more realistically what is essential to that freedom from the mere accretion of custom; undertaking more effectively the responsibilities imposed by it; and accepting a role in society carrying corporate, as well as individual, social obligations.

The profession no longer sees all the proposed organizational changes in health care as inevitable threats to its freedom or quality of medical care, although it fears some might be, as indeed they could. The profession is willing, even eager, to participate in the process of change as it was not a decade ago, and to do it in co-operation with others, including governments and laymen. From isolation and superiority, the medical profession is moving toward equality and social involvement in a new way.

Saskatchewan has been influenced by this changing climate in the rest of Canada, but has also contributed substantially to it. The Saskatchewan crisis of 1962 opened the era of government intervention in personal medical care and the profession's re-evaluation of its own position, even though both took several more years to develop.

The Saskatchewan doctor's strike left deep scars on the medical psyche everywhere, as well as creating rifts and bitterness within the profession that still have not entirely disappeared. Doctors resent the word strike: they say they set up an emergency service during the 23 days in July, 1962, and, in any case, were not employees and therefore could not strike.

Nevertheless, the doctors' "withdrawal of services" was seen as a strike, a labor-management connotation that created further resentment by its implication that doctors were seen as employees.

That doctors would actually refuse to treat patients in any circumstances shocked everyone, including the doctors, but it denoted the depth of their feelings. Few even today regret the action: they feel they fought for an important principle, that their stand drew national attention to the dangers of Government controls that influenced later events even though medicare was introduced throughout Canada.

Dr. H. D. Dalgleish, president of the College of Physicians and Surgeons of Sas katchewan in 1962 and today its registrar, said: "We thought it was the right thing then. I would certainly act the same way, given the same situation, but you can't transport the past to the present."

It was no accident that medicare came first to Saskatchewan, which had a long history of co-operative action born of adversity. With a one-crop rural economy dependent on the vagaries of harsh climate and fluctuating markets. Saskatchewan people had often survived hardship only by community action, often through local councils backed by Government. These characteristics of self-reliance combined with communal co-operation flowered during the Depression, which hit Saskatchewan savagely.

Saskatchewan doctors suffered the economic squeeze at least as much as the patients on whom they depended for a living. From early in the century they led in community action to combat illness, first against tuberculosis, the major scourge of that era, and later against cancer. In 1929 the doctors proposed and worked with Government to establish a publicly financed cancer program that has been a model for Canada. In 1919 the Government authorized municipalities to use taxes to pay retainers to keep doctors in communities.

As early as 1916 the first legislation was passed allowing local tax levy for hospitals and by 1927 the legislation was amended to permit municipalities to pay hospital costs from general tax revenue.

In 1947 hospital insurance was brought in for all Saskatcheman residents, 12 years before Ontario acted.

In 1942 the Saskatchewan College of Physicians and Surgeons wrote to the Government, saying it favoured "state-aided health insurance on a reasonable fee-for-service-rendered basis."

With this background, why, 20 years later, was there an outcry and, of all things, a doctors' strike, against medicare?

In 1942, the voluntary, non-profit, prepaid medical insurance plans were only four years old. By 1962 they covered nearly 70 per cent of the population, so the profession felt a blanket government scheme was no longer necessary when two-thirds of the people were insured. The Government looked at it from the opposite direction, saying that with a third of the population not covered a broader scheme was needed.

More important, the college's 1942 proposal had included the