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Our History of Family Medicine

The Herzl Family Practice Centre and Department of Family Medicine of the Sir Mortimer B. Davis Jewish General Hospital

Montréal, Québec

1912-1994

by Michael Regenstreif

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This book is dedicated to all those people mentioned here – and those not mentioned – who served the Herzl Dispensary, Herzl Health Centre, and Herzl Family Practice Centre so nobly and generously over the past 82 years.

November 1994
Montréal, Québec

The cover illustration was graciously donated by Ghitta Caiserman-Roth. It is symbolic of healing hands holding the flame and passing it on from generation to generation. We are grateful to the artist for her support.

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Preface

"Our History of Family Medicine" is being published during the United Nations Year of the Family as our way of expressing appreciation for the dedicated work of so many people who paved the way for us as members of the Sir Mortimer B. Davis Jewish General Hospital Department of Family Medicine and the Herzl Family Practice Centre. I learned from reading this book that we share the same concerns for our community today as those who first developed Herzl. The history of dedication to family well being you will read about here is the essence of Family Medicine today. We have our ancestors to thank for a tradition of caring. We have, and have always had, the commitment and generosity of so many named and unnamed people, and it is to these people I wish to mention a special word of gratitude. It would also be difficult to name here all the people responsible for the development of this book, but I would like to thank our historian, Eiran Harris, previous author, Dudley Cordell, researchers, volunteers, archivists, photographers, book designer, support staff, Sara Lazzam, Carmelina Ricciuto and Gigi Grein and of course those who initiated the project about 8 years ago, Dr. Michael Klein and nurse Karen Tafler as well as those who kept the flame alive until now including Dr Cheryl Levitt and Dr Ron Ludman and the rest of the editing committee.

Those who contributed to this book know what a monumental task this was, taking years of work by many people to plan, collect, discuss, write, rewrite and rewrite again. I must mention that this book represents our best attempt at piecing together many recollections into one coherent story. However, I feel that Michael Regenstrief has done a wonderful job of doing the impossible. He has created a story which really brings the present day issues facing our department into their historical perspective, a task worth doing from time to time. I think we can be very proud of the goals of the original charter of Herzl of 1912 and strive to return to our roots of philanthropy and good will in the service of families.

Dr. Janet Dollin,
Chair, Editing Committee

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Dr. Milton Snarch, Chief,
Department of Family Medicine
1966-1968.

This Department had a very difficult childbirth. It took many years of hard labour which involved all of our general practitioners and a very few specialists. It is with pride that we now have a department which is active in all spheres of health serving the community at large.

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Dr. Isaac Tannenbaum, Chief, Department of Family Medicine, 1968-1975

Michael Regenstreif has done a masterful job of developing an historical perspective of the establishment of medical care in the Jewish Community of Montreal. This is the first concise picture of this issue.

One sees the evolution of the Herzl Dispensary from an acute medical clinic to the Herzl Health Care Centre with its stress on prevention, the introduction of a team approach and other innovative programs. This is what the provincial health system is now trying to achieve.

The history of the establishment of the Department of Family medicine and later the development of the residency training program was simplified in the text. It did not come easy and required many hours of negotiations, argumentation, and frustration before it all came to fruition. It also involved many people in the process.

Much credit must be given to the support provided by the administration, particularly Mr. Archie Deskin, Mr. Hirsch Cohen and Dr. Michael Gold, who as Director of Education at the hospital, played a formidable role in helping to develop a residency program which first was accepted by the College of Family Physicians of Canada and later became the prototype of the McGill program.

It is exciting to see how the fortuitous merger of Herzl and the Family Practice Centre of the Jewish General Hospital created a unit greater than their sum. It now provides more than either organization ever anticipated in community health care and in the training of future primary health professionals.

I commend Mr. Regenstreif for a job well done.

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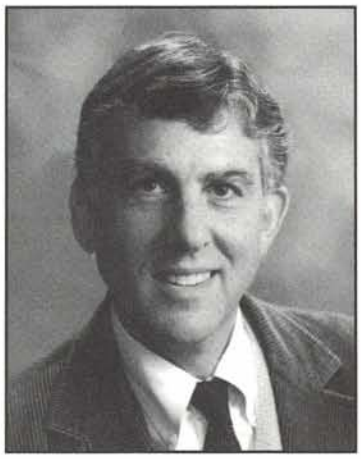

Dr. Michael Klein, Chief, Department of Family Medicine, 1975-1990

In 1975, when I took over as the second Director of the Herzl Family Practice Centre and the third Chief of the Department of Family Medicine, I found a Family Practice Centre and a Department in good shape. Dr. Isaac Tannenbaum had managed to create a well-functioning family practice unit that was exploring team concepts, family systems and the classic problems of sharing resident education with our specialist and sub-specialist colleagues. In the next five years we struggled with whether we should be doing full maternal and child care and decided that the answer was yes. Dr. Mark Clarfield arrived, thinking that he might do "a little geriatrics", and within short order had created a model in geriatric patient service and the best geriatric teaching and practice presence in the city. We moved heavily into collaboration in obstetrics and obstetrical research. The excellent teaching of residents was perhaps best personified by the commitment of Dr. Irene Kupferszmidt, who taught every Wednesday morning from the mid-1970s until the early 1990s, providing clinical information and practical wisdom. But the most characteristic feature of the Herzl Family Practice Centre and the overall department was a sense of intimacy and caring, true concern for all members of the staff - the professional, the administrative, and the residents. It's only from the vantage point of my new job in British Columbia that I can fully appreciate the intensity of the teaching/practice environment. I remember with great appreciation the close working relationship with our team nurses, Karen Tafler and Barbara Johnson, with whom I worked for 17 years, and who provided the patients, as was the case with all the nurses on all the teams, with a level of support and attention that is unparalleled. And when my wife became severely ill, the staff and the patients cared for me and later for her in ways that allowed us both to survive and be sustained. These memories are the essence of the Herzl and the Department of Family Practice. Our gratitude can never be fully expressed.

When I moved on in 1993, the Department was left in capable hands: old programmes were continuing to evolve and improve and new programmes and a strong research capability were continuing to progress. Best wishes for the next 20 years.

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Dr. Cheryl Levitt, Acting Chief, Department of Family Medicine, 1990-1992 and Chief, Department of Family Medicine, 1992 - present

In 1984, I joined the Department of Family Medicine and the Herzl Family Practice Centre. As the residency coordinator, I got to know the hospital staff, department members and community members while working to ensure that the newly trained doctors got the best possible training at the Sir Mortimer B. Davis Jewish General Hospital. It was a wonderful job because the people I interacted with were committed to the principles of quality primary care and outstanding training for doctors.

When I took over as Chief of the Department of Family Medicine in 1992, I was awed by the responsibility invested in me to ensure that our community and our residents in training continue to receive the care and caring that was their historical experience. Furthermore, I am entrusted with the task of developing a strategic framework for action for the Department of Family Medicine to ensure that it is addressing the primary health needs of our community in the nineties. This could only be possible in the context of the excellent physicians, nurses, psychologists, other health professionals and support staff, who work unconditionally to provide the best possible care to our community.

The history of the Department of Family Medicine provides us with a window into the dedication and commitment of the people who have worked to bring the highest form of primary care to the community. These dedicated individuals ensure that the doctors and other medical professionals trained within the Herzl Family Practice Centre will proudly continue the tradition.

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Introduction

Entering the Herzl Family Practice Centre of the Department of Family Medicine at the Sir Mortimer B. Davis Jewish General Hospital in the waning years of the twentieth century, one takes – or is at least tempted to take – for granted the medical and social services found within. It is easy to forget that there is a history here: a history that brings together people, institutions and communities. A history that spans the breadth of the century.

Today's facilities are part of the resources of a modern teaching hospital connected to McGill University's Faculty of Medicine. In 1912, more than two decades before the Jewish General Hospital itself opened in 1934, the original Herzl Hospital and Dispensary – popularly known as the Herzl Dispensary – opened in a small house at 832 St. Dominique Street in the then-Jewish immigrant ghetto near the centre of the Island of Montreal.

The Herzl Dispensary provided rudimentary medical care to a community of limited means. Today's Herzl Family Practice Centre provides a comprehensive range of medical and social services to a clientele that cuts across all socio-economic levels. Notably, the centre is also a highly regarded training facility for doctors of family medicine.

Following its genesis as a simple dispensary in the years leading to the First World War, doctors at the Herzl Dispensary helped to spearhead the establishment of the Jewish General Hospital. The Herzl Dispensary was also instrumental in establishing the Federation of Jewish Philanthropies of Montreal, the forerunner of today's Federation-CJA, the umbrella organization of Montreal's Jewish community. In fact, the federation's first home was at the Herzl Dispensary.

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As the needs of its community changed, the Herzl Dispensary evolved into the Herzl Health Centre. Later, in further recognition of its community's changing needs, the Herzl Health Centre merged with the Jewish General Hospital's own family practice centre to create the Herzl Family Practice Centre of the Department of Family Medicine.

Meanwhile, following its founding as a community-based hospital in the years of the Great Depression, the Jewish General Hospital developed as the focal point for general health care in – but certainly not restricted to – Montreal's Jewish community.

This, then, is a story of a community's intertwining institutions. It is also a tribute to all those people who guided and helped in the long evolution of a simple medical dispensary into the highly regarded facility that it is today. Regrettably, space permits only a very few of the names of those people to be mentioned here. Readers should appreciate the long lasting and ever appreciated contributions of the many other unsung heroes.

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A Dispensary For the Community

Chapter 1

Although Jews have lived in Canada since the eighteenth century, it was during the mass migrations of Jews from Eastern Europe during the late-nineteenth and early-twentieth centuries that the Jewish population in Canada generally, and in Montreal specifically, grew rapidly. In the decade from 1901 until 1911, the Jewish population of Montreal multiplied six-fold from 5,000 to 30,000. Over the next two decades, that population nearly doubled again to reach beyond 57,000 by 1931.

By the time the Herzl Dispensary was established in 1912, a small proportion of Montreal's Jews had already achieved economic success and were living in suburbs such as Outremont and Westmount. The vast majority however, were concentrated into an area in the centre of Montreal that, continuing to this day, has long been home to successive waves of immigrant communities. The neighbourhood's Jewish era has achieved literary immortality through the pens of several writers, particularly Mordecai Richler. The area's prime thoroughfare, Boulevard St-Laurent or St. Lawrence Boulevard, and popularly known as the Main, still retains many landmarks, such as Schwartz's Montreal Hebrew Delicatessen and Moishe's Steak House, that harken back to the neighbourhood's Jewish past.

Health care in Montreal at the turn of the twentieth century was substandard, particularly in the working class areas. The infant mortality rate was shocking: 26.76 percent of all babies born in Montreal between 1899 and 1901 died before having a first birthday. By 1926, the rate had improved to fourteen percent but was still double that of comparable cities like New York and Toronto. Communicable – and often preventable – diseases such as tuberculosis, diphtheria, typhoid and smallpox were all too common, sometimes reaching epidemic proportions.

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Health problems in the city were exacerbated by the conditions under which many people were forced to live: overcrowded and poorly heated housing with inadequate plumbing facilities was common. Dr. Alton Goldbloom recalled living as a child *"in a small flat with running water – cold only – and no bath or toilet. Lighting was by kerosene lamps. A latrine in the backyard smelt to high heaven."*[1] Garbage collection was woefully inadequate. The infrastructure of the city could not cope with the rapidly-expanding population and governments showed little inclination to deal with the many problems.

Thus, if medical and social services were to be provided within the city, it fell on specific communities to take the responsibility of providing for themselves. The Jewish community of Montreal rose to that challenge through the long-established tradition of *tzedakah* that they had brought with them from Europe. *Tzedakah*, which dates back to biblical times, includes charitable giving and encompasses communal responsibility to care for the sick.

By the seventeenth century, Jewish communities in many of the shtetls of Eastern Europe had developed medical programs that included physicians' services and the provision of medicine to care for the sick as well as various other support systems to provide for the social and religious succour that was also needed. As a religion, Judaism is specific in its promotion of good health and in taking measures to prevent disease. Many of the Jewish dietary laws of *kashruth* are rooted in steps that were necessary to maintain and promote a healthy lifestyle in ancient times.

Canada's first Jewish philanthropy was the Young Men's Hebrew Benevolent Society, founded in Montreal in 1863. By 1900, the society had evolved into the Baron de Hirsch Institute, in honour of the eminent French Jewish philanthropist who was then financing Jewish emigration from areas of Europe racked with anti-Semitism, and it opened the city's first health service for the Jewish poor. It hired a doctor to visit and treat patients in their homes and later opened a medical office. It is interesting to note that the first physician hired was Dr. David Alexander Hart, the great-grandson of Aaron Hart whose settling in Trois-Rivières in 1760 is the first recorded settling of a Jew in Canada. However, this was a time of rapid expansion for Montreal's Jewish population and this basic service quickly proved to be incapable of meeting the community's needs.

So it was that Montreal's Jewish community, in the first decade and a half of the century, established a series of institutions that provided the foundation for today's Jewish health care system. These institutions included the Mount Sinai Sanatorium, the Montreal Hebrew Orphans Home, the Hebrew Maternity Hospital and the Herzl Hospital and Dispensary. These institutions allowed the mostly-immigrant Jewish community to receive services in a Yiddish-speaking environment from doctors who understood the cultural milieu of the community.

The Herzl Dispensary grew out of a meeting held on New Year's Day of 1912 between a group of concerned Jewish physicians and other community members. They felt that Montreal's Jewish community was in dire need of a dispensary: a clinic where doctors could treat the poor at little or no charge and where medicine could be distributed on a non-profit basis. The Hebrew Ladies Benevolent Society worked hard to create the dispensary's first charter.

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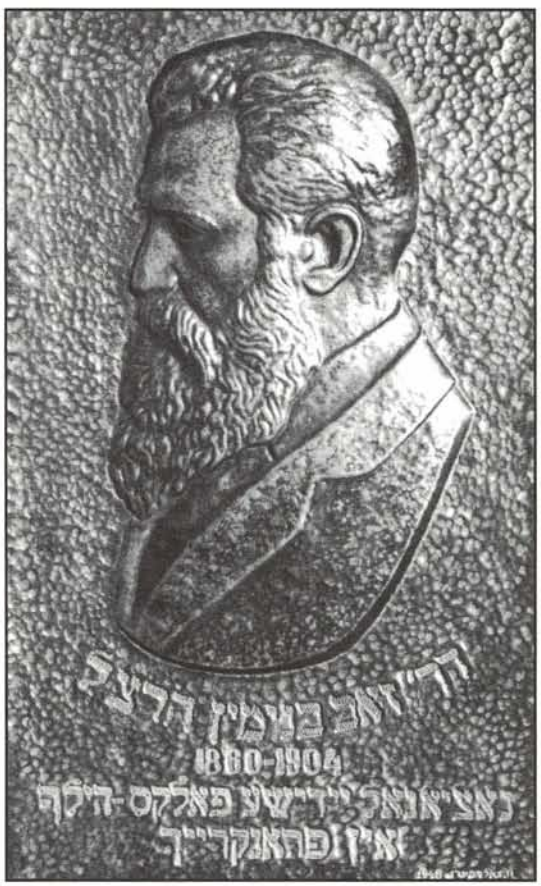
The following March, a public meeting was held that elected a board to oversee the creation of the proposed dispensary. This board included Drs. Samuel Ortenberg, N. Schacher, Simon Sperber and David Tannenbaum. Non-physicians on the board included Mrs. Fannie Adler, Mrs. Dora Bloomberg, Mr. I. Goldberg, Mr. L. Goldman, Mrs. Taube Kaplan, Mrs. Anna Rost and Mr. B. Steinhouse. The house on St. Dominique Street was found and leased as the dispensary's first home.

It was decided to name the dispensary in honour of Theodore Herzl, the father of modern Zionism. Herzl was a Jewish journalist and playwright from Vienna who became convinced that the answer to Europe's rampant anti-Semitism was a Jewish state, preferably in the ancient Jewish homeland of Israel. Herzl founded the World Zionist Congress in 1897 and dedicated himself to convincing world Jewry and world governments of the importance and necessity of his goal. Despite poor health and a weak heart, Herzl worked tirelessly on behalf of the Zionist movement until his premature death in 1904 at the age of 44. Herzl had become, and to this day remains, a hero to many Jews.



This bronze of Theodore Herzl currently watches over the registration desk at the Herzl Family Practice Centre.

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קענעדער אדלער

Montreal Friday June 7, 1912

הערצל דיספענסערי טאָג היינט

The Herzl Dispensary's official opening was on June 2, 1912, a hot Sunday afternoon. Throngs of people arrived to tour the facilities and hear speeches by doctors and Jewish community leaders. Speakers noted that the Jewish community would now be better able to care for its own people, with less dependence on Gentile institutions. However, it was also pledged that non-Jews seeking assistance from the dispensary would never be turned away.

Announcements from the "Canadian Adler" 1912 boasting the opening of the new Herzl Dispensary.

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Herzl's Early Years

Chapter 2

The Herzl Dispensary became immediately popular. Records indicate that in a one year period from November 1912 – just a few months after opening – until November 1913, there were 13,049 medical consultations at the dispensary. Of these, 5441 consultations were with new patients. This means that the dispensary was attracting an average of more than 250 patients – including more than 100 new patients – each week. Also, one can understand the extent of poverty in the Jewish community at that time by observing that more than fifty percent of the patients were treated and given their medicine at no charge. Those that could pay were charged only a dime for an examination and a nickel for a prescription.

Of all those treated in that year at the Herzl Dispensary only a scant thirty-five people – representing one-quarter of one percent of the total – were not Jewish. Because non-Jews were specifically to be welcomed at Herzl, it can be concluded that the era's widespread anti-Semitism contributed to keeping some non-Jews from seeking treatment from Jewish doctors.

Inside the two-storey house on St. Dominique Street, the Herzl Dispensary facilities included examining and consultation rooms, a pharmacy and operating and recovery rooms for minor surgery. Initially, the dispensary had four medical departments: "medical," "surgical," "ear, nose and throat," and "women's." However, as physicians with specific expertise were found, new departments would open. Occasionally, departments were forced to close when departing doctors could not be replaced by new ones with their expertise. Twelve physicians formed the Herzl Dispensary's first medical staff. They included Dr. David Tannenbaum, who served as the medical superintendent, and Drs. A.A. Hart, Simon Sperber, J. Kolber, M. Wiseman, C.J. Gross, Samuel Ortenberg, S.F. Stein, O. Marcuse, D.H. Bernstein, J.S. Budyk and N. Schacher.

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The pharmacy was operated by dispensing chemist Dora Schacher and the nursing staff came from the Victorian Order of Nurses.

The Herzl Dispensary treated common ailments and performed minor surgery that did not necessitate long-term hospital care. For example, tonsillectomies were performed routinely in the dispensary's operating room. More complicated infirmities and major surgery was referred to a larger hospital like the Montreal General or Royal Victoria.

By November 1913, the Herzl Dispensary had developed a solid infrastructure to take responsibility for the ongoing functioning of it's organization. This included a Board of Officers to set policy, a Ladies Auxiliary to conduct fundraising drives and organize volunteers, and the staff physicians who formed a Medical Board to deal with medical issues. The first Board of Officers of the now-functioning Herzl Dispensary included Mark Workman as president, A.M. Vineberg as vice-president, Sophie Slatkoff as secretary and directors Nathan Gordon, Louis Burke, Joseph Merson and Paul Katz. The Ladies Auxiliary was organized by Dora Bloomberg, Fannie Adler and Anna Rost.

The Herzl Dispensary was always guided by a sense of idealism growing out of the concept of noblesse oblige: the duty of the well-off to care for the less fortunate. Mr. A.M. Vineberg clarified that sense of idealism when he wrote in the Herzl Annual Report of 1913:

> *"No greater charity can exist than the work we are trying to do. God alone knows the inner sufferings of our poor people, and it is our duty as good Jews and human beings to alleviate the distress, if it is within our power."*[2]

The doctors at the Herzl Dispensary were all unpaid volunteers. Mrs. Judy King, the daughter of Dr. Samuel Ortenberg, a Herzl Dispensary founding-physician who was secretary of the Medical Board from 1912 until 1929, recalled that her father typically donated half his professional time to charitable organizations like Herzl.

It was important to the doctors of the Herzl Dispensary that they treat their patients with compassion and dignity. Dr. Harold N. Segal, who established the Herzl Dispensary's cardiac clinic in the nineteen-twenties, recalled insisting that he and his assistants treat their patients like "dukes and duchesses.

"In the presidential report of 1913, Mr. Mark Workman wrote:

> *"Here we have a staff of Jewish physicians who are capable and efficient. They devote their time to our work with a self-sacrifice that is worthy of our highest admiration. They speak the language of the patients, they understand their words and their feelings and thus, they can and do handle them with real Jewish gentleness and sympathy."*[3]

In dealing with a community that was largely made up of recent immigrants carrying Old World superstitions, a Herzl doctor could occasionally be up against generations of handed-down folklore and conditioning. A 1915 article in the Canadian Jewish Chronicle illustrates the problem:

> *"Once in a while, there is a complaint about the doctors and the medicine. The doctors have frequently to contend with a most trying combination of ignorance and ingratitude. There is a class of patients who think they can teach medicine and surgery to their medical attendant.*

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One often has to hear the description of a fearful and wonderful condition of internal anatomy which the doctor has not been able to follow and therefore he is an ignoramus. 'Die Medizin Schmecht Nicht!' That is a very bad condition. It is fatal to the reputation of medicine in the judgement of some of the patients when it does not taste strong. A medicine to be effective must be of a deep orange or violet colour, and must gripe well. A good peppery mixture that burns the throat, or creates nausea, or permeates everything that is taken for the rest of the day, that is good medicine and the doctor is an understanding man. If the drug is tasteless or colourless, it is taken in contempt and the patients comments to his friends are enough to stir up a revolt against the medical administration of the dispensary."[4]

Though trying at times, having the opportunity to treat difficult patients, such as those described in that article, made for valuable experiences for the doctors and nurses at the Herzl Dispensary. Primarily because of the ubiquitous anti-Semitism that existed in Montreal at that time, few Jewish physicians obtained staff memberships or even internships at Montreal's English-language hospitals and virtually none at the city's French-language hospitals. Also, few Jewish nurses were hired at those same hospitals. Thus, it was at the Herzl Dispensary that young Jewish medical professionals were able to obtain the practical experience necessary to complement their academic educations.

The situation for Jewish doctors at Montreal hospitals would remain unchanged for decades. In her study of anti-Semitism in Quebec from 1929 to 1939, political scientist Esther Delisle relates an incident from 1934:

"The interns at five French Montreal hospitals, outraged at the hiring of a Jewish colleague, went out on strike to get him fired. Samuel Rabinovitch, the intern in question, the head of his graduating class, was part of a handful of Jewish students admitted to the Université de Montréal, where, as we learn from Le Devoir in 1933, '...the maximum is required from foreign students and particularly from Jewish students. And so, in the Faculty of Medicine last year, out of 160 Jewish candidates, only seven were admitted.' Rabinovitch, who had stuck to his guns until that point, finally decided to give up and resigned when the entire medical staff of the hospitals threatened to join the strike."[5]

In February 1914, the Herzl Dispensary and Hospital received its Act of Incorporation from the Quebec Legislative Assembly. The Act of Incorporation reflected the idealism of the dispensary's founders by stating that the mandate of the dispensary was *"to aid those who are in indigent circumstances and partially or wholly unable to provide medical or surgical treatment for themselves."* In keeping with the opening-day pledge that non-Jews seeking assistance from the dispensary would never be turned away, the act specified that the Herzl Dispensary would be open to *"all races and creeds without distinction."*

Curiously, it was the Act of Incorporation that led to the first serious dispute between the Herzl Dispensary's lay leadership and the doctors involved in the Dispensary's founding and early operation. The act named its petitioners – Fannie Adler, Dora Bloomberg, Lena Brucker,

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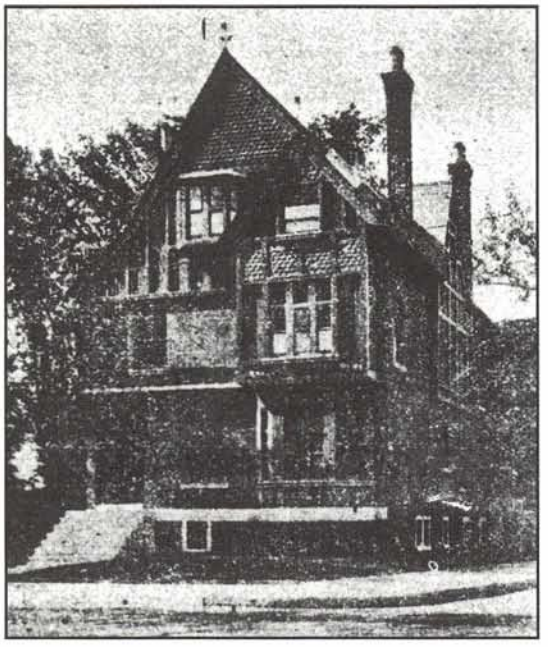
Louis Burke, Rachel Firestone, Fanny Fohrman, Hyman Goldman, Esther Katz, Netty Littner, Tillie Lonn, Dora Merson, Annie Press, Anna Rost, Rosie Ruttenberg, Rebecca Sharp, Bessie Slaboski, Samuel Slatkoff, Benjamin Steinhauss, Lea Usher and Eva Wagner – to be the Herzl Dispensary's Board of Directors. This new Board of Directors, who were mostly from among Montreal's wealthier Jews, decided to oust some of the doctors from their executive positions and to appoint a new Medical Board. The new executive justified its actions by claiming that they were merely putting the dispensary's affairs onto a more business-like base. Although this particular dispute's resolution is unknown, reports in the Montreal Daily Star and Montreal Standard on May 16, 1914 indicate that nine of the Herzl Dispensary's doctors withdrew their services, at least temporarily.

Private correspondence written over the decades indicate that there continued to be occasional disputes between the Herzl Dispensary's doctors and its lay leadership. However, they do not appear to have permanently affected the long-term functioning of the organization.

May 1914 also marked the Herzl Dispensary's move from St. Dominique Street to a three-storey building at 632 St. Urbain Street. The original premises had quickly become overcrowded necessitating larger facilities. The St. Urbain Street facilities included a board room, office, pharmacy, three examination rooms, two recovery rooms, an equipped amphitheatre, a surgical operating room and a waiting room. There was also a caretaker's apartment and living quarter's so that at least one nurse could be on duty at all times in case of emergencies.



The second home of the Herzl Dispensary, 632 St. Urbain St. Was spacious, modern and well equipped at least for a while. It was home to Herzl for 22 years.

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The financial stability of the Herzl Dispensary was aided by the founding of the Federation of Jewish Philanthropies of Montreal in 1916. Herzl and eleven other Jewish organizations banded together to coordinate fundraising efforts through a central campaign office. This led to greater efficiency in fundraising efforts for all the organizations and set up a structure that has grown and developed into today's Federation-CJA. It should be noted that the Federation's first office was located at the Herzl Dispensary until its own headquarters could be established on Bleury Street.

The post-First World War years were a period of growth and expansion for the Herzl Dispensary. Although a worldwide influenza epidemic in 1918 forced a temporary closure of the dispensary, its natural constituency was swelled by the influx of Jewish refugees following the war.

New people became involved at Herzl and new clinics were established broadening the range of services that the dispensary offered to the community. These included an X-ray clinic in 1918, a tuberculosis clinic in 1920, a dental clinic in 1922, a metabolism lab for the treatment of diabetes in 1923 and a cardiac clinic in 1927.

The tuberculosis clinic was operated through an arrangement with the Mount Sinai Sanatorium under which all detected cases of tuberculosis were handled by Herzl prior to admission to the sanitorium. Following release, Herzl again assumed responsibility for the patient's follow-up care. The success of the clinic in dealing with tuberculosis was such that the Royal Victoria and Montreal General Hospitals began to refer TB patients there. Thus, in 1923, fifty percent of the tuberculosis clinic's patients were not Jewish; a highly unusual statistic for that era.

By the early-nineteen-twenties, about forty percent of all the Jewish physicians in Montreal were involved, in one way or another, with the Herzl Dispensary. This meant that Herzl logically became the place for Jewish doctors to gather to discuss medical issues and ideas and to exchange information. This led to the formation of the Montreal Clinical Society which held its first meeting at the Herzl Dispensary on April 25, 1923.

The aims of the society included advancing the medical knowledge of its members, encouraging medical research, increasing the levels of health within the community, conserving the principles of medical ethics and urging the establishment and construction of a Jewish general hospital. That last objective was achieved in 1934 at which time the Montreal Clinical Society moved its meetings from the Herzl Dispensary to the new hospital.

The increased poverty brought in by the Great Depression strained the capacity of the Herzl Dispensary. The great numbers of people forced into poverty increased the demands for Herzl's services at the same time that the fundraising base was shrinking. The dispensary's record year for attendance was 1933, the year before the Jewish General Hospital opened. That year, Herzl was swamped by 27,660 patient-visits.

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The Jewish General Hospital and Herzl's Changing Role

Chapter 3

The need for a Jewish general hospital had long been recognized. As a dispensary, Herzl was limited in the services that it could provide. Herzl's 1919 Annual Report noted:

> *"We regret to say that we are daily confronted with a great obstacle in this institution, in that we are compelled to turn away many of our cases owing to the fact that we are not in a position to handle them as a dispensary, for they are really hospital cases. When we recommend these cases to public hospitals, we find that in most instances they are unable to be admitted owing to the lack of room and for the reason that they are subjected to investigation by a social services department, who are usually of the opinion that they cannot afford to pay for medical services, consequently they are turned down....Such is the barrier that our unfortunate sick are placed face to face with daily. Our doctors feel this stress so keenly that we are left open to one question only: Is it not time for our Montreal Jewry to come forward and establish a JEWISH HOSPITAL?"*[6]

It should be noted here that poor people from other immigrant communities were also being turned away from both anglophone and francophone hospitals for the same reasons as noted in the above passage. However, the Jewish community was the first that sought to remedy that situation by taking steps to create its own general hospital.

In addition to the lack of access of Jewish patients to the established Montreal hospitals there was, as has been noted, a lack of opportunities for Jewish medical professionals at the established hospitals. Also as noted, an aim of the Montreal Clinical Society – founded by doctors at the Herzl Dispensary in 1923 – was to press for the establishment of a Jewish general hospital.

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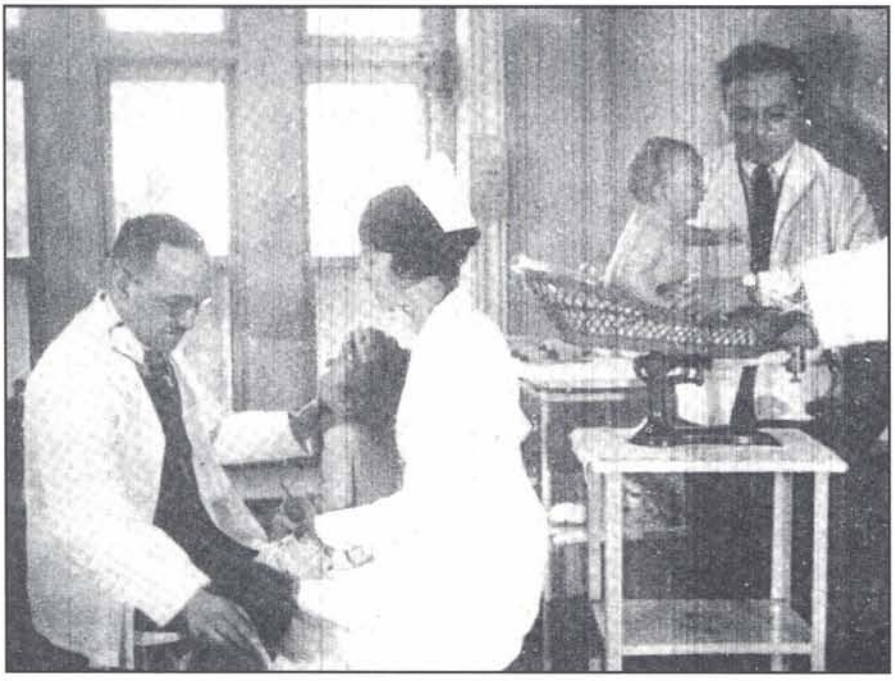
Scenes from the Herzl Dispensary Clinic, 1922.

"Waiting their turn"



"Aren't these doctors just awful"

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So it was that in the nineteen-twenties in Montreal, the Jewish community realized the need for a general hospital and the considerable forces needed to make that dream of a hospital into a reality came together for the long process of raising funds, planning, constructing and opening of the Jewish General Hospital.

The dream became a reality on October 8, 1934, when the Montreal's Jewish General Hospital opened its doors. A detailed description of the arduous processes leading to turning the dream into a reality can be found in "Our Tribute Everlasting," Alexander Wright's history of the Jewish General Hospital's first fifty years published in 1984.[7]

Following the opening of the Jewish General Hospital, the Herzl Dispensary was forced to reevaluate its place in the community. With the hospital now functioning with its more complete facilities, was there even a need for the dispensary?

HERZL HOSPITAL AND DISPENSARY

632 ST. URBAIN STREET

MONTREAL, P.Q.

Board of Directors:

DR. E.C. LEVINE ..... President
PHILIP LEVY ..... Vice-President
LAURENCE TANNENBAUM, N.P. ..... Secretary

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DR. J. HIRSHBERG — DR. A. SOLOMON
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DR. A.P. SHIP (Ex Officio)

Medical Staff:

DR. J. ROSENBAUM ..... President
DR. D. TANNENBAUM ..... Vice-President
DR. D. L. MENDEL ..... Secretary

DR. E.C. LEVINE — DR. S. F. STEIN
DR. S. ORTENBERG — DR. J. KOLBER
DR. S. EIDLOW — DR. J. LEAVITT
DR. M. W. BLOOMBERG — DR. J. SEGAL
DR. J. LANDE — DR. M. WISEMAN
DR. J. HIRSHBERG — DR. J. BUDYK
DR. J.R. GOODALL — DR. H. GARBER

Medial Superintendant: DR. A.P. SHIP

Dental Staff:

DR. L. ROSEN — DR. F. ROSENBAUM
DR. N. LANDE — DR. S. H. FELDMAN (in charge)

Nurse in Charge

E. O'BRIEN, R.N.

Dispenser:

MISS D. SCHACHER

Admitting Clerk

MISS F. KROLL

TO THE MEMBERS OF FEDERATION OF JEWISH PHILANTHROPIES

Ladies and Gentlemen:–

I beg to present to you the Annual Report of the Herzl Hospital and Dispensary. You will note that we have treated during the year 10,700 patients and dispensed 8351 prescriptions – an increas over last year of about 1,700 cases. It is needless for me to draw your attention to the fact that the Dispensary is a valuable adjunct to the Federation as a whole.

E.C. LEVINE, M.D., President

In this Annual Report from 1922, we can see the tiny budget that kept this institution alive. Yet it was able to accomplish a maximum of service and later form a nucleous for the larger and much needed Jewish General Hospital.

– Courtesy of the collection of Mr. Allan Raymond

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EXPENDITURES

December 1st, 1921, to November 30th, 1922

EXPENDITURES		
Physical Maintenance of Buildings and Equipment		
Repairs and Replacements to Buildings and Equipments	$23.17	
Repairs and Replacements to Furniture	40.18	
Wages for Repairs	3.00	
Materials for Repairs	17.25	
Physical Operation of Plant		$83.60
Janitorial Service	900.00	
Laundry, Cleaning and Disinfecting Supplies	180.58	
Janitorial Equipment	11.97	
Light, Heat and Power	95.27	
Fuel	467.21	
Cost of Administration		1,655.03
Salaries of Officers, Clerks, etc.	342.00	
Printing, Postage, Stationary	145.00	
Office Equipment	35.00	
Telephone Service	88.23	
Institutional Operation		610.23
Refrigerating Supplies	2.91	
Household Supplies and Eqiuipment	17.40	
Linens and Beddings	28.00	
Wearing Apparel	12.00	
Medical and Surgical Supplies and Equipment	1,208.22	
Salaries of Nurses, Orderlies, etc.	2,114.56	
X-Ray Macine	91.21	
Dental Clinic Equipment	419.26	
Dental Clinic Supplies	263.12	
Fixed Charges		4,802.68
Insurance	22.15	
Rents	2,600.00	
Interest	78.64	
Taxes	44.80	
Miscellaneous		2,745.59
Transportation	4.15	
Advertising	1.32	
Sundries	24.65	
		30.12
		$9,927.25

INCOME	
Attendance	$1,935.93
Drugs Supplied to Patients	802.36
Drugs Supplied to The Hebrew Sheltering Home	67.00
Drugs Supplied to The Hebrew Orphan's Home	25.50
Drugs Supplied to The Family Welfare Department	139.00
Donations	780.02
	$3,749.81

SUMMARY	
Total Expenditures	$9,927.25
Total Income	3,749.81
Net Cost to Federation for One Year	$6,177.44

In a February 1933 meeting, the Medical Board decided to recommend to the Board of Directors that the Herzl Dispensary be merged with the Outdoor Department of the soon to be opened hospital.

However, in the months following the actual opening of the hospital, it was observed that there had been no decline in the number of patients being treated at the Herzl Dispensary. It was observed that most of Herzl's clientele lived within walking distance of the dispensary while the hospital was across town; public transit was inadequate and expensive for a community feeling the effects of the Great Depression. Furthermore, some of the services offered at Herzl – such as the dental clinic – were not yet being offered at the Jewish General Hospital. It was also felt that the Herzl Dispensary could remain a valuable venue for physicians to gain needed experience and supplement their medical training. Therefore, by March 1935, it was decided that Herzl would not be merged into the Jewish General Hospital and that the dispensary would refer to the hospital any cases that it could not treat.

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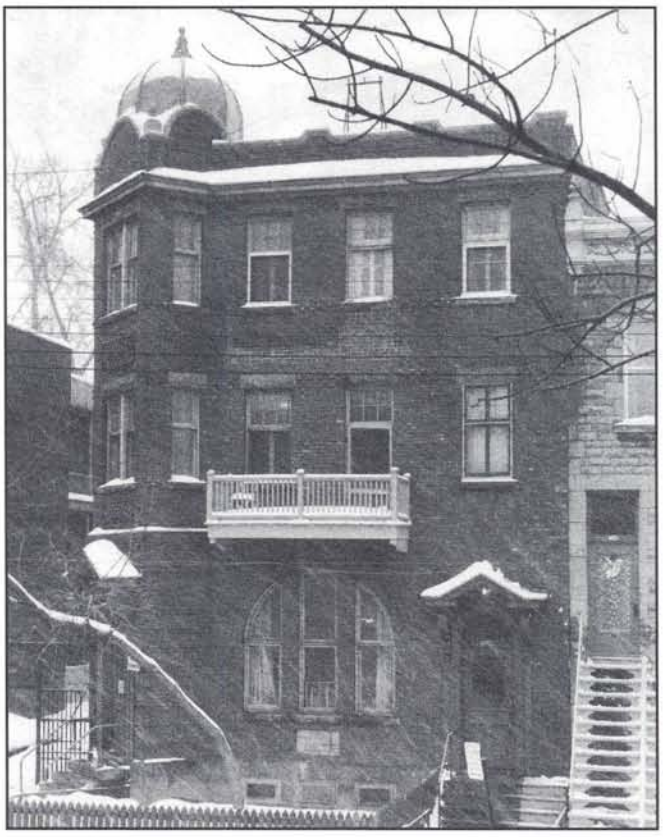
In 1936, after twenty-two years on St. Urbain Street, the Herzl Dispensary again moved to larger facilities at 4652 Jeanne Mance Street. The building, a former orphanage, was renovated and up-to-date equipment was installed.

Although it appeared in the mid-nineteen-thirties that the Herzl Dispensary was not immediately adversely affected by the opening of the Jewish General Hospital, over time it became clear that with the existence of the hospital, and with the gradual geographical shift of the Jewish population closer to the hospital, Herzl's days as a dispensary would be limited.

The number of patient-visits to the dispensary – which had peaked in 1933 – began to fall in the late-nineteen-thirties and slid dramatically during and after the Second World War. In 1947, there were only 6053 patient-visits to the Herzl Dispensary. All the while, patient-visits to the out-patient clinic at the Jewish General Hospital were continually multiplying.

For the Herzl Dispensary, the handwriting appeared to be on the wall. Recognizing that Herzl's role had to change, the Herzl Board of Directors established a new entity, the Herzl Health Centre. The Herzl Health Centre was opened on the dispensary's premises in April 1941 and, for the next six years, coexisted with the dispensary. The Herzl Dispensary functioned in the mornings and the Herzl Health Centre was open in the afternoons.



The Dispensary moved to 4652 Jeanne Mance

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The focus of the Herzl Health Centre was community-oriented, diagnostic and preventative medicine. This meant that in addition to medical screenings, examinations and treatments, there was a focus on social service programs and community health education on such issues as hygiene and nutrition. In a nutshell, while traditional medical care in poor communities – including most of the care given at the Herzl Dispensary – focused on curing disease, the Herzl Health Centre intended to focus on prevention.

Although the Herzl Dispensary and the Herzl Health Centre shared a Board of Directors and the same premises, doctors, who were all volunteers at the dispensary, were paid for their services at the health centre. For example, in 1948 the fee was four dollars for an examination or conference with a patient. The physician-in-charge of the Herzl Health Centre was Dr. A.B. Illevitz, a long time veteran of the Herzl Dispensary. At the time of its founding, the staff included three physicians, eight physician-consultants, three dental surgeons and a secretary. There were also volunteer assistants.

Meanwhile, the fate of the Herzl Dispensary was sealed with an advisory report commissioned by the Federation of Jewish Philanthropies of Montreal and released on March 26, 1948. The report was prepared by Dr. Charles Wilensky, Executive Director of Boston's Beth Israel Hospital. Wilensky found the dispensary premises to be run down and much of the equipment to be obsolete. Wilensky also found that the absence of certain personnel such as medical social workers and X-ray and lab technicians to be inexcusable.

The report went on to contrast the facilities at the Herzl Dispensary with those at the Jewish General Hospital: *"The general public becomes conscious of the difference between modern equipment utilized in a scientific, professional environment and an old building with old equipment."*[8]

Wilensky pointed out that with the arrival of hospitals, dispensaries had generally become obsolete and he suggested that the Herzl Dispensary be closed. Wilensky even found that as an outlet for Jewish doctors unable to practice elsewhere, the dispensary had outlived its importance. Of the Herzl Dispensary's thirty doctors, twenty-four were also on staff at the Jewish General Hospital and four were also on staff at non-Jewish hospitals.

So it was that on June 30, 1948, the Herzl Dispensary closed. A dinner to honour the Herzl Dispensary staff was held the following December. It was estimated that in the dispensary's thirty-six year existence, doctors had voluntarily donated 393 years of their time to the dispensary. Two of the Herzl's Dispensary's original twelve physicians from 1912 – Drs. David Tannenbaum and S.F. Stein – had been with the dispensary for its entire history. Another, Dr. M. Rabinovitch, had been there virtually as long.

Though the Herzl Dispensary was closed, the Herzl Health Centre lived on.

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The Herzl Health Centre

Chapter 4

Following the closing of the Herzl Dispensary, any of its programs for which there still remained a need, were maintained by the Herzl Health Centre. Of particular note was the always-in-demand dental program. However, the emphasis of the health centre differed from the dispensary in its accent on diagnosis and prevention. For example, children would be examined twice yearly and all would receive a patch test for tuberculosis. A positive test would result in examinations, tests and chest X-rays for the entire family and – if possible – neighbours and others having close contact with someone testing positive.

As a matter of course, all necessary vaccinations and inoculations were administered at the Herzl Health Centre and special attention was paid to diet and nutrition. If it was found that aspects of good nutrition were not being met, counselling was available and vitamin supplements were distributed.

From its inception, a principal function of the Herzl Health Centre was to act as the medical referral centre for a number of institutions including neighbourhood schools, the Family Welfare Department of the Baron de Hirsch Institute, Jewish Immigrant Aid Services and Jewish community summer camps. It's role as a true community clinic was nurtured by it's social worker director, Mrs. Shirley Kantrowitz, who served as executive director of Herzl from 1957-1973.

Montrealers in that era had a particularly bad reputation for the poor state of their dental care. Early on, the Herzl Health Centre recognized the benefits of good dental health to one's overall state of health and the dental clinic remained a priority. The dental clinic's hours expanded into the evenings in 1951 and beginning in 1955, dental examinations were added to the annual physical examinations required of all children before attending Jewish community camps.

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Mrs. Shirley Kantrowitz was responsible for the development of programs to meet the goals of Herzl, to allow medical and dental services, to truly reach the community it served. In her 17 years as Executive Director, Herzl grew to accomplish many of these goals.

In 1956, the Herzl Health Centre established a new program that was unique to Montreal at that time: an adult-well-being clinic. This clinic was held in the evening to accommodate work schedules and its purpose, in providing free physical examinations, was early diagnosis of problems in adults who otherwise appeared to be healthy. The Herzl Health Centre was unique in Montreal at that time as there was no other medical institution that would provide examinations at no charge to adults displaying no obvious symptoms or outward signs of disease. If a health problem was discovered in a patient, the examination results were sent to the patient's own doctor or, in the absence of a personal physician, to the Jewish General Hospital for follow-up. The adult-well-being clinic soon proved its benefit. In 1961, for example, the clinic examined 2097 patients. The examinations found sixteen tumours in their early stages and revealed 331 cases of heart disease and other abnormalities.

Dating back to the first days of the Herzl Dispensary in 1912, Jewish immigrants to Montreal had been a prime source of Herzl's clientele. This continued to be the case at the Herzl Health Centre.

In the years following the Second World War and the Holocaust, more than 11,000 Jewish refugees from Europe were admitted to Canada. Of these, about forty percent settled in Montreal. Then, following the failed revolution in Hungary in 1956, another 4500 Jews came to Canada and, of these, about one-third settled in Montreal. Thus, in the late-nineteen-forties through the mid-nineteen-fifties, about 6000 new immigrants – most of whom initially settled in the immigrant district near the Herzl Health Centre – were added to the Montreal Jewish community. Most of their health care needs were serviced by the Herzl Health Centre. These numbers were added to in the nineteen-fifties and 'sixties with the arrival in Montreal of several thousand French-speaking Jewish immigrants from Morocco.

Helping immigrants lost in a new culture posed a special challenge to the doctors and staff at the Herzl Health Centre. Early in Shirley Kantrowitz's tenure as executive director, she overhead Dr. David Tannenbaum reprimanding a mother because she was feeding her child salami and virtually nothing else. Mrs. Kantrowitz

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realized that Dr. Tannenbaum was dealing with an immigrant mother unable to take proper care of her child because "she was lost in a supermarket."

Mrs. Kantrowitz also recalled a nurse who would berate some mothers because their children were always dirty. Visiting the homes of these patients, she found them living in squalor, usually with rusted and chipped cast iron sinks in the kitchen and no showers or bathtubs. Rather than from neglect, the children's uncleanliness was due to a lack of bathing facilities in the home. Her band-aid solution was to get flannel to line the rusty sinks so that they could be used to bathe the children. She was then able to take great satisfaction in seeing these formerly dirty children, "sparkling clean."

Each wave of immigrants had problems that were specific to themselves. The Jews who came to Canada from Morocco were used to a diet centred on such things as lamb and fresh fruits. This diet was prohibitively expensive when these items were not in season. The Herzl Health Centre began training volunteers to work with families in planning healthy, inexpensive meals.

As a medical centre whose services were targeted to the underprivileged, Herzl had to overcome the feeling held by many people that there was a stigma attached to going there. There were also misconceptions that time in the waiting room would be endless and that there would be humiliating questionnaires – demanding to know one's complete financial situation and other personal information – to fill out.

The Herzl Health Centre overcame many of these problems by giving specific appointment times whenever possible, by being careful in the use of questionnaires and by charging a small fee to those who could afford to pay for their service; of course, no one was made to feel uncomfortable for not being able to pay the fee.

The advent of government funding in the late-nineteen-fifties allowed the Herzl Health Centre to upgrade its equipment and hire more staff, thus becoming better able to serve its clientele. Federal and provincial government grants in 1958 and 1959 allowed for the acquisition of new dental office units, X-ray machines and darkroom equipment. In the nineteen-sixties, Herzl became the first health care facility in Quebec that was not a hospital with beds to receive annual funding from the provincial government. Until that time, only hospitals with beds were the only health care facilities that were even considered eligible to receive annual core funding. This type of funding is important because it allows an institution to make provisions based on a financial base that is guaranteed to be at least at a specific minimum level.

The organized Jewish community continued to be a source of funds for the Herzl Health Centre. Annual funding was received from the Federation of Jewish Philanthropies and its successors.[9] As well, a variety of community groups including the Mount Royal Lodge of B'nai Brith, the Junior Jewish Welfare League, the Ladies Auxiliary of Mount Sinai Hospital, the Alpha Omega Dental Fraternity and the Rotary Club of Montreal provided either financial donations or organized volunteer assistance. Volunteers at Herzl were organized by Shirley Kantrowitz in the nineteen-fifties. In the nineteen-sixties, Mrs. Sheila Zittrer organized a large corps of active volunteers who gave their time and assistance to Herzl.

In 1961, Herzl celebrated fifty years of service to the community. One physician, Dr. David Tannenbaum was honoured for fifty

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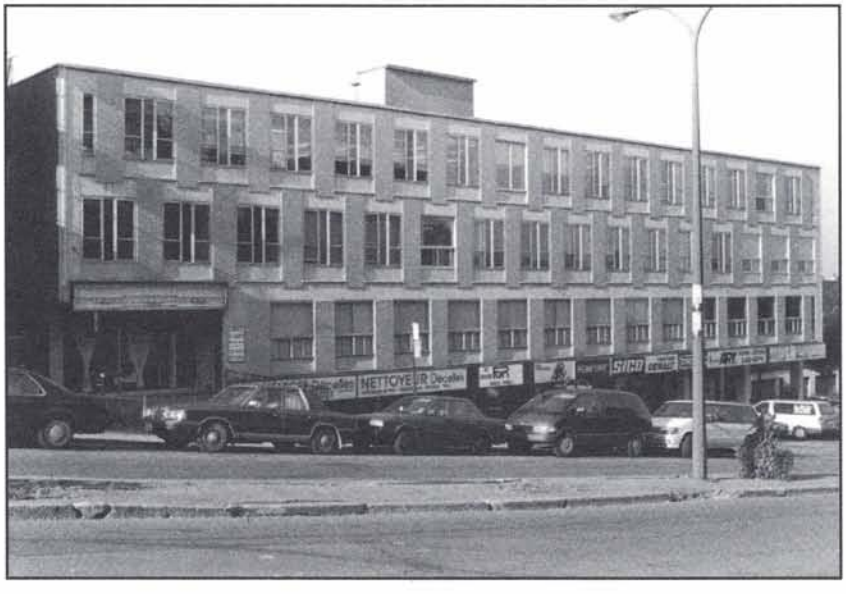
years of service to Herzl. Dr. Tannenbaum had been one of the founding physicians of the original dispensary and continued his service with the health centre. Another physician, Dr. A.B. Illievitz was honoured for his thirty-five years of service to Herzl.

Herzl had changed and developed dramatically from its birth as a dispensary in 1912 through to its maturation as a health centre. That change and development was to continue through the turbulent decade that was the nineteen-sixties.

By the nineteen-sixties, the demographic make-up of the neighbourhood around the Herzl Health Centre had changed greatly. Since the end of the Second World War, the Jewish community had been moving to the western sections of Montreal and to western suburbs such as Côte-St-Luc. Although new Jewish immigrants were still settling in the old neighbourhood in the post-war years, by the late-nineteen-fifties even the new Jewish immigrants were tending to settle in the west end. Herzl, as a Jewish community institution was no longer near its community.

Needing to be accessible to its community, the Herzl Health Centre left Jeanne Mance Street in June 1965 for 6000 square feet in a low rise office building at 5780 Decelles Avenue in the Côte des Neiges district not far from the Jewish General Hospital. Herzl's new premises were newer and more attractive than the old building on Jeanne Mance.

The Herzl Health Centre always endeavoured to meet changing needs by expanding its programs and creating new ones. For example, the Herzl Health Centre was one of the first institutions in Quebec to introduce the multidisciplinary team strategy to health care. With this



Always in search of more attractive and functional space,
the Herzl Health Centre establishes itself at 5780 Decelles Ave in 1965.
Thirty years later, this home no longer appears modern.

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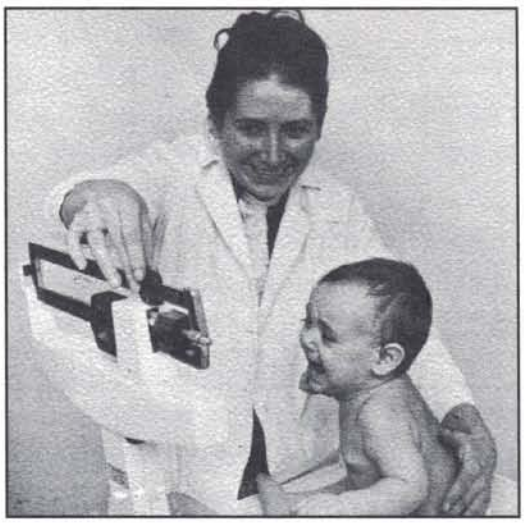
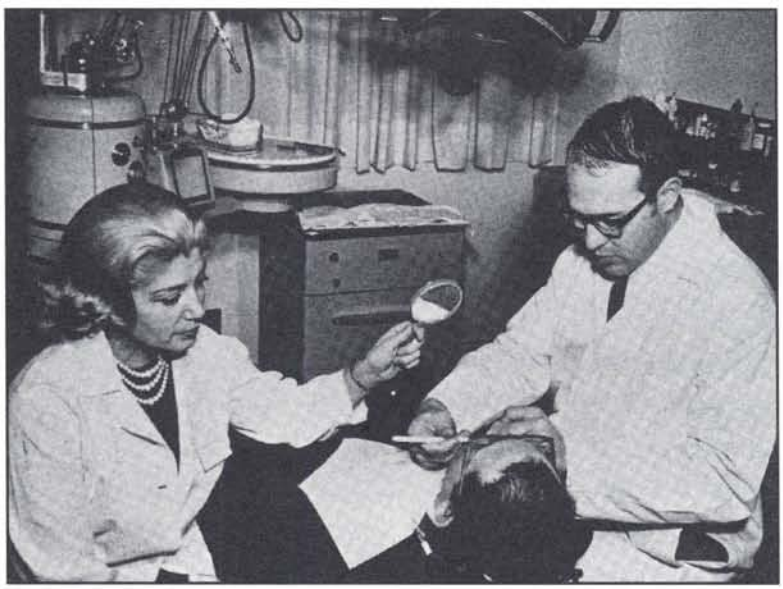


Here, Mrs. Tillie Segal is seen assisting Dr. Schtull in Herzl's Dental Clinic and an unhappy baby is weighed in by Nurse Jenny Wood, circa 1965.



innovative approach, that today is regarded as rather commonplace, a team of personnel from a variety of disciplines works together to provide comprehensive care to the patient. At Herzl, the teams evolved over time to include doctors, nurses, dentists, social workers, psychologists and clerical staff. Each member of a team contributed to its success.

In a speech to the Annual Meeting of the Herzl Health Centre in May 1968, Mr. G.B. Rosenfeld – a consultant in hospital administration – stated: "Times have changed since the Herzl Dispensary got started, but the need to fill new horizons in the area of health care has not."

The Herzl Health Centre recognized that a patient's overall health was affected by his or her emotional and psychological well being.

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Therefore, mental health services – facilitated by the hiring of social workers and psychologists – became an important component to Herzl's services. These services came to include mental health assessments during routine physical examinations, counselling for both individuals and families and psychological testing for children. When necessary, referrals were made for psychiatric evaluation and/or care.

During the nineteen-sixties, the Herzl Health Centre introduced some other programs aimed at their clientele's psychological well being. They included a clinic for obese teenagers utilizing group therapy techniques and a psychological testing program for kindergarten and first grade pupils at Jewish day schools. This program was aimed at identifying children's learning and behavioural problems.

The turbulence of the nineteen-sixties was reflected in the clientele of the Herzl Health Centre. In the early-nineteen-sixties, ten percent of Herzl's patient caseload was described as coming from "multi-problem" families. By 1970, that statistic had multiplied five times to reach fifty percent; many families turning to Herzl were in – or on the verge of – crisis. Also by 1970, eighteen percent of the patients at Herzl's pediatric clinic were from single-parent households. Many of these youngsters were suffering from problems associated with negative self-image and were expressing difficulties in their dealings with parents, family, friends and school.

During the nineteen-sixties, the Herzl Health Centre joined together with the Jewish General Hospital to co-sponsor several programs. One was a liaison program in which all newborns from the hospital's public maternity ward were referred to Herzl following their release from hospital. A public health nurse from Herzl would visit the home to insure that the parents knew how to care for their baby properly. The child would also receive its immunizations and other infant care services from the Herzl pediatric clinic.

Another joint program of the Herzl Health Centre and the Jewish General Hospital was a family planning clinic. Among the clinic's approaches – that were novel for that era – was the insistence that both the husband and wife participate in the program. Also, because it was suspected that the birth control pill could cause depression, women on the pill were closely monitored by the clinic.

Despite the Herzl Health Centre's new and expanded programs, the late-nineteen-sixties and early-nineteen-seventies forced Herzl to face a number of major problems. One was a constant lack of space. The dental clinic, for example, was forced to turn away clients rather than add them to a waiting list that had grown to 1500 by 1969.

The significance of overcrowding was such that although it was estimated by Allied Jewish Community Services that less than half of Montreal's Jewish poor were clients of Herzl, the lack of adequate space to serve the clientele was critical. An Allied Jewish Community Services study of health services in 1970 – the Agnew-Peckham Report – described Herzl's facilities:

> *"The reception and waiting room is crowded. There is no separate adjacent playroom for youngsters. There are three small decentralized waiting rooms. Two are in alcoves off a main corridor. One (the pediatric waiting area) is related to a playroom. The administrative areas are crowded.*

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An administrative assistant and a secretary share one office. Their board room doubles as the hearing and eye testing centre. The two-chair dental clinic is undersized for the number of people working in it. There is an office for a social worker and one for a public health nurse. These are used, when empty, by case aides and volunteers. In the clinic area, there are four examining rooms, one gynaecological room and the child and maternal health nurses office. Change cubicles are used; these open directly on a cross corridor and thus do not offer a great deal of privacy for patients in a semi-undressed state...The ventilation is poor."[10]

The introduction of universal Medicare to Quebec on November 1, 1971 had a profound effect on the Herzl Health Centre. One of Herzl's main mission had always been to serve people whose income level prevented them from otherwise obtaining medical care. Under Medicare, the poor had the same access as the rich in obtaining doctor's services. Interestingly, even after the introduction of Medicare, Herzl maintained and even increased its caseload for most of its clinics. Presumably this was because of the clients' loyalty owing to familiarity with the facilities and satisfaction with the services. Also, certain services – such as the dental clinic or the evening clinics – were still not available elsewhere.

Also with the arrival of Medicare, Quebec began to reform the health care system under Bill 65. Aspects of Bill 65 included dividing all provincially funded health care institutions into specific categories and the creation of a network of government-sponsored community health clinics. These clinics, known as CLSCs – Centre Local de Services Communautaires – were to be community based and would offer a range of services to local clienteles.

Although it was similar to a CLSC – and, in fact, was considered by many to be a prototype of the CLSC – the Herzl Health Centre did not fit neatly into any of the categories designated by Bill 65. This created a dilemma for Herzl. How could Herzl adapt under the new law? If Herzl were to become a CLSC, it was feared that it would be forced to give up its Jewish identity. On the other hand, if Herzl did not become a CLSC, where would it fit into Quebec's new health care scheme? Furthermore, what would be the effects to Herzl if a CLSC Côte des Neiges were created?

Meanwhile, in 1972, the Jewish General Hospital had established a family practice centre and questions began to be raised about the wisdom of the community having two institutions, within a few short blocks of each other, offering similar services. It became obvious that time and conditions were opportune for some type of merger of the two institutions.

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General Practitioners In A Specialized World

Chapter 5

Doctors at the Herzl Dispensary had been among those who had first lobbied for the establishment of the Jewish General Hospital and by 1948 almost all of the dispensary's medical staff was also on staff at the hospital. Still, by the end of the Second World War, the hospital had begun to develop into an institution geared to the practice of specialized medicine.

What then of the role of the general practitioner at the Jewish General Hospital? After all, it would not be until 1966 – thirty-two years after the hospital's opening – that there would be a Department of General Practice.

In an interview[11], Samuel S. Cohen, the Jewish General Hospital's executive director from 1933 – a year before the hospital opened – until 1968, remembered that when the hospital was founded, virtually all of the general practitioners in Montreal who were Jewish were given staff appointments at the new hospital in the Department of Medicine/Internal Medicine. Mr. Cohen estimated that, at that time, there were about 100 to 150 Jewish general practitioners in the city.

In return for their hospital appointments, these general practitioners would devote an allotted period of time to treating patients in the outpatient clinic. As was the practice in hospitals at that time, doctors were not financially remunerated for their hospital work. However, they were given privileges allowing them to admit their private patients to the hospital. Under the direction of the department chief responsible for a particular ward, general practitioners would then supervise the hospital care given to their patients. However, any final decisions about calling in specialists for consultation or treatment were made by – or with the approval of – the department chief.

The Jewish General Hospital – like most metropolitan hospitals in North America – entered the era of rapidly expanding medical specialization after the Second World War.

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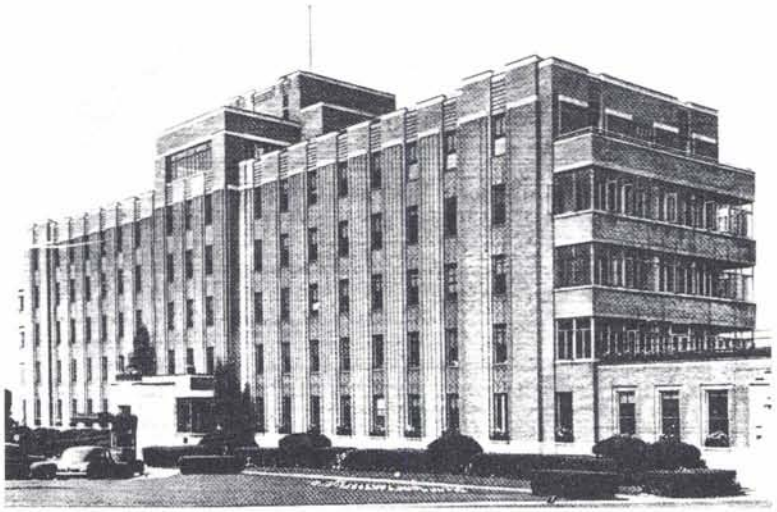

The Jewish General Hospital as it stood in 1934.
What would be the role of general practicioners in the new Jewish General Hospital?

Although there had always been a certain degree of specialization in hospitals, there were a number of reasons for the now rapidly escalating trends toward specialization. For example, the sheer amount of available medical knowledge was exploding at this time. New specialties were developing and dividing into sub-specialties. Furthermore, as medical science learned more and more about the workings of individual specialty areas, there also developed a myriad of new techniques and technologies. Therefore, it became impossible for any doctor to keep on top of all of the latest developments in all fields of medicine and to gain the experience needed to practice all of these new techniques. The result of this is that a doctor with a specific interest in an area of medicine would be attracted to specializing in it.

It should also be mentioned that, at that time, the certification process for specialists was much simpler than it is today. Prior to the advent of the type of training programs that are now needed for a specialist's certification, it was recognized that a doctor who had been in practice for more than ten years, and who had devoted a certain proportion of his or her practice to a specialty area, would be recognized as a specialist in that area. Therefore, a great many doctors took advantage of that route to gain the added status that specialists were perceived to have.

Another major reason that a large metropolitan hospital would be interested in developing its recognition as a provider of specialized services – and this was certainly true of the Jewish General Hospital – is that it increases the hospital's attractiveness as a training facility to university medical schools. Affiliation of a hospital to a major medical school brings much expertise and prestige to a hospital. Although the Jewish General Hospital was approved in 1939 as an institution where McGill University medical graduates could serve their internships, it would not be until much later that the hospital received fuller recognition as a teaching institution.

In 1954, reflecting the fact that the hospital was successfully participating in the post-war trend toward specialization, the Royal College of

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Physicians and Surgeons of Canada gave approval to the Jewish General as a facility for the advanced training of resident doctors in a number of fields including medicine, surgery, gynaecology and obstetrics, urology, pathology, and diagnostic and therapeutic radiology.[12] This list of specialties approved by the Royal College of Physicians and Surgeons of Canada would be expanded upon in the following years.

Still, it was not until 1970 that the Jewish General Hospital was granted full affiliation as a teaching hospital by McGill University's Faculty of Medicine. With this affiliation, undergraduate medical students could and would be assigned to the Jewish General Hospital as part of their training and studies. This affiliation as a McGill University teaching hospital was initially in the areas of anaesthesia, diagnostic radiology, general surgery, internal medicine, nuclear medicine, neurology, obstetrics and gynaecology, ophthalmology, orthopaedic surgery, pathology, paediatrics, psychiatry, therapeutic radiology, and urology.[13] It is easy to see from these lists that the areas of specialized expertise within the Jewish General were greatly expanded between 1954 and 1970.

With the expansion of medical specialties, there was also pressure from some patients to be treated by specialists for all but the most mundane of conditions. Thus, for patients with that mind set, general practitioners came to be seen as dispensers of routine physical examinations who would then frequently act almost as referral agents to specialists. The reality, of course, was that general practitioners were continuing to provide a full range of primary care services.

The heightened prominence that was being given to specialists by the early-nineteen-fifties had a major effect on the relationship between the Jewish General Hospital and its general practitioners. Until that time, from the time of the hospital's founding, general practitioners were given staff appointments – with admitting privileges – in the Department of Medicine. This practice, of granting such appointments to general practitioners, was discontinued after 1952.

General practitioners whose admitting privileges were already established did not lose their privileges. However, after 1952, and until the establishment of the Department of General Practice in 1966, new general practitioners wishing an association with the Jewish General Hospital were limited to seeing patients in the outpatient clinic. If a general practitioner joining the hospital's staff after 1952 wished to have a patient admitted, it would have to be done through a physician with admitting privileges. Once a patient was admitted to the hospital, a general practitioner without admitting privileges was also limited to making recommendations about the patient's care. Actual decisions about the patient's care in the hospital would be made by the admitting physician or another ranking specialist brought in on the case.

Thus, new general practitioners became excluded from making many important decisions about their own patients for almost a decade and a half. This would be the order of the day until the founding of the Department of General Practice in 1966 when the importance of the family – or primary care – physician had come to be recognized and that the community was in great need of such doctors.

An interesting side note to all of this is that while the demand for specialists was growing at this time, there was not yet enough

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demand for services in some specialties to support some specialist's full time practices. This meant that such doctors would end up doing a certain amount of general practice despite their status as specialists. Some general practitioners who were active in that era have suggested that some specialists achieved their certification as a specialist only so that they could get a hospital appointment and privileges. They would then turn around and make their living as a general practitioner but with the added advantages that came with the hospital staff appointment and privileges.

There is disagreement about why the Jewish General Hospital's policy toward its general practitioners changed after 1952. Many of those involved with the hospital at that time suggest that the hospital was simply reflecting the rapid trend toward specialization that was going on at that time. Similar attitudes toward general practitioners could be found at many urban hospitals throughout Canada and the United States. Others have suggested that certain specialists and department heads felt strongly that the only role for general practitioners was to channel patients to the appropriate specialists and that this attitude came to prevail.

Be that as it may, the years between 1952 and 1966, are generally not remembered as golden years for the general practitioners associated with the Jewish General Hospital.

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The Department of General Practice

Chapter 6

By the nineteen-sixties, following many years of rapid growth in the trend toward specialization, the medical profession and many hospitals were reevaluating the importance of the primary care physician to the patient's overall care.

It came to be recognized that about ninety percent of a typical patient's medical care over a lifetime could and should be handled by the primary care physician; a doctor who establishes an ongoing relationship with the patient and who is familiar with the whole patient. Also, when possible, the same primary care physician should be treating the patient's entire family. Despite this recognition, the ratio of specialists to general practitioners in Quebec at that time was fifty-five (specialists) to forty-five (general practitioners) percent.

As in many other hospitals, this reevaluation was taking place at the Jewish General. On February 24, 1966, after at least three years of discussion, the hospital's Medical Board recommended to the Board of Administration that the hospital create a Department of General Practice.

In some parts of Canada this reevaluation and recognition of the importance of primary care had begun even earlier. In "Strength In Study," a history of the College of Family Physicians of Canada[14], author David Woods notes that the Vancouver General Hospital became the first major hospital to establish a department of general practice in 1953 and that the college itself – founded as the College of General Practice of Canada – was established on June 17, 1954 at a meeting in Vancouver.

The College of General Practice of Canada was itself founded by a group of doctors frustrated by the short shrift being given to many general practitioners in that era of great expansion of specialized medicine. As at the Jewish General and other hospitals in Montreal, general practitioners were being excluded from hospital appointments in other parts of Canada. The college, which by

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New Department of General Practice Created

"The trend toward specialization has begun to swing back", says Dr. Milton Snarch who was appointed Chief of the Hospital's newly created Department of General Practice on December 28th, 1966. The Department of Medicine increased in size. Its office will be opened in the new wing this year.

"For some time now", says Dr. Snarch, "all medical authorities have recognized that the shortage of general practitioners is serious. While it is felt that GPs can take care of 95% of the population's medical needs, the existing proportion of specialists to general practitioners in Quebec is 55% to 45%. This shows how out of balance the situation is. It's the result of the trend toward specialization which as existed in North America in the past 20 years".

But the trend is changing now. Hospitals are beginning to create departments of general practice; medical schools are taking on GPs as teachers; and Calgary's General Hospital and University of Western Ontario are offering three-year postgraduate residencies in general practice. "We hope to start a residency training program here", says Dr. Snarch, "because the young doctors who take such a three-year course will, at the end of it, be thoroughly prepared for general practice careers."

The new Department's immediate goals are two-fold: in the educational line – education in medicine being an on-going, life-long process – it will hold weekly meetings to discuss difficult clinical problems; in the administrative vein, it will attempt to integrate its members into other departments according to their individual competence and training. Dr. Snarch adds: "But the long-range objective we should work toward is preventive medicine. Not enough emphasis has been placed on the practical aspects of this most important field. By "preventative medicine", I mean the prevention of emotional disturbances as well as of physical disease, and an attempt to reach the optimal state of health for the members of our community. This is a medical responsibility. Among other things, it will involve teaching people how to care for their health. The general practitioner has a unique opportunity to be the liaison between scientific medicine, and its interpretation and application to the public.

Dr. Snarch graduated from Queen's Medical School in 1951, interned in the Ottawa Civic and Kingston General Hospitals, and did his residency at Montreal's JGH. Having always been interested in general practice, he is strongly associated with the College of General Practice of Canada where he is a past President of the Montreal Chapter; Chairman of the Committee on Education, Quebec Branch; Quebec Director of the College's National Board; and Chairman of the Precentorship Program – a conjoint project between the College and McGill University.

A psychiatrically oriented general practitioner, Dr. Snarch has published several papers, among them *"The General Practitioner's Part in the Treatment of His Emotionally Disturbed Patients"*, which appeared in the *College of General Practice Journal* in November 1965. In the same year, he was also involved in the making of the National Film Board's teaching film, *Emotional Factors in General Practice*.

Dr. Snarch is married to the former Florence Gold. They have two children: Joanne, 20 and Gary, 15.

1967 would evolve into the College of Family Physicians of Canada, provided the stimulus for the development of departments of general practice and family medicine in Canadian hospitals and medical schools and set the standards upon which their residency programs were based.

Many of the specialists within the Jewish General Hospital were not favourably disposed toward the creation of the department. However, despite the opposition of some doctors, including some at very senior levels within the hospital, the Jewish General Hospital created the Department of General Practice. Dr. Milton D. Snarch, a graduate of Queen's University Medical School who had been among the last crop of general practitioners to be granted admitting privileges by the hospital in 1952, was named to be the department's first chief on December 28, 1966.

The first meeting of the now-functioning department was held on February 1, 1967. In its first year, the Department of General Practice had a staff

Clipping from Jewish General Hospital News, February, 1967.

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of thirty-seven physicians, making it the second largest staff of doctors in the hospital. Because of the hospital's orientation before the creation of the department, most of the general practitioners who were already established in their practices limited most of their practice to internal medicine. However, members of the Department of General Practice, particularly the younger physicians, asked for and received clinical privileges in various other departments such as psychiatry and paediatrics. These privileges were, and continue to be, awarded on an individual basis to physicians with the warranted proficiency, experience or training to reasonably qualify them for such privileges.

The department formed a number of committees to take responsibility for all aspects of the department's administration as well as for education and research. The policy committee – which was to be elected annually – was vested with the final responsibility for running the department. The department chief chaired the policy committee but was a non-voting member.

With the founding of the Department of General Practice, the status of general practitioners within the hospital was increased substantially. Although general practitioners would primarily continue to see patients in the outpatient clinics, they all now had privileges allowing them the right to admit patients to the hospital and to then direct their care. This was an immense improvement in the privileges that general practitioners had enjoyed in the hospital over the previous fifteen years since only general practitioners appointed to the hospital's staff up until 1952 had continued to enjoy such privileges after that date.

In the department's early days, Dr. Snarch and the policy committee looked forward to a residency training program to certify general practitioners and an ongoing process of continuing education for established physicians. To that end, weekly lectures – with topics chosen to be of practical use to the general practitioner – were begun almost immediately. Also, a preceptorship program was begun for medical students.

Dr. Snarch resigned as department chief in 1968. Noting the demands of the department chief's responsibilities, Dr. Snarch – in his letter of resignation – suggested that his yet-to-be-named successor be given an office, a secretary and financial remuneration. Until that point, being a department chief at the Jewish General – and virtually every other hospital – was a voluntary, unpaid position and with rare exceptions, this remained the case until the introduction of Medicare.

Dr. Isaac Tannenbaum, who was no relation to the Dr. David Tannenbaum who played such a large role in the Herzl Dispensary and Herzl Health Centre, was selected as the Department of General Practice's new chief. Furthermore, the responsibilities of the position were expanded to include taking charge of the Medical Outpatient Department. Following Dr. Snarch's recommendation, Dr. Tannenbaum – who would be spending half of his time in the hospital – was paid a half-time salary; the first department chief at the Jewish General Hospital to receive such compensation.

The main preoccupation of the department was now to establish the residency training program. In its first year, circa 1970, the residency program was limited in size to a

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single resident and was tailored to the type of practice he anticipated having. The first general practice resident, Dr. Stanley Sinclair, had a one-year residency that included three months of psychiatry, three months of paediatrics and six months of medicine.

In 1971, Dr. Irwin Segal became the department's first two-year resident in a program designed to meet the standards set by the College of Family Physicians of Canada and to enable achievement of certification in family medicine by the college.

While it may appear that these initial residencies were largely improvised, and in a sense they were, the medical competency that they produced was very highly regarded and they paved the way for the department's residency program that was to develop.

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The Department of Family Medicine

Chapter 7

By the early-nineteen-seventies, universal Medicare had been introduced in Quebec and the concept of family physicians as the primary care providers to the general public was taking hold. Family doctors were no longer – and should never have been – thought of by some as referral agents to more highly trained specialists. It was clear that family doctors also needed that higher level of training and that it could be best obtained in a curriculum-based residency program that would train young doctors to face contemporary challenges.

It was also clear, that family medicine could no longer simply be thought of as general practice. By July 1967 the College of General Practice of Canada had already become the College of Family Physicians of Canada and in 1972 the Jewish General Hospital's Department of General Practice became the Department of Family Medicine.

After protracted negotiations over available space within the hospital, the Department of Family Medicine established the Jewish General Hospital's Family Practice Centre on the main floor of the hospital's east wing near the side entrance from Côte des Neiges Road. The centre officially opened in June 1972. The centre was to provide comprehensive primary care services to the hospital's clientele and would be a training centre for physicians pursuing careers in family medicine.

With the launch of the Family Practice Centre, the residency program began to expand and in short order there were twelve first and second year residents. Although most of the teaching of residents was done by part-time instructors drawn from the ranks of the department's staff, it was immediately felt that there must be at least one full-time teacher within the Family Practice Centre. Dr. Stanley Sinclair, who had earlier been the department's first resident and had now begun a practice, was enticed to leave his practice and become that first full-time

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The Jewish General Hospital, Herzl Family Practice Centre opened in June 1972.

teacher; his second "first" within the Department of Family Medicine. The department's excellent reputation as a training facility for residents began to grow quickly. Demand for space in the residency program was high and would remain so as the size of the program increased in the following years.

In describing the goals of the residency program, Dr. Isaac Tannenbaum, Chief of the Department of Family Medicine wrote:

> *"...in this program candidates are being trained to see and treat patients within the context of family and community rather than strictly as a disease. That is, they are being trained to be person-oriented rather than disease-oriented."*[15]

The residency program included workshops, seminars and regular rounds and meetings with staff physicians. Residents also assumed responsibility for a case load and would spend between one and four months each in other departments including Emergency, Psychiatry, Surgery, Medicine, Paediatrics and Obstetrics and Gynaecology. Residents would also spend time at either the Maimonides Hospital and Home for the Aged or the Jewish Convalescent Hospital.

In 1973, the residency program was enhanced when the McGill University Faculty of Medicine established a Department of Family Medicine and the Jewish General Hospital's Department of Family Medicine became an integral unit of McGill teaching program for family practitioners. Dr. Isaac Tannenbaum became the first family doctor to hold an academic appointment at McGill.

David Woods notes that compared to most other Canadian medical schools, McGill was actually slow to establish its department of family medicine because of its *"specialist orientation."*[16] This perception of McGill's specialist orientation would occasionally prove to be a contentious issue in later years.

So, with the increased appreciation of the importance of the primary care physician that developed in the nineteen-sixties, the Jewish

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General Hospital evolved – within the short span of about a half-dozen years – from an institution with only limited recognition to the general practitioner to establish a Department of General Practice and to have that department evolve into the Department of Family Medicine. The department in turn established the Family Practice Centre with its training program for residents planning to practice in the field of family medicine.

In describing the newly founded Family Practice Centre, Dr. Tannenbaum wrote:

"The Family Practice Centre is an attempt to incorporate a newer concept of health care delivery whereby emphasis is placed on the individual in his total environment, and is not disease oriented as in the past. The psycho-social approach to the individual is emphasized and greater attention is paid to preventative care."[17]

A description of an approach that sounded remarkably similar to that of the Herzl Health Centre.

Meanwhile, the situation at the Herzl Health Centre – just a few blocks away – was coming to a head. How could Herzl adapt to Quebec's health care scheme created under Bill 65? Should it become a CLSC? If so, would Herzl be forced to give up its Jewish identity? It became clear that a merger of the Herzl Health Centre with the Jewish General Hospital's Family Practice Centre was a favoured option for many people involved with the two institutions.

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The Merger

Chapter 8

As detailed in Chapter Four, the Agnew-Peckham Report on health services in the Jewish community published in October 1970 found that the facilities of the Herzl Health Centre were overcrowded and inadequate to meet the needs of its clientele. As a possible solution, the report suggested that the Herzl Health Centre be integrated into a Jewish community hospital; the Jewish General was the most obvious possibility.

In the following couple of years, this obvious possibility became even more logical with the evolution of the Jewish General Hospital's Department of General Practice into the Department of Family Medicine and the establishment of the Family Practice Centre. In effect, the two institutions were now offering overlapping services to an overlapping clientele. So, in early 1973 meetings between representatives of the Herzl Health Centre and the Jewish General Hospital began to be held with the aim of effecting a merger.

In October 1973, Dr. Sidney Lee, McGill University's associate dean of Community Medicine who had been a member of the Castonguay Commission which paved the way for the introduction of Medicare and reform of the province's health care system, prepared a report for the Minister of Social Affairs advocating that the Herzl Health Centre and the Jewish General Hospital Department of Family Medicine – with its Family Practice Centre – be integrated. This report was but one more signal that the merger was inevitable.

Coming to the decision to go ahead with a merger was not easy for those involved with the Herzl Health Centre. One of their principal considerations was to protect Herzl's long-standing commitment to community and preventative health care. They feared that as a hospital-based training centre for residents, priorities could shift from the needs of the community and the patients to the needs of doctors. They also feared

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The Canadian Jewish News, Friday, January 25, 1974 - page 7

Organizations and People

Herzl Health Centre no longer autonomous

By GORDON BURKE

MONTREAL –

After 60 years as an autonomous health agency in the Cote des Neiges area of Montreal, the Herzl Health Centre is to be merged with the family medicine unit of the Jewish General Hospital.

The merger was activated as a result of Chapter 48, the legislation re-organizing health and social services in the province. The Herzl Board, with the authorization of the government and the co-operation of the Jewish Hospital, decided to integrate its services into the Jewish General in developing the family medicine department.

Herzl will move into the nurses residence left vacant when Quebec's community colleges (CEGEPS) took over the responsibility of training nurses.

Herzl was originally founded to serve the health needs of the immigrant Jewish population in the east-end of Montreal. "Our aim has always been to maintain the health of the people in the district we serve", said Sheila Zittrer, President of Herzl. "We are a family oriented clinic dedicated to improving the quality of health services for all who come to us. Our services include not only regular health problems but dentistry as well". According to Mrs. Zittrer, the integration with the Jewish General was a natural occurrence. "The JGH operates a family medicine unit and we are a health agency with a family orientation. Our present location on Decelles Avenue is just too limiting for our needs.

"We see no reason why the quality of health services that are dispensed need be any lower simply because we will be operating in a larger atmosphere. In fact, the quality of service may even improve with hospital back up", she added.

One advantage will be positive for people who use the dentistry services of the agency. The combined number of chairs will be able to service 10 patients at a time. Presently, there are two full time dentists.

Mrs. Zittrer began as a volunteer helping to structure its volunteer program. She has served at the board level for the past 12 years.

The merger will be a unique opportunity to see what we can do. We have always tried to articulate the needs and sensitivities of the recipients. The merger will enable us to offer even more comprehensive medical services to families. We may lose a portion of our autonomy, but the sacrifice is well worth it if the quality of services can be improved in any way."

The Herzl will retain its name and it board composition in order to supervise the new operation with the Jewish General Hospital.

that by becoming hospital-based, Herzl's focus would shift from prevention and well-being to treatment of disease. There were also concerns about how autonomous Herzl could remain once it became part of the much larger institution.

Despite these reservations, an agreement to merge the Herzl Health Centre with the Family Practice Centre of the Jewish General Hospital's Department of Family Medicine was achieved in 1974. A joint executive committee, including eight members of Herzl's Board of Directors and three members of the Jewish General's Board of Directors, was formed to govern the merger. Sheila Zittrer, President of the Herzl board was appointed to chair the new joint executive committee. At the staff level, Hirsh Cohen, Assistant Director of the Jewish General Hospital, was given administrative responsibility for bringing about the merger. Dr. Isaac Tannenbaum, Chief of the Department of Family Medicine, would be chief of the consolidated organization.

The memorandum of agreement concerning the merger of the Herzl Health Centre with the Jewish General

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Hospital's Family Practice Centre was finalized in 1975. The consolidated organization would henceforth be called the Herzl Family Practice Centre of the Jewish General Hospital. Retaining the Herzl name for the centre served to maintain the line of continuity and logical development of an institution stretching back more than sixty years to 1912 and the original Herzl Dispensary on St. Dominique Street.

The previously noted concerns of the Herzl Health Centre that the centre retain its community orientation were delineated in the agreement which stipulated that the Herzl Family Practice Centre be adaptable to the health and social needs of the community and that services be provided in a humane and responsive manner.

The agreement further stipulated that the aforementioned joint executive committee would continue to oversee all aspects of the merger and that the merged organization would retain Herzl's charter and that it would remain a constituent agency of Allied Jewish Community Services. The clientele of the Herzl Health Centre was to be transferred to the new Herzl Family Practice Centre at

The Canadian Jewish News, Friday, January 10, 1975
Organizations and People

'Special' Herzl Health Centre, 'proud' Jewish General Hospital adjusted well to unusual union

By S. BRUSSELL
(First of two parts)

MONTREAL –

An unusual marriage took place last May. The groom was the Jewish General Hospital, the bride, the Herzl Health Center. The bride's dowery was 63 years of compassionate attention to the Montreal Jewish community, a unique tradition of caring, and an approach to health services years ahead of its time.

Montreal's Jewish General is one of Canada's great hospitals and an institution of which the Jewish community has been justly proud. Its highly trained professionals, its enormous resources of equipment and facilitites provide all Montrealers with the best efforts of modern medicine.

But Herzl had something special - a talent for humanity. Will thsi talent be wasted, or nurtured in the new setting? And why was it tampered with at all?

Born in 1911, and called the Herzl Hospital and Dispensary, the center was first located on St. Urban Street in the heart of the St. Lawrence"Main" area. This is where they came, the immigrant Jews full of hope for the future, but burdened with the fears and superstitions of the past.

Herzl grew with the community, changing its location when the population of the community shifted. Now, because the medical facilities of the Jewish General fulfilled the treatment needs of the immigrants, Herzl's focus changed to preventive medicine.

A dental service was instituted in 1922, a pediatric well being clinic in 1932, an adult well-being clinic, an outgrowth of the children's service, began in 1956, because a troubled or sick child often comes from a similarly troubled home.

The Herzl approach since that time has been evaluation and diagnosis of the family unit. This concept is presently revolutionizing medical care ideology, but at Herzl it was always the norm.

Herzl provided a total family service that included doctors, nurses, social workers, psychologists, lab facilities. It was small and limited, but to the people it served, it was everything.

Herzl's director from 1957-1973 was Shirley Kantrowitz, a trained social worker, an immigrant herself. Kantrowitz, however, came from New York City, where the crest in the immigrant tidal wave came early in the century. She was shocked at first by the crying need of Herzl's patients.

She tells of a nurse who constantly complained how dirty the babies and children were, who castigated their mothers for their apparent lack of caring.

Kantrowitz investigated, visiting homes to see the conditions under which Herzl's people laboured.

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Continued from page 41

She found decaying slums where a bathtub was unknown, where the sinks were aged cast iron rusted and chipped, where winter weather blew through cracked or broken panes and where rats played on balconies.

Kantrowitz and her team taught the mothers to overcome the shortcomings of their homes.

The center's public health nurse visited babies born at the Jewish General, counselling and encouraging new mothers.

The adult well-being clinic was held four evenings a week so that men who worked during the day and who could not afford to lose money and time could come for check-ups. women who could not afford baby-sitters could see doctors at night.

When serious illness was detected in a family member, he or she was referred to a private physician, to the Jewish General Hospital or another suitable service for treatment.

Herzl's focus was prevention in a population where such a concept was practically unknown. It was a team approach to medicine with each member of the team working for the benefit of the client.

A major component of Herzl's appraoch was to re-educate the client. When it came to innoculating children against disease, Herzl had a record of 100%, whereas the City of Montreal had a significantly lower record. Herzl painstakingly explained what the innoculation was for and how it worked, thus dispelling the superstitions of the old country.

In 1968, 80% of Herzl's patients were new immigrants, many of whom came from North Africa. The adjustment of North African Jews is even more monumental than it was from the Europeans. Herzl tried to meet their needs.

The Family Planning program was alsobased on the total family approach, since a husband and wife must jointly determine the size of their family and the means of controlling it. Herzl determined that both should be involved. If a woman expressed an interest in birth control, she was asked to come with her husband, to a special evening get-together.

Out of the Family Planning program, in true Herzl tradition, another need arose and was met. Many of the couples selected the pill as means of birth control. Concerned that the pill was known to cause a minor depression in many patients, the Herzl team assessed the client. At home in North Africa, mothers were part of an extended family with relatives to turn to for help and support. Here they were alone, and the mother was isoloated, lonely and already depressed.

College educated volunteers from the Jewish Junior Welfare League were enlisted and trained by the Herzl center. Each volunteer was assigned a family whom she essentially befriended.

The pride and self-respect of the newcomers was always of paramount concern to the center.

The history of Herzl is full of such tales, but there were many shortcomings as well. In spite of every effort of the Herzl "team" and its pioneering approach to care, they could not do everything. They could not reat patients and thus the "continuity" of medical care was interrupted.

They were severly limited by space, budget and personnel. There were social changes going on all around them that they had to deal with, changing provincial laws, changing needs, a changing community.

the Jewish General Hospital and the dedication to preventative health care was to be reinforced. As much as possible, the staff of the Herzl Health Centre was to be transferred to the merged organization and Herzl's corps of volunteers was to be encouraged to continue with their participation.

Dr. Isaac Tannenbaum, Chief of the Department of Family Medicine and now Director of the Herzl Family Practice Centre, expressed the feelings of the joint committee when he stated:

> *"It was our[18] hope that their[19] expertise in preventive medicine and community health care delivery would complement the services and training that was being carried on in the Family Practice Centre.*
>
> *In all modesty, I can state that the new Herzl Family Practice Centre will be foremost among community health centres in this province in providing primary, comprehensive and continuing care of a preventative and therapeutic basis. Our work is not confined to the hospital. Through*

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various community projects, we are extending our scope into the community at various levels."[20]

It should also be noted that the dental services offered by the Herzl Health Centre were merged with the Jewish General Hospital's Department of Dentistry. The infusion of Herzl's dentistry budget into the hospital allowed for great expansion of the hospital's dental services and upgrading of equipment.

Mrs. Sheila Zittrer presenting the President's Report at the 64th Annual Meeting of the Herzl Health Centre. From left to right are: Dr. E.C. Burman; Dr. B. Slimovitch; Dr. I. Tannenbaum, Director of the Herzl Family Practice Centre; Mr. Julian Kotler; Mr. Peter Bronfman; and Mr. Mark Berkowitz.

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The Herzl Family Practice Centre

Chapter 9

With the merger of the Herzl Health Centre into the Department of Family Medicinecine of the Jewish General Hospital, the Herzl Family Practice Centre emerged as a comprehensive health care centre serving both the primary health care needs of a diverse clientele and as a highly regarded training facility for family physicians.

There is a cliché that says the more things change, the more they stay the same. This has certainly been true of Herzl in its evolution from a small dispensary to a health centre to a family practice centre that is part of a large hospital. Although it was not formalized as a training facility until its merger into the hospital, the Herzl Dispensary and Herzl Health Centre were always places that physicians were able to obtain the much needed experience they required in order to practice their profession. The multi-disciplinary team approach that was first introduced at the Herzl Health Centre was continued at the Herzl Family Practice Centre. Under this approach, as described by Dr. Isaac Tannenbaum:

> *"Each team, composed of an attending physician, residents, a family practice nurse, a social worker and a secretary, works as a semi-autonomous unit to provide continuing and comprehensive care. In this way we hope to provide, for the community, a broad based preventative and therapeutic service involving various health professionals, each with their own expertise."*[21]

Also continued were Herzl's traditional emphases on preventative medicine and the delivery of health care services in a humane and sympathetic manner.

On the other hand – to reverse the cliché – the more things stay the same, the more they change. With the merger, prevention and diagnosis, Herzl's traditional focuses, have been

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augmented by a greatly increased capacity for treatment. During Herzl's days as a dispensary and health centre, patients frequently had to be referred elsewhere – generally, after 1934, to the Jewish General Hospital – for all but the most fundamental of care. This changed dramatically when Herzl became part of a comprehensive hospital. It should also be noted that Herzl's frequent need to refer patients to other institutions served to mitigate against physicians and patients developing ongoing doctor-patient relationships.

It should be further noted that also mitigating against ongoing doctor-patient relationships at the Herzl Health Centre prior to the merger was the segmentation of the clientele into the various clinics such as pediatric, family planning, adult-well-being, etc. Of course, there was little other choice than this type of segmentation for an organization serving a largely poor clientele prior to the introduction of Medicare. It was only under Medicare that poor patients were placed in the position of being able to develop a continuing relationship with a family physician. In the new context of the Herzl Family Practice Centre, these clinics thus became obsolete and were abolished.

In 1975, Dr. Tannenbaum decided to return to his practice on a fulltime basis; although he would continue to teach residents at Herzl. Dr. Michael Klein succeeded Dr. Tannenbaum as Chief of the Department of Family Medicine and Director of the Herzl Family Practice Centre. Dr. Klein would be department chief and director of Herzl until 1990.

HERZL FAMILY PRACICE CENTRE
Left to right: Dr. Michael KLEIN, Director 1975 –
Dr. Joseph LEAVITT, Early pioneer Herzl Health Centre 1921 – 1974
Sheila ZITTRER, President Herzl Board 1973 – 1976
Dr. Issac TANNENBAUM, Director 1973 – 1975

1975 marked the transfer of leadership from
Dr. Issac Tannenbaum to Dr. Michael Klein

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Dr. Klein was originally from California, where he graduated from the Stanford University School of Medicine in 1966. He first came to Canada as a pediatric resident at the Montreal Children's Hospital in 1967. After completing residencies in pediatrics and biochemical genetics at the Children's and in neonatology at the Royal Victoria Hospital, Dr. Klein returned to the United States. There he practiced pediatrics and became an assistant professor of pediatrics at the University of Rochester. He returned to Montreal and his appointment at the Jewish General Hospital as Chief of the Department of Family Medicine and Director of the Herzl Family Practice Centre in 1975. That same year, Dr. Klein also became the first member of the Jewish General Hospital's medical staff to be appointed to a full time, tenure track professorship at McGill University's Faculty of Medicine.

Under Dr. Klein's direction, the Department of Family Medicine and the Herzl Family Practice Centre quickly began to expand their activities. While continuing to balance the priorities of serving the Herzl clientele and teaching residents, there was also an emphasis on the role of the community. To that end, 1975 saw Herzl introduce a very successful public lecture series that covered such topics as regular check-ups, stress, cancer and nutrition. There were also services provided to children's day care programs, a Golden Age flu vaccine program, and physical examinations and psychological evaluations for Jewish community summer camps.

A provincial election held in Quebec on November 15, 1976 elected a new government under Premier René Lévesque and the Parti Québécois. This election of the Parti Québécois, which advocated sovereignty-association between Quebec and Canada – that is political separation with certain economic ties and a common currency – was to have major detrimental effects on Montreal's anglophone and Jewish communities. Over the next few years, many thousands of anglophones and Jews would decide to leave Quebec for other parts of Canada and the United States. Most of those leaving Quebec were young and well-educated and this migration was felt immediately within the Department of Family Medicine. In his report for 1977-'78, Dr. Klein stated:

> "The Department's year was very much influenced by the political and social contentions in the province and there was a great deal of movement within the Department during this academic year. Most notably, we had a turnover of eight members of the Department, with most individuals leaving to emigrate to the United States."[22]

This turnover represented about fifteen percent of the active physicians within the Department of Family Medicine at the time and was reflective of the trends toward outward migration within Quebec's anglophone and Jewish communities during the mid-to-late nineteen-seventies.

The full time academic staff at the Herzl Family Practice Centre – which then included Drs. Jay Brock, Sidney Feldman, Jackie McLaren, Stanley Sinclair and psychologist Yvonne Steinert, Ph.D. – reflected the turnover the department was then experiencing. Two vacancies were created among these five full time positions when Drs. Brock and Sinclair departed for the United States.

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As the nineteen-seventies drew to a close, the Department of Family Medicine and the Herzl Family Practice Centre continued to expand their programs and areas of responsibility. In 1979, a ward was established in the hospital for patients requiring long term care and was staffed by the department. The long term ward, which would have a high proportion of geriatric patients and was located in the hospital on 8 West became part of the residents' rotation and it developed an excellent reputation as a humane place for patient care and as a teaching facility for residents in the program.

Around this time, geriatrics became an important priority for the Department of Family Medicine and Herzl Family Practice Centre. This recognized two important and overlapping demographic realities: firstly, that the Jewish community in Montreal is an aging community with a high proportion of elderly; and secondly, that the neighbourhoods in the general vicinity of the Jewish General Hospital have the highest proportion of senior citizens of any similarly sized area in Canada. Thus, it was recognized that geriatric patients would be an increasingly larger part of Herzl's natural constituency.

It was also around this time that some members of the department began to recognize the conflicts involved in delivering primary care services within a university hospital that was simultaneously expanding its position as a highly specialized provider of tertiary care services.

In a way, the Jewish General Hospital was somewhat unique in that it was clearly an institution with strong community roots, which would have mitigated in favour of primary care. However, it was also now a major university teaching hospital. As such, many specialists would have preferred to give primary care a low priority in a hospital setting that had become highly specialized and technological. Some within the department and within the larger hospital family would give this issue, and how to reconcile the desire and need to provide both kinds of services, much thought and discussion in the following years.

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Meeting Challenges

Chapter 10

As the nineteen-eighties dawned, other issues that would challenge the Department of Family Medicine and the Herzl Family Practice Centre in that decade began to rise to the surface. One of those issues – which has grown continuously and continues to be of increasingly grave concern to providers of medical and social services – is government funding cutbacks.

One of the first areas to feel the effect of government cutbacks at Herzl was social work. Cuts to the provincial social service system were passed on to the hospital and subsequently to those departments – such as the Herzl Family Practice Centre –that used social workers. One of the consequences of this was that the remaining social workers were faced with heavier case loads compromising their availability as both teachers within the residency program and as providers of services within their team units.

It should be mentioned that the Herzl Family Practice Centre never really had direct control of its allocation of social work positions. The positions were actually held by Jewish Family Services which seconded them to the hospital which in turn seconded them to Herzl. Eventual erosion of these positions was such that all five social work positions that existed at the time of Herzl's merger into the hospital were eventually eliminated. Reflecting on the erosion of social work positions in a 1993 letter, Dr. Michael Klein also recalled that the social workers who initially worked at the Herzl Family Practice Centre had certain specialized skills in areas such as psychotherapy, family therapy and family dynamics. As these social workers were removed from Herzl, they tended to be replaced by more general case workers without those skills. Eventually, all of Herzl's social work positions were eliminated. Most of Herzl's current social work needs are now supplied through agreements with the various CLSCs that service Herzl's client base on a geographic basis.

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Another problem – also somewhat related to government cutbacks – was the placement of residents within the department following their residencies. In the nineteen-seventies, graduates of the residency program were routinely brought into the department. However, in the nineteen-eighties, availability of positions within the department – and more widely within the greater hospital itself – became dramatically limited. This meant that residents successfully completing the program would have no guarantee that membership in the Department of Family Medicine would necessarily follow. There were fears expressed that this unavailability of positions within the Department of Family Medicine could possibly lead to the eventual stagnation of the department if there were not a sufficient number of newer family physicians coming into the department in the future.

It was also recognized that the residents participating in the program were coming from increasingly varied backgrounds and that it could no longer be assumed that all – or even most – would eventually practice in an urban setting. Many residents were planning to practice in suburbia, in small towns and in rural areas. Therefore, programs were created giving residents increased exposure in such areas as obstetrics, anaesthesiology, acute care and critical care medicine. As well, in order to broaden their range of experience in non-urban situations, residents in the program were now being sent to spend two months each in rural settings such as Inuvik, Temiscaming or Dalhousie, New Brunswick.

By 1980, the Herzl Family Practice Centre's physical space – on the site of the former nurses' residence on the east side of the hospital near the Côte des Neiges entrance – was bursting at its seams. Doctors and other staff were doubled up in offices, examination rooms were at a premium and were fully booked on a constant basis. This led to the conclusion that there was little capacity for the further expansion of Herzl programs without a new facility in which to expand. However, there would continue to be a drive to expand and/or improve programs despite the concern over a now-chronic lack of space.

In 1981, reflecting the priority of better serving elderly patients discussed in the previous chapter, the Department of Family Medicine collaborated with the Departments of Internal Medicine and Psychiatry in establishing a Division of Geriatrics to coordinate the many different geriatric services that were dispersed within the hospital. The aim of the division, which was to be administered as part of the Department of Family Medicine – although its first director was Dr. Rubin Becker of the Department of Internal Medicine – was to provide elderly patients with a more comprehensive level of services in a manner that would ensure a maximum level of independence for the individual patients.

Within a year, the success of the Division of Geriatrics began to be felt. The division's Geriatric Assessment Unit began to coordinate virtually all of the geriatric assessments being done for all long-term facilities within the Jewish community. A by-product of this was an increasingly rapid turnover of geriatric patients throughout the hospital – including on the long-term ward – because of better coordination with the community's chronic care and long-term institutions.

More consequences of budget cuts were felt by the department in 1981 when several positions were eliminated at the Herzl Family

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Practice Centre. Also, the hospital's General Medical Clinic was closed forcing the already overloaded Herzl, and the private practices of other Family Medicine Department members, to absorb the patients of the General Medical Clinic. Many of the patients coming from the General Medical Clinic had extensive social service needs which placed a heavy load on Herzl's already diminished social service staff.

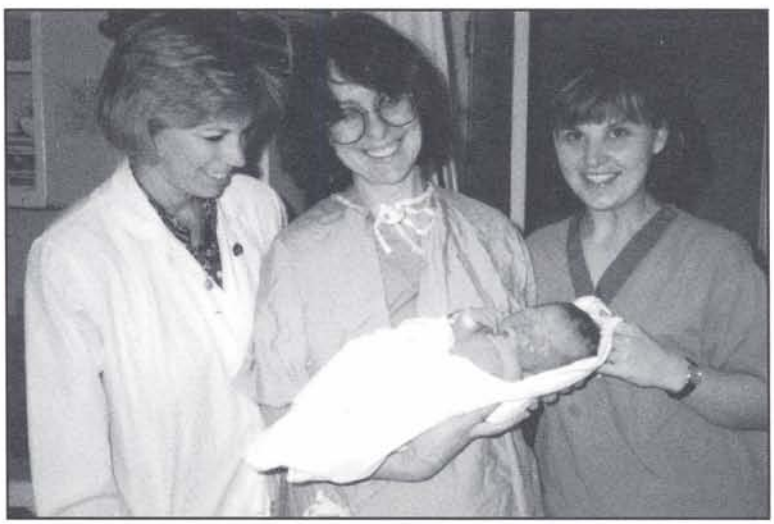
Still, despite the problems caused by the chronic lack of space and interminable budget cuts, the Department of Family Practice continued to develop new programs simultaneously aimed at improving service to the patient clientele and broadening the training being given to residents.

In 1982, Drs. Michael Klein, François Gilles Boucher and Michael Malus formed an Obstetrics Group at Herzl. This meant that Herzl's obstetrical patients could be cared for at Herzl by their own family physicians and that residents would benefit from the training opportunities that this provides. Obstetricians remained available as consultants for high risk or problem pregnancies or to step in for the small percentage of difficult pregnancies that could not be handled by family physicians.

Although most family physicians in the city of Montreal did not deliver babies at that time, those practicing in small towns or rural areas did. Dr. Malus, for example, had practiced in a rural setting before coming to Herzl. It made sense, therefore, that delivering babies should be a component of family medicine; particularly in that ninety percent of pregnancies that are considered to be of low risk to mother and baby.

Since many of Herzl's residents would ultimately be practicing outside of Montreal, this obstetrics training became especially valuable for those residents preparing to practice in rural areas and small towns where family physicians are frequently called upon to practice obstetrics as a major component of their practice.

There also developed a community medicine aspect to the Obstetrics Group. Dr. Louis T. Montour, a past graduate of the residency



Dr. Cheryl Levitt, Chief and Dr. Karen Prokai, resident with Nurse Karen Tafler demonstrate their favorite part of practising obstetrics.

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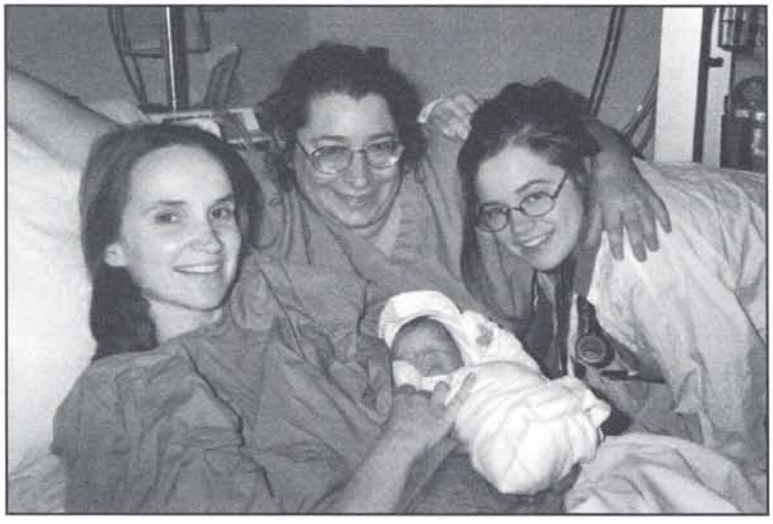

Dr. Pearle Feldman and Dr. Olivia Sampson share in the joy.

program at Herzl practicing on the Kahnawake Mohawk Reserve south of Montreal, joined the Obstetrics Group and began providing obstetrical services to Kahnawake patients. As well, there was collaboration with the Lakeshore General Hospital in family practice obstetric services.

In 1983, the Division of Geriatrics initiated the Medical Home Care Services Program under Dr. A.M. (Mark) Clarfield, the division's chief. The program supplied and coordinated medical services to organizations providing home care such as CLSC Côte des Neiges, the Home Care Service of the Jewish Nursing Home and foster homes sponsored by Jewish Family Services. As well, the program facilitated hospitalization when it was required by home care patients.

By this time, Herzl had developed the HAIM – or Herzl Ambulatory Internal Medicine – program in collaboration with the Department of Internal Medicine. This program, under the direction of Dr. Sidney Feldman, treated patients with complex medical problems with the humanistic approach of family medicine. Through HAIM, family medicine residents were able to broaden their experience with this type of patient and internal medicine residents greatly improved their skills at interviewing patients and in dealing with patients on an ambulatory basis.

The importance of the ongoing role of Dr. Feldman at the Herzl Family Practice Centre has been frequently stressed by many of the doctors who work – or have been trained – at Herzl. Dr. Feldman, who is both an internist and a family physician, is one of Herzl's long-time team leaders and senior teachers. Former Herzl residents have referred to his outstanding teaching skills and his kindness in helping them through the hardest years of their training.

By 1984, the Department of Family Medicine had begun to develop a collaborative relationship with CLSC Côte des Neiges which would grow in following years. As noted above, the first area which bore fruit from this collaboration was the Division of Geriatrics' Home Care Program. Under this collaboration,

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services between the two institutions were coordinated with the Division of Geriatrics providing doctors' services and consultations and the CLSC providing nursing and homemaker services and some medical services. A portion of the salaries of some Department of Family Medicine doctors participating in this program came from CLSC funds.

It was also in 1984 that the Herzl Family Practice Centre received an award from the Jewish Immigrant Aid Services honouring Herzl's long standing commitment to the provision of services to new immigrants.

By the end of the 1984-'85 academic year, it was decided that residents coming into the training program at the Herzl Family Practice Centre would have to be oriented to the total range of activities within the practice of family medicine. That range of activities included such areas as obstetrics, paediatrics, behavioral science, geriatrics and adolescent medicine. Applicants to the program were now going to be priority ranked according to their orientation to the different areas encompassed by family medicine.

That same year, Dr. Michael Malus established an Adolescent Clinic at the Herzl Family Practice Centre that came to find its primary clientele among anglophone high school students in areas accessible to the hospital. In the following years, the Adolescent Program would expand its informational role providing educational services to students at area high schools. Herzl now operates a twenty-four hour hot-line where teenagers can get the information and referrals that they need. Also in the area of adolescent medicine, Herzl was servicing the medical needs of Elizabeth House, a home for unwed young women.

In his annual report for 1984-'85, Dr. Klein called attention to the heavily increased workload being borne by the nurses of the Herzl Family Practice Centre. In the decade that had passed since the creation of the centre, the nursing staff had remained constant at four full time

1994 photo of some nurses at Herzl Family Practice Centre
Barbara Johnson, Gail Steele, Pauline Lam Po Tang, June Smith.

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nurses. However, in that time, the number of patient visits to Herzl had risen from 13,000 annually to more than 20,000 per year. In addition, the nurses' work loads were complicated by the types of cases that they were being called upon to deal with. This included an increasing number of geriatric patients with their many needs and the developing obstetrics program. The nurses' work loads were further complicated by the fact that nurses were covering much of the practices of residents while they were away on their rural rotations and by the increasing numbers of immigrant patients who have heavy social needs. Dr. Klein noted that the hospital's budgetary situation prevented the hiring of even one more nurse and that fatigue and morale problems among the overworked nursing staff *"can be well imagined."*[23] Eventually, by 1986-'87, the physicians at the Herzl Family Practice Centre sought to help ameliorate these workload pressures on the nursing staff by hiring an additional full time nurse from their own earnings.

However, despite these work load pressures, the nursing staff continued acting as clinical teachers for senior students at the McGill School of Nursing Undergraduate Program. The nurses were also responsible for organizing monthly obstetrical antenatal rounds and evening sessions to supplement childbirth education for expecting couples. As well, the Herzl Family Practice Centre nurses took part in a series of public seminars in 1985 celebrating the fiftieth anniversary of the Jewish General Hospital's Nursing Department.

In 1985, many members of the Department of Family Medicine took great pride in sharing receipt the Nobel Peace Prize awarded to the International Physicians for the Prevention of Nuclear War (IPPNW) founded by Drs. Bernard Lown and Eugene Chazov. Those department members shared in the Nobel Prize through their membership and participation in the IPPNW's Quebec affiliate Health Professionals for Nuclear Responsibility which had its office at Herzl and which was under the founding chairmanship of Dr. Michael Dworkind, the Herzl Family Practice Centre's Associate Director of Medical Services.

These global concerns that were reflected by the Nobel Peace Prize in many ways cut to the heart of the philosophy of family medicine. Many family physicians define their roles expansively recognizing that principles of family medicine imply that they have a social responsibility to fight for healthy environment and a peaceful planet, to get to the root of so many social and health care problems by working to eliminate poverty and violence in the home and in society.

Dr. Dworkind is one of those doctors frequently cited for his various contributions to Herzl, the department, and to the hospital at large. These contributions date back to his Herzl residency in the mid-seventies. For example, while Chief Resident in 1976, Dr. Dworkind established a still-functioning multi-disciplinary program aimed at primary and secondary prevention of heart disease in patients who have had uncomplicated heart attacks. Dr. Dworkind was also instrumental in establishing the links between Herzl and the CLSC Côte des Neiges where he has served as Director of Medical Services and président de Conseil de Médecin. More recently he has become involved in developing and instituting a multi-disciplinary palliative care program for dying cancer patients. This supportive care consult team offers palliative hospital-based care and supports the community

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home care program involving the Mount Sinai Palliative Care Unit in community service.

The 1986-'87 academic year was the "Bar Mitzvah year" for the Herzl Family Practice Centre which had, by then, been training residents in family medicine for thirteen years. There were now approximately 120 graduates of the Herzl program practicing family medicine in various parts of Quebec, across Canada, in the United States and – in some cases – in other parts of the world. That Bar Mitzvah year also saw the number of residents at the Herzl Family Practice Centre increase a further twenty percent from twenty residents to twenty-four. There was also a significant advance that year in the family medicine education being received by undergraduate medical students at McGill University. Previously, undergraduates' exposure to family medicine was on an elective basis but, starting that year, all undergraduates became obligated to do a six-week clerkship encompassing family medicine, geriatrics and community medicine. The Herzl Family Practice Centre accepted the responsibility of providing these students with appropriate experiences in a variety of situations including at the private offices of department members, at CLSCs and in rural settings.

Also that year, the Herzl Family Practice Centre continued to expand its collaboration with the CLSC Côte des Neiges by merging several service and teaching activities at the two institutions under the direction of the Herzl director and staff. Specifically, the CLSC Côte des Neiges became a designated "teaching CLSC" with a mandate to provide appropriate experiences to both undergraduate and postgraduate trainees in family medicine. It became the Herzl Family Practice Centre's responsibility to recruit and develop the CLSC's medical staff. Consequently, a new medical staff was hired for the CLSC and because of its teaching designation, all doctors henceforth working at the CLSC Côte des Neiges were required to have joint appointments at McGill and at either the Herzl Family Practice Centre or the St. Mary's Hospital Family Medicine Department.

The 1986-'87 year was also one of great expansion in the Department of Family Medicine-administered Division of Geriatrics. In October of 1986, the capacity of the geriatrics ward was substantially increased from thirty-six to sixty-three beds when it moved from 8 West to 6 West and 6 Northwest. This allowed for the transfer of long-term care patients from other departments of the hospital as well as greater flexibility in the admission of acute care geriatric patients from the emergency room or from their homes.

Patients on the geriatric ward were treated from a multidisciplinary point of view incorporating doctors, nurses, occupational therapists, physiotherapists and social workers. This approach was credited for improving the quality of life of geriatric patients to the point that a number of patients who had been declared long-term care patients were able to be discharged either to their own homes, to foster care, or to chronic care institutions.

By the 1987-'88 academic year, Quebec's provincial health ministry had abolished the system of rotating internships for new medical school graduates. Before practicing, new doctors now had to pursue postgraduate training and obtain certification in either family medicine or in a recognized area of specialization. This meant that the number of residents being

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trained at the Herzl Family Practice Centre took a dramatic jump that year. There were now more than thirty residents in the program and it was predicted that there would soon be more than forty. This particular expansion was taken on somewhat reluctantly by the Department of Family Medicine. It should be mentioned that the abolition of rotating internships placed heavier demands on the residency program to pick up much of the service void created by the absence of rotating interns and to create more educational opportunities for graduating medical students. However, at that time, there was concern expressed about the potential for loss of intimacy in small group teaching situations and about the pressures being placed on Herzl's already overburdened faculty, nurses and support staff.

Herzl's Adolescent Program also experienced development in 1987-'88 by expanding its high school educational services to include school-based clinics. Dr. Morrie Golden, one of Herzl's clinical psychologists, worked closely with Dr. Malus to develop these clinics.

The need for expansion sights led Herzl to begin to collaborate with the Point St. Charles Community Clinic. The extra residents coming into the program could be accommodated by receiving training at Herzl, the CLSC Côte des Neiges and the Point St. Charles Community Clinic.

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New Premises and the End of An Era

Chapter 11

In 1989, the Herzl Family Practice Centre, along with the Division of Geriatrics, moved into their new home in the newly-built Cummings Family Pavillion on the hospital's west side with street-level accessibility from Legaré Avenue.

Although the new premises were designed to solve the chronic lack of space that Herzl had endured during most of the time that it had occupied its former premises in the hospital's east wing near the Côte des Neiges entrance, various expansions of services and the residency program has meant there have continued to be certain problems of space shortages.

In 1990, Dr. Klein stepped down after fifteen years as Chief of the Department of Family Medicine and Director of the Herzl Family Practice Centre. Those fifteen years had been remarkable ones in the department's and in Herzl's history and, in fact, covered all but the first two years of the department's training program for residents in family medicine.

It is illuminating to look at some of the changes that occurred in the department during Dr. Klein's tenure. When he took over as chief, the department had fifty-six member doctors; including only four women. By the time he resigned as department chief, there were 100 members; including twenty-seven women. In 1975, the Department of Family Medicine did no research, gave few presentations and had almost no publications. In the 1989-'90 academic year, the department's research work was reflected by sixty-four presentations and eighteen publications. In 1975, the Division of Geriatrics did not exist, adolescent medicine did not exist and obstetrics were rarely being practiced by family doctors. In fact, in the decade from 1980 to 1990, family physicians at the Jewish General Hospital went from delivering virtually no babies to more than 300 per year. Also, direct collaborations with other institutions like CLSCs and community clinics were still very much in the future in 1975.

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The newest home of the Herzl Family Practice Centre on Legare Street.

In his final annual report (1989-'90) as Chief of the Department of Family Medicine and Director of the Herzl Family Practice Centre, Dr. Klein reflected on his tenure by dividing those fifteen years into what he referred to as a series of five epochs.

Dr. Klein's first epoch was the Behavioural Science period. Established by Herzl psychologist Dr. Yvonne Steinert, Behavioural Science became an important part of Herzl's program and quickly grew to include three full-time psychologists. In fact, Behavioural Science, as it developed at the Herzl Family Practice Centre has been almost unique among family practice institutions in Canada and, is in its genesis, a legacy of the old Herzl Health Centre.

As was mentioned in Chapter Four, the Herzl Health Centre pioneered the concept of a team approach to serving patients and part of the team at the Herzl Health Centre team was a psychologist. When the Herzl Health Centre merged with the Department of Family Medicine's Family Practice Centre in 1974 to create the Herzl Family Practice Centre, the psychologist's position and services were included. The Herzl Health Centre's inclusion of a position for a psychologist at the time of the merger was the financial foundation on which the Behavioural Sciences program was able to develop.

It was during this Behavioural Sciences period that Herzl graduates began to permeate the Côte des Neiges and Snowdon areas as well as other West End and West Island suburbs.

The second epoch was marked by the development of the Division of Geriatrics under the leadership of Dr. Mark Clarfield. The development of the Division of Geriatrics and the broad span of its activities – which has been discussed in earlier chapters – was such that Dr. Klein stated that it had reached the point that serious consideration should be given to upgrading the division's status to that of a department. However, to this day, the Division of Geriatrics continues to be shared by the Departments of Family Medicine, Internal Medicine and Psychiatry.

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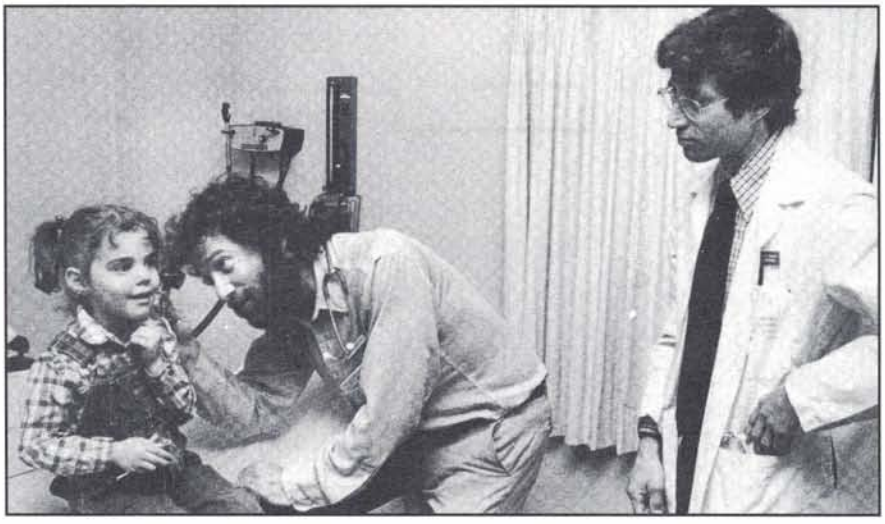
The third epoch centred on maternal and child health care and very positively answered the question of whether obstetrics could be practiced successfully by family physicians in a city and medical atmosphere dominated by specialists. The department's very significant output of research in this area made it a leader in the field of family practice obstetrics in North America and such publications as the Maternity Manual by Dr. Cheryl Levitt have served to maintain that leadership.

The development of the department's substantial activities in obstetrics during Dr. Klein's tenure is somewhat ironic in view of an anecdote related by Dr. Stanley Sinclair. Dr. Sinclair recalled being present when the Executive Committee of the hospital interviewed Dr. Klein as a prospective candidate for director of the Herzl Family Practice Centre. According to Dr. Sinclair, when asked if family doctors should deliver babies, Dr. Klein replied that they have no place in the case room.

The fourth epoch was marked by the growing outreach of the department into the community. This included the development of relationships with the CLSC Côte des Neiges and Point St. Charles Clinic as well as the work done by Dr. Louis T. Montour at Kahnawake. It was during this epoch that Dr. Michael Malus developed the practice of Adolescent Medicine including the provision of both education and services to the Protestant and Jewish school systems.

Dr. Klein's final epoch – which was still current at the time he wrote that report – was dominated by the expansion of the residency program and was characterized by underfunding and shortages of space. On a positive note in this epoch, Dr. Klein called attention to Herzl's Faculty Development program, personified by Dr. Steinert.

The Faculty Development program grew out of Behavioural Sciences and is geared to enabling the McGill Department of Family Medicine's teachers to manage all the various



Spring 1983 – Dr. Henry Neider, a resident, examines Deborah under the supervision of Dr. Michael Malus. Dr. Malus would later develop the Adolescent Outreach Program.

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teaching, academic and clinical responsibilities that they must carry. Similarly, because of the great amounts of stress that doctors often find themselves under, the department has developed a Physicians-Well-Being program and referral service so that doctors can get the assistance that they themselves sometimes need. Since their schedules are usually full, and often overextended, physicians occasionally need to be reminded that they are only human and are subject to encounter physical and psychological stresses related to the profession. Because of the success of this program, the availability of its services has been widened to all doctors within the hospital. The Physicians-Well-Being program and referral service has been recognized and praised as a unique, department-based program.

Dr. Klein also positively pointed to the department's various community involvements personified by Drs. Michael Dworkind and Vanya Jiminez at the CLSC Côte des Neiges and Dr. Perle Feldman at the Point St. Charles Community Clinic.

After stepping down as Chief of the Department of Family Medicine and Director of the Herzl Family Practice Centre, Dr. Klein carried on with his practice and research and became Director of the newly-established McGill/Jewish General Hospital Department of Family Medicine Research Centre in 1991. In 1993, he accepted an appointment in Vancouver, British Columbia, where he has continued to develop academic Family Medicine.

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Family Medicine Research

Chapter 12

One area of substantial activity of the Department of Family Medicine that has only been mentioned peripherally in previous chapters has been that of research, publications and presentations. As noted in Chapter Eleven, in 1975 the Department of Family Medicine did no research, gave few presentations and had almost no publications. In the 1989-'90 academic year, the department's extensive research work was reflected by sixty-four presentations and eighteen publications.

Although it is not possible to provide a comprehensive listing of the Department of Family Medicine's research activities here[24], it is interesting to look back at the growing importance of the department's research as reflected by its publications and presentations. It should be mentioned that many of the presentations by members of the department have taken place outside of the Jewish General Hospital or McGill University. Indeed, many have taken place on a national and international scope.

In 1975, there was but one presentation: Dr. J. Steirman on the treatment of bed sores with granulated sugar. A few years later, the 1979-'80 annual report showed that there had not yet been much of an increase in research activities. There were only three publications and still only one presentation. Clearly, the nineteen-eighties were to be a decade of tremendous growth in the importance of research activities to the department.

By the 1981-'82 academic year there seemed to be an explosion of research activity, presentations and publications. By this time, some patterns in the department's research priorities had already begun to emerge. In a number of presentations and articles, Dr. Klein was focusing on the area of family practice obstetrics which included his leadership in an expansive birth room study. Dr. Mark Clarfield was doing likewise in geriatrics and Dr. Yvonne Steinert

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was concentrating on behavioural sciences as an area of importance to family physicians. All three of these areas became important priorities to the Department of Family Medicine in the following years. It should be remembered that it was about this time that the Division of Geriatrics and the Family Practice Obstetrics Group were formed.

In 1984-'85, the birth room study was published and established the department's national and international preeminence in the area of family practice obstetrics. As well that year, Dr. Michael Malus's research into the needs of adolescents led to the establishment of Herzl's Adolescent Medicine Unit which would come to have growing significance in following years.

Over the course of the decade, the department continued to increase its output of publications and presentations on a wide variety of subjects. For example, the department's 1985-'86 annual report shows that there were more than fifty presentations and more than twenty publications – including several book reviews – that year on such varied subjects as the interrelationships of aerobic fitness with stress and health, preventive medicine in the elderly, and on whether women are more at risk to receive an unnecessary caesarean section when their birth is attended by an obstetrician rather than by a family physician.

Much of the department's research was aimed at improving the services provided to patients and the training provided to family physicians. There were a number of studies over the years looking at how those areas could be further developed and improved.

Some have felt that within the greater Jewish General Hospital community, there has been a tendency, by some, to downplay the research emanating from the Department of Family Medicine because so much of the department's research is ultimately concerned with improving the ongoing practice of medicine rather than with new – or newsworthy – scientific discoveries. However, when this research results in better doctors who are better able serve their patients, and it conclusively has, there can be little dispute as to its long-term value and importance.

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Into the 1990s

Chapter 13

In September of 1990, Dr. Cheryl Levitt assumed the roles of Acting Chief of the department and Acting Director of Herzl. However, any uncertainty about the department's future leadership was ended in the 1991-'92 academic year when she was permanently appointed to those positions.

Dr. Levitt was born and trained in South Africa where she did her internship at Soweto's Baragwanath Hospital at the time of the anti-Apartheid riots in 1976. She subsequently came to Canada for further training in obstetrics in British Columbia and then went into rural practice there for eight years. Dr. Levitt was recruited to Herzl by Dr. Klein in 1984 and she became Residency Coordinator from 1984 until 1990. As various physicians at Herzl were developing programs in areas such as obstetrics, Dr. Levitt was leading the development of the complementary residency training programs. This has included a new curriculum in maternal and infant care for family physicians that is now taught throughout the McGill system.

As well, Dr. Levitt was appointed to the Canadian Institute of Child Health and she has nationally represented the College of Family Physicians on child health issues and on committees dealing with maternal and infant care. At present, Dr. Levitt is heading a task force for the College of Family Physicians on child health.

Dr. Levitt was succeeded as Residency Coordinator by Dr. Ron Wilson from 1990 until 1992 and by Dr. Roland Grad since 1992.

As well, there was a change in the leadership in the Division of Geriatrics in 1991. That July, Dr. Mark Clarfield – who, one year later, emigrated to Israel to practice Geriatric Medicine at the Herzog Ezrath Nashim Hospital in Jerusalem – resigned as division chief to become Chief of the Division of Geriatric Medicine of the

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Department of Medicine at McGill University. Dr. Clarfield was succeeded as Chief of the Division of Geriatrics by Dr. Howard Bergman.

One of the areas constantly being reevaluated by family physicians is their role in the care of their patients admitted to hospital. That role has fluctuated over the years but there is now a growing feeling that patients need the involvement of their primary care physicians while they are being cared for in the hospital. The practice of obstetrics has helped reintroduce family physicians to caring for in-hospital patients. Also helping to reintroduce family physicians to in-hospital care has been the recent development of the Neuro-Family Medicine Ward.

The ward began to develop in 1988 when the Department of Neurology, which had no residents of its own, asked for help in caring for the medical needs of their patients. The Department of Family Medicine began supplying staff physicians for short blocks of time to service to neurology wards. In 1993, the scope of the ward was expanded and it now also cares for all manner of family medicine cases. Family medicine patients on the ward are drawn from the practices of physicians at Herzl and the CLSC Côte des Neiges and residents from Herzl and the CLSC have been integrated into the staffing of the ward. Initially, the Neuro-Family Medicine Ward was under the direction of Dr. Steve Rosenthal. He was succeeded by Dr. Howard Goldstein, a full-time Herzl physician who had been Herzl's Chief Resident in 1990.

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Herzl's Nurses

Chapter 14

Although this book has primarily concentrated on the work of family physicians, it's important to remember that another constant presence at the Herzl Family Practice Centre – and indeed at Herzl's previous incarnations as the Herzl Health Centre and Herzl Dispensary – has been nurses.[25]

In 1974, the nurses at the new Herzl Family Practice Centre were relatively traditional pliers of their trade and functioned primarily as doctors' assistants. At Herzl, their role quickly began to change and develop into something much more. Today, the nurses at Herzl do much of their work on their own with important functions that contribute much to the success of both patient care and the overall operation of Herzl and its teams.

In 1975, the team of nurses at Herzl included Karen Tafler, Pauline Lam-Po-Tang, Rona Levitt and Linda Braha. Interestingly, Karen Tafler and Pauline Lam-Po-Tang are still members of Herzl's nursing staff. Also interestingly, Linda Braha left early on to attend medical school and is now a community family physician affiliated with the Department of Family Medicine.

It was in 1975, when Dr. Michael Klein became Herzl director, that the role of nurses really began to change and expand. The nurses began to receive teaching sessions and, in short order, they began to develop various areas of interest and expertise. For example, Karen Tafler – who was a pediatric nurse before becoming a Herzl team nurse – continued her interest in pediatrics. When Herzl physicians began to practice obstetrics, she became highly involved in prenatal care.

Over the years, the Herzl nurses have continued to expand their skills and areas of expertise through continuing education, attending conferences and, of course, through practical experience. By 1984, the nurses' expertise was

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recognized with appointments as teachers within the McGill Department of Family Medicine. These appointments have allowed the nurses to further develop their skills and expertise through greater participation in such activities as department conferences.

Today, there are six nurses – four full-time and two part-time – on staff at Herzl. In many ways, the nurses act as liaison, providing continuity, between patients and physicians; particularly on behalf of residents who are frequently occupied elsewhere in the hospital.

The nurses share in patient care with the physicians and are active in areas such as patient counselling, physical examinations and assessments. Frequently, for example, after seeing a physician for something, the patient's follow-up work will be handled by the team nurse. The nurses will also fill gaps by seeing a patient when their physician is not available. In such circumstances, the nurses will receive backup from other physicians who may be available at the time.

As teachers, the nurses are involved in giving lectures, in orienting residents on how to work in the Herzl environment, in demonstrating such techniques as giving vaccinations and giving prenatal examinations and well-child checkups.

The nurses at Herzl have come to feel that they work in a friendly family-type situation. According to long time nurse Karen Tafler, *"there must be something great about Herzl because we don't leave."* Indeed, it has already been noted that nurses Karen Tafler and Pauline Lam-Po-Tang have been at Herzl since 1975. All of the other members of the nursing staff – Barbara Johnson, Elizabeth Schwartz, June Smith and Gail Steele – also have long records of service. According to Karen Tafler, another reason for the longevity of service of all the Herzl nurses is that *"Herzl is a tremendous environment for learning. We're always learning."*

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The Community Family Physicians

Chapter 15

In looking at the evolution of the Department of Family Medicine, we need to remember that the vast majority of the doctors who make up the department's membership are not geographical full time physicians at the Herzl Family Practice Centre. In fact, they are community-based family physicians whose offices are spread across the Montreal region from Anjou to the West Island and in off-the-island-of-Montreal communities such as Kahnawake.

In addition to treating patients in their offices, many of the community-based family also do primary care for their patients in the hospital and in other community facilities such as the Jewish Hospital of Hope, the Mount Sinai Hospital, the Julius Richardson Convalescent Hospital, the Jewish Rehabilitation and the Maimonides Geriatric Hospital. The fact that these department members are involved with other institutions – in some cases as directors general – has helped to integrate services within the community into a much more efficient system than it might otherwise be.

Perhaps surprisingly, given the popular image of doctors in this day and age, there are many community-based family physicians who still make house calls. Many also act as health care providers to senior citizens' residences, foster homes and other institutions such as drug rehabilitation centres.

Many of the community-based physicians in the Department of Family Medicine are also involved in the part-time teaching of Herzl Family Practice Centre residents and McGill medical students. In fact, the program relies on the important contributions that these physicians make.

Through development and participation in the department's continuing medical education program, community-based family physicians are able to keep well informed about new developments in the profession and maintain ongoing professional contact with their colleagues.

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It should be noted that all members of the Department of Family Medicine – both Herzl-based and community-based – are guided by the Principles of Family Medicine that have been defined by the College of Family Physicians of Canada (CFPC). These principles include:

1) THE DOCTOR-PATIENT RELATIONSHIP IS CENTRAL TO THE ROLE OF THE FAMILY PHYSICIAN. This principle incorporates the concepts of continuity of care, including caring for a patient the context of the family and society, and also the role of the family physician as patient advocate. The continuous relationship with a patient gives the family physician access to insights not otherwise available, and the opportunity to follow and study disease processes over long periods of time.[26]

2) THE FAMILY PHYSICIAN IS AN EFFECTIVE CLINICIAN. The family physician must possess good clinical skills. A wide range of clinical problems presents in the family practice setting. The family physician must possess the general knowledge and skills necessary to deal with these problems. These aspects of family medicine have major implications for the nature of the postgraduate family medicine residency programs. The college believes unequivocally that experience in family medicine must for the basis for any CFPC accredited residency program, and the involvement of medical colleagues in other disciplines and of other health professionals must always be guided by the goals and principles of family medicine.[27]

3) FAMILY MEDICINE IS COMMUNITY BASED. The context in which patients are seen may include office, hospital or other health care facility, and home. In addition to acute and life-threatening disease, there is a high prevalence of chronic illness, emotional problems and transient disorders. Patient care is significantly influenced by community factors. Clinical problems presenting in primary care are not pre-selected and are commonly encountered at an undifferentiated stage. The family physician must be prepared to deal with any problem a patient presents.[28]

4) THE FAMILY PHYSICIAN IS A RESOURCE TO A DEFINED PRACTICE POPULATION. The family physician must be able to apply knowledge and skills efficiently, including the ability to evaluate new knowledge and its relevance for practice in the community. An awareness of one's own limitations, and a knowledge of and a willingness to draw upon community resources such as consultants, allied health professionals and other agencies, are also important.[29]

Many physicians involved in the Department of Family Medicine have remarked how similar these principles, as defined by the CFPC, are to the policies that have guided the Department since its founding as the Department of General Practice in 1966 and to the standards set out by its early leaders such as Drs. Milton Snarch and Isaac Tannenbaum.

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Epilogue

The journey from the founding of the Herzl Dispensary in 1912 in an old house on St. Dominique Street to the present spans more than eighty years. As detailed in earlier chapters, Herzl's history has spanned the twentieth century and the institution has changed and adapted to meet the needs of its clients. These changes have taken Herzl from its years as a dispensary through its incarnation as a community health centre to its present status as a family practice centre that is part of family medicine department in a large university hospital. The range of its activities, services and clientele at the end of the century would astound those visionaries who recognized the need for a dispensary in the century's early years.

Similarly, the history of the Jewish General Hospital – now known as the Sir Mortimer B. Davis Jewish General Hospital – has spanned about sixty years since opening in 1934. It's interesting to look back and remember that it was in the Herzl Dispensary's annual report for 1919 that the idea of building a Jewish General Hospital was first put forward to the community and that it was doctors at the Herzl Dispensary in the nineteen-twenties whose lobbying efforts helped rally the community to actually build the hospital.

In attempting to briefly tell the interrelated stories of Herzl and the Jewish General Hospital, of the role of general practitioners over the years in the hospital, of the founding of the hospital's Department of General Practice and its evolution into the Department of Family Medicine, a very few names have been mentioned. However, the names of the vast majority of the many people whose contributions are integral to these stories are, regrettably, not mentioned. These men and women include doctors, nurses, technicians, administrators, support staff, volunteers, community leaders, financial contributors and patients. Their importance to these stories cannot be overestimated.

Clearly, the Department of Family Medicine of the Sir Mortimer B. Davis Jewish General Hospital and its Herzl Family Practice Centre have a proud and often distinguished history. Considering that history together with the dedication and expertise of those now involved in the department, one can safely assume that much will be added to that history in the years to come.

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Memorabilia

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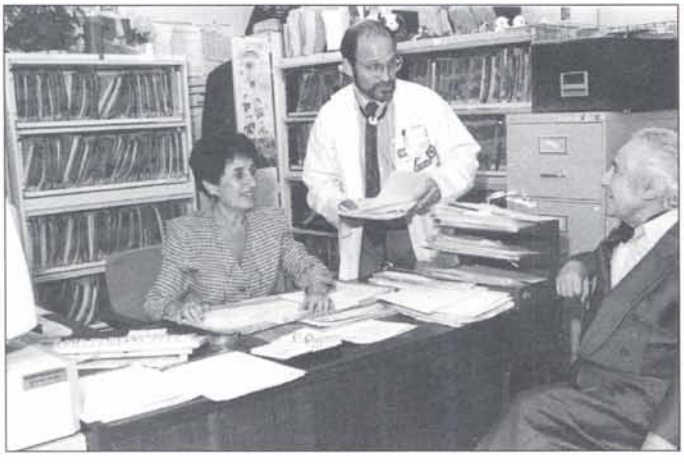

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Michael Regenstreif
Montreal
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25 The author is indebted to Karen Tafler for her assistance in the preparation of this chapter.

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