

Lu Hill

MINUTES of meeting of the Council of the Australian Cancer Society held at 412 Albert Street, Melbourne, on Friday, 22nd April, 1971.

PRESENT:

The President, Dr. C. Craig (in the Chair)
N.S.W.

- Dr. K.W. Starr } Vice Sir J. Goodsell,
The Hon. J.A. Weir } The Hon. R.R. Downing and
Dr. H. Selle

Victoria

- Sir William Kilpatrick
Mr. W.A. Dick
Dr. D.M. Metcalf

West Australia

- Dr. R.A. Barter
Mr. J.J. Devereux

South Australia

- Dr. B.S. Hanson
Mr. T.R. Brown

Queensland

- Dr. K.S. Mowatt
Mr. A.G. McDonald

Tasmania

- Mr. L.J. Baillie (in addition to Dr. Craig)

Mr. W.R. Hudder, from Queensland, was also present as an observer.

APOLOGIES:

Apologies were received from Sir John Goodsell, The Hon. R.R. Downing and Dr. H. Selle, and a welcome extended to Dr. Starr and The Hon. J.A. Weir.

MINUTES:

The minutes of the previous meeting of Council held in Sydney on 16th October, 1970, having been circulated to all members, were taken as read and confirmed, subject to the following amendments:-

(1) (By Dr. Hanson) ... That, under the heading of "Chairman of Committees" on page 4, the following be substituted, viz.

- "Some discussion ensued on the policy with respect to the election of chairman and the tenure of office when elected. It was resolved
- (a) that the chairman of a committee should be elected annually;
- (b) that a chairman could be reappointed annually by his committee until he has served three successive terms;
- (c) that after a chairman has been in office for three successive years, he may be elected for a fourth or later succeeding year, only with the approval of Council."

This notification of the Minutes was accepted by those present at that meeting. However, it was foreshadowed by Dr. Mowatt that he would move in a contrary direction at the next meeting - on the basis that each Chairman of Committee should be appointed for a substantive period of three years.

(2) (By Dr. Gray) - relative to page 2, line 29 of the Minutes, with the deletion of the words "determine ways and means for supplementing" and insert in lieu thereof the word "implement". This modification was also carried by those present at the previous meeting.

International Cancer Conference, 1972.

International Cancer Conference in Sydney, 1972, was reported on exclusively by the Medical Adviser. The resignation of the Executive Secretary was discussed and accepted, and the appointment of Mr. Peter Schrader noted. Dr. Hanson raised the issue of the title of the leader of the Conference from Australia, and suggested that the President of the International Union Against Cancer would properly be President of the Conference since this was an International Union Meeting.

William Kilpatrick affirmed that these aspects of organisation were discussed with the UICC, and it was advised that the organisation and direction of the Meeting would be entirely from the host country. Sir William agreed with Craig that he regarded himself as President of the Organising Committee, and it was agreed that a Committee comprising Dr. Craig, Sir William Kilpatrick and Dr. Hanson consider these matters of protocol in relation to the International Union and decide accordingly.

Constitution Amendment.

The constitutional amendment of which notice of motion had been given at the October 1970 meeting viz: Rule 22 paragraph (b) be amended to read as follows:-

"(b) All other moneys and funds of the Society shall be deposited to the credit of the Society with its bankers. Cheques may be drawn on the Society's account on the signatures of the Secretary and one member of the Executive Committee OR ANY REPRESENTATIVE APPOINTED UNDER RULE 6(a) OF THE MEMBER ORGANISATION WHICH IS PROVIDING THE SOCIETY'S SECRETARIAL SERVICES. Cheques made payable to the Society may be negotiated on the signature of the Secretary."

Note: Suggested amendment is typed in block letters.

The motion was carried.

CORRESPONDENCE.

Chairman, Cancer Education Committee.

A letter of resignation by Mr. W.A. Dick from the position of Chairman of the Education Committee was discussed. Mr. Dick was supporting Council policies that the Chairman not hold his position in perpetuity and further he had been concerned that the lay vice-presidential appointment from Victoria at the last meeting had not indicated any appreciation by Council of his work in initiating the Australian Cancer Society as far back as 1956. Mr. Dick did not wish any hiatus to occur with the Education Committee and was prepared to accept re-appointment as Council Appointee, but not as Victorian representative. The appointment of Mr. Dick as Chairman of the Education Committee was carried unanimously by Council. It was accepted that Mr. David Hill be the Victorian representative on that committee.

Dr. F.G. Smyth, Department of Public Health, Territory of Papua/New Guinea.

A letter from Dr. F.G. Smyth in relation to the formation of a cancer society of Papua/New Guinea was raised and the difficulties of such a society discussed. It was believed important to study the extent of the need in the Territory before pushing this further and it was left to the Medical Adviser to explore this and report to the next meeting.

American Cancer Society.

A letter was received from the American Cancer Society seeking official invitations to members of the American Cancer Society to attend the Conference. The Council were advised of the warm assistance previously given to members of the Australian Cancer Society by their fellows in the American Cancer Society. The Council was happy to agree with such official invitations being issued.

COMMITTEES REPORTS.

National & Scientific Committee.

The Chairman of the Committee reported on the excellent success of the 1st Leukaemia Study which had almost drawn to a close, and of the outstanding work of the 2nd Leukaemia Study, which included New Zealand, and which was having a beneficial effect on the treatment of Leukaemia throughout the country.

The work of the Soft Tissue Tumour Registry was commended, particularly its effect on improving the standard of pathological opinion throughout the country, and it was clear that this study would need to continue for at least 5 years.

The Committee had been greatly heartened in its scientific meetings by the rapid growth of two clinical groups, a Head & Neck Oncological Group and a Breast Cancer Group which were levying fees to conduct their meetings in association with the Australian Cancer Society. These bodies wished to continue their association with the A.C.S. and under its aegis, and Council accepted the recommendation that all activities of these groups be energetically encouraged, and that they might be permitted to continue in association with the A.C.S. to use the Society's letterhead. It was agreed that the activities of the groups be reviewed formally by Council after one or two years. Brief reports were made on the standing agenda items of carcinogenic substances, cancer detection, cancer registration, the Cancer Research Register, professional education and applications for further studies.

Cancer Education Committee.

The Chairman reported on Dr. Barter's study to carry cervical cytology effectively to lower socio-economic groups, and to follow up young females with squamous dysplasia.

Council accepted the recommendation that the matter of the studies of motivation to cigarette smoking in juveniles be pursued under the auspices of the National Health & Medical Research Council.

The Committee's recommendations on a seminar program were discussed, and the recommendations to Council were accepted that a cancer education seminar be held in 1972 supported by the Australian Cancer Society, and that, if practicable, this be held in Queensland, organized by the Queensland Cancer Fund, on educational problems associated with skin cancer. Council voted a grant of \$2,000 in 1971 in 2 components, one of \$500 as a grant in aid to Queensland to cover the costs of the Conference if it were decided to be held, and \$1,500 to be set aside for the costs of an overseas speaker if it were decided that one should be invited. Council would consider this further at the October meeting in the light of a concrete proposition. Council accepted the recommendation that Dr. John Kristen, Director of Health Education in the Department of Health in N.S.W. be co-opted on to the Education Committee.

The position of retention of a Cancer Education Consultant was discussed at length and it was agreed that such a role did not fit the Society's purposes at this time. Dr. Alan Maclaine subsequently resigned this position. Council unanimously moved to invite Dr. Maclaine to join the Cancer Education Committee, and he is to consider this.

Cancer Service Committee.

The Acting Chairman reported on considerable discussion on nursing home care and home nursing care for terminal cancer patients, and the proposition for an ad hoc committee comprising Drs. Selle and Mrs. Esson was accepted; the committee was empowered by Council, with the support of the President, to approach the Minister for Health on these matters, and to prepare a report for use by each of the member organisations with their own Health Ministers prior to the June meeting of State Health Ministers.

approach to pursue the matter of repatriation benefits for ex-servicemen suffering from lung cancer, an ad hoc committee was authorised to approach the Minister for Repatriation, and also to enlist the co-operation of an officer of the Returned Servicemen's League. This committee comprises H.S. Hanson and Mr. L. Baillie.

Approaches to the Life Offices' Association were noted and Council supported the pursuit of the principle of involving health insurance companies in schemes of cancer detection and prevention.

COMMITTEE ON SMOKING AND HEALTH.

The Sub-Committee on Smoking and Health reported on a letter sent to the Minister and to the Minister for Health, and on the current activities of the Anti-Cancer Council of Victoria in buying television time for anti-smoking advertising. Various approaches to members of Parliament were discussed and it was accepted that all Parliamentarians be approached to seek their opinion on television advertising. The submission to be prepared by the Sub-committee of the A.C.S. is also to be distributed to all member organisations, and it was requested that member organizations visit their State Parliamentarians particularly to pursue matters which fell under State responsibility. It was agreed that all political parties be approached and all members of the Cabinet. The point was made that all were being asked to state their attitude to the problem, not being called on to support a particular line at this time. That is, a submission paper was submitted and they were asked to state their relationship to that position. Dr. Gray is producing a submission similar to the "Smoking and Health Review" produced for the Anti-Cancer Council of Victoria and this will be distributed to all States for them to use as they see fit. It was further agreed that all Royal Colleges should also be informed of the attitude of the A.C.S. on these matters, and similarly the National Health & Medical Research Council.

A letter from the Australian Council on Smoking & Health was received and the reply to the President should note that submissions are already in hand to the Prime Minister, largely on economic matters. It was agreed that the submissions to the Prime Minister and the Minister for Health are to be sent to the Australian Council on Smoking & Health to ensure that there be no conflict in the propositions from the separate bodies.

AUDITORS.

The auditors, Arthur Anderson & Co., who have previously audited the accounts of the Australian Cancer Society when in Melbourne, were appointed as auditors to the A.C.S. in its new location at a fee to be mutually agreed upon.

ACCOUNTS AND BUDGET for 1971-72.

Payments made in accordance with schedule of cheques from No. 3201 to 3270 incl. were confirmed by Council.

The budget of estimated income and expenditure for 1971-72 was approved, with deletion of the fee to the Educational Consultant.

The question of provision by the States of funds for the International Cancer Conference was raised and the opinion of member organisations sought in relation to the retention of any residual sum after the Conference was over. A position was suggested of guaranteeing funds for the Conference rather than committing them at this time. Sir William Kilpatrick was asked to write to Sir Roderick Chamberlain to put forward a written request for funds from South Australia.

REVIEW OF AIMS AND ACTIVITIES.

Mr. Dick raised the matter of the style of function of the A.C.S. noting that it worked ordinarily as an ad hoc body and without a clearly defined set of short-term and long-term objectives. He suggested a small working group to review where the Society was going and to prepare a paper before the next meeting. A sub-committee was devised comprising Mr. Dick as Convenor with Dr. Metcalf, Dr. Gray and Prof. Cox, with the expectation of a series of working papers being presented before the next meeting.

MEMBERSHIP OF COMMITTEES.

McDonald raised the matter of membership of committees by Council members, and this will be pursued individually with Council members.

DATE OF NEXT MEETING.

Dates of the next meetings of Council and the several committees of A.C.S. are set down for 13th, 14th and 15th October, 1971.

Confirmed.

_____ President

_____ Date

MINUTES of Cancer Education Committee meeting
held at Melbourne on Thursday, 22nd April,
1970.

PRESENT:

- | | |
|---------------------------|----------------------|
| Chairman | - Mr. W.A. Dick |
| Medical Adviser
A.C.S. | - Professor K. Cox |
| Education Consultant | - Dr. A.G. Maclaine |
| Members | - Mr. T.R. Brown |
| | - Mr. J. Holliday |
| | - Mr. J.T. Carr |
| | - Dr. A.B. Lilley |
| | - Mr. W.L. Rudder |
| | - Dr. R.A. Barter |
| | - Dr. C. Craig |
| | - Mr. D. Hill (Vic.) |

APOLOGIES:

Apology received from Dr. A.B. Lilley, who could not attend owing to medical reasons.

BUSINESS ARISING FROM MINUTES:

(a) Cancer Detection Examinations.

Dr. Barter tabled a report for the perusal of members (dealing specifically with cervical smear tests) and emphasized the main problems associated with the public examination of women, with particular reference to women in the 15-20 years age group. In effect, the group most affected was in turn the hardest group with which to communicate. There were also distinct problems in accurately identifying this group.

It was generally felt that little could be done by way of mass screenings in this field, and perhaps the best method of dealing with the problem was at the level of General Practitioners, and in public hospitals and clinics which were already set up to carry out smear tests on women.

It was noted that Dr. Barter's report would be referred to the Medical & Scientific Committee meeting later in the day.

(b) Overseas Experts.

Dr. Maclaine intimated he could suggest one or two prominent names and this would be covered in his later submission to the Committee.

(c) Workshop Activities (or Seminars)

Considerable discussion took place following the submission of a paper by the Chairman on the subject of cancer seminars. Mr. Dick posed the question as to whether cancer seminars were the appropriate vehicle for developing new understandings and increasing the educational skills of those responsible for cancer education.

The feasibility of conducting seminars and the economics of the proposal were also discussed. The need for an inter-disciplinary audience was stressed. Two main avenues were open to achieve this objective 1) to bring different disciplines together on a seminar dealing with specific types of cancer, and 2) to focus on education approaches, human behaviour and attitude change as they affect cancer education.

The paper recommended that the Australian Cancer Society should work with its member organisations in arranging a program of seminars designed to achieve the most effective pay-back in each of the State programs. It recommended also that an approach be made to A.N.Z.A.S. with the aim of organizing a symposium on a subject dealing with behaviour and attitude change as they affect cancer education and control.

Following the offer of Mr. Rudder on behalf of the Anti-Cancer Council of the Queensland Cancer Fund, it was resolved to recommend to Council that a Cancer Education Seminar be held in 1972 - to be supported by the Australian Cancer Society; and that if practicable it be held in Queensland and organised by the Queensland Health Education Council, with the main theme being Educational Problems Associated with Skin Cancer.

As a further element to this proposal, it was also resolved that Council be requested to provide a grant up to \$2,000 in the 1971-72 budget to support Queensland in the financial requirements of such a seminar - in particular \$500 as a grant-in-aid and \$1,500 for the purpose of inviting an international expert to the seminar.

REPORT OF EDUCATION CONSULTANT

A report was tabled by Dr. Maclaine which covered his reactions following visits overseas last year and discussions with a number of overseas experts in Europe, Canada and U.S.A. Dr. Maclaine commented on matters referred to in his report.

Arising from his comments on the survey undertaken by the National Health and Medical Research Council, it was decided to recommend to Council that the Commonwealth Government be urged to complete the survey by researching the reasons why children smoke.

REPORTS FROM MEMBER/ORGANISATIONS

Written reports were tendered in respect of education programmes now proceeding in the various States except Victoria. A verbal report was made covering highlights of Victorian activities. Copies of all reports were distributed for perusal by members.

BUDGET PROPOSAL FOR 1971-72.

Concerning budget proposals for 1971-72, it was agreed that Council be asked to set aside an amount of \$2,000 for Dr. Maclaine and his additional administrative expenses. A second item of \$2,000 would be necessary to give effect to the proposal for assisting the Queensland Cancer Fund to stage the Seminar already referred to.

ADDITIONAL MEMBERS OF COMMITTEE.

It was noted that in future Mr. D. Hill, of the Public Education Sub-Committee of the Anti-Cancer Council of Victoria, would represent that State on the Cancer Education Committee, vice Mr. W.A. Dick, who would continue as Chairman. A welcome was extended to Mr. Hill.

It was agreed to recommend to Council that Dr. S.J. Krister, Director of Health Education, N.S.W. Department of Health, be invited to join the Cancer Education Committee as a co-opted member.

EDUCATION CONSULTANT

Following discussion on the future engagement of Dr. Maclaine, it was agreed to recommend to Council that his appointment as Education Consultant be renewed for a further period of twelve months at the existing remuneration.

RESOLUTION OF CHAIRMAN

Discussing the appointment of a new chairman, it was noted that only Mr. Brown was constitutionally able to accept appointment. Mr. Brown indicated for health reasons, he would be unable to accept the appointment. Under circumstances Mr. Dick agreed to carry on until a suitable appointment was made.

Confirmed.

_____ (Chairman).

_____ (Date).

DISCUSSION PAPER ON CANCER SEMINARS

PREPARED FOR MEETING OF CANCER EDUCATION COMMITTEE
OF AUSTRALIAN CANCER SOCIETY - 22/4/71

WHAT PART SHOULD CANCER SEMINARS PLAY IN CANCER EDUCATION
IN AUSTRALIA?

Can they help to fill any gaps in present approaches and
if so, are they the most effective vehicle for so doing?

Would they foster the future development of cancer
education in Australia? If so, would the benefits out-
weigh the costs of organising seminars? The benefits
relate to:

- # Developing new understanding
- # Increasing educational skills
- # Increasing educational resources
- # Removing environmental barriers to educational effectiveness

Need to consider both the feasibility and economics of
cancer seminars as well as the scope.

Cancer education in Australia is conducted by each State
own organisation as well as by a limited number of organisations
available for community health.

To this extent the effort is diffused and therefore there
is a need for interchange of viewpoints and experience as well
as the lifting skills of those engaged in cancer education to the
highest possible common denominator. The number of people so
engaged directly in cancer education in a population the size of
Australia's is very small.

The degree of development of education programs in the several
States differs widely and thus the potential scope for effective
cancer seminars differs both in direction and degree.

Some States' organisations have well-developed programs even
to world standards. The scope for cancer seminars in these
situations lies in two areas:

1. To re-think future direction and emphasis in cancer
education programs to achieve medical and social
objectives.
2. To re-kindle interest in cancer education so as to
extricate it from routine and save it from mediocrity.

In those States where programs have not been running for
long the scope for seminars is more practically oriented:

1. To develop ideas for programs from the experience
of others.

2. To build resources for carrying out programs.
3. To gain support for cancer education within the medical profession, para-medical workers and the community at large.

It is fair to draw the conclusion that there is scope for using seminars as a vehicle for rendering State programs more effective but that there are different needs according to the level of development of current programs. If this is a sound conclusion, the pattern for development of seminar programs should be at the State level sponsored by the Australian Cancer Society. In this way the objectives of seminars can be better planned and closely oriented to the requirements in each State. Obviously there is scope for inter-state participation. But there does not appear to be any Australian requirement, partly because there are no Australian education programs and partly because there is no homogeneous Australian problem in cancer education.

FEASIBILITY

Whether or not a successful seminar can be run will depend on a variety of factors, but three are critical:

1. Having a self-supporting theme which is capable of commanding papers of calibre and sufficient of them to fill out the program.
2. Having a theme, venue, speakers and papers of sufficient appeal to get the target audience.
3. Having a capable and committed organising group able to plan, gain support and implement the program.

If the first two of these requirements are to be met, it seems that cancer seminars in Australia, because of the small population, would need to be inter-disciplinary. If this is so, the choice of a theme will be rendered more difficult if it is to be marketable in any of our capital cities.

CONCLUSIONS

It would be ideal if a seminar could be made self-supporting from an expense viewpoint. With cancer education, however, the potential audience is rather small and this could throw a cost burden on to the State cancer organisation in the form of organising time and straight out cash disbursements. If the benefits can be seen to be real and advantageous, it can be expected that State organisations would be willing to make the outlay.

It is likely that interstate and/or overseas papers will be needed to provide the required pulling power. This would increase the extent of outlays. Whether or not it would be desirable to make a charge for attendance would need to be carefully considered.

One possibility of enlarging the potential audience and making the seminar self-sustaining from a cost viewpoint would be to interest ANZAS in incorporating a cancer symposium into its annual conference. This would be getting away from the State oriented seminars but might prove a possibility for a well-chosen subject.

SEMINAR TOPICS

Inter-disciplinary seminars would fall into two distinct

1. Those associated with specific types of cancer such as -

- Cancer of the breast
- Cancer of the uterus
- Lung cancer
- Skin cancer

In these cases, the medical profession, para-medical workers, social workers, psychologists, media, health educationists and other groups would form the potential target audience as well as contributors.

2. Those associated with community education focussed on school children, students at secondary and tertiary level, adults involved in education, the community at large and others. Relevant subject matter in this area would be -,

- Human behaviour and attitudes related to individual and community health
- Barriers to health education effectiveness
- Requirements for effective cancer education
- The problem of attitude change in health education

- The psychological inter-action of education, attitudes and behaviour in public education on cancer

- What part should cancer education play in health education.

Whatever topic is chosen from each of these areas, it would be highly desirable that perspective is achieved in the organisation of the seminar program so as to cover:

The existing state of the art embracing current practice and research into results and effectiveness

Current problems

Future opportunities.

Further, it is desirable that careful attention should be paid to the seminar theme and topics with the object of eventual publication or dissemination to interested bodies and people. The aim in so doing would be fourfold:

1. To gain the maximum impact to foster the effectiveness of cancer education in Australia.
2. To publicise the activities of State cancer bodies.
3. To enhance the influence of the Australian Cancer Society.
4. To influence government and other authorities.

CONVENTION

Firstly, The Australian Cancer Society should work with its other organisations in arranging a program of seminars designed to achieve the most effective pay-back in each of the State systems. The seminars should be organised firstly around specific areas of cancer to provide the greatest interplay between the various disciplines involved. Concentrated and skilled attention is needed in planning the theme, topics, organisation and participation. Nothing should be sacrificed for quality of papers and contributors including if necessary invitations to overseas and interstate people. A pilot seminar is desirable and should be considered by the Australian Cancer Society.

Secondly, the Australian Cancer Society should consider making an approach to ANZAS with the aim of organising a symposium on a subject related to the second category of educational subjects - behaviour and attitudes in education.

AUSTRALIAN CANCER SOCIETY

EDUCATION OFFICERS' WORKSHOP

SYDNEY, 16TH APRIL 1969.

TOPIC: INVOLVING KEY GROUPS IN CANCER EDUCATION

TRANSCRIPT OF PROCEEDINGS

PRESENT: DR. A.G. MACLAINE (Chairman)
DR. K.R. COX
MR. D. HILL (V.)
DR. D.W. RANKIN (V)
DR. NIGEL GRAY (V)
MR. R.N. STEVENSON (N.Z.)
DR. S.J. KRISTER (N.S.W.)
MR. J. BURKE (N.S.W.)
MRS. J. DAVIES (W.A.)
MR. J. CARR (W.A.)
DR. D. HOLDEN (Tas.)
MR. J. HOLLIDAY (Q)
MR. W. RUDDER (Q)
DR. V.G. SPRINGETT (S.A.)
MR. T.R. BROWN (S.A.)
MR. T.R. OSBORN (S.A.)

DR. A.B. LILLEY (N.S.W.)

Guest speakers: DR. A.W. CLARK
DR. MALCOLM COPPLESON
MR. P.F. LAZAR

AUSTRALIAN CANCER SOCIETY
EDUCATION OFFICERS' WORKSHOP

Held at the Conference Room, 13th Floor, State
Office Block, Bent and Phillip Streets, Sydney,
on Wednesday, 16th April, 1969.

Topic: Involving Key Groups in Cancer Education.

ATTITUDE AND BEHAVIOUR CHANGE

Speaker and Discussion Leader: Dr. A.W. Clark, Senior
Lecturer in Social Psychology, University of
New South Wales.

(Note: Copies of two papers, "Attitudes and Attitude
Change" and "The Relationship between Attitudes and
Behaviour", were distributed by Dr. Clark to those
attending the Workshop. Unless otherwise stated,
references in the following remarks are to the longer
of the two papers, "Attitudes and Attitude Change".)

DR. CLARK: If in some way you can divide your attention between
what is in the paper headed "Attitudes and Attitude Change"
and what I am going to say, it will help, as there will be
a relationship between the two.

I start by saying that I do not know what your
jobs are and all I can hope to do is give some broad points
from my background as a Social Psychologist which may be
different from the way you have been looking at the world
and from them hope that here and there something jells and
you say "That may be useful to me" or something falls into
place that was previously fragmented. In no way can I
interfere directly with your jobs, nor would I want to.
All I can do is throw out these points and see what happens.
Please pull me up at any point if you want clarification or
to explore something further. I have constructed the material
to a considerable extent so that if we do not finish or if
you want to take things further yourselves, there are refer-
ences at the end and there is a framework from which you can
move on independently of me.

In the Introduction I try to give you an idea of
my thinking about attitudes and the theories that seem to
be most useful and helpful. I make a very strong plea that
the various elements of the theory are looked at, so that
you can proceed into a diagnostic step with some sort of
guidance.

I am not going to buy into ethics. When I said
I was coming here, someone said, "Why shouldn't people die
happily in their own way?"; my reply was, "That is their
concern and they can work out whether they are going to try
and change people against their wishes, or not". The point
is that if you have not a reasonably explicit theoretical
position that leads you into diagnosis, then although your
attempts at changing attitudes may work, there will be
no feed back into something more explicit on which to base
further information. There will be no correction mechanism
in the system and whilst you have people adept at changing
people's attitudes, it will be simply an art some people
can master and others cannot.

The whole business of Social Science is making
these things explicit, to get an idea of where we are going
in correcting the habit paths.

The first point is that attitudes are embedded in systems at a personality level. The whole person is involved in an attitude, not just a piece of him. Furthermore, to my mind the person does not exist in a vacuum and because the person is embedded in a system, the attitude itself is enveloped in a developing system; the system goes down into personality and thus the attitude is a part of personality. It follows that if a system is defined as having a number of interdependent parts, trying to change one without looking at the characteristics of the system is fruitless.

I am not saying you have to understand the system completely, because sometimes the lucky move sets it going and by a fluke the system changes, but that is a long way from an appreciation of the system properties and an attack that has some rationale.

I will look at some of the successful attempts at attitude change reported in the literature.

Part I deals with THEORY. As the definition says, attitudes are something quite regular. If a person expresses a view once and you ask him the same thing the next day and he has shifted ground and if, on the third day, he has shifted ground again, then you can hardly take any one as an instance of an enduring attitude. The point I am making is that attitudes are caught up with the person's thoughts, feelings and actions. The proportions of these can vary but to my mind it is a very broad concept. Some people, of course, view attitudes as a narrow, peripheral part of the person, but I do not buy that argument. It seems to me that if you can specify a person's attitude to politics, religion, other people and himself, you have a leverage towards understanding a person's complete personality. If that is so, I cannot agree that an attitude is a small, superficial part of a person: I think it is a very central part.

There are something like 79 definitions of personality. When you bring them altogether, you find they are something very similar to what I am saying about attitudes, with the additional point that it pre-disposes action. You may have read Macdougall; this is what he was saying. It went out of fashion for a time, but it still has something to do with how people behave. If you set out to change a person's attitude, it is not a peripheral part of a person, but a central aspect. This would hold more particularly if you are talking about matters of health.

The examples I have given are the very important ones of political attitudes, democracy, religion, other national and ethnic groups, unions, authority, friendship, love and self. Some people link in attitudes to alcohol, oysters, etc., but I do not think they will worry us all that much. The more central attitudes are what we are concerned with.

In passing, I say one thing. One of the dangers in attitude work is that we assume that people hold an attitude to a particular issue. I think that a lot of the interviewing that is done gets a blank to start with and then prompts a person to express some attitude. This is usually done because of time and economy and unskilled staff, but it is a great trap in contrast with a free flowing interview that maps out a person's attitudes in terms of the permanence, strength, etc. My preference is for the heavier, in-depth type study rather than the 75 questions.

I think it is nonsense to say that what is needed is a representative sample. I will not go into that, but what I am making a plea for is some understanding of the mnemonics of association within which a person operates.

Turning now to the formal characteristics - COMPONENTS - the first is Cognitive, the rational thinking type attitude. For an example, take the attitude to the Vietnamese war: you have a person start by talking about costs and the budget and give an historical analysis of the current outbreak of aggression or the necessity for aggression, and this type of thing, and with all this you are getting the cognitive type rational component of the attitude.

These are important. I am not downgrading them because our society rests on rationality, substantially, but we do place a lot of stress on giving a rational account for our views or actions.

The second component is the Emotional element; it gains a lot of support from the psychoanalytic positions and people who believe in the unconscious. No doubt attitudes have a very strong emotional connotation and I think the area you people are working in is a beautiful example of this. When you start facing up to the prospect of having cancer, there are emotional forces involved in whether you can do so. Any analysis of the situation that leaves this out would be completely misleading

The third component is the Action element. Not only do you think about something and feel about it, but there is some pressure to act. You have all faced the proposition when you have sat in a situation face to face with someone who has crossed one of your little lifelines and you immediately feel that press to act, in this case to say something, and you inhibit it or not according to the circumstances.

People who are separated in their thoughts, feelings and actions, who think that these are three entirely separate pieces of themselves, of course are mad. That is perhaps a rash statement, but you see the feeling I am trying to get at. It is that somehow people are units: they are better or worse integrated, but the three go together, and if a person is constantly acting differently to the way he is thinking, it produces a kind of dissonance. There is a lot of jargon for it in the clinical world. "Schizophrenia" in the old term is a split personality; it is a split in the sense that there is a feeling that does not go with the thought or with the actions.

This is captured in the diagrams on page 2. No. 1 shows the formal components and No. 2 shows the relationship to the other things - the core of humanitarianism enables one to predict other attitudes. The simple point here is that attitudes do not occur in isolation; they are embedded in the personality and they are related to other sets or clusters of attitudes. Diagram No. 3 runs on from that: the person himself is embedded in a social context. He is in three main groupings - work, family and associations. Unless one adopts and understands the forces generated in those settings, then one will not understand the shape and dynamics of the attitudes he holds.

My next point (page 3 - FUNCTIONAL) tries to link what I have been saying to my belief that attitudes perform functions. I have always been shaky about the functional theory because there is no contrary instance and yet somehow I feel that functionalism makes sense. I think therefore that attitudes are not held fortuitously; they perform functions in people and in groups. These are listed under four headings on page 3.

1. Instrumental. If a person begins to train as a doctor and at that point of time comes from a radical type family that is all for the nationalisation of medicine, one can watch him during training gradually shift to the opposite view. Perhaps this strikes somewhat at your experience. It is not instrumental in a group of medicos to defend nationalisation of medicine. Therefore it is functional for the person in terms of his group relations and career and the rest of it to shift his attitude. Put bluntly, it sounds like the animal that changes its colour according to its setting, but it is not as blatant as that. I now defend the universities but as a student I led revolt after unsuccessful revolt: I have been so many years in academic life, that they have got me, and I can drum up reasons for being conservative? The point I am trying to bring out is that we hold attitudes for instrumental reasons. That is one function.

2. Ego-defensive, is another. We build up a self image. Our attitude towards ourselves is a very central attitude. The other day I used some research funds to publish a study I had done earlier in the same area; someone asked if I thought that was a proper thing to do, spend a current research grant to publish past research findings, and I defended myself by saying it was in the same stream of work. That is hollow, really, because I have a self concept that says I am reasonably honest and I now have to defend my self concept. You can see the dissonance there: it is an attempt to use attitudes in a way that will protect the ego being defended.

I tend to think that (2) was a little overdone in some of the earlier work because it was used in the Authoritarian Personality Studies to account for racial prejudice and feelings towards negroes. To my mind, that was trying to explain a sociological phenomenon in terms of psychological dynamics. In the preface to these Studies, the authors said they would look at the social context of the Deep South and make an analysis of Nazi Germany in the 1930's, but progressively the book became a kind of account of authoritarianism as a defence against feelings of inferiority. I think this is nonsense, to say that everyone in the South or who was a Nazi had feelings of inferiority. I think that is a clear case of needing an analysis of the social state - the extent of poverty, etc. - allied to a personality analysis before one can understand the behaviour. It is still reasonable to keep in mind that people do use attitudes to defend their egos. I suggest care before all the world's ills are taken back to a personality characteristic of an individual.

3. Value-expressive. I have covered this in passing. This is simply the values that a person has. People learn, pick up, adopt and modify attitudes so that they are consistent with these values and so that they can express them in a consonant and comfortable way. However, this is not interchangeable with No. 1, Instrumental.

4. DR. A.W. CLARK.

16/4/69.

SECTION

ACCV RECORDS

MR. CARR: Do we acquire attitudes so that they will be instruments of goal achievement or are they communicated by the goals we hold?

DR. CLARK: I think it operates both ways. This is the matter of translating the systems type thinking. It is simply a goes. I am sure there are instances and seeing how it their attitude to their behaviour, and that is where it is the opposite process. When we are looking for causal connections, the pressure is to take an arrow with a head at one end. If we put a head on both ends, then we have to think of the group instances where it operates in one way and in the other.

4. Knowledge or meaning. This is very much the rational type function, an attempt to obtain a stable ground to operate on, backed up by stable knowledge. As an illustration I am trying to think of a society that is less concerned with a rational defence and more concerned with the feeling function. Would it be true to say that some of the Zen Buddhists' approaches to the world insist less on a rational/logical approach and more on this?

MR. CARR: The whole Hippy movement is an example.

DR. CLARK: Yes.

MR. HILL: It is hard to judge, since we look at any of these things from the point of view of our own rational structure.

DR. CLARK: Yes, but very often we say that a person is right and are rational about it and would rather have someone who is wrong, with some fire in their belly. Again I think it is a matter of balance. Marx got onto this. A productive system has to be controlled by rational means. I think it would stand a rough generalisation, that we do have a lot of people in our society who are very concerned with getting their attitudes into line with existing knowledge and facts and so forth.

MR. CARR: We would hope that most of the professional groups would have this.

DR. KRISTER: From this group's point of view, would not the interesting fact be the way it varies?

DR. CLARK: Yes, if you are trying to mount some sort of programme.

DR. KRISTER: Even in terms of urban/rural.

DR. CLARK: Yes. There was a study I will mention later about introducing innovations into farming practice. The people who seemed most open to the efforts of the Agriculture Department were those who had left the rural community at some stage, either for schooling in city surroundings or to go to war or travel, - in some way they had been away from the rural background and then had gone back into farming. They had a more managerial rational type of approach to farming, whereas the people less open to influence seemed to have the more traditional approach - "If it was good enough for Dad, it's good enough for me" sort of thing. I think the point is well taken that there should be some analysis of the population in these terms and of the conventions that might be supporting existing attitudes. This is what I meant when

I said any attempt to get people to have an examination for cancer is very much rooted in emotional, ego-defensive type attitudes.

DR. MACLAINE: You have looked at attitudes in the functional sense and perhaps these could be mutually supported in terms of a single attitude to smoking and how people latch on to someone who says we have not located the causes of lung cancer. These people are trying to reinforce ego-defensive and value-expressive aspects.

DR. CLARK: Sir Roland Fisher was an example. He would not buy the causal theory. He said it was a statistical association and that was not an argument. Perhaps he might have been having us on. I think the point is well taken that we often mask these other things in a great battery of rationality.

Just going on to try and build up the theory, let me tell you about the sort of theory that has become prominent in the last 10-15 years, the BALANCE THEORY. It stems from this type of systems approach.

1. Osgood (1960) said that 7 per cent of heavy smokers believed that the association between lung cancer and smoking had been demonstrated, compared with 20 per cent of light smokers and 29 per cent of non-smokers. In other words, if you have a vested interest in continuing, to keep your system balanced you need to reject the association between smoking and lung cancer.

DR. N. GRAY: Could it not be argued that it should be the other way around? Could it be that more heavy smokers have remained heavy smokers because they did not believe the association had been demonstrated.

DR. CLARK: I think you need a longitudinal approach to sort it out. I would have no counter for your interpretation. It is valid because it is a deduction from the evidence.

DR. GRAY: My interpretation is yours, but I was interested in the reverse.

DR. CLARK: Other studies begin to heighten it. If people who have bought a certain brand of motor car are then exposed to newspapers, one finds they take more time looking for the advertisements for the car they bought than for others. This does not heighten this evidence but the body of evidence supports the selective interpretation of what is available so that it is consistent with what people want to believe. I do not think this denies the proposition for someone dominated by more rational processes - and the incidence of smoking in the medical profession has decreased - but people who want to continue smoking will latch on to the G.P. who smokes like a chimney but ignore the G.P. who gives it up.

DR. MACLAINE: Two things support this. Many smokers have been smoking for a lifetime and the evidence linking smoking and lung cancer was not available when they began and therefore was not a factor in their starting or stopping. The other thing is this, that plenty of people acknowledge that there is a direct link but will not give up smoking because it has hooked them too securely. I think in the particular instance of smoking and health I would go along with this.

DR. CLARK: One function is omitted here, the pleasure function, self indulgence, hedonistic.

There is enough evidence that for a great many people making decisions helps in social situations and in situations where enough people say this to suggest it is true, and in this sense it has a value.

A person says, "Here is a future risk, it is very important, I may not get it but if I do it in a long time in the future, but here in immediate satisfaction, the pay-off is immediate, and I can talk to people more easily". We have been rationally than that, of course, but I am glad you brought this up.

Solomon Ashe, a very prominent theoretician in social psychology, stressed the rational aspects of human behaviour. In contrast to the position supported in the 1930's and into the 1930's, through Macdougall, and people like that. Le Bon in 1895 said that if you brought a group of people together, the notion of democracy was nonsense, because an individual in a group acted according to the condition of the spinal column. Freud was caught up in that movement and it established the whole intellectual climate at the turn of the century. We then had a reaction against that and Ashe was part of it in stressing rational aspects. Now we are going back to a more balanced position and saying people are all of these things, both social animal and saint.

The diagrams on pages 3 and 4 set out the position in regard to smoking and lung cancer. It all has a flavour of after the ball is over, but, on the other hand, as a rough guess it is not too bad.

MR. CARR: I would agree with your general position but these diagrams do not account for the people who give it up.

DR. CLARK: They do if we draw them in again. Their attitude at the time was available. Then we put in a foreign piece of information into the system, that there could be an association between lung cancer and smoking, and this has to be incorporated in some way other than denied and externalised completely. Once they let it in, we have to shift around some of the elements to balance the system.

You can do this by saying it is only a statistical association anyway, or "I will be dead before that" or "I may not get it" or "It is worth the risk". At that point, you can reject that thing and continue with your existing attitude. At some point in terms of the various forces that are operating the thing has to take a new balance which puts pressure on the attraction and feeling towards smoking. This is a subtle business.

I do not want to bog you down so let me move on, but what a lot of these things are trying to do is to account for what happens and then to develop experiments and test out whether it happens again, and the thing is constantly being revised. This is what is happening with this type of theory and I am giving a rough outline.

MR. CARR: These tend to ignore the earlier point that these attitudes are social as well.

DR. CLARK: The diagrams show a very internal cognitive - one stream is cognitive and the other stream is very much socio-rational. The next example comes from that, No. 2. Emery and Oeser were Melbourne social psychologists who were asked to look into why farmers did not adopt practices that were in their own interests. These were dairy farmers.

The study was based on the approach of the supports for attitudes and practices. What they found by analysing the situation was that if a farmer came to like a district agricultural officer who was initially regarded as a city theoretician and who was younger than the farmer anyway, some progress could be made. It is a slow process but if the farmer comes to like him and the agricultural officer has a particularly positive attitude towards a procedure, then there is a pressure or strain on the farmer to adopt that practice. This is how the evidence came out. I give it to you as a theory.

In point of fact, you could test this in a variety of ways. A simple one would be to ask them in a questionnaire or in a 5-6 hour interview how they felt about the agricultural officer. If they were adaptors, you would find a positive attitude; if they were non-adaptors, the reverse would be so.

"Information, Decision and Action" is the name of the book in which these findings are published; it is a first-class book and one of the most useful I have.

I now go on to try and draw out some of the implications for change. I have already anticipated a number. First of all it is necessary to diagnose the supporting and opposing forces in the system. An example is when you get into an argument and keep trotting out all your best arguments in your repertoire and the other person, instead of being overwhelmed by the logic and lucidity of it all, just keeps bringing up counter arguments. That is because you are attacking his ego and values instead of eroding the supports. Have you ever had the experience where you have one of these discussions and walk away hot under the collar with the impression that there has been no shift on the part of the other person, and then later you hear him bring forth one of your arguments? This is because it has been thought about and absorbed in a way which does not challenge the person so severely, and it is accepted. What you have done is weaken some of the supports for the attitudes and this has allowed the other person's resistance to drop a notch, whereas when you applied direct pressure, all he did was resist.

DR. MACLAINE: This is an intellectual matter. Your immediate reaction is to defend your own position but then you think it over and find it is not as inconsistent as you thought.

DR. CLARK: It has come to be known as a sleeper effect, too. It is a tricky concept but has supporting material. It can also come in an opposite way. You get an immediate change but the person reverts to the old position. You get a great flurry of enthusiasm when a congress is on - a meeting of hospital administrators, for example - which brings about a complete change in attitude. When you measure it six weeks later, all the old pressures have begun to operate again and back the person goes, so this is a sleeper effect against the direction hoped for.

If the strongest function being served is emotional, you can talk without stopping but rational arguments will get no where. If it is rationally supported, you get nowhere with bluster or demagogy. Isolating the support is the trick of the business. Attack on an emotional level and shift when faced with rational argument.

If attitudes and people's behaviour could be pushed around too easily, there would be chaos on the

personal and social level. People should change slowly if they change at all, and in their own dynamics rather than through external example. There is the example of the American Government and integration. The most effective thing has been a good bit of legislation with some teeth in it. When it is illegal to refuse to rent your house to a negro and you are likely to finish up in court, you let your house to a negro.

DR. CLARK: This does not necessarily change the attitudes to the negro.

DR. CLARK: To balance it you get shifts.

DR. CLARK: If you can force people to behave in a particular way, there are signs that they change their attitudes to conform with the shift. There was a considerable shift in attitudes to favour Hitler-type methods because people were forced to change them.

DR. CLARK: This is quite a thing with fluoridation.

DR. CLARK: It is interesting to note the reaction of the group to this. If my interpretation is right, you are not too keen on force, you do not think it has a value. This is built into our ethics and yet I think there could be a good case now and again for it, but it has its dangers.

DR. MCCLAIN: We have reached a point where the reason for us having a session like this is so very evident, that in health education we have so often taken the view that we are on a good thing because it is health and all we have to do is tell people and they do it. But as soon as you tell people anything, you are up against attitudes and variations in attitudes in a community. This brings us back to the need to do social research to establish the basis on which we will work. This applies to cancer and fluoridation and is the justification for painstaking research right at the beginning, in cancer education, to try and isolate the attitudes and dimensions of the attitudes that the different levels of the population have. Then we can begin to prepare our educational programme based on this knowledge and do not have to go blindly into it.

We will get a good example when we visit the Dental Research people. Their Martin Report deals with the attitudes involved in the dentist-patient relationship. Some very interesting results have come out of this study, and they have been able to build their programme on that basis. I will give you all a copy of this at lunchtime.

DR. CLARK: To add to that, you have a few strategies open to you. One is that you can move into basic research about a particular area and try and understand and uncover and explore and so on. Then you face the problem of application and you find the situation in which you are trying to apply it is different. Another way is to move on an action research level rather than a stand off type level and try to establish what one group in a community might feel about something, try it and see, and you quickly get kick backs which make you correct the process. You have introduced a leverage and you see what the reaction is and find the best basis for change. The medical practitioner does this every day: he makes his first diagnosis, sees what happens and proceeds from there. If he has a nice piece of knowledge to kick off with, that is wonderful

but it is not always so. No practitioner, whatever his field, is in a position to do good research every day. There are the pressures of time, and so on, but that is the place where the good work can be done. Very often someone coming in from the outside will be ignorant about the concrete details of a particular area. Sometimes the outsider will pull it off because his background fits the business a little. I think this is what happened with the study of the farming community. Here there were concrete attempts at change, and this is what happened. They also isolated the fact that there were particular farmers in the district who filled exemplar-type roles and these leading farmers tended to be the ones who formed relationships with the agricultural officer. Whereas an individual farmer might not want to change, it would be possible to influence him through the farmers who were high prestige people, well-established in the community. This is the diffusion-type process of innovation. You try to trace it through a network of influence patterns and if the intervention is at the point where there are lots of channels - leading farmers in this instance - you are really exploiting the theory of the two-step process of communication put forward by the Columbia-type research people. This is the view that mass communication does not go direct to the consumer although it looks as if it does; instead, it filters through another group of people.

MR. CARR: There is considerable evidence that there is a direct line from the mass media straight through to the mob.

DR. CLARK: I add a little - supported by face to face relations. I am thinking of the Father Brown religious broadcasts in the 30's. He arranged for people to listen to the broadcasts in a group. The material came to that group and was pushed around and the social pressures operated for its acceptance. I do not know whether you would call that a two-step process. What the authorities in the Church tried to do was to make sure there was someone they approved of as a leading layman in each of the groups.

MR. CARR: Lazarsfeld's view was that the leader was influenced by the mass media and he then influenced the group.

DR. MACLAINE: The information can go straight through to the mass but a lot of these people take it with a grain of salt and half accept it and then look to an opinion leader to see what he thinks about it. If the opinion leader accepts it, they do too. They obtain a cachet from someone they look to.

DR. CLARK: I think it is a better model.

MR. HOLLIDAY: Your contention is that the actual mass media does not change attitudes directly, that the attitude change comes in a two-step process - change of opinion is made through the mass media but change of attitude is made through another person?

DR. CLARK: These are wild theories, in a way, but what is being said is something about the frequency of the business. On occasions there is an immediate and direct impact.

MR. HOLLIDAY: Would not that be according to the background?

DR. CLARK: In these terms - you have been softened up for it,

you have been talking about a particular issue with a set of colleagues and you have been softened up and you read something in a journal and it jells and you shift.

DR. MACLAINE: Or if it is a neutral thing, you will accept it. There are very many of these.

DR. CLARK: We are always simplifying because we cannot talk otherwise, or investigate anything. If we tried to investigate everything in one go, we would not get very far. Some people have been planning a study for 10 years and will go on for the next 10 years because they keep bringing in all sorts of relationships. Rough and ready research is my favourite occupation, because otherwise I would never start. One has to get off the ground.

What I was going to try and do here was bring out the relation between effective change attempts and what is happening. In this first example there has been an exploitation of the existing relations between people in that community. There is something also about the instrumental function that it is good business to adopt this practice, but he would not take this on without the other supports, and if the man thinks he is a good farmer, this is consonant with that.

There is another example on page 6, referring to "The American Soldier" series of studies during the 1939-1945 War, which captures a very important behaviour change. They asked white outfits with no negroes what they felt about having negroes and had negative expressions of opinion. The situation was simple: there was no interdependency, no immediate way in which a black and a white soldier were dependent on one another. The authorities placed a certain proportion of negroes in certain units and, to get a control, none in others. The outcome was that those groups which had negroes came to change their attitudes. The most marked attitude change came when these became combat units and the men were directly dependent on one another for their own safety. At that stage they did not care what colour the bloke alongside was, as long as he was there. This does bring out the question of interdependence. If you are in a working relationship with a person and it is a close and important relationship and the job is dependent on it, you have to start shifting your attitude, to see the good side of this person. I am not saying there are no troubles between colleagues or no departmental and inter-departmental strife, but where there is direct interdependence, you can say it is so important that people have to get along with one another. The direction of the pressures is towards liking the person and accepting some of his behaviour and attitudes which you might previously have rejected. The evidence was quite clear in this study.

The Lewin studies in the 1940's were very useful and the Coch and French work in 1945 was a very interesting study in a pyjama factory. The management wanted to change its methods of production and the social scientists convinced them it should be done by different means with different groups, to see what would happen. They used four groups. I will tell you about the extremes: one was simply told that the management had decided on the change, that the piece rates would be so much and that the new scheme would start on Monday; at the other extreme, the group was told, "Here is the problem we are faced with, what can we do about it?" and set to work and worked out a production system, decided

the piece rates, did the job and produced more and were happier. This was the beginning of the whole participation type business of the British and French Governments and of some of the Eastern European States which have built it into their procedures for union-management co-operation.

What did they exploit in this attitude change? The group dynamics and the pressures amongst the group, the solidarity and loyalties of the group towards each other. Once a decision was made through the group to try such a method at certain piece rates, then to maintain viable relations within the group, each member continued to accept what had been decided or supported attempts to change the group, but the group did not fight the management. The group which had the change imposed on them, on the other hand, jacked up against it and did all they could to frustrate management, and they did it quite effectively.

I think this study points to the group as the carrier and supporter of attitudes. Every magistrate knows this. Send your delinquent to the Police Boys' Club and what happens? You try to strip him of his past group relations. You are saying to him, "You have a set of friends with attitudes against the Government and Law and so on; we do not want you to mix with them any more but we do want you to mix with these nice clean boys here". You cannot really expect people to build up a completely new set of values and behaviours.

Point 4 on page 6 deals with Role socialization studies. I mentioned this earlier in regard to nationalisation of medicine. Merton and his group did a study of this taking in the positive sides as well, of support from colleagues, etc.

The old classic study is the Bennington study, reported in 1943 by Newcomb. This study showed that in the 1930's practically every member of the faculty of Bennington College was a Democrat-New Deal advocate, while the students were girls from Republican families. Over the years, the changing political values of the students were measured and it was found that there was a systematic movement to the Left. Republican support became less and less popular, while Democrat and Communist/Socialist groups got more support. The dynamics were analysed in terms of the poor little rich girls trying to cope with Dad at home saying the Republicans were it and with their teachers saying Roosevelt was a good guy. The people who did not shift clung to their families' values but the vast majority, because it was a residential college, made a quite profound shift that held up against parental opposition. There you had prestige and expert opinion and day-to-day interaction being exploited to change attitudes.

On page 7, point 5, I mention Lazarsfeld. It has been developed further and we have added a little ourselves. There is still reasonable ground for saying that face to face support will heighten the change by the mass communication process.

One of the tremendous sources of study here is the credibility of the informant. This has even got into our newspapers and their readers in regard to Mr. Gorton.

In my Conclusion on page 7 I have stressed and am stressing the functional aspect and the embeddedness of

attitudes in personality and social systems, the need for some diagnostic step, and the need to plan your programmes and your target group in terms of this analysis. Then I suppose you have to try and devise some method of measuring the effectiveness of the business and start all over again.

DR. MACLAINE: On the target group - there will be a lot of target groups in a population.

DR. CLARK: That makes it so difficult. If you mobilise all the resources of knowledge that we have and try to change one person, it is very difficult. Then we blithely set off to change great groups of people. The assumption of communicators of the past - and of some of the present ones - is that the recipient is a passive piece of rice.

DR. MACLAINE: The other thing is that in talking about attitude change we have in mind the further step of behaviour change, but there are all kinds of impediments between the two. You may change an attitude but there may be too many impediments to bringing about a change in behaviour.

DR. CLARK: It was on that ground that I prepared the other paper, headed "The relationship between attitudes and behaviour", which has been circulated to you all today. I will not work through this. The simple point I want to make is that there is a strain, as I have said earlier, to get one's behaviour in keeping with one's attitudes and values. When this does not flow easily, the next step is to look for the constraints or the hurdles that would prevent this happening. The person of socialist views working in a big organisation is unlikely to express them to his immediate superior. It is not functional in that situation to label oneself; any extreme of opinion would be avoided.

The studies on voting behaviour support the proposition that pre-election expressions of preference tend to come out in the voting figures. There are last minute shifts and there have been breakdowns for the pollsters, but overall the studies are good because unless something critical happens in the last moments before a vote is taken, there is a fairly close correspondence between earlier expressions and actual voting behaviour.

I do not think there have been many studies supporting this view and yet it is a common conclusion that there is this consistency. I think it would be a fascinating thing to go into more thoroughly. There are a few studies of inconsistencies, because they are more dramatic.

Right back in the 1930's, one man went with a Chinese couple into restaurants in the United States, and they were served. Then he wrote questionnaires to these people asking about serving Orientals and received a negative answer. Yet in a concrete situation, these people served Orientals. There was a repeat study in New York with negroes. This was done the opposite way: the questioner was told No over the telephone but when he turned up with the negroes, unannounced, they were all admitted.

This was an instance of an attitude held but not expressed. One could look for the constants and among them are such things as the desire not to kick up a fuss in any place of business, which means that immediate

pressures do prevent the expression of the attitudes.

I also quote the example girls being photographed with a negro male. Their attitudes towards negroes were measured previously. About two-thirds acted in a way that was consistent with their expressions of attitude and about one-third shifted towards a denial of their expression of attitude.

There is another point in this paper about coal mining towns. In one case the coalmine was integrated and the town was not. There you had about 20% of the people acting consistently: they were friendly towards the negroes at work and in the town. About 60% made a nice functional adjustment by being friendly in the work situation when there was interdependence and behaving in the ordinary, rather distant way in the town setting.

The general point I am making is that if there is not an expression of attitude, you look for the constants.

E. MACLAINE: We will be having more Workshops, so I do not suggest that this will be the last time we will look at this particular aspect.

(Short adjournment)

INVOLVING THE MEDICAL PROFESSION IN CANCER EDUCATION
(Including a discussion on medical education)

Speakers: Dr. Malcolm Coppleson and Dr. Dulcie Holden.

DR. COPPLESON: All of us here today are obviously aware of the need for improvement in cancer education amongst the medical profession. I feel at a disadvantage in speaking to you in that until now I have had no idea of who you all were, whether you were doctors or otherwise, and what in fact were your aims and purposes in working with this Society.

Looking at this problem from the professional angle, as someone involved in the management of cancer and the problems associated with it, there are three questions to be considered:

1. Why do we have to improve cancer education in the medical profession?
2. In what respect has it to be improved?
3. How might we be able to do it?

We can see the importance of this in the figures from the public hospitals contrasting the five-year survival rates, which are 95% in cases in the early, localised stage, compared with 5% in advanced cases. If we can get hold of people even a few weeks earlier, it can make a difference.

(slide) This shows the assessment by the Strang Clinic in the U.S.A.: 35% or one in three is cured of cancer by the present existing methods of diagnosis and treatment and 41% of individuals die unnecessarily because earlier diagnosis is not being made and treatment is not being instituted. The President's Commission on Cancer in the U.S.A. has estimated that 48 million Americans now living will develop this disease of cancer unless the incidence of cancer decreases and of that 48 million, 16 million will die of cancer.

This figure of one in three has improved from one in four, which has resulted in 50,000 lives of men and women being saved annually by that slight increase in results.

In what respect does cancer education need to be improved in the medical profession? There is no doubt that the medical people have a gloomy pessimism about the effects of cancer, and the image of cancer is largely determined by the rather distressing picture which all doctors have seen of individuals dying from the disease. The spur to greater interest in cancer must spring from confidence in the new methods of management and from confidence that the introduction of these methods of management is going to be successful in achieving cures.

(slide) Probably most of you are aware of the Eason, Manchester, study which tried to assess what the doctor or nurse knew about the incidence of cancer of the breast and cervix. This was an assessment of the pessimism in the profession. The three groups surveyed were medical students about to do their final examinations, nurses, and general practitioners. The group answer was 75% for cancer of the breast and of the cervix.

(slide) Here are the results in regard to the breast. The students were not too bad, the nurses were more pessimistic and the GP's were very much more pessimistic.

(slide) These are the results for the cervix. Again, the students are not too bad but the nurses and general practitioners are extraordinarily pessimistic.

Having established this unawareness of the results of treatment of early disease, Eason then tried over a three-year period to educate students on this one aspect of cancer education, namely prognosis, and the clinical teachers were instructed to drive the message home at every opportunity.

(slide) These are the results in 1964 and 1966 which show that despite the effort to teach the students and despite the greater amount of information disseminated through the mass media, the students were more ignorant at the end of the efforts than they were at the beginning.

Eason lays the blame for this at the feet of the clinical teachers. He implies that they were not particularly interested in the project and did not really drive the message home.

Who is to be educated, and how are they to be educated? The undergraduate, the general practitioner, the hospital doctor and the specialist involved in the treatment of cancer.

Most undergraduates arrive at their final year with a very broad knowledge but know very little about cancer. It is my opinion that the teaching of cancer at the final year level is bad, certainly in the universities in this city. There is no comprehensive coverage in any way. It is not planned. Too often there is duplication of certain aspects and complete omission of others. What is taught is at the scientific level, with a minimum of information in regard to clinical management and actual treatment.

How can this be overcome? In some universities in the U.S.A. there is a Cancer Co-ordinator. Obviously, of course, the university has to be provided with money for the appointment of a Cancer Co-ordinator. His task is to improve the curriculum of the undergraduate and to stimulate the interest of the clinical teachers. It has been found that the success or failure of this method depends on the powers he is given in organising the programme and on the resistance or otherwise from the teachers with whom he has to work. There can be great success if there is a co-operative effort.

Secondly, the general practitioner. This is a group on whom the improvement in results of treatment mainly depends. They are asked to detect cancer from the enormous welter of diseases passing through their hands and therefore they must be kept abreast of modern developments. Refresher courses only get to a minimum of people and will only continue to get to that minimum. The dissemination of pamphlets and journals is wide enough but unfortunately most GP's do not seem to have the time or inclination to read them, so that method is not particularly successful. The dissemination of information by radio or television, such as the N.S.W. Radio of the Air, is an excellent scheme, but again only seems to be reaching small numbers of practitioners.

An excellent method, which I think has been the best for country areas in this country, is to go on a five-day tour of a selected area, taking three people

interested in the various aspects of cancer. The group visits a whole series of country towns. On two circuits, with morning and evening sessions, about 90% of the doctors in the towns turned up. They were given a brief talk and this was followed by an informal discussion. This has been enormously successful in getting the message to the group.

Specialists and hospital doctors are in a smaller group and are easier to get at, with the establishment of smaller cancer groups in the hospitals. It is a sad thing that many specialists treating cancer in this country are still unaware of the improvements possible and the importance of team control and of having the opinions of other people in other areas interested in this disease; they do not treat the disease in an environment and have little idea of staging. This means we still have to reach the specialists within major organisations.

Cancer fellowships within the hospitals and demonstrations in depth might be valuable. The Memorial Hospital in New York has a one-day seminar on a specific cancer. All these things could improve considerably the cancer education of this particular group.

Finally, getting more to my own gynaecological interest and to do with the control of uterine cancer, the obvious aim is to get the message to as many women as possible about the availability of the test and what it might accomplish and that it should be repeated regularly.

(slide) Source of knowledge re pap. smear, a Vancouver study. The doctor introduced the subject to the patient in only 10% of the cases. Other people thought mass media was the most successful method and that television, particularly, was the method that reached directly to all socio-economic groups, especially the low socio-economic group which is one of the high risk groups.

In the Manchester series, 50% of the women did not know that such a test existed. Failure of communication was shown by over one-third of the women who had the smear not being told that it should be repeated; 66% were totally unaware of the importance of the repeat.

(slide) This is an American study: on a cost to the nation basis it shows that the national economy benefits by the successful treatment of cancer patients, that there has been a nine times increase in the benefit to the economy compared with the proportion of money spent on the treatment, etc.

(slide) The Americans have also worked out the doctors' time. If 60 million women want the smear, that equals 10 million doctor hours or 28,000 physician years. It is an enormous problem if one is screening every woman in every country. Therefore, what is required is identification of the high risk group.

The cost of making a diagnosis of cancer of the cervix with one smear is \$300, in women having a second test it is \$900, and the third time round it is \$2,000. The fourth time it is something of the order of \$5,000.

Finally, the message and emphasis I got at the recent conference in New Orleans was that the group with the greatest incidence of the disease is the very group we are not getting through to, the so-called high-risk group. Ways and means have to be established. These could include

sending people to the homes in the areas where these groups live.

(slide) This table gives the high risk and low risk groups in terms of nationalities. The South American figure, for example, is 150 per 100,000, a high risk group. In this country the figure is 20 per 100,000. Amongst Jewish people the figure is 4 per 100,000.

Table 2 sets out the groups of women found to be in relatively low and high risk of cervical cancer. Among the low risk group are Moslem, Amish, Jewish, Seventh Day Adventists, Italians, protestant and catholic. The greater the increase in promiscuity and intercourse and the lower the socio-economic status, the more likelihood there is of being in the high risk group. This is a sexually transmitted disease and early adolescence is the vital time. Thus the groups on the left of this table, all of which have high religious conviction, do not have intercourse in early adolescence, and this is a protective force. In this country it is for us to identify who these groups are and get at them, because this is the very group we have to get to.

DR. MACLAINE: Thank you, Dr. Coppleson. If you are all agreed, we will hear Dr. Holden now and have a general session on what she and Dr. Coppleson have to say when she finishes.

DR. HOLDEN: I probably suffer from the opposite of Dr. Coppleson's complaint - I know you all too well, so that it is a little difficult to talk to friends - and potential enemies! I think.

There are various things to be considered in this matter of involvement of medical practitioners. I do not divide them but lump them all together. Maybe the very situation we are in with the Australian Cancer Society, which has no public image as far as I can find out, is a great advantage, because we can start from the beginning. If we want to involve medical practitioners, whether they are specialists, students or general practitioners, we have to understand them. This situation depends entirely on understanding them as they are in Australia.

I think we here are in the minority. I find that on the whole, whether he is a general practitioner or a specialist, the ego image of the doctor in Australia is very high. He thinks that he knows and he intends not to be told things by non-medical people if he can help it. He is usually busy, he does not read much. I am rather inclined to think that the overall picture of reading as a means of gaining information is losing its power - but that is another thing and I will not go into it here.

If we are to get to these doctors, we have to "set a thief to catch a thief". To do any educating, in most cases it is going to be necessary to set a doctor to do it. At least a doctor meets other doctors as someone with equal qualifications and it often amounts to a doctor saying "Oh yes, so and so is a good person, I know him and it is worthwhile listening to what he says about cancer".

There are exceptions to using a doctor to teach doctors. People in the paramedical services can often go into the same fields as doctors and because of their

position they do have a similar effect to another doctor. One has to do this, if possible, personally. I do not think it is ever successful to involve anybody unless you do it personally. Dr. Clark gave us a good many reasons for this but to do it personally is usually the best way.

I am quite prepared to agree that "involving" in its modern sense means "including". In the older sense, it meant "to be together" and in the Wycliffe Bible is meant "charge with trouble".

I believe this involvement of practitioners is going to mean "charge with trouble" to anybody attempting a health education campaign without strong medical backing.

To go on from this, we have to start a campaign. This is your choice of person, followed by starting the campaign. How is it started? By announcing the choice of person to all organisations concerned, medically, first. This gives an opportunity for any dissension to come. It also gives the opportunity of circularising and having the letters read by organisations like the A.M.A.

Here I feel we are going to have to try and do something as a Cancer Society, because the A.M.A. has said that no doctor can use their name publicly. On the other hand, unless a name is attached to this education officer, he will have no standing and no status, so some sort of arrangement and some kind of co-operation has to come here.

Now we have the person and we have introduced him medically. Obviously, the next stage is to introduce him publicly. In the larger States we may have a number of speakers who can go from place to place. In the smaller States it may be just the one person who will do it all. Whatever is to be done - public displays or lectures, a circuit through an area - is advertised, and the public can take it or leave it. If the public takes it, then more work has to be done by contacting the local general practitioners, specialists and nurses. This can be done and is not too difficult. As Dr. Coppleson said, nearly always there is 100% response by the doctors: they will come and co-operate and usually are willing to listen, participate and do all sorts of things.

One thing I should stress here is that if it is asked for, any material that the doctor or speaker is going to use should be available for prior looking. In Victoria I know they used to show this to city councils before having the Cancer Week in the city. It is very essential, because the doctor knows what is going to be shown. If he does not like it, he feels he had the opportunity of turning it down, - I have not had a doctor do that - and he feels he is in it from the beginnings.

There is something else that is worth doing, if possible, and that is to find out what local tragedies have occurred. This does help, if you know that there is a family in the area that has had leukaemia three times. You must be careful what you say about heredity, because people will not believe you on that one point, and this could breed antagonism, and you could get antagonism the whole way through.

These are the straightforward things to do, but other things happen. No population is uniform and what research we do on their attitudes and behaviour is almost out of date before they finish because as we ask the questions

We are altering their balances. The whole thing is very fluid and moves all the time as you look at it. You will find that curious things that have happened quite a while before will influence groups. We used to have Cancer check-up Clinics in Tasmania; they finished in 1952 but they still have a strong influence, not on the public, but on the doctors who at that stage felt that their patients went to the clinics and went away from them and so they learned a great deal more about cancer to get their patients back. Even now there is a feeling among doctors that they want to know about cancer. This is one thing that can happen that is not expected, because this campaign was for the public; it did not do much for the public but did assist in educating the doctors.

You also have particular responsibilities when you deal with parents and children. You should make careful preparation to ensure that the same things are going out at the same time, preferably, otherwise you find that things are going in to the children and are then being cancelled out at home. This is not so prevalent in the pap. smear area, although you still find that older people who have never heard of smears or who are actively against going to the doctor when one is well can have a backward influence on their daughters and daughters-in-law, so that you can have some trouble here in getting all the women to attend.

There are other thoughts that we should put here, that although health is a birthright in a country such as ours, it is not going to be attained by doing nothing about it. We have to get this idea put over in a hundred and one ways. Here a great deal more influence is possible if the educator, particularly in cancer, is known, and well known, in other fields of health. There is always the slight feeling that if people are in only one branch of health, they are cranks. You must remember that on the whole the public wants to do the wrong thing, with smoking. It is the same with smears - women will go for smears but on the whole they consider it a bit of a bother and tend not to go and you have to keep on asking them to go.

There is another side to this, and another thought. Educators are available, they are around, but they have to be paid. Otherwise you meet this attitude which is very strong in Australia, that if someone is doing something for nothing, it cannot be any good. This, again, is a matter of knowing your public and the type of people you are dealing with. For this reason you cannot necessarily graft one set of rules on to another set of people because the essential facts do differ.

There is not very much more that I want to say, but I would like to close by saying that a great deal of work has to be done before the campaign starts. One of our greatest difficulties here, particularly in cancer work, is the lack of political support, government support. In fact it has become so bad that we have no public image at all, that I find, now, that it is becoming a danger. After all, to the public, silence often means consent and the public says that while no one says publicly at government level that smoking is bad, then it must be all right. Because these people are supposedly knowledgeable and are experienced and should know the right answers, then if they say nothing, the public says well, someone is wrong somewhere, and so people tend to take the easiest course and so they smoke.

DR. MACLAINE: We have a lot of issues before us here. We must concentrate on the involvement of the medical profession out of all this. We have two reasons for this. One is key of the key groups we want to look at. We have to keep in mind, too, that we are involved in public education and with the meetings on Friday of the Public Education and Medical and Scientific Committees, anything we can do today can pay a dividend in a couple of days time.

We have the problem of medical education and of involving medical people in other ways towards influencing patients and so on. Yet another point brought out by Dr. Coppleson was that the evidence we have shows that medical opinion, as a whole, does not keep up with advances made and with the cure rates in cancers. Yet we have a lot more encouraging evidence that where education is effective, there is an immediate dividend by the saving of lives. When one is working in medical research and towards a cure or improvement in the treatment of cancer, one is in a field which is very nebulous, with a lifetime of effort involved, possibly. In terms of public education we know that if we improve public education, and the education of medical practitioners in relation to cancer, we have an immediate pay-off in the saving of lives.

I would like you to take it up from there with those assumptions.

MR. CARR: Do I take it, Dr. Holden, that you were talking of the involvement of the medical profession and extending Dr. Coppleson's remarks about the education of doctors. In referring to general public education, you were not suggesting, surely, that only a doctor can be a cancer educator?

DR. HOLDEN: I say no campaign will be totally successful, involving both public or doctors, unless it is heavily medically backed. Doctors do not necessarily have to do it or be executive officers, but they must back it, because I find that doctors will only listen to doctors - and sometimes they do not listen to them either.

MR. CARR: You seem to have a fairly heavy gloom about the possibilities for success with the thought that only a doctor can contact a doctor. I wonder. Is this an enormous arrogance, that medical people reject the fantastic range of skills of other people, like Dr. Clark who was here this morning, or Dr. MacLaine?

DR. HOLDEN: I have no research on this but from my own experience, I would say it is true.

DR. GRAY: In regard to the American figures on the cervical smear given by Dr. Coppleson, these are gloomy in comparison with the Australian experience. Figures taken out by Mr. Hill show that in Victoria 59% of the smears were taken at the instigation of a doctor, as against 10% in America.

DR. HOLDEN: We have those figures in Tasmania too.

DR. GRAY: I think the campaign in Australia has sent a lot of people to the doctor - we have created a demand. The medical profession does not reject the campaign. In Victoria this campaign has put 1½ million dollars into the pockets of the medical profession and has brought them to the situation of looking after their patients' health

and therefore it has been a very valuable exercise in preventive medicine. This 59% results from public pressure, probably, and was possibly built up by the mass media - this is what I suspect.

DR. HANKIN: I have done quite a few talks for the Cancer Council and my colleagues and I have done quite a number of films on breast self-examination and cytology. In the early stages, my experience was that I often had comments from the audience that "My doctor does not believe in this, so what should I do?" and I have been guilty of saying, "You are perfectly at liberty to find a doctor who does". I think other people here have experienced the same situation. This sort of question has not been nearly so common over the last two years. This may or may not be significant, but it is of interest to mention it. Not only the medical speakers, but nursing speakers of the Anti-Cancer Council and lay educators are motivating the public and they in turn are motivating the doctors with their "All right, doctor, if you won't, I'll go to one who will".

DR. SPRINGETT: As far as South Australia is concerned, we had a postal survey in 1967. We sent out 1100 questionnaires to the doctors in the State. The reason for doing this was the large variation in how-when-and-why attitudes of medical practitioners towards cytological examinations. Of the number sent out, 673 were returned, which is a reasonably good proportion. Again, we found that in 1966, in one part of America, over 40% of people sought a smear test because of the advice of their doctor, and that the doctor led the field above all others.

Some of the questions in our questionnaire overlapped, for testing reasons. The various replies are set out in the A.M.J. of 30th May 1967. The results showed that 460 took smears and 213 did not. This latter group consisted almost entirely of non-gynaecological specialists and ancillary personnel and yet most of them specifically mentioned that they supported or referred patients for cytological examination.

The results also showed that a large number, 361, took smears from clinical suspicions of the cervix; 225 took smears only if they were suspicious of the appearance of the cervix; 13 took smears only if the patients had symptoms; 399 took smears only at two-yearly intervals or as recommended by the cytological services; 24 took smears only every five years; 44 said they took smears only at patients' requests. We assumed they did not take them at any other time.

These were some of the main questions. We raised several issues and came to several conclusions, namely:

- There should be a cytological examination of all women over 20 who have had sexual intercourse. There was no upper age limit for immunity and all GP's should know this and be pressing home the need for the examination.

- The need for repetition of further smear tests at least five years thereafter. There are different standards of judgment of the time that should elapse between smear tests - two years followed by five years, or three year intervals.

- We also found that the smears should be taken from symptom free and clinically healthy women.

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The questionnaires were accompanied by a letter and I am still getting letters from doctors about timing and what is to be looked for - all this from the 1967 questionnaire. We feel that the ten points raised here are the minimum any doctor should know and if we can get them over, we will be doing very well.

MCCLAIN: The survey had an educative effect and revealed an inconsistency in aims in public education and what was actually happening in terms of medical support.

WELLS: In regard to self-examination, this is probably another example of where public education contributes to medical education. About a third of the women in the Victorian survey by Mr. Hill answered "yes" to the question about practicing self-examination regularly. If they find anything they go to the local doctor. I suggest it is unfair to assume that the medical profession is any more ignorant than the public at large.

W. GARR: I would not like to leave any vague impression that laymen should be involved in the medical education of doctors. Only one kind of person can teach a doctor about cancer, and that is a doctor, but in the areas of education and communication doctors are perhaps more ignorant.

HOLDEN: The Tasmanian clinics that closed in 1952 educated the doctors tremendously. It is true that what you teach the public rebounds and forces a doctor to learn, but this is all very well when you are talking about smears and breast self-examination and, even, up to a point with warning signs, but it is not effective in smoking. Doctors who smoke, smoke. A lot of them have given it up but those that remain smokers have a very difficult problem. Don't any of you have problems in this respect?

MCCLAIN: There is to be a session on that particular issue but what strikes me at this stage is that we talk of public education forcing education on the medical profession. This occurs, but whether we should accept it as being the best way of proceeding is another matter altogether, as is whether we generate antagonisms by forcing the doctor to accept something he does not want.

SPRINGETT: One of the problems is that a course of medical education as it has been planned in the past and even today does not think of cancer as a separate condition or group of conditions, in itself. It regards cancer as a pathological study which affects many organs - ear, nose and throat, bowel, skin and so on - and so it comes into every section affecting a particular system and is not taught as a subject as a whole.

COPPLESON: This is one of the major deficiencies in the universities, I would guess, throughout this country. Somehow or other I think a systematic coverage of cancer is needed. A start in this direction has been made in other parts of the world. Perhaps a compromise is to drive home the message with a part-time undergraduate co-ordinator of cancer programmes in the universities, to run some sort of course which he does not teach but which involves others and which he co-ordinates, so that the students will get the message that cancer is an overall thing throughout the body, rather than think in terms of cancer of the stomach or colon. This is the time to get them, because when they graduate in medicine, they know nothing about cancer. After one year in hospital they go to general practice and their training at this point is not very much on which to build any subsequent efforts to get at them.

DR. HOLDEN: Following up that remark, I have made a question and answer machine on cancer questions. We tried it on the medical students and their knowledge of incidence of cancer - which, if you include skin cancer, is 1 in 4 - was shown as appalling. Their's was worse than the general public's, judging from the response by the people that used this machine and answered the questionnaire. Of the 500 got the correct answer, the 1 in 4. The question asked was "Do 1 in 4 in an affluent society get cancer?" and one could answer "yes" or "no". Most people put "no". This was one thing that struck me.

MR. CARR: It is a threatening question.

DR. HOLDEN: Yes, but we tried all sorts, and one is limited, with this machine.

MR. RUDDER: In Queensland we felt that our educational programme was not receiving the full support of the medical profession and that the programme we had established was outstripping the services that doctors were prepared to give and were actually giving. We called together the College of General Practitioners and they agreed to run a special seminar for general practitioners in Queensland on cancer education, and this has just been completed. Some of the points which arose from this seminar, attended by some 100 doctors from all over Queensland and financed by the Fund but totally organised and carried out by the College, were:

1. The GP should be constantly aware of the need to educate patients at an individual personal level, where unique opportunities exist.
2. He should also be prepared to talk to local community groups, which is something we have not had in the past as far as general support is concerned.
3. The risk of inducing cancer was emphasised and this should be considered in publicity campaigns through mass media and questionnaires and groups such as the Queensland Cancer Fund should discuss these factors with the medical profession and do joint promotions.
4. Anti-cancer publicity should reach the GP and the public at the same time. The public have been receiving the information before the medical profession knew what was going on. The pap. smear provides a good example of this: there was a tremendous response in Queensland and they felt it would be an even greater success if the GP was brought in simultaneously.
5. The need for closer communication between the medical specialist and the GP. Better education of the GP will produce earlier diagnoses and better management.
6. Check-ups and insurance standard examinations should include a full skin examination.
6. The frequency of examination depends on finance and the need for team work and management. Management should be designed to promote the patient's comfort, not necessarily to prolong life.

We felt this was a major breakthrough and that it was our fault that we had not got through to the doctor before and brought him to show him what we could do for him. I suggest this is the type of action we as a Cancer Society should encourage and foster.

They were worried about cancer phobia because they felt too much publicity about cancer could create an atmosphere of "keep away from the doctor", rather than of encouraging him to come.

DR. COPPLESON: I think that definitely has been disproved and it has been shown that publicity brings about quite the reverse position, that it creates a feeling of warmth and comfort in the community to know what it is all about, to know the message is getting through. In all cancer clinics there is the initial feeling, but it is quite reversed.

MR. RUDDER: One other point on the pap. smear: they felt that the success was due to the fact that there was such a small detection rate, that women went because they were confident there was nothing wrong with them. This does not apply in all cancers.

DR. COPPLESON: There is a difference between symptom free and otherwise. The girl who has symptoms has to be driven to the doctor whether she wants to go or not.

MR. HILL: I think there is obviously a suspicion amongst the group of doctors in that seminar that cancer phobia is quite a significant danger in cancer programmes, and this seems fairly crucial to this issue. If you talk about education of doctors in cancer education programmes, I think this is something which holds many doctors back. It obviously is a prejudice but there does not seem to be much evidence that it really is a danger, but it is an influence.

DR. MACLAINE: If you involve the medical practitioner and work with him on this, it would dissipate this particular trouble, because they would feel that they had some measure of control and would not worry about the prejudice.

MR. HILL: I think this is a good one for something like a survey, psychologically, because symptom free women are coming in, so there is no need for it to be associated with neurotic fears of cancer. There is a good chance that a doctor would be reinforced by turning up a positive case, which he is likely to do in the case of one in every 200. When he does turn one up, it reinforces the procedure. Anything that can be used and tried and done to give them their own reinforcement is critical.

MR. CARR: There was the experience of a couple of years ago of a cervical smear campaign in a town in Queensland where the GPs were not informed and they found out about it only when the women began pouring into their surgeries.

MR. RUDDER: That is not the story. Townsville was the city concerned. We sent a doctor up from Brisbane as part of educational week campaign and the general hospital was flooded by applications which they could not cope with; although they knew this was going to happen, they did not realise the impact it would have. It created all sorts of problems locally. This situation does not occur now because the demand is not so great and people are going more regularly for this particular service. It was not that they were not informed, but that they could not cope.

DR. HOLDEN: This happens in Tasmania. You cannot assess the success but it is worked through and it is gone: it never happens again.

MR. CARR: You suggested that the influence of the educator might be greater when he is seen to be identified with other health areas. What does this do to the concept of cancer societies doing cancer education, rather than include cancer education in a general health education programme?

DR. HOLDEN: I am of the opinion that I would prefer cancer education to be done as a general part of the overall preventive methods, preventive against disease, or for the maintenance of health. I think they are all better done together, as you had in Queensland.

MR. CARR: We do everything back to front. The Cancer Council withdrew from cancer education and pays the Health Education Council to do it, which has managed to include it in a general overall health education programme. I wonder whether this might not be best. I think logically it is likely to be more effective.

DR. SPRINGETT: In South Australia that is happening in Teachers Training Colleges, where they have a general health course and various doctors lecture to the students, including cancer educators. This has been part of their public health course for the last four years.

DR. HOLDEN: It is coming in in Tasmania.

DR. MACLAINE: I can see a trend to make this an aspect of just maintaining health. When you are working towards preventive measures rather than curative ones, your cancer speciality is blunted in terms of looking at it from a general health point of view. Cancer specialization makes the work more manageable, plus the fact that society is used to specialised organisations, as the medical faculty is. There is nothing inconsistent in having a cancer organisation as such and it does not have a deleterious effect on the public image.

DR. SPRINGETT: On this question of the way cancer is being taught and whether it should be a speciality of its own, is there no place for having pathological cancer taught in clinical aspects, as it has been, and the public health aspect of this condition (using "public health" in the broad term) added to an enlarged public health course so that it would become part of the general training of an undergraduate?

DR. COPPLESON: This interests me because of my experience at the recent conference organised by the American Cancer Society in New Orleans, which was a great success. What disturbed me most was the fantastic emphasis placed on the pap. smear and the measures to be taken throughout various countries of the world to get women to take the smear. There was not one word of mention about total health of the community, and this involved under-developed countries where there were far more important issues.

On the other hand, I wonder if the cancer aspect should not be fitted in as a very important part of total health education. At the undergraduate level I would think that cancer has to be nailed down and taught as a characteristic, which is not being taught now. On the public education and GP level, it has to be highlighted in a general overall pattern aimed at disease prevention.

An encouraging aspect from New Orleans - and I do not think that this is prejudice - is that in the round table discussions it was clear that we are further ahead, so

far as cytology is concerned, than any other country, including the U.S.A. We have to go beyond this point and educate people in some of the finer points, particularly the doctors. There are a number of doctors who feel that if they do have a positive smear, the uterus has to come out to save the patient's life, yet this is necessary in the case of less than half the women with cancer of the cervix, so a significant proportion of the positive smears are being treated unnecessarily in this way.

Another point of interest in New Orleans was that people in lay organisations who were disseminating the information did not recognise the difference between cancer in the upper part of the uterus and cancer of the cervix. The smear test is totally unreliable for cancer in the upper part of the uterus. It was surprising to me how many of these people did not realise this most important distinction, that the smear is not for cancer of the uterus but for the cervix.

These are points we should be getting around to consider because we are much further along than the general impression one gains from this discussion today. Both the public and the profession are far better educated here, in my opinion, than they are in other parts of the world.

DR. MACLAINE: Do you agree that the basic first step is in the medical schools where training is being put into operation, on the ground that here you have students in the formative stages and you can lay the foundation for what you do later and have a co-operative atmosphere?

MR. CARR: Who will educate the educators of the students? This is where it breaks down.

MR. HALLIDAY: We have to educate the educators.

DR. MACLAINE: This is the key problem.

DR. COPPLESON: Do you mean a new approach or method of instruction?

MR. CARR: Yes.

DR. SPRINGETT: We have a group of educators.

MR. CARR: No, we have a lot of people who know a lot about cancer and this might not make them good educators.

DR. SPRINGETT: Cancer is being taught in the framework of various parts of the body. Whether they have to be re-orientated is another matter. We do start with people who know what they are doing.

MR. CARR: I am ^{not} suggesting this, but that the experts in cancer should now be influenced to become better educators, so that the behaviour of their graduates, their students, towards cancer is better.

DR. SPRINGETT: This has happened throughout the centuries - it has to evolve.

DR. MACLAINE: You have a key area in terms of medical education right at the outset but one of the things brought out by Dr. Coppleson was that once you get the medical practitioner in the field and try to get at him educationally, your

... seem to have limited usefulness, in terms of conferences, radio and television, and what he will read.

MR. COPPLESON: In my opinion the tour is the best method; you have to go to them.

DR. MACLAINE: How do you get on in the city situation, where most of the doctors are and where you do not have this kind of motivation?

DR. HOLDEN: It is a lot more difficult but they do have meetings and it is not difficult to ask for time to talk to them.

MR. COPPLESON: I would suggest at meetings of the local association.

DR. MACLAINE: Find out how the group functions in the city and fit in with them.

DR. HOLDEN: It is always the same, it is a matter of personal contact. I think the educator has to act, he is the mobile person.

MR. CARR: This means an approach by the A.C.S. or the local bodies to the A.M.A. which represents X proportion of doctors. Who should make this approach, the local Council or the A.C.S.?

DR. HOLDEN: Try your local Cancer Council.

MR. CARR: In Western Australia these are mostly doctors and individually I am not too sure I would be happy to let any one of them go.

DR. HOLDEN: This is what I have been saying. It depends so much on the choice of person to do this. In the beginning in Liverpool and some of the big centres in England they could get nowhere with the public health authorities because the nurses in the Child Welfare Department would do nothing. As soon as they put a woman medical officer in, they were all right, they got the entrance.

MRS. DAVIES: Because she was a woman or because she was the right type of person?

DR. HOLDEN: I think it was because she had children herself. The child welfare organisation was run separately then. It would apply here with cancer.

MR. CARR: What do you want this woman for?

DR. HOLDEN: To influence other doctors. She has to be qualified.

MR. CARR: Why would a woman doctor influence men doctors?

DR. HOLDEN: It might not be a woman. I am only suggesting this, but so far it seems it is another doctor that has to approach the doctors.

DR. SPRINGETT: The answer is that in each group area, the local cancer foundation or society has to approach the various branches of the local association of the A.M.A. As far as we are concerned, there are a number of local groups of doctors who make up their own programmes and decide whom they will have to speak. We can ask them to ask for speakers on cancer but cannot guarantee that they

will. Each group has to solve its own problem.

DR. MACLAINE: We have lunch arranged for 1 o'clock and in the first session this afternoon, we will be dealing with the Exemplar Role of the Medical Practitioner. The sub-committee's report on this has been distributed; it is very broad and allows us to focus on the aspect we have been talking about since morning tea. If you can come back about 20 to 2, we will run two films we have.

DR. COX: Before you go, just a couple of comments on the last part of the discussion. The people you want to educate are available at three levels. Undergraduates: the way you approach the undergraduate is through his university and hospital. In this respect, Dr. Coppleson's suggestion that we channel classes on cancer co-ordination has been broached before the Medical and Scientific Committee some three years ago and gained little support. It is difficult to do this through the university, to include new material in a curriculum which is already overcrowded, and because of the rigid departmental structure of the universities in the way disease is looked at and taught, it is difficult to introduce disease-oriented teaching, even though this is one of the directions in which the specialist medical practice is going. The disease oriented speciality and societies like our own will eventually have much to do with disease-oriented teaching for the undergraduate but this is not presently what is possible. It is not easy to introduce curricula change within a university but a cancer co-ordinator provides a link between bodies like this and clinical teaching.

The same applies at graduate level. There the controlling bodies are the Royal Colleges; they are the ones who are responsible and it is they through whom one should attempt to exert influence, though, again, a cancer co-ordinator can play a very valuable role in the hospital.

Then there is the group outside, those you deal with by continuing education. I suggest the A.M.A. is not an educative body and they are not very much concerned with education. The way to approach these people is through the Post Graduate Committee and through mobile tours such as those conducted by the N.S.W. State Cancer Council and through seminars to assist continuing education.

DR. SPRINGETT: Do you not have local branches of the A.M.A. which make up their own programmes?

DR. COX: I think one should not look on the A.M.A. to have scientific programmes.

DR. SPRINGETT: In South Australia our local area organisation has its own programme.

DR. MACLAINE: It depends on the local people, then.

(Luncheon adjournment)

Before the afternoon session commenced a film prepared in South Australia to demonstrate self-examination of the breast was shown.

THE EXEMPLAR ROLE OF THE MEDICAL PRACTITIONER AND PARA-MEDICAL GROUPS IN RELATION TO SMOKING AND HEALTH
(Discussion of the Sub-Committee Report on this subject).
Study paper: Sub-Committee Report on the above.

MACLAINE: There have been some amendments to the original report sent to you. Firstly, on page 2, part II: the criticism of the original report was that this was very general - so general that the original terms of particular reference to the medical practitioner were lost in the generality. This was done on the assumption that you cannot involve the medical practitioner without involving the A.N.A., but I have added a third point.

At the end a further page has been added, page 5, which gives a summary of the position in relation to the medical practitioner.

On page 2, section III - C. This was in relation to what we should ask the medical practitioner in relation to smoking.

Our original recommendation was that we thought the medical practitioner should examine his own smoking habits. Mr. Dick made the point that that might get a negative reaction from the doctor who smoked and he suggested the more cautious and tactful approach.

All of this is a matter of recommendation at this stage and it is something which will be brought forward to the Public Education Committee tomorrow. If the Public Education Committee is satisfied, it will go forward to Council and then may become official Council policy.

In this session I would like your collective thinking on this in terms of looking at particular areas you may quarrel with or in terms of more general matters, to see if there is anything we can think of to make this a better instrument or to deal with anything you want to discuss before it goes before the other Committees involved with our Society. I leave it open to you now on that basis.

I could go through this paragraph by paragraph if no one wants to do anything at this stage. Let us look at it that way, then. The first page is a preamble and will appear almost in its entirety in an A.M.A. Gazette shortly, telling medical/practitioners that this sub-committee work is going on. This is to alert them that we are operating in their field. We have suggested that if they have anything to offer and want to co-operate and write in, they can do so, and we might get a little medical support. That is as far as it goes. We have not said anything about the recommendations; we have not said, even, that the recommendations have been prepared.

When it comes to the recommendations themselves, this is where you may wish to come in. This brings us on to Section III and here the matters are straightforward.

In the first one we have a basic standpoint of approaching the A.M.A. and other professional bodies which are interlinked with the A.M.A., in many cases. We have recommended an approach to every learned medical body we could think of. We have asked for four things to be said on the health hazards of smoking and we think this is very appropriate with the cardio-vascular and other people.

some of the recommendations might be knocked out in committee anyway. We put down what was desirable. We discussed it briefly and thought in terms of mass media and any other media that would air it. We have not formulated a statement as yet but if it was accepted, the Society might. Dr. Krister has this in mind; he said we want to get these people working together and he elaborated on this at some length.

DR. GRAY: One thing strongly in my mind is that the government's advisers are the N.H.M.R.C., which had a sub-committee on this that has made recommendations. We want to be careful before we disagree with that. I would think they are sensible recommendations to the Government and I would think they would be the basis for the Australian Cancer Society.

DR. MACLAINE: It would be reinforcing what they have put through.

DR. GRAY: It will be considered by the Australian Health Ministers in July. This is the advice to the Government from its advisers. I would have thought it would be politically desirable to incorporate this in whatever policy the Australian Cancer Society would have.

DR. MACLAINE: Do we know the content of this?

DR. GRAY: It is widely published.

DR. MACLAINE: It would not be crucial at this stage but if this document did go forward, it would be necessary for the Council to consider that. This is only a document for discussion at this stage and what the Public Education Committee and the Council ultimately do to it, we do not know. This seems to be a good way of doing it because it is then reinforcing the considered thoughts of several committees on the matter.

If there are no other points on Section III.A, we will look at section B. Here we have in mind the Australian Cancer Society working through the State member bodies of the Society and working at State level. We have different things here - the public hospitals and clinics (we had in mind the N.S.W. work here on discouraging smoking). We had a note on smoking withdrawal clinics, but we felt that this was subsidiary to the main issues.

On page 3, very important in our thinking was the training in medical schools and other training centres. We thought the Divisions of Post Graduate Studies were very important for the inclusion of matter relevant to smoking and health and the exemplar role of members and allied propositions. We had in mind the nurses here, as well.

Section (c) applies to other aspects of smoking and health. In section (d) we thought the university health services would have a role to play here in terms of getting information and prompting action amongst the student body against smoking. We felt that those in particular who were medical students would have an important exemplar role because in view of the specialised knowledge they were gaining, they would carry more weight than the ordinary university student. As the medical practitioners of the future, their attitudes to smoking would be important. In (e) we deal with nurses and their training, as they are a particularly significant group in regard to smoking and health.

DR. RANKIN: B(a) - "Along the lines already adopted in N.S.W.": does this include discouraging the setting up of cigarette vending machines as in Victoria?

- Mr. LILLY may know what the position is in NSW, I would answer that affirmatively. I think they do, haven't they found no leave them in the States, I think that was the answer that was given.
- I can find out for you by tomorrow.
- It seems like undesirable no-alcoholism smoking in all States and to have restrictions in the hospitals. In the States you are not allowed to smoke in hospital with heavy restrictions. I remember that in the N.S.W. hospitals this specifically.
- We will check on that.
- It would be interesting to have a workshop to list all the kinds of double standards that Governments have in regard to smoking.
- That is true - you often have that. I can well imagine that happening in regard to the vending machines.
- I think something happened in Queensland with the signs stopping them from barring vending machines in hospitals.
- I think that is so. Then again you have signs in lifts saying "no smoking" but the driver is.
- I know there are lots of problems and one of the reasons for putting this in is to reinforce the general medical attitude towards smoking and health, and the inconsistencies are noted by the public.
- In B(a) - "Urge State Health Departments to discourage smoking...." You are not saying "forbid".
- This was a carefully chosen word. There was the thought of the dying man being comforted by smoking.
- I think many Governments would be very chary of forbidding smoking for that reason. It is hard to forbid a 75-year-old who will die in a few months from enjoying one of his few pleasures.
- We do not buy the idea of forbidding anything. When you forbid something, you invite the breaking of the rules. Running all through this is we tend to discourage this. In connection with the medical practitioner, he does not forbid his patients to smoke; he suggests it or advances something else. We are not advocates of prohibition.
- What about producing a union crisis if you suggest the wardsmen do not smoke? It creates a lot of trouble. In the hospitals in Queensland this has happened. You have to have everyone on side and get down to the union itself.
- This was pushed around quite a bit in committee and these difficulties were recognised. We were not there to iron out the specific difficulties and when these were mentioned, we concluded that, to get down to essentials, we had to think in terms of health and the well-being of the patient. Therefore, when it comes to a ward basis, we may have to differentiate between a convalescent and an active treatment ward when deciding on policy in relation to smoking.

DR. MACLAINE: Dr. Lilley may know what the position is in NSW.

DR. LILLEY: I cannot answer that offhand. I think they do.

MR. BROWN: Weren't they forced to leave them in the kiosk. I think that was the answer that was given.

DR. LILLEY: I can find out for you by tomorrow.

DR. RANKIN: It seems less undesirable to discourage smoking in hospitals and to have machines in the hospitals. It is saying "you are not allowed to smoke in hospital but here is the means to do it". If that is not in the N.S.W. recommendations, I recommend that A.C.S. consider mentioning this specifically.

DR. MACLAINE: We will check on that.

MR. CARR: It would be interesting to have a workshop to list all the kinds of double standards that Governments have in regard to smoking.

DR. MACLAINE: That is true - you often have that. I can well imagine that happening in regard to the vending machines.

MR. CARR: I think something happened in Queensland with the unions stopping them from barring vending machines in hospitals.

MR. RUDDER: I think that is so. Then again you have signs in lifts saying "no smoking" but the driver is.

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DR. SPRINGETT: In B(a) - "Urge State Health Departments to discourage smoking...." You are not saying "forbid".

DR. MACLAINE: This was a carefully chosen word. There was the thought of the dying man being comforted by smoking.

DR. SPRINGETT: I think many Governments would be very chary of forbidding smoking for that reason. It is hard to forbid a 75-year-old who will die in a few months from enjoying one of his few pleasures.

DR. MACLAINE: We do not buy the idea of forbidding anything. When you forbid something, you invite the breaking of the rules. Running all through this is we tend to discourage this. In connection with the medical practitioner, he does not forbid his patients to smoke; he suggests it or advances something else. We are not advocates of prohibition.

MR. HOLLIDAY: What about producing a union crisis if you suggest the wardsmen do not smoke? It creates a lot of trouble. In the hospitals in Queensland this has happened. You have to have everyone on side and get down to the union itself.

DR. MACLAINE: This was pushed around quite a bit in committee and these difficulties were recognised. We were not there to iron out the specific difficulties and when these were mentioned, we concluded that, to get down to essentials, we had to think in terms of health and the well-being of the patient. Therefore, when it comes to a ward basis, we may have to differentiate between a convalescent and an active treatment ward when deciding on policy in relation to smoking.

MR. BURKE: It is easier to introduce non-smoking into a hospital from a staff point of view because there are areas in a hospital where the staff cannot smoke - e.g. operating theatres and kitchens. These are areas where the employees are not allowed to smoke and it only takes it another step further in the industrial area to say "Joe is not able to smoke, so why should you be?". Smoking during morning and afternoon tea breaks and the lunch hour is not forbidden. However, you could not tell a patient not to smoke.

DR. MACLAINE: The thing to bear in mind is that when it comes to a State level, the situation differs from one State to another, and you even find variations between hospitals within a State. Necessarily, what N.S.W. is able to do in their hospitals on an administrative basis may fall down for some reason in Queensland. All we can do is set out recommendations and hope that others will think of ways of implementing them.

DR. GRAY: One of the reservations I have about the problem is that most of the States have bulletins on smoking and the Australian Cancer Society is about to formalise a policy, so we have to consider what the States have already done and what the National Health & Medical Research Council and the National Heart Foundation have done. There are a lot of people who have general policies. I see difficulty in converting the report into a policy which the Council can vote on at this stage. The attempt is being made now to co-ordinate this.

MR. BURKE: This is being done in a dictatorial manner without taking into account the States' attitudes, you mean?

DR. GRAY: I was not suggesting dictatorial. I am suggesting that the Australian Cancer Society is facing the situation where the State bodies were first in the field and therefore had a policy first. If the Australian Cancer Society has a policy, it is embarrassing to the States if they disagree. An example is the Victorian policy in regard to tar free cigarettes. The Victorian policy is set out in the annual reports which are tabled in Parliament each year and we would be very careful about changing our policy. We could change it but we have to be very careful about what goes up to the Australian Cancer Council for a vote of approval on Saturday.

DR. MACLAINE: This means that anything like this report has to be a general statement. As soon as it particularises, it is certain to clash with State policy. We have to watch that, but on the other hand, the Council is a conglomerate of State members and there is nothing dictatorial in the situation.

DR. GRAY: How many States are not supplying the medical people with literature and information?

DR. MACLAINE: One of the functions the recommendations of this report can perform is to raise the level of smoking and health action in some of the States.

DR. HOLDEN: Could we have a more positive approach by suggesting that smoking in hospitals should only be allowed in canteens or convalescent wards, etc. This would not necessarily be in conflict with anything at present. It would be a more positive approach by the Australian Cancer Society. It is a thing to be discouraged, but instead of saying "do not do it", we are suggesting it be done only here or there.

DR. MACLAINE: You restrict it, but in positive terms. I favour the positive approach.

DR. HOLDEN: It is a change from a "No Smoking" sign to a "Smoking Here" sign.

MR. HOLLIDAY: Our Minister said he would not forbid smoking in hospitals.

DR. SPRINGETT: When you take away a right from a person, you are hitting at what the Government calls a fundamental responsibility to see that a man retains as many rights as possible in civilised living, and one has to prove to Government that smoking is incompatible with civilised living.

DR. MACLAINE: I think this is so. I cannot think of anything that has been recommended here that would hit at these rights, with the possible exception of the way you interpret the hospital matter, and there Dr. Holden's suggestion of the more positive approach may cover that point. I would not be surprised if Dr. Gray's comment comes up again in terms of what the States are already doing and we have to keep this in mind.

Any other points on page 3?

MR. OSBORN: "(d) Approach University Student Health and Counselling Services..." I have been to see Dr. Hadley, the Director of the Health Services at the University of Adelaide. He was most interested and co-operative. He has done a thesis, a study of 1500 university students, part of which concerns the smoking habits of first year students at the University of Adelaide. He relates the factors, including the faculty, father's occupation, mother's occupation, secondary school attended, area where parents live and where the student lives during the university year, death, separation or divorce of parents, and the area of birth. He has come up with quite interesting conclusions.

DR. MACLAINE: When you have someone who is involved in the area, you are on the right track in getting him further active. He is someone to follow up.

MR. OSBORN: In Adelaide, the students of the Faculty of Economics were the greatest smokers.

DR. MACLAINE: Section C is self-explanatory. Section D deals with the distribution of supporting documents for medical practitioners in relation to smoking education of patients. Section E is directed at Governments and section F is a survey of smoking in the medical practitioners' field. Any comments on those?

MR. HOLLIDAY: Section E would be hard to implement, would it not?

DR. MACLAINE: We are not certain about this. We think we should be able to speak with some kind of united voice to any government or government office.

MR. HOLLIDAY: We discussed this with the Minister several years ago and he said the Government would support an educational campaign but would not support any restriction.

DR. MACLAINE: Section E could be so difficult that it could be deleted from the final draft because of state problems.

On page 4, Section G deals with the need for the availability of figures on the incidence of lung cancer etc.

DR. GRAY: I am worried about that on the grounds that it is easy for Registrars to get lung cancer death certificates, but to get smoking related to that is difficult. It would cost a lot of money, and is it worth it?

DR. MACLAINE: We feel that if we can get more reliable information beyond a state level, it will help. Sometimes we cannot even get it at a state level.

MR. HILL: Does this mean you think there is some difference between the results obtained overseas and here, that the overseas results might not apply in Australia?

DR. MACLAINE: Dr. Krister was particularly concerned. He could not get Australia-wide figures for various diseases connected with smoking and health. Not only in this area but in other areas medical statistics are quite chaotic.

DR. HOLDEN: The GPs of Australia have organised a committee to do just this.

DR. MACLAINE: We do not recommend that we do it and I am glad to hear this is being done, because it is basic to our need.

Section H is straightforward. As Dr. Holden has said, in public education the medical practitioners have to be one of the main bodies involved in giving lectures and in writing. We feel this is one of the supporting means.

Section I is for later on in trying to demonstrate that there is a pay-off in terms of improved health along many dimensions. Improved functioning is something the Americans are looking at.

Section J refers to the National Smokers' Test which is being devised at present in America and we have it only in an experimental form at present.

(Short adjournment to enable those present to travel to the offices of the Dental Health Education and Research Foundation, University of Sydney, 89 William Street, Sydney, for the next section of the Workshop Programme.)

A PROGRAMME OF INVOLVEMENT OF KEY GROUPS IN ACTION - The Dental Health Education and Research Foundation, University of Sydney.
Speaker: Mr. Peter Lazar, Director of the Foundation.

Background Papers: "How to Reach People with Dental Health Education" (a paper prepared for the XIV World Dental Congress, Paris, July 1967). D.H.E.&R.F. Achievements, 1966.

MR. LAZAR: Welcome to the Dental Health Foundation. I am hopeful that this will be a fairly unstructured session in which you can ask questions and say things as we go along. I will try briefly to outline to you something about the foundation, why it was formed, how long it has been going, and what it has done, and then to spend the main part of the time on the development of a National Dental Health Week. I would like you to meet our Executive Director and our Publicity Officer (who also operates our puppet theatre) and I have asked her to hand you material on that particular programme.

The Foundation was formed in 1962 because dentists in N.S.W. felt that the N.S.W. public were not interested in dental health or, if they were interested in it, they apparently did not care very much about maintaining their own dental health and did not know how to go about it, or care. The A.D.A. has had a dental health committee, a statutory body, but their funds were limited and they were unable to do a great deal of work because of this. They were also limited in manpower because the members of the committee were practising dentists who met once a month.

Realising that with a lack of money and manpower to do a dental health education job, they had a major problem, they decided to raise a large sum of money to appoint full-time people to do this work. They were advised not to seek to have a button day appeal from the general public because dental health was not considered a very appealing subject on which to raise money in this way, and that therefore they should start by raising money amongst themselves.

The target set was £65,000 over five years. Considering there are only 1200 practising dentists in N.S.W., this was a high target, since this was the number of people who would contribute the money. To everyone's surprise, they went over the target and raised about £80,000 from the dentists in N.S.W. That enabled them to appoint a staff - a girl and myself in 1963. The intriguing thing was that they did not appoint a dentist, although just about everyone expected them to, including myself. They decided for obviously very good reasons to appoint a non-dentist who could operate in the area of communications rather than the area of dentistry. This has worked out - only the future will be able to say how well.

We have had an interesting six years. During this time a number of programmes have been implemented and research has been made into the problems in the areas of dental health. It is these particular areas we will talk about. To begin with some of the major programmes of the Foundation, it was considered that the problem dentists saw to exist, namely, the lack of knowledge by the public, the lack of a positive attitude on the part of the public, was not so much the fault of the ignorant public as of the dental profession itself. If the dental profession had