before we came here, and you know there was no doctor for us in the county.. In Alabama you have to pay a white doctor first, before he'll go near you. And we don't have but a few colored ones. (I've never seen a one.) There was this woman we'd go to, and she had gotten some nursing education in Mobile. (No, I don't know if she was a nurse or not, or a helper to the nurses, maybe). Well, she would come to help us. With the convulsions, she'd show you how to hold the child, and make sure he doesn't hurt himself. They can bite their tongues real, real bad.

"Here, I don't know what to do. There's the city hospital, but it's no good for us. I went there with my husband, no sooner than a month or so after we came up here. We waited an' waited, and finally the day was almost over. We left the kids with a neighbor, and we barely knew her. I said it would take the morning, but I never thought we'd get home near suppertime. And they wanted us to come back and come back, because it was something they couldn't do all at once – though for most of the time we just sat there and did nothing. And my husband, he said his stomach was the worse for going there, and he'd take care of himself from now on, rather than go there.

"Maybe they could have saved him. But they're far away, and I didn't have money to get a cab, even if there was one around here, and I thought to myself it'll make him worse, to take him there."

from "Like it is in the Alley"
Robert Coles

USA – Consuelo Kanaga
from The Family of Man