

# The Evolution of Canadian Health Care: Poetry, Policy and Prospects

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**M**any may puzzle at my choice of title for this paper. “The Evolution of Canadian Health Care: Poetry, Policy and Prospects.” What does poetry have to do with policy?

My inspiration for endeavouring to examine the evolution of Canadian health care and its prospects by utilizing poetry came from John Fitzgerald Kennedy.

When power leads man toward arrogance, poetry reminds him of his limitations. When power narrows the areas of man’s concern, poetry reminds him of the richness and diversity of his existence. When power corrupts, poetry cleanses, for art establishes the basic human truths which must serve as the touchstone of our judgment.<sup>1</sup>

I miss the eloquence that John Kennedy and Martin Luther King brought to political and policy discourse. It is my hope to review the progress of Canadian efforts in the field of health with the assistance of a few of my favourite poems. It will be my assertion that Kennedy’s basic human truths and his affection for poetry have much to commend themselves when we examine Canadian health policy and its prospects. Rest assured that I have not turned my own hand to iambic pentameter preferring, sensibly, to leave the poetry to recognized and capable poets.

As Robert Frost once noted, “A poem begins in delight and ends in wisdom.”<sup>2</sup> One can only hope to aspire to such a lofty goal for a Gow Lecture.

## **Context**

Let me begin with the context of health policy: its history, principles, expectations of our citizens, and other elements that form what is needed and what is possible. Only then can one outline progress to date and the challenges that lie ahead.

## **History**

I intend to review briefly four distinct phases in the evolution of what we loosely call Canadian medicare. The broad history of the first phase of Canadian medicare can be captured in a single sentence. Innovation and leadership in the provinces have been followed by the use of the federal spending power to render these innovations into national programs. This statement does bear repeating!

This was the recurrent pattern from the 1940s through the 1970s. Provincial innovation, first in hospital insurance, was converted to a national program through the powerful use of the federal spending power. There were two great cycles to this first phase: hospital insurance and physician services insurance. Each had its original roots in the prairie soil of Saskatchewan, then Canada's poorest province. Each had the evangelical fervour of socialist Premier Tommy Douglas to propel it. Each sweep from provincial initiation to full national program required a decade to accomplish and the full use of the federal spending power.

I had the remarkable privilege of working with Stanley Knowles and Tommy Douglas in Ottawa in 1974. They had graduated in the same class from Brandon College in 1930, and Stanley Knowles recounted the story of the two new graduates sitting in the dust outside their college as the Depression of the 1930s began around them.

Tommy said, "I am going to do something about health care." Knowles replied, "I would like to do something about pensions." Off they went for the next 50 years. Their passion and their persistence changed health care and pensions in Canada for the better.

These were not bloodless or boring policy decisions, but real life struggles. Tommy Douglas faced down a doctor's strike to bring about insured physician services. The Hall Royal Commission laid the groundwork for a national program.

Medicare was part of the dream of the New Jerusalem for Douglas along with the most passionate of his followers. Canadians have embraced and clung to that dream, fearing Langston Hughes' words

Hold fast to dreams  
For if dreams die  
Life is a broken winged bird  
That cannot fly

Hold fast to dreams  
For when dreams go  
Life is a barren field  
Frozen with snow.<sup>3</sup>

But let me not dwell on Saskatchewan!

*Phase Two: Continued provincial innovation and expansion.* The second phase of medicare featured further innovation and the broadening of those services funded by provinces. This time the federal government did not join in utilizing 50/50 cost-sharing. Instead, the federal government, worried about funding without credit, instituted a tax point transfer. Provinces could both tax and spend on health services.

Home care was initiated as a provincial program in Manitoba in 1974; and since then each province offers some form of home care to its residents. Drug coverage was initiated in Ontario in 1984 and has yet to become a full national program. Provinces decided to be separate in program terms as they continued to be policy innovators in phase two.

Medicare was popular. Expanding it became the road to election and re-election for many premiers.

Phase Three: Federal and provincial cost containment. The third phase of medicare featured the cost containment of the 1990s and the resultant restructuring of the hospital delivery system at the governance and management levels. Efficiencies were achieved through shorter stays, movement toward more out-patient services, and expanded day surgery.

There was also damage to the health labour force as a result of reductions in nurse and physician training and layoffs within the hospitals. The health labour force contracted, but the work of caring for Canadians did not. Overwork and excessive overtime led to a demoralized nursing workforce with a high rate of workplace injury and resultant absenteeism.

The federal government unilaterally cut the health transfer in a significant way. This decision in the mid-1990s broke the uneasy trust between the federal and provincial governments. It created a decade of deep resentment and lasting mistrust. In phase three, the provinces were forced to go it alone on both the management of most containment and in the funding support growth.

Phase Four: Reinvestment/return of the federal spending power. We are now in the fourth phase, which is characterized by a return of the federal government to a use of the spending power. In 2000, 2003, and again in 2004 the federal government committed billions of new dollars to the provinces for health care. The nature of the new style of agreement is shared, with publicly declared objectives, but no specific legislated mandates. The provinces agree on a plan of action and the federal government transfers the health-care dollars. There are a few exceptions, such as the Diagnostic and Medical Equipment Fund, where requirements on the provinces are more specific.

Another development in phase four is the special purpose national organizations in the health sector. Many of these organizations feature shared governance or arms-length governance. New national organizations represent a novel way of doing business in medicare and within the Canadian federation. Examples of these organizations include: Canadian Institute for Health Information; Canadian Blood Services; Canadian Institutes of Health Research; Canada Health Infoway; Public Health Agency; Patient Safety Institute; and the Health Council of Canada.

Time will be the judge, but it may turn out that the new organizations created through the past decade may be a virtuous answer to the dysfunctional Federal/Provincial/Territorial process.

## **Canada in the World**

Solidarity and universality have gone out of fashion in many areas of social policy in favour of income testing and targeting or the rough justice of the market. I strongly believe that the right path remains that of maintaining our differences in health care and sharing the burden of health costs on our broad collective shoulders.

When I consider that our American neighbours, our friends, now spend over 14 percent

of their gross domestic product and still have 45 million uninsured; and when I learn that 500,000 American families face bankruptcy each year due to high medical bills I am reminded of the words of Robert Frost:

Somewhere ages and ages hence:  
Two roads diverged in a wood, and I-  
I took the one less traveled by,  
And that has made all the difference.<sup>4</sup>

In health-care financing, Canada took its own path. We took the path of universality, the path of solidarity. I am grateful and proud that we did.

Our American cousins can learn from us about how to insure each citizen. We can also learn much from them. American health care has an impulse for innovation and micro efficiency that would be valuable for us to learn. It is wrong to be smug about our situation or to be unwilling to look hard at the lessons, positive and negative, available to us from the experiences of other nations.

We also have much to learn from the innovation of Prime Minister Blair in the United Kingdom, and from the other European nations. In a remarkable transformation Blair, building on work started by Prime Minister Thatcher, has brought about a dramatic improvement in the responsiveness of the National Health Service.

## **Public Expectations**

Our expectations for health services have expanded. In fact, these expectations have been derided by some British critics who use the phrase “nanny state”, suggesting that we are seeking a “cradle-to-grave” health-care system.

Certainly, the baby-boom generation seeks attributes in a health system that will test the abilities of providers, managers, and funders. We seek greater speed, quality, and appropriateness in services. We are impatient patients: “Health care should be free at the point of service and available in 30 minutes.”

## **Politics and Politicians and Markets**

Some say we have too much politics in our health care and not enough market. Others say we have too many politicians and not enough experts. In my experience, we have plenty of both. The real challenge is to sort out roles so that our elected leaders set broad policy, those with expertise in management implement policy, and those with expertise in clinical care actually deliver that care. We need to avoid micro management by the political level, a real danger in a system made extraordinarily responsive to individual cases through House of Commons Question Period theatrics. Equally, we need to avoid the fiction that resource-allocation decisions can be made in an entirely technocratic fashion. Real choices in a democracy are taken by the elected, as imperfect a process as that may be.

There is plenty of room to capture the virtues of markets well beneath the umbrella of universality without undermining it. For example, I chair the board of St. Elizabeth

Health Care. We are a Catholic not-for-profit home-care provider. We bid on contracts awarded by Ontario's Community Care Access Centre — the public bodies allocating tax dollars for home care. This internal market works rather well. There is direct competition among not-for-profit and for-profit providers on both price and quality. The competitive approach has improved value for money in home care.

e.e. Cummings once cruelly remarked:

A politician is an arse upon  
which everyone has sat except a man.<sup>5</sup>

It is true that we are very hard on our politicians. We elect them and then turn upon them. We encourage them to promise the impossible in order to gain office. We are keen to hound them from office for failing to deliver the impossible. I reject Cummings most days. Yet, I hope for a return to the more careful political leadership of my youth that took under-promising and over-delivering as a responsible approach to governing. This was easier, one suspects, in the decades before the 24-hour-a-day news channels yearning to be fed.

Nor do I subscribe readily to a Marxist view of politics, although I do enjoy this insight purported to be from Groucho Marx, "Politics is the art of looking for trouble, finding it everywhere, diagnosing it incorrectly and applying the wrong remedy." Groucho has much more to commend him as a source of health-policy insight than his namesake Karl.

## **What Has Been Done?**

### **Studies**

We have had a wealth of studies of health care in Canada. In the past decade we have seen the National Forum on Health, chaired by Jean Chrétien; the 2002 Royal Commission on Health Care, led by Roy Romanow; the paper by the Senate Committee on Social Affairs, Science and Technology (2002) chaired by Michael Kirby; and the report on palliative care by the Senate Committee on Social Affairs, Science and Technology written by Sharon Carstairs in 2000.<sup>6</sup>

Frank Scott once wrote critically of Prime Minister Mackenzie King: "The height of his ambition was to pile a Parliamentary Committee on a Royal Commission."<sup>7</sup> Clearly with regard to health-care policy Jean Chrétien had MacKenzie King's legendary patience for public policy.

Each of the provinces has undertaken its own study. These have been led by various people: Robert Spasoff, John Evans, Ken Fyke, Don Mazankoski, and Michel Clair. If excellent studies alone could fix a health system we would have an unchallenged claim to being the best in the world.

## **Financing**

Rudolf Klein has observed, and he is a keen observer and commentator on the National Health Service of England, that “governments are manic depressives when it comes to funding health systems: either spending wildly or cutting back savagely.” Nevertheless, Rudolf and I remain convinced of the merits of the solidarity principle and the public funding of health services. Our current prime minister, perhaps inspired by Rudolf Klein, has included an extremely important escalator clause in the most recent agreement with the provincial premiers. The importance of the escalator clause, set at six per cent, is that it moves the Government of Canada back into its historic role as a committed funding partner for medicare. The predictability and stability sought by provinces are met. This is real and, one hopes, lasting progress.

## **Wait Times Progress**

Wait times are for Canadians the “canary in the mine.” Wait times are the means that citizens use to judge the system’s performance. During the 2004 federal election, Prime Minister Martin put “wait times” centrally on the agenda of his new government. In September 2004, the first ministers agreed to the prime minister’s “Wait Times Reduction Fund” proposal. Legislation has been introduced to provide a multi-year fund of \$4.5 billion, a portion of which will roll into the permanent transfer. There are no strings of any kind in the legislation.

Across Canada, provincial governments are taking varied measures to reduce wait times. They are driven, not by federal requirements, there are none, but by their own political realities. Reduced wait times are how their provincial electorates will judge the performance of health reform and health management.

In Saskatchewan, a province-wide surgical care network has been developed under the careful stewardship of Dr. Peter Glynn. In Ontario, Dr. Alan Hudson is leading efforts to purchase additional volumes of procedures within the public hospital system. Much progress is occurring.

## **What More Needs to Be Done: Our Seven Key Challenges**

I believe that the future success of Canadian medicare rests on our collective ability to meet seven challenges. What is intriguing is the degree of consensus in the country about these directions. Our real challenge is implementation. We talk a great game on health reform. We are passionate in our beliefs. We are generous in our willingness to pay higher taxes to support health services. The central question is: Can we actually deliver the goods to Canadians?

## **A Healthier Nation**

We have known for a long time about the broader determinants of health. Enormous progress has been made since the Lalonde Report of 1974 on tobacco reduction, reduction of drinking and driving, and highway safety.

Canadians enjoy relatively long life expectancy and despite all of our efforts, life expectancy has steadily increased over the decades. Public health is being addressed by actions already underway. There are two key areas, however, where we continue to fail.

## **Aboriginal Health**

The federal government has direct responsibility for health services to Aboriginal Canadians. It is a continuing disgrace that our Aboriginal citizens live ten years less, on average, than all other Canadians. It is past time for an intelligent, concerted, and sustained effort to improve this situation. There are, however, a few promising beginnings.

It is likely that better education for Aboriginal children will have a greater impact on life expectancy than any other single initiative. In addition, the improvement in infrastructure needs, including sewer and water, will go a long way toward better health. Finally, there is acknowledgement of the need for a sustained effort to train Aboriginal Canadians as health professionals: doctors, nurses, pharmacists, and health technologists.

## **Healthier Children**

The next impending health disaster is obesity, particularly in children. It is, in fact, an epidemic of inactivity of which the consequence is obesity. Sadly, given the progress on reducing tobacco consumption the obesity issue is capable of adding even more long-term illness and cost to our health system. This obesity is driving increased diabetes and heart disease in teenagers and even younger children.

One small step would be to secure the agreement of the premiers that all children should have access to sports and recreation in school. Labour disputes have eliminated school-based sports for many children. As well, it is important to shift the focus in young children to sports that allow life-long participation. Football is not a life-long sport; neither is basketball nor volleyball for most Canadian adults. Why don't we, through comprehensive school and community recreation programs, teach our children, all of them, to swim, to golf, to hike, to bicycle, to play soccer. This allows them to keep active through their entire adult lives.

A good start would be a concrete commitment from each premier that one hour per day of physical activity will be the goal for every school-age child in the nation.

## **Health Human Resources: Sufficient Numbers of Well-trained Professionals**

Two serious policy errors were made in the 1990s. As a result, Canada is now coping with a significant shortage of nurses and a severe shortage of doctors. It is important to examine the root causes of these policies in order to learn from our experience. The decision to reduce medical school enrolments in the early 1990s was based on an - exhaustive study carried out by Greg Stoddart and Morris Barer.<sup>8</sup> Yet, ministers and deputy ministers, of whom I was one, took only some of their recommendations, not the

suggestions of the whole package.

No study was conducted, nor was a collective decision taken, with regard to the training of nurses. Over the decade, Canada reduced the training capacity for registered nurses from 12,000 per year to as few as 4,000. As hospitals consolidated and nurse education migrated from hospital to community college and from community college to university, overall enrolment numbers were cut dramatically.

Mea culpa.

We must learn from our mistakes if we are to avoid repeating them. What have I learned?

First, be careful with policy recommendations not to “cherry pick” the easiest to implement or the recommendations with the least opposition. A package often has an important logic. The logic of the Barer-Stoddart package was the reform of primary care to a multidisciplinary model requiring fewer family doctors. We got the fewer doctors without the reformed system, resulting in the current shortages. Second, review decisions taken frequently. It was apparent that we were going in the wrong direction after only a few years. It took nearly a decade to reverse direction.

The Health Council of Canada is convening a Health Human Resource Summit in June 2005. I hope it will become an annual gathering of knowledgeable decision makers and analysts. I hope that it will allow us to look at our actions and determine what needs to be done. The best position for Canada is to have at all times a modest surplus of health-care providers to allow for catastrophic situations, such as the SARS epidemic, as well as the normal retirements and turnovers, and for considerations of quality.

## **Enhanced Information Management**

T.S. Eliot in his Choruses from *The Rock* asked:

Where is the wisdom we have lost in knowledge?  
Where is the knowledge we have lost in information?<sup>9</sup>

Information technology, the electronic patient record, is not a panacea. In health care there are none. It is, however, a powerful and essential tool. Its virtue is not the displacement of the provider — be it the physician, nurse or pharmacist— but the provision of professional skill and judgement. This is provided with a comprehensive insight into the patient’s history and current state. We need to “wire” the Canadian health system and implement telehealth, electronic patient records, and electronic prescribing. We have a national organization, Canada Health Infoway, poised to move forward with this essential task. With a determined national effort and lots of local and provincial interest, these tasks could be accomplished by 2010. On the current track, it will take 15 years, not the five it could and should. We will get there in 2020, not 2010.

## **Structural Reforms to Delivery: From Hospital Governance and Management to Health System Governance and Management**

Nine provinces have reorganized their structures of health-care delivery. Beginning with Quebec in the 1960s, and with eight other provinces joining in the 1990s, Canada has moved from a system in which individual hospitals have governance toward a broader health-system governance. For Ontario it has been, despite the important restructuring undertaken by Duncan Sinclair and the Health Services Restructuring Commission in the 1990s, a delayed consideration of health-system governance.

Along with Yeats, one might wonder:

And what rough beast, its hour come round at last,  
Slouches towards Bethlehem to be born.<sup>10</sup>

It is past time for Ontario to join the rest of Canada in this reform. The Local Health Integration Networks (LHNS) may or may not succeed. The system of two levels of governance is not a stable long-run solution. In other jurisdictions, the individual hospital governances have given way to the broader region.

If we want a healthier nation, then regional and local governances need to oversee both services and population health. The evidence is overwhelming from health regions in every other province. Great progress is being made in tackling public health and health promotion. In Winnipeg, low birth-weight babies have nearly been eliminated in low-income families through better pre-natal care. In Edmonton, flu shots for seniors have become a successful, broad measure in the effort to maintain a healthy population.

### **Broadened Coverage**

As noted, the early decades of medicare, hospitals and doctors represented 80 percent of health services. Now they account for much less than 50 percent. And how can we possibly claim comprehensiveness in the system of Canadian medicare when 600,000 Canadians have no public or private financial coverage for drugs?

It is past time for drug coverage and home care to join hospitals and doctors within the structure of medicare. This is not to argue that the full set of Canada Health Act principles should apply to drugs and home care. In fact, there is a strong case for allowing additional private insurance and co-payments in drug programs. No limits should be set on home-care purchases by private individuals or insurance for long-term care.

In the wake of the medicine, Vioxx, recall and other troubling episodes, it is clear that an independent source of advice on medicines and appropriate prescribing are key issues to be tackled.

### **Vastly Enhanced Patient Safety**

The landmark Baker-Norton study established startling statistics on patient safety.<sup>11</sup> In Canada, of 2.5 million patients admitted to hospital in the year 2000, between 141,000

and 232,000 of these suffered an adverse event. As a result, 30 percent were left with a permanent impairment, and five per cent died. These preventable deaths represented between 9,200 and 23,700 people. In the words of Bob Dylan: “how many deaths will it take till he knows that too many people have died.”<sup>12</sup>

The answer is not blowin’ in the wind. It is staring us in the face. We need to make hospitals and the health system as safe as aviation. It will take a serious local, provincial, and national effort to make our health system safer.

We have a new Patient Safety Institute, ably led by John Wade and Phil Hassen. It has much work to do, but at least a start has been made. This effort to steadily and dramatically improve patient safety must engage all levels of health-care delivery and regulation. From the prescribing doctor to the dispensing pharmacist, from the ward nurse to the surgeon — all must be engaged. We need practice environments where errors are admitted. To encourage this change, we may want to consider the New Zealand approach to no-fault compensation for adverse events. It has proven to be a good means of reducing litigation and defensive medicine.

## **Greater Transparency and Accountability**

I now chair the Health Council of Canada. And like Sydney Carton in a Tale of Two Cities, I can appropriately conclude as did Sydney on his way to the guillotine: “It is a far, far better thing I do than I have ever done before. It is a far, far better rest I go to than I have ever known.”<sup>13</sup>

There are some dark days. No one openly opposes greater transparency and accountability in health, but a thousand small decisions by the fearful and defensive at political and governmental levels delay and hamper efforts. Each time I feel information being withheld or learn of a Canadian denied the care they need, it takes a part of me. At these times I seek solace in Dylan Thomas:

Do not go gently into that good night.  
Rage, rage against the dying of the light.<sup>14</sup>

Or occasionally in the even more biting, but ultimately optimistic, words of Dorothy Parker:

Razors pain you,  
Rivers are damp,  
Acids stain you,  
And drugs cause cramp,  
Guns aren’t lawful,  
Nooses give,  
Gas smells awful,  
You might as well live.<sup>15</sup>

There are, thankfully, more good days than bad ones and little by little the struggle for the accountability and transparency we need is being won. We presented our first annual report in January 2005. André Picard of The Globe and Mail commented that we had shown that we had bark. Time will tell if we have bite!

Our seven challenges are: (i) a healthier nation and reduced disparities; (ii) a health workforce of sufficient size and quality to meet our needs; (iii) modern information technology, including the electronic health record; (iv) reformed delivery structures for governance and management; (v) broadened coverage for home care and drugs; (vi) vastly enhanced patient safety; and, finally, (vii) greater transparency and accountability.

Taken together they represent a way forward to renewed health and health care. There is one more ingredient for success. We need to have a philosophy of innovation. Our progress against disease has been through innovation. Our progress in achieving efficiencies in the delivery of care has come through innovation. Now, more than ever, we need to harness the enormous talents of our researchers, our scientists, and our clinicians to show us a better way.

## Conclusions

In concluding, I turn not to the wisdom of poets but to a recent e-mail from my 20-year-old daughter Genevieve, a second-year university student.

As you know, I have come to take a great liking to the field of Psychology, particularly Neuroscience. Yes, the left frontal lobe! The brain fascinates me and I have found my calling ... I am interested in anything to do with health research. I am not so fond of health policy. Probably as a result of witnessing countless battles you have had trying to transform the system. I know way too much about health policy for someone my age. For that I thank you. You have been a great source of information, inspiration and, at times, humour. I am much more interested in implementing the changes you foresee than continually talking about them.<sup>16</sup>

From the mouths of babes!

Genevieve is right. Deeds, not words, will heal medicare.

I know we will each, in our own way, continue the very Canadian struggle for a nation made stronger by the health of its citizens: men and women, young and old, rich and poor, southern and northern. And I am certain we will continue this struggle to build high quality, appropriate health services accessible by all on a timely basis to meet their needs. Our children and their children will need to grapple with the myriad challenges of technology, demographics, chronic disease, and the forward march of science.

I remain optimistic that we will continue to succeed.

Many deeds remain to be done and,

I have promises to keep,  
And miles to go before I sleep,  
And miles to go before I sleep.<sup>17</sup>

## Notes

- <sup>1</sup>John Fitzgerald Kennedy, *Address*. Amherst College (26 October 1963).
- <sup>2</sup>Robert Frost, "The Figure a Poet Makes," in *Collected Poems* (New York: Henry Holt & Co., 1939), Preface.
- <sup>3</sup>Langston Hughes, "Dreams," in *The Collected Poems of Langston Hughes* (New York: Alfred A. Knopf/Vintage, 1994), p. 32.
- <sup>4</sup>Robert Frost, "The Road Not Taken," in *Mountain Interval* (New York: Henry Holt & Co., 1921), p.9.
- <sup>5</sup>E.E.Cummings, "No. X," in *Complete Poems, 1936–1962*, G.F. Firmage (ed.) (London: MacGibbon & Kee, 1968), p. 550. (Originally published in 1944).
- <sup>6</sup>Roy Romanow, *Building on Values: The Future of Health Care in Canada* (Ottawa: Government of Canada, November 2002); Standing Committee on Social Affairs, Science and Technology (Chair, Michael Kirby), *The Health of Canadians: The Federal Role* (Kirby Report) (Ottawa: Government of Canada, October 2002); Standing Senate Committee on Social Affairs, Science and Technology (Chair, Sharon Carstairs), *Quality End-of-Life Care: The Right of Every Canadian* (Ottawa: Government of Canada, June 2000).
- <sup>7</sup>F.R.Scott, "W.L.M.K.," in *The Eye of the Needle: Satire, Sorties and Sundries* (Montreal: Contact Press, 1957).
- <sup>8</sup>Morris Barer and Greg Stoddart, *Barer/Stoddart Report: Toward Integrated Medical Resource Policies for Canada*. Report prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health (May 1999).
- <sup>9</sup>T.S.Eliot, "Choruses from *The Rock*" (Play) (London: Faber & Faber, 1934).
- <sup>10</sup>William Butler Yeats, "The Second Coming," in *The Collected Poems of W.B. Yeats*, revised 2<sup>nd</sup> edition, R.J. Finneran (ed.) (New York: Scribner Paperback Poetry, 1966).
- <sup>11</sup>G.R. Baker, P.G. Norton, V. Flintoft, R. Blais, A. Brown, J. Cox *et al.* "The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada," *Canadian Medical Association Journal* 170 (11, 2004):1678-86.
- <sup>12</sup>Bob Dylan, "Blowin' in the Wind," *The Freewheelin' Bob Dylan* (Columbia/Legacy Records, 1963).
- <sup>13</sup>Charles Dickens, *A Tale of Two Cities* (New York: The Copp Clark Publishing Co. Ltd., 1935; originally published in 1859).
- <sup>14</sup>Dylan Thomas, "Do Not Go Gentle into that Good Night," in *In Country Sleep and Other Poems* (New York: Shelfmark, CUP, 1952), p. 8.
- <sup>15</sup>Dorothy Parker, "Resume," in *Enough Rope* (New York: Boni & Liveright, 1926), p.61.
- <sup>16</sup>Confidential e-mail from Genevieve Roch-Decter.
- <sup>17</sup>Robert Frost, "Stopping by Woods on a Snowy Evening," in *New Hampshire: A Poem with Notes and Grace Notes* (New York: Henry Holt & Co., 1923), p. 87.