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**PROFESSIONAL POWER AND PROLETARIANIZATION?
A CLASS ANALYSIS OF CANADIAN PHYSICIANS**

by

SHAHID ALVI, B.A., M.A.

**A thesis submitted to the Faculty of Graduate Studies and Research in partial
fulfilment of the requirements for the degree of**

Doctor of Philosophy

Department of Sociology and Anthropology

Carleton University

Ottawa, Ontario

September, 1994

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**PROFESSIONAL POWER AND PROLETARIANIZATION?
A CLASS ANALYSIS OF CANADIAN PHYSICIANS**

submitted by

Shahid Alvi, B.A., M.A.

in partial fulfilment of the requirements
for the degree of Doctor of Philosophy

Chair, Department of Sociology and Anthropology

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ABSTRACT

This dissertation advances an empirical analysis of the process of class transformation experienced by Canadian physicians since the implementation of Medicare. By focusing on the dialectical interplay between the professionalization process, doctor's ownership relations and changes in the labour process in the context of the rationalization imperative characterizing the "logics" of capitalist development, the study shows first, how the majority of Canadian doctors were able to make a transition from a set of semi-organized trades to members of the old middle class. With the inception of Medicare, Canadian doctors struggled to maintain this class position. Subsequently, and in the context of increasing pressures to rationalize the health care system, proletarianizing forces have continued to influence physician's class experiences.

The dissertation finds that since Medicare, and in terms of the economic dimensions of class, Canada's physicians have become fragmented along class lines. Moreover, their class relations tend to be ambiguous and in a state of flux. The majority of doctors have either reproduced their position as members of the old middle class or have made a successful transition from the old middle class to the new middle class and/or fragments of the capitalist-executive class. Correspondingly few physicians have become part of the working class proper. Moreover, the essence of this successful transition is located in the articulation of physician's political, ideological and economic practices and experiences as expressed by the interplay of the ideology of science, direct links with the dominant political and cultural milieu and the creation of practice forms that effectively reproduce technical and financial autonomy.

The findings imply that for physicians in Canada, the capacity to resist proletarianization processes is rooted in their capacity to both mystify their work and to act in (hitherto) politically effective ways. Nevertheless, the current fiscal crisis in Canada and the attendant intensification of proletarianizing forces characterizing the health care system will continue to affect the profession in uncertain ways.

ACKNOWLEDGMENTS

I would like to thank, first, my supervisor Wally Clement for his steady support and ability to stand in the background while exerting a guiding influence. I would also like to thank my committee members, Bruce McFarlane and John Harp for their assistance with my studies and their illuminating insights. In addition, the warm encouragement and positive attitude of my friend and fellow student Karl Froschauer made it easier to cross the many bridges making up the Ph.D. experience.

A great deal of this research could not have been accomplished were it not for the support of many librarians at the Canadian Medical Association, the National Archives, The Conference Board of Canada, and McGill and Carleton Universities. In particular, I am grateful to Orville Adams and Paul Childs, both formerly with the Economics Department of the Canadian Medical Association, for granting me access to the Physician Manpower Questionnaire data and for patiently providing many runs even after it was supposedly all over.

Most importantly, I would like to thank my wife Pamela for her unwavering support, her love and her willingness to listen to the rantings of an ABD.

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CHAPTER ONE

INTRODUCTION

1.1. Introduction.

The unfolding role of the middle classes in capitalist societies has for some time been one of the central issues in class analysis as well as the sociology of stratification. In academic discourse, references to the middle class often fall within the context of theoretical and empirical debates concerning its rapid increase in the latest phases of capitalist development, its subsequent decline, as expressed in discussions of the “declining middle,” (the process characterized by income polarization, high taxes, and unemployment), and the “boundary problem” (dealing with ambiguous positions within the class structure).

Within the middle class, the professions have also received a great deal of scrutiny. Sociological analyses of the professions however, have tended until relatively recently to emphasize the definition, emergence and characteristics of professions. Little systematic empirical attention has been focused on the role and position of the professions within the changing configuration of class relations in capitalist society. This study employs a marxist approach to understand the insertion and movement of one occupation—medicine—within the Canadian class structure with a particular focus on this profession’s class practices and relations since the implementation of Medicare.

The study will attempt to better understand the shifting economic, political and ideological practices of physicians in Canada to partially address questions pertaining to the changing nature of the middle classes and the implications of these changes for

professionals. More specifically, this study will examine the class practices and experiences of Canadian physicians to better understand the answers to the following set of questions: *under the transformative pressures that characterize capitalism, what happens to professionals within the middle class? i.e., as the old middle class faces pressures that might force its decline, where does it go: to capital, labour or the new middle class, and under what conditions?*

1.2. Professional Labour in Capitalist Society: Proletarianization or Embourgeoisement?

The debate over the position of professional labour within the class structure of capitalist societies has taken several directions. Some authors, assuming a “post-industrial” society, have argued that professional’s credentialed knowledge is directly related to the difficulties associated with rationalizing professional work processes. As societies become more dependent on knowledge-based occupations, professionals, who possess a body of knowledge which they alone control, will become pre-eminent in the class structure. Professions are here seen as occupations with special importance for the effective and humane functioning of modern society. Professionals are therefore experiencing a process of embourgeoisement and constitute a group that will eventually become the controlling class (Bell, 1974; Freidson, 1973, 1970).

In reference to the medical profession, the most outspoken proponent of this argument is Freidson, who while recently acknowledging evidence that medicine is in some senses being “deprofessionalized,” nevertheless argues that as a “corporate entity” it has not weakened. His reluctance to view physicians in relation to the class structure stems from his tendency to treat professional occupations as homogeneous entities and

his failure to understand the dominant tendencies in advanced capitalism. Thus he is prone to the illusion that professions are immune to intra-occupational fragmentation, in which some groups of “professionals” within the same occupation may be performing more types of collective labour processes in sites they do not own or control, while others may have become more administrative and/or supervisory in their functions in sites over which they have some degree of ownership, thus placing them in a position tending towards the capitalist/executive class. Moreover, Freidson’s approach is restrictive in the sense that it is unclear to what extent his arguments would have application to nations other than the United States, and particularly for those countries with national health insurance schemes.

In opposition to the assumptions of post-industrialists are those who belong to various strands of the marxian tradition and who argue that professions, like other occupations, are being proletarianized. A central assumption of many orthodox approaches within this tradition is that professional labour, like any other labour, is subject to a linear and inevitable process of rationalization in which the power to resist is minimized or ignored altogether (see Braverman, 1974, and his critics). More sophisticated variations of the proletarianization thesis centre on the process of gradual loss of control over the ends to which professional labour addresses itself. Yet these approaches have provided little or inadequate empirical evidence of this process (see Larson, 1980; Derber, 1982; Hafferty, 1988).

Whereas the old middle class acted as independent commodity producers and were able to exist “outside” the capital/labour relationship, many fractions of the new

middle class of today are forced to sell their labour power to capital. This process, in the estimation of Derber (1982), constitutes the loss of control over the ends of labour. In addition, the modern setting has witnessed the increasing application of “scientific” methods of labour intensification which has resulted in the loss of control over the process of work. Like the working class, these fractions of the middle class possess no economic or occupational independence, are employed by capital and its offshoots, possess no access to the labour process or the means of production outside that employment, and must renew (their) labours incessantly in order to subsist (Braverman, 1974: 403).

Derber (1982) argues that historically workers first lost control over the ends of labour while retaining control over the means. Loss of control over the means of labour was only lost with the coming of the factory (also see, Marglin, 1975). For Derber, the process of proletarianization involves two “moments,” which he conceptualizes as “ideological” proletarianization followed by “technical” proletarianization. Ideological proletarianization “creates a worker whose integrity is threatened by the expropriation of his values or sense of purpose rather than his skill” (1982: 12). The professional worker within the new middle class demonstrates an increasing ideological proletarianization reflecting loss of control over selection and allocation of tasks. But at the same time, the professional is able to continue a “craft-like autonomy” within a highly specialized and skilled technical arena. Thus, in Derber’s estimation, technical autonomy and status privileges camouflage the loss of control over the objectives of labour. He goes on to argue that technical proletarianization—the loss of control over the technical plan of

production and/or rhythm or pace of work—has come to be seen as the process of proletarianization itself. But clearly, the process (he argues) developed in stages with ideological proletarianization coming first.

According to Larson (1980: 139) the classic proletarian condition is constituted by the fusion of three dimensions of alienation: which result from the historical development of the forces and relations of production. (1) Economic: the formal subjection of a seller's time and capabilities to a buyer and in which a quantitative element of skill, speed or capacity to perform under time pressure becomes part of the ordinary conception of discipline (and self-discipline) at work. (2) Organizational: a stage of forced cooperation (corresponding to the era of the "manufacture" described by Marx) which de-individualizes the worker's skills and qualifications by submitting them to the whole alien organization of the work setting and by controlling from above the conditions of any increase in skill, and (3) Technical: dispossession of control over the execution of work.

Still others have argued that the development of capitalist society has led to the creation of a new set of positions in the social division of labour. The occupants of these positions typically exhibit a high degree of individualism and consumerism which arises from the strong integrative forces of the new post-industrial society. It is argued that demand for job security in this society will lead to demands for structural reform and these members of the "new working class" will, by virtue of their superior knowledge, skills and attachment to the norms of the open society, lead the rest of the working class in social and economic struggle (Mallet, 1975; Touraine, 1971). Others such as the

Ehrenreichs (1979) have argued that professionals should be seen as a distinct class in monopoly capitalist society whose function is to reproduce cultural and class relations.

Finally there are those who agree with Haug's (1973) hypothesis that the professions are being "deprofessionalized," a concept meant to denote the gradual decline of status, monopolization of esoteric knowledge, autonomy in work performance, and authority over clients.

In the context of these debates, recent analyses of the medical profession have maintained that medicine is maintaining its corporate authority (Friedson), or being "socially transformed" (Starr, 1982) or have emphasized the gradual proletarianization of physicians through their ties to state sponsorship, escalating bureaucratization, and/or the loss of control over the means of and ends of labour (McKinlay and Arches, 1985; Derber, 1982; Lowellsmith, 1994). A recent issue of the Milbank Memorial Quarterly (Vol. 66, Suppl. 2, 1988) was devoted to an examination of shifts in the health care manpower situation with particular emphasis on the fate of doctors. Within this context, the debate has been posed in terms of the proletarianization versus professionalization dichotomy.

In Canada, little empirical work has been done on the class experiences of physicians. Swartz (1977: 327) argues that while the proletarianization process may be affecting some components of the middle class it has certainly not affected the medical profession who, he claims, have been given *de facto* control over the production process, particularly in hospitals. Yet he provides little evidence for this assertion. Johnson (1972: 167-168) contends that there has been a "deterioration of independence" amongst

the independent sectors of Canadian professionals and utilizes data on income gains and salaried status to argue that physicians have not succumbed to this tendency. However, he ignores the fact that surplus labour can still be extracted from a highly paid individual and that "salaried status" particularly in regards to physicians can have many different forms and therefore many different class implications. Wahn has argued that particularly in hospitals, doctors' work is being rationalized and degraded such that some physicians are experiencing "forms of economic and organizational alienation very similar to those experienced by the skilled craftsmen [sic] of the Industrial Revolution" (1987:438). However, his analysis does not provide much specifically Canadian evidence of this process and his conclusion calls for more systematic empirical research on doctors. Similarly, Coburn et. al. (1983) have argued that there has been a "decline in medical dominance" although they reluctantly place this decline in the context of the proletarianization process since the latter "poses difficulties," namely, an *a priori* view of class structure/class relationships/the class struggle, and the suggestion that there are specific criteria, related to the picture of the class structure used, to assess the degree to which medicine is being proletarianized (1988: 93). Above all, (they argue) difficulties arise because few have attempted to be explicit about these matters.

Coburn's arguments point to the lack of conceptual clarity surrounding the issues of proletarianization and professionalization, which are in turn, linked to the conceptual difficulties attending class analyses of the professions. Clearly, there are a multiplicity of approaches to the study of professions in general and to the study of their position in the class structure in particular. Notwithstanding the theoretical value of these varied

approaches, the fact remains that with respect to physicians in Canada, the great majority of these arguments have remained either empirically unverified or unconvincing.

Accordingly, this dissertation attempts to address these conceptual and empirical gaps by employing a class *struggle* analysis of the medical profession in Canada. As such, this involves the analysis of relationships between the characteristics of Canadian medical professionalism, the logics of the capitalist mode of production and the state.

1.3. Outline of the Study

The theoretical approach employed in this study is discussed in detail in Chapter Two. In that chapter, a theoretical framework is advanced that emphasizes the fluctuation of class relations within the context of the changing economic, political and ideological social formation. Attention is also paid to the concepts of profession, old and new middle class and their relationship to the state, and the centrality of economic relationships underpinning class.

Chapter Three outlines the historical and contemporary data sources utilized in this study. To address the changing political and ideological practices of the medical profession particularly in terms of their rise to professional status, primary historical data as well as socio-historical commentaries on Canadian medicine were examined. To address the economic dimensions of class—here conceptualized as ownership relations and the labour processes embedded in these relations—three empirical studies of physician practice patterns were used.

In Chapter Four, doctor's rise to professional power via the "professionalization project" is documented and specific attention is directed to the nascent medical

profession's relationship with the Canadian state. In Canada the arrival of Medicare between the early 1960's and 1970's signalled the beginning of a new relationship between the state and physicians. Since the implementation of this legislation, other developments have played a vital role in conditioning the class experiences and practices of physicians. These include the rise of technology, the influence of related medical industries such as pharmacy, and, perhaps most importantly, the influence of the managerial demiurge characterizing late capitalist societies in fiscal crisis. The nature and effect of these factors on physicians are taken up in Chapter Five.

Chapters Six, Seven and Eight deal with changes in the economic dimensions (the labour process and ownership relations) of the class experiences and practices of physicians in general (Chapter Six), in terms of the experiences of solo and group practitioners (Chapter Seven) and in the hospital (Chapter Eight). Chapter Nine analyzes the political and ideological practices of physicians in order to show how these practices have articulated with the economic dimensions of class and in the context of the forces discussed in Chapter Five. Chapter Ten summarizes and concludes the study.

CHAPTER TWO

CLASS STRUGGLE ANALYSIS, PROFESSIONALS AND THE STATE.

2.1. Introduction

This dissertation examines the relationships between the key transformative forces making up the capitalist mode of production and the economic, political and ideological practices of one professional stratum of the middle class in Canada—physicians in Canada. An understanding of the nature of these relationships requires clarification of three central theoretical concepts—class formation, profession and state—and the relationships between them.

Although there has been a good deal of interest in the role and position of professionals in the class structure, many analyses attempt to ascertain the “position” of professionals in the “empty structure of places” that constitutes the capitalist class structure. This study takes the position that such approaches ought to be reformulated as attempts to understand the constant *fluctuation* of class relations. The concepts of place, or static position, do not permit us to understand the historical formation, transformation and dissolution of classes, although they do serve as signposts to important relationships. In particular, the peculiar nature of the middle classes calls for an analysis that recognizes their mutability (Oppenheimer, O'Donnell, Johnson, 1982). Class analyses of professions have also often been complicated by an uncritical acceptance of the concept of “profession” itself. Thus, the class analysis of professions must not only reformulate

the project in terms of an emphasis on the dialectics of process, but must also critically reappraise the concept of "profession."

In addition, as Johnson (1982) points out, historically the professions and the state have had a "permeable relation" with one another, in that there has been interpenetration and intermingling between them. It is important therefore to understand the functions of the state with specific reference to what professionals do (their work) and the status of the professions to which they belong, while emphasizing the changing context in which relations between state and profession are created and maintained.

2.2. The Old and New Middle Classes

It is in the old and new middle classes that we find the "classical" professions of law, medicine, and divinity. Marx only wrote tangentially about such professions, arguing that they were immaterial to his analysis precisely because his project—to discover the "laws of motion" of capitalism and to theorize the antagonistic and contradictory relationship between Capital and Labour—was formulated at a higher (more abstract) level of analysis that prioritizes the historic role of these two "great historical camps." The results of this inquiry reveal, of course, that capital is the owner of the means of production, the non-labourer, exploiter and/or oppressor, whereas labour is the non-owner who is exploited or oppressed.

At an intermediate level of analysis, we should account for the existence of other social groupings within the context of this fundamental division between capital and labour. Thus, at the socio-economic level of analysis, we are able to theorize the old and new middle classes in terms of the notion of a "multi-class complex of class relations in a

bipolarizing structure” (Oppenheimer, O. Donnell and Johnson, 1980: 256). Accordingly, in this study the concrete analysis of the nature of medicine and the physicians who practice it will be placed in the context of a more abstract level of analysis. It will be argued that physicians, like other members of the old middle class, have been part of a historic shift in which the old middle class has moved from relative independence within class structures, to mediating control structures between capital and labour.

The concept of the new middle class (NMC) refers to a group of people who do not own, in either the legal or real sense, the means of production, yet perform both the functions of the collective worker (coordination and unity of the labour process) and the function of capital (supervision and control) (Carchedi, 1977). Essentially, many members of the NMC work for salaries within bureaucracies and often have a say over how the organization is run (i.e. they may *participate* in tactical or strategic decisions but would not have formalized voting powers), in addition to significantly directing the labour power of others. Substantive expressions of the NMC are to be found in the mass of managerial or service workers whose jobs came into existence as a result of the need to manage growing contradictions between capital and labour (for example, nurses, social workers and other “welfare state workers”) in addition to dealing with the sheer magnitude of managerial work created by the administrative and managerial revolutions. For example, at a certain stage of capitalist development, the attempt to generate higher rates of profit spawned the growth of managerial staff responsible for the supervision of labour at the point of production, and the sectors of the economy where the circulation and realization of capital are carried out. Accordingly there has been a large increase in

the numbers of "Industrial Relations" experts, "Human Resource" practitioners, accountants and "middle managers."¹ Similarly, we will see that the rise to prominence (from a set of semi-organized trades to old middle class) of Canadian physicians can be partially explained by reference to the development of a capitalist society which needed to ameliorate the economic and political consequences of ill health by socializing the costs of health care production and controlling potentially dangerous or unproductive segments of the population.

In contrast to the New Middle Class, the Old Middle Class (OMC) consists largely of independent commodity producers who own (in both the legal and real sense) the means of production and perform the function of the collective worker as well as that of the *individual* capitalist. As Marx points out, "the self employing worker is his own wage labourer; his own means of production appear to him in his own mind as capital. As his own capitalist he puts himself to work as a wage-labourer" (1977: 1042).

Substantive expressions of the OMC are the traditional shopkeepers, farmers, fishers, truck drivers and others who essentially own the means of realizing their labour power yet do not employ the labour power of others to any significant extent. While the notion of "significant extent" is somewhat problematic—i.e. what separates a small scale business person from a large scale capitalist?—following Clement (1990) I have chosen to identify as old middle class, all those who in addition to meeting the appropriate ownership relations and labour process functions criteria, also employ two or less persons.²

Given this conceptualization of the old and new middle classes, what precisely is meant by the economic functions of capital and labour and how do they underpin class relationships?

2.3. The Economic Relationships Underpinning Class

This study focuses primarily on the economic *identification* (i.e., the definition in terms of production relations) of one professional fraction of the old middle class while taking into account the dialectical relationship between production relations, and political and ideological practices (see Carchedi, 1975). Accordingly, the central (but not the only) theoretical concepts associated with the project of identifying shifting class positions revolve around two specific economic relationships:

- (1) the nature and forms of ownership of productive property and
- (2) the nature of the labour processes carried out within the context of these ownership relations.

As capitalism has matured, and in particular with the creation of the joint-stock company, ownership relations have undergone some important transformations. These transformations can be understood in terms of the concepts of real and legal ownership. Legal ownership is ordinarily passive, and tends to accrue to shareholders, stockholders and rentiers who sometimes have the capacity to influence the administrative operations of the “firm.” Administration as a function can be further divided to include tactical and strategic decision making. By contrast, real ownership is active, meaning that capitalist/executive owners are *actively involved* in controlling the means of production with respect to both tactical (short term, day-to-day) and strategic (long-term) decisions regarding accumulation and investment (see Chandler, 1977). They are able to dispose of

the products of production as they see fit. A further distinction should be made between capitalists and executives *within* the category of the capitalist/executive class, namely, that capitalists are managers who also appropriate surplus value or labour (from three or more employees) and command that labour power because they own the means of production whereas executives are “senior managers” making direct decisions about the products or services delivered, budgets, the number of employees, methods of production and their amount. Both capitalists and executives are also a part of a management hierarchy at the top, upper or middle management levels and would enjoy binding decision-making authority either themselves or as voting members of a group (Clement, 1990: 467-468) (see Figure 2A).

Within real ownership, there is a further distinction to be made between those who can control investment and accumulation, and those who in Poulantzas' (1975) terms have *possession* of the means of production. Possession refers to the “capacity to put the means of production into operation,” and more concretely, refers to the rights of some agents in the technical division of labour to direct the labour process; that is, to exert control and surveillance. With the maturation of capitalism, the functions of control and surveillance have become assigned to an often hierarchically organized system of agents who perform “the global function of capital.” This is in contrast to earlier systems of capitalist production in which the functions of supervision, control and surveillance tended to be performed by an *individual* capitalist. (See Poulantzas, 1975; Carchedi, 1975; and Clement, 1983).

Figure 2A Typology of Canadian Physician's Class Relations³

Source: Adapted from Clement, 1990

Thus, one important question to be addressed in this work is the extent to which the work of formerly *primarily* independent doctors has been supplanted by a “team based” (collective labour) and hierarchically organized “health production process” in which physicians have diminished control over their own work as well as the work of others (either medical or non-medical workers).

It is also important to distinguish the ability to direct and control the labour process from another process which Carchedi (1977) calls coordination and unity of the labour process. As Clement (1990:21) argues:

Coordination and unity is necessary to any large-scale system of production for the production of value; control and surveillance, however, follows from the requirement to “impose discipline on the worker” resulting from the requirement to extract surplus value and/or surplus labour from workers (depending on the particular relations of production). The latter requirement is essential to support capitalists and executives....

Thus it is possible for many workers to coordinate the labour process of others—since the performance of this function is necessary to any system of production—while being excluded from the rights associated with real economic ownership. In other words, a person can be involved as an “organizing influence” within a labour process which is performed *collectively* and still belong to the working class economically identified. An example of this amongst physicians would be the salaried hospital surgeon who, although an employee, is nevertheless the “key actor” in the performance of an operation because the surgeon coordinates, unifies and otherwise “manages” the work of a team of health workers while also performing aspects of that labour. Carchedi refers to this latter labour process as “collective labour,” which, in addition to the criteria of non-ownership of the means of production, makes up the essential economic characteristics of the working class. A typology applying these economic criteria to physicians is found in Table 2.1.

<p>Table 2.1 Economic Concepts Central to Class Analysis and their Substantive Expressions for Physicians</p>	
Theoretical Construct	Substantive Expressions
Functions of Capital	<ul style="list-style-type: none"> • Managing other workers, (supervision and control of clinical or non-clinical staff) • Administrative work (e.g., hospital committee work) • Practice Management: participation in strategic planning for one's own practice, or on behalf of other physician-owners
Functions of Collective Labour	<ul style="list-style-type: none"> • Diagnosing patient ailments (involves coordination/unity) • Performing operations/clinical procedures (involves coordination/unity) • Research • Teaching

2.4. Class Struggle Analysis: The Interplay Of Politics, Ideology and Economics

While economic relationships play a critical role in class analysis, this study locates itself conceptually within a tradition which understands the process of class formation as a complex phenomenon, not entirely determined by an individual's relationship to the means of production. In contrast to economistic and static approaches to class analysis that propose the "location" of individuals within an "empty structure of class places" based on ownership of the means of production and the production and appropriation of surplus labour/value, this study emphasizes the *dialectical process of class formation*. This approach emphasizes the interplay of structure and agency in which the conditioning effects of structural qualities endemic to the logics of the capitalist mode of production interact with human resistance (social practices) to these forces. Classes are formed and dissolved dynamically in response to the conditioning effects of basic contradictions which arise from the logics of capital accumulation. Thus, for example, the antagonism between the capitalist class and the working class is based on the structural contradiction between capital and labour *vis a vis* the private appropriation of the surplus value generated by social labour, *as well as their political and ideological practices*. It will be shown in this study that contrary to the experience of many other members of the old middle class, Canadian physicians have been able to reproduce and "extend" their power *because* of their historically cultivated and socially accepted ability to resist the rationalizing forces associated with welfare state medicine - forces which are generally identical in scope and aim to those experienced by the working class.

Social historians seek to remind us that the category of "class" finds its basis in accordance with the lives of real people who do not simply occupy passive "positions" within capitalism. They create, respond to and often struggle against structural pressures and changes with varying degrees of success. The notion that classes are formed as a result of the interaction between people and human-made structures constitutes the foundation of the model of class formation and transformation used in this study.

Accordingly, this dissertation proposes that it is essential to understand the formation of classes as a historical reproduction or supercession of the entire bundle of economic, political, ideological and cultural relationships between people as part of the daily reaffirmation of existing relations of production. Class, it will be argued, is much more than an economic relationship, although the economic level has a "conditioning" effect (in the sense of setting limits) upon the play of politics and ideology. Thus, *at the highest level of abstraction*, the relations of production play a determinate role:

...production relations are the most important relations (they are the determinant relations) in the specific sense that they call into existence all other social phenomena, i.e. social relations and their manifestations (forms) as conditions of their own reproduction or supercession (Carchedi, 1987: 90).

Concrete political and ideological struggles (for example, the political actions of a self-interested medical professional association working to counteract the tendency in capitalism to subsume all labour power as wage labour) are also central to the process of class formation in that they are capable of either reproducing or superseding the production relations (economic level) to which they are dialectically linked. Thus, classes come into existence as a result of the complex relationship between objective

economic conditions which determine the limits of class struggles and these struggles themselves. As Przeworski (1977: 388) contends these "objective conditions determine realms of possibility...their analysis is thus necessary but not sufficient for the understanding of concrete struggles."⁴ Moreover, as Johnson (1982: 67) points out:

ideological and political factors do not have a "constitutive role....in the determination of social classes." *Ideology and politics are elements of class relations and expressions of class struggle.* As "superstructural" phenomena (i.e., as expressions) politics and ideology are given their basic content by the development of the economic process as a whole and are set in motion by class situations, by the life experiences of people within classes, their forms of consciousness, and the practical activities. As the content of class relations and the expressions of class struggle, ideology and politics then relate back to and impact on the economic process and, in mediated and reciprocal form....on the constitution of classes as historical actors.

This conceptual framework motivates the concentration in this study on physicians' ownership relations and the functions they perform in the labour process. At the same time, these economic dimensions of class are related to the changing nature of Canadian physicians' relationships to the state and the public as expressed in their political and ideological practices.

Finally, it should be stated that this analysis recognizes that gender, race, age, ethnicity, region and other factors are critically important to the richness of class experiences. Since this study is limited in scope however, a detailed examination of the interplay of these factors certainly merits investigation but awaits further research.

2.5. The Process of Professionalism

Having dealt with some of the more abstract but central theoretical elements of class analysis, I want to turn now to an examination of the theoretical relationships

between the concepts of "profession" and class. Sociology in general, and class analyses in particular, have often been complicated by an uncritical acceptance of the concept of "profession." This dissertation will employ a demystified concept of profession based on the notion that to be a professional is to experience the end result of a *process of professionalization*. Moreover, the counteracting tendency to achieving professional standing can be understood via the concepts of proletarianization or deprofessionalization.

Professionalization is the set of economic, political and ideological processes by which an occupation attempts to first create and then reproduce certain production relations between its own labour, the state and the client. Thus professionalism, or the "professional condition," will be conceptualized as the *result* of a self initiated professionalization process. This is a process by which a "service ethic" ideology is constructed and which is ultimately a "sheer mystification of status claims and a device to silence the critics of monopoly, privilege and power to which professionals are alleged to cling" (Halmos, 1973: 6; and see Oppenheimer 1980; Esland, 1980). As strong as this contention is, it implies that focusing on the process by which occupations achieve (or struggle to achieve) professional standing is more sociologically useful than wholesale and uncritical acceptance of the term "professional" and all that this term implies. Critical discussions of the concept of profession, while few, are not new. Becker (1961) placed the notion of profession at the level of folk concept—"a semantic technique for winning occupational status and minimizing occupational constraints" (and see Haug 1988). Criticisms of the attribute or "inventory" models of professionalism are also well

known (see Hughes, 1961, for a classic statement). This model “adds up” various criteria such that the sum of these attributes denotes a profession, i.e., any occupation possessing these traits should properly fall into the category of a profession. Yet this approach also leads to uncritical acceptance of professional’s definitions of themselves, that is, as knowledge-based occupations requiring high degrees of skill and education and demonstrating high degrees of autonomy in work as well as a service ethic. While such attributes may be the outcome of the process of professionalization, the term “professional” has, especially in the writings of the attribute theorists, become a reified construct—where the actual actions, relationships and processes involved in achieving professional standing are ignored such that the qualities of professionalism appear as objective characteristics. As Cain writes:

the concept of profession, even in its most radical formulation, obscures more than it reveals about the work people do...alternative concepts *based on the specific practices of various occupational groups should be substituted.* (my emphasis)

Similarly, Grant and Foucher (1992: 5) argue that professionalization is a “social transaction” in which the outcome “reflects the power wielded by the professional group.”

This study advocates placing the concept of profession into a context emphasizing process, history and tendency. Put differently, it argues that it is more important to understand the situation of professionals in terms of their insertion into the historical push and pull of the forces of proletarianization and professionalization. It will be shown that particularly in regard to physicians, occupations will often attempt to create and/or sustain their economic, political and ideological power by engaging in the process of

professionalization, or by citing "professional values" (such as the right to autonomy, collegial control etc.) to reproduce this power. Furthermore, in this process, counteracting tendencies to control, de-value and otherwise proletarianize the occupation will also be present. Thus, the analysis of how physician's work is controlled and organized, and the consequences of this control and organization for the medical profession and society is more sociologically important (in this study) than attempting to determine whether medicine is or is not a profession (see Dickinson, 1989). In light of this conceptualization, the processes of professionalization and proletarianization need further clarification.

2.5.1 Proletarianization and Professionalism

Some Marxists (Larson, 1977, 1980; Braverman 1974; Aronowitz, 1973; Oppenheimer, 1970, 1973; Haug, 1973; Roslender, 1981; Carchedi, 1987; D. Johnson, 1982) have argued that as components of the middle class (old or new) professionals including doctors, should be understood as a group of occupations which are constantly experiencing pressures which could result in their proletarianization or "deprofessionalization."⁵

Proletarianization can be understood as the unity of economic, political and ideological *processes* (in which, once again, the economic level has a determinant or "conditioning" effect on the other processes). Thus, professionalization is also conceptualized as political, economic and ideological processes which tend to counteract the former process.

Understanding the proletarianization process first of all involves analysis of changing (economic) production relations which in turn are conceptualized in terms of ownership relations and the functions performed in the labour process. These changing ownership and labour process relations are in turn to be understood within the context of capital's need to sustain stable rates of profit or, in the case of non-capitalist state enterprises (discussed below), the need for state managers to control costs. In addition, political and ideological processes also play important roles in the proletarianization and professionalization processes. A good example of the interplay of economics, politics and ideology within medicine is the professional oath. When they invoke the Hippocratic Oath, physicians are ostensibly taking an oath of allegiance to the profession and the patient that includes obligations to serve to the best of one's ability, to maintain confidentiality, to disallow unqualified persons to practice for the physician, and to be financially disinterested (see Blishen, 1969). However, such ideological pronouncements are more symbolic in nature than real, given that physicians (as will be shown) are rational self maximizers like anyone else. In effect, the professional oath has given a "gentlemanly patina to what (is) essentially a matter of business like anything else" (Grove, 1969: 16). Thus, the professional oath was essentially an ideological construct that played an important historical role in the process by which physicians gained and reproduced their economic position. More recently, many physicians have used the professional oath to reiterate their "commitment to patient care" which in turn links to the notion that cutbacks to the health care system and the banning of extra billing (both of which would affect physicians incomes) might adversely affect patient health. To the

extent that such pronouncements are successful then, ideology can play an important role in reproducing professional standing in the face of proletarianizing pressures.

The professionalization process will generally involve attempts to impose closure over a body of esoteric knowledge in order to control the market for services, and *claims* to specialized skill, a service orientation and the right to autonomy in the practice and control over work (collegial control). None of these rights can be achieved without the willful compliance of the state which is instrumental in granting autonomy over such things as the determination of fee structures and levels, training and curricula, validation of credentials and ultimately over the exercise of work itself.

Thus the professionalization process involves a series of activities which, if successful, result in the professional condition. It is fundamentally a process by which workers in occupations solicit and acquire state sanctioning for autonomy in the labour process, as well as the guarantee that non-professionals are excluded from legally practicing the trade. In the case of physicians, it will be shown that prior to their involvement in a very direct way with the Canadian state, medicine was by no means a homogeneous entity—competition within the profession between different orientations typified “medical practice.” Moreover, allopathic medicine (the dominant strand) was one of many competing “healing arts” with as much claim to autonomy as chiropractic, homeopathy or midwifery. It was in large part an elite fraction of the profession’s successful alliance with members of the state that was instrumental in granting them the power they now enjoy and at the expense of competing health occupations.

While professionalism is a process that tends to advance and maintain the class position of producers, proletarianization is its dialectical counterpart. Traditionally, proletarianization has been conceptualized as a process in which there is a shift from ownership of the means of production to non-ownership, independence to dependence, economic well-being to simple subsistence, loss of control over elements of the labour process and the loss of prestige and qualifications (Carchedi, 1987). The proletarianization process is rooted in the logical structure of capitalism in that if capitalism is to continue to exist, it must continually attempt to maximize rates of profit.

Historically, capitalists have done this by:

1. appropriating production formerly under the control of small independent craftworkers
2. gathering these producers under one roof (i.e., into workshops and factories) to produce for the capitalist in exchange for wages
3. rationalizing and degrading work by: reducing labour power to its simplest elements, separating conception from execution, increasing productivity by lengthening the working day or introducing "labour saving" technology to the production process, and by hiring managers to supervise and control the labour process.

Importantly, the experience of proletarianization is different for the old and the new middle classes, the latter of which is involved in a much more complex process of proletarianization. With respect to the members of the new middle class (NMC), and in terms of the economic dimension of class, the process involves a gradual devaluation of labour power from skilled to average and the progressive loss of the functions of capital coupled with an increase in the time spent performing the functions of the collective worker. An example of this would be physician-managers employed by, and working in hospitals who find that their management workload (functions of capital) is being reduced

and replaced by the work of non-physician managers while the time spent in patient care (diagnosis, treatment etc.) increases.⁶ Political and ideological practices that may be involved in such a process could act in ways that thwart this process of economic proletarianization. For example, such physicians may engage in frequent strikes, withdrawals of labour or lobbying efforts. Alternatively, physicians may acquiesce to the process by showing no resistance to the hospital's efforts to take away their non-clinical managerial authority. They may, for example, argue that patient care is more important than administrative matters, or that the new realities of bureaucratic practice forms entail acceptance of the managerial demiurge and the transformation of the physician into an "organization man or woman." In these ways then, political and ideological practices may reproduce economic class positions in the face of proletarianization pressures, or they may act to justify and condition the descent or ascent into new class positions.

A detailed analysis of medical ideology would be an immense undertaking and is not the focus of this study. To advance a well rounded class analysis of the medical profession however, at least some attention should be paid to politics and ideology. The detailed examination of these factors must be the subject of another investigation.

2.6. The Role of the State in Class Formation

In this study, the role played by the state in the process of class formation/dissolution is critical since in Canada the health care system in which physicians work was forged and continues to be controlled by the state.

The Canadian state has historically intervened in the development of the health care system according to pressures exerted by state managers, capital, labour and the

sectional interests of the medical profession. As I shall show in the following chapters, state endowment of professional status to an elite faction of the medical profession in the 19th and early 20th centuries acted to consolidate their position as members of the old middle class mainly through the guarantee of occupational autonomy and a stable market. And yet the pressures exerted on the state in the post World War Two era (the need to legitimate the contradictions attending the accumulation of capital) gave rise to the development of policies which affected the labour process and ownership relations *vis à vis* medical practices, created the context within which physicians' class experiences were gradually transformed, and changed the nature of their struggles with the state.

In this study, I will be examining a very specific example of the interplay between a profession and the state in relation to class formation. Thus the study focuses on the interplay of Medicare as a state policy (implemented over the course of a decade beginning in the early 1960's) and the class transformation/fragmentation of the medical profession. In a more general sense, I have assumed that the capitalist state is forced to act in a way which benefits the long term interests of capital (where capital is viewed as a process and not necessarily as a subject or subjects). Particularly since the Second World War, the state has played a stabilizing role in the capitalist societies by undercutting the costs of production (through nationalization of some industries) and amelioration of the contradictory outcomes of capitalist development—such as the creation of unemployment insurance, welfare, pensions and nationalized health insurance schemes.

These kinds of activities have been conceptualized by O'Connor (1973) in terms of two contradictory functions of the state. In his view, the state plays a functional role in

the *accumulation* of capital but must also *legitimate* the social conditions which both lay the foundation for and are the result of the accumulation process. His analysis shows that in attempting to resolve the contradiction between the functions of accumulation and legitimation, the state produces a "structural gap" between revenues and expenditures, resulting in fiscal crisis, which in addition to other effects, crucially influences the experiences of those engaged in state-financed work (1973:9). For instance, the development of national health insurance in most countries has partially been the result of perceived crises of legitimacy *vis a vis* the disproportionate rewards of capitalism, and the state's need to provide employment for and services in education, health and welfare, such that a social "safety net" becomes critical to the ongoing functioning of the economic system (Chorney and Hansen, 1980). In Canada, the introduction of health care insurance served the long term interests of capital (accumulation) as well as a legitimation function by extending the rights of citizenship to all while providing equal access to care (Walters, 1982: 169). With the periodic economic crises characterizing capitalism and the concomitant reduction in revenues from taxes, it becomes difficult if not impossible for the state to sustain levels of spending on such programs. Such conditions have forced the reconfiguration of the welfare state characterized by cut backs to funding and the rationalization of labour within the health care system. as has been the case in the United Kingdom, Germany, Canada and elsewhere. Often, this restructuring process is coupled with encouragement for "competitive individualism, self-reliance and market mechanisms (Flynn, 1992: 3).

O'Connor's analysis points out the centrality of the accumulation function of the capitalist state, and reminds us that the state's ultimate role is to ensure favourable conditions for the accumulation of surplus value. In laying out the two basic contradictory functions of the state—accumulation and legitimation—we are able to understand in general, what the state *does*. But it is also important to understand *how* the state performs these functions.

Contrary to the position of “instrumentalists” who argue that the state acts at the command of the capitalist class, I adopt a more nuanced position which has its roots in the assumptions of the relative autonomists. This view maintains that politically and ideologically the state cannot be seen to be acting at the command of capital, and indeed must be seen to act on behalf of other, relatively less powerful groups if political and ideological hegemony is to be sustained. It is in this sense then, that the state can be seen to operate on behalf of capital, acting in its long term economic interests while simultaneously constructing short term compromises and concessions to the working class in order to maintain an “unstable equilibrium of compromise.” In this conceptualization, the capitalist mode of production defines the formation of social classes and is a redefiner and reproducer of class relations within a political sphere (Poulantzas, 1978: 26-27).

At the level of appearance, the state in capitalist society must attempt to divorce itself from direct expressions of class interests, that is to say, it must be “relatively autonomous” from class struggle. In order to preserve its relative autonomy, the state engages in two important processes. The first of these is the “effect of isolation” in

which the state isolates agents of production so that what are in reality class relations are experienced as relations amongst fragmented groups. An example of this in relation to physicians and the state is readily found when we examine the bargaining process between provincial governments and medical associations. These associations act in ways that closely approximate the activities of working class unions, and hence, in theory there are at least some grounds for cooperation and similarity of views between them. However, the state typically isolates physician associations (and other interest groups) such that what are really class relations similar in nature and scope to those experienced by the working class (e.g., working conditions, autonomy, job security) are experienced as the narrow interests of an elite professional stratum "without wider normative appeal to the population as a whole (Chorney and Hansen; 1980 73).⁷

A second and related process is the "unity effect" in which the state presents itself and what it does in terms of the general interests of the nation.

In this way, the capitalist state constantly appears as the strictly political unity of an economic struggle which is in itself a sign of this isolation. It presents itself as the representative of the "general interest" of competing and divergent economic interests which conceal their class character from the agents who experience them (Poulantzas, 1973: 133).

For Poulantzas the creation of state funded health insurance would represent a short term positive function, even though this function represents a long term political and economic agenda. In effect:

The state...continually adopts material measures which are of positive significance for the popular masses, even though these measures represent so many concessions imposed by the struggle of the subordinate classes (1978: 30-31).

As I will show in Chapter Four, the implementation of national health insurance in the context of a crisis of legitimacy is an important example of this tendency for capitalist states to take seemingly positive actions on behalf of the popular masses.

In addition to the central role given to class struggle, the major strength of this approach is that it allows us to understand how the state can continue to organize the consent of the subordinate classes to capitalist relations of production without sacrificing the long term interests of the “power bloc.”⁸

One important difficulty with this approach is its tendency towards what Miliband calls “structural-superdeterminism”—in which the subject is left out of the analysis. Put differently, in an approach which downplays the influence of human beings, it is difficult to see exactly *how* the structural constraints imposed by the capitalist system affect the development of policy. Thus, Miliband’s approach to the state constitutes an important qualifier to the Poulantzian model by stressing the role of interpersonal links between capital and members of the state.⁹

In addition to the insights derived from such analysis, Miliband also points out the importance of taking into account “powerful impulses to state action generated from within the state by the people who are in charge of the decision making power” and whose interests may not correspond to those of the dominant classes (Miliband, 1983: 9). This latter argument points to the importance of non-class forces (such as popular movements) which are excluded from Poulantzas’ “class theoretical” approach, as well as the influence of “state managers” in the process of policy making and hence class formation.¹⁰ Accordingly, in this study it will be important to show how the logics of the

capitalist mode of production motivate state actions *vis a vis* the health care system. But it will also be important to show how, and in what conjunctures, inter-personal linkages between members of organized medicine and the state have conditioned the class practices and experiences of physicians.

Thus, in contrast to a purely "instrumental", "structural" or "pluralist" approach, I will argue that state policy should be seen as a set of decisions which are formed in the crucible of historically specific economic, political and ideological class relations. This means that the contingencies of specific historical moments must be understood as contributing to the formation of a particular set of state policies and functions within the context of a changing social formation. Thus while elements of "instrumentalism" (for example, clear personal links between the members of an elite—such as physicians—and members of the state) can have some explanatory validity in certain conjunctures, it is equally plausible that the state's need to express relative autonomy can have explanatory power in different conjunctures. As Panitch (1977: 9) argues:

....the exercise of the various state functions is by no means uniform in all periods and in all societies, and that the size and prominence of any one of the three state functions must be examined in light of the 'empirically given circumstances' of a particular society. Indeed what is striking as one turns to an analysis of the Canadian state is how at each point the Canadian state reflects particular characteristics which mark it off in a comparative sense from other capitalist states

Finally, it is important to deal briefly with the theoretical role of physicians as members of a class within a state-financed health system. While it is possible to view workers within the health care system in Canada as employees merely because the state provides the funds to run the system, this depiction oversimplifies the real economic

relationships which exist. Some clarification of the economic class position of workers within the state-financed health care system is necessary, particularly since at first glance the relations between physicians and the state are not always clear cut employee/employer relationships. Furthermore, as Carchedi (1977) and Carter (1985) have pointed out, health care cannot properly be placed within the umbrella of capitalist production, since in the health care sector, (with the exception of the pharmaceutical industry) money is not advanced in order to expand itself. The state financed health care sector in Canada is not a capitalist enterprise and can therefore be conceptualized as a *Non-Capitalist State Activity* (non-CSA). However, this does not preclude the possibility that some state activities (such as Crown corporations) are run for profit and are therefore *Capitalist State Activities* (CSA).

The distinction between capitalist state activities and non-capitalist state activities has been dealt with in some detail by Carchedi (1977) who argues that the class identification of employees in the non-CSA follows the same lines as those of unproductive workers—those who produce no surplus value but may have their surplus labour appropriated. Furthermore, it is what workers in the service sector (non-CSA) actually do in terms of the labour process that is fundamentally important to comprehending the economic class position of these workers. While non-CSA's exist as services, providing use values, they are not exempt from the contradictions of capitalist production techniques since the service sector exists within (and indeed is part of) the capitalist mode of production. Health services are "controlled by identical strategies and mechanisms to those organizations operated on a profit basis because pressure on the

controllers...to reduce its unit costs is not lessened" (Carter, 1985: 144; and also see Salaman, 1980). Thus, although the majority of physicians are paid on a fee-for-service basis, their incomes are financed from public coffers, thus placing the state and doctors in a *mediated* employer-employee relationship. In particular, economic constraints on hospitals, which are primarily funded by the state, are increasingly forcing physicians to act as if they are salaried employees of the hospital though technically most are self-employed (Wahn, 1987). It comes as no surprise therefore, that state employees such as nurses and (as we shall see) some doctors, complain about the rationalization of their labour and the alienation, loss of autonomy etc. which has also characterized the work experience of the mass of industrial workers.

2.7. Conclusion

The theoretical framework utilized in this dissertation allows us to understand the political, ideological and economic practices of the Canadian medical profession in terms of its shifting location within the context of a class society. This project differs from analyses preoccupied with the attempt to situate people within an empty structure of places within a pre-determined class "map." Instead, a relational model is utilized—focusing on the relationships between technology, people and social structures that have made and continue to make up the class experiences of Canadian doctors. This model of class focuses on the daily activities of people located within a social structure which itself is both determined by and determining of the contradictory economic relationships which constitute capitalism. The dissertation thus advances a historical and dialectical approach to class analysis in which classes are seen as fluid, complex forms of social organization

within which a static “definition” of class location merely plays an elementary role. As Clawson (1980: 90-1) argues: “‘class location’ is a rough and tentative beginning, but from then on however, progress is made by analyzing the historical dynamic in order to see what happened over time, rather than by refining static categories.”

A central theoretical claim made in the dissertation is that the middle class as a whole is in a constant state of flux as fractions of it are subject to the logics of capital accumulation. Some elements disappear altogether, such as the ideal-typical craftworker of the mid 19th century. Other components of the middle class gradually decline in numbers as their labour is rationalized and as they lose their ability to stave off the intrusion of large scale capital. Other fractions of the middle class only come into existence because of the development of conditions which have fostered the growth of occupations required to maintain capitalism. Advertising executives, for instance, help to realize surplus value, and social workers are primarily engaged in an attempt to ameliorate the social contradictions of capitalist relations of production. Similarly, a cadre of health workers—professional hospital administrators—have only recently come into existence as hospitals come under increasing pressure to rationalize labour processes, cut costs and become more “productive.”

Yet another fraction of the middle class changes in nature—from old to new middle class—through a combination of structural circumstances which continue to generate the need for certain kinds of labour (like some engineers, doctors and lawyers) and the self interested assertion of these groups..

In what follows, I will show that Canadian doctors, through the political and ideological mechanism of professionalism, struggled to identify themselves as a privileged occupation within the context of a developing capitalist society.

Professionalization should be viewed as a self conscious process of class formation, but the self-interested assertion of the medical profession should not be understood as the only significant factor in the formation of class. It is crucial to take into account the development of the accumulation process fundamental to the capitalist mode of production within which the process of professionalization occurs and which also generates a rationalization process fundamental to the continued development of this mode of production. These rationalizing or proletarianizing forces represent counteracting tendencies to the professionalization project against which the medical profession has struggled. Finally, the shifting role of the state *vis a vis* both the class experiences of physicians and the playing out of the logics of capitalist development will also inform the conceptual framework within which doctors' fortunes will be analyzed.

ENDNOTES

¹ More recently in Canada, it is this class of new middle class workers that has borne the brunt of layoffs, downsizing and "readjustment" to the new economic environment. As organizations re-configure their workforces in order to compete on the global stage, they have engaged in wholesale restructuring, mostly consisting of "delaying" the top-down hierarchical nature of companies while implementing new technologies to replace now superfluous labour. The result has been a large increase in the displacement of "middle managers" and professionals.

² Clement (1990:30) recognizes that there is some arbitrariness involved in deciding how many employees would constitute the dividing line between capitalist and old middle class. Nevertheless, he argues, "at a common sense level, this means those who work for themselves and hire one or two others to assist them (often family members controlled by patriarchal relations) still rely primarily upon their own labour power whereas those who regularly employ three or more others are beginning to rely primarily upon the labour power of the others. In practical terms this is also the break-point used in the Canadian labour movement....in its rules for membership eligibility."

³ Although this diagram has been simplified for clarity, it should be noted that other dynamics would be occurring in this scheme. For instance, elements of the working class may be moving towards the old middle class or some other class. Alternatively, as note 1 above argues, components of the new middle class are being drawn into the working class.

⁴ The concept of determination warrants some consideration here. In this dissertation, "determination" is conceptualized as a set of material and non-material conditions which imposes or sets limits on both the experiences of human beings and the possibilities of human action. Moreover, I have not imposed the artificial and somewhat dogmatic condition which argues that the "economic instance" is in the final analysis the ultimate determinant. Instead, I have utilized an approach which Carchedi (1987) calls "dialectical determination," where it is argued that since the social experience of human beings is determined by many facets of the social formation—structural as well as those based on human agency—only a dialectical approach can help us to understand the real experiences of those human beings.

⁵ Importantly, it is by no means clear yet as to whether these two processes are the same, or whether they are related in some way. (see Coburn et.al, 1983). However, in this study I advocate the use of the concept of proletarianization because it encompasses the trends and forces experienced by other members of the class structure—not just professionals as the notion of "deprofessionalization" would seem to imply. In effect, the concept of proletarianization is more of a "global" term, whereas deprofessionalization is a much narrower concept. The deprofessionalization process can be understood as the process in which status, privilege, loss of control over the labour process and property rights are the results of proletarianizing forces. These forces can be conceptualized in terms of tendencies, within the capitalist mode of production, in which skilled labour is reduced to simple labour, autonomy is subject to erosion through the subjection of the labour process to different forms of control and in which independent labour is transformed into wage labour (salarization). Fundamentally however, the loss of status, market control and so on which traditionally define the deprofessionalization process *are the economic, political and ideological results* of the proletarianization process.

⁶ For a classic discussion of the strain involved in practicing medicine and administration within bureaucracies such as hospitals, see Hall, 1959.

⁷ It should be noted that physicians do not typically see themselves as sharing common class interests with the working class. For the most part, this failure has a great deal to do with the ideology of professionalism itself.

⁸ Nevertheless, one of the most cogent criticisms of this approach is that it “overpoliticizes” the state and thereby underestimates the influence of economic and ideological regions in shaping the political (see Jessop, 1982: 181-191). For this reason, it is important to take account of economic and ideological factors as shapers of public policy, particularly with respect to the constraints which politics and ideology imposes on the policy making process and outcomes. Thus, state policy on health care does not occur in a political vacuum, but is “shaped” by economic and ideological/cultural influences.

⁹ In the Canadian context, these kinds of links have been emphasized in the empirical work of Clement and Olson. (See Panitch, 1977)

¹⁰ In the Canadian context, Mahon (1977, 1979) has worked out a useful approach for understanding the process of social policy formation, which integrates the notion of ‘interest groups’ into her Poulantzian informed theory. She argues that although the function of interest groups is primarily to represent a particular interest, state organs simultaneously *represent* a particular interest and are bound by a commitment to reach a compromise, to see beyond the particular to the “general” or “national” interest. In addition, the claims of interest groups do not possess authority whereas representatives inside the state, once a compromise has been reached, are empowered to force the compromise on the very forces they “represent.” Thus for example, the state, through welfare policy, is an important organizer of consent of the working class to capitalist relations of production. In relation to state policy: “The state’s role as organizer of hegemony means that its activity will reflect inter and intra-class contradictions - contradictions which are likely, however, to be resolved in such a manner that the *general political interest* of the power bloc will be maintained.” (1977: 168-170)

CHAPTER THREE

METHODOLOGY

3.1. Introduction

This chapter presents the methodological procedures guiding this study. The chapter discusses the historical parameters of the study, as well as the characteristics of the historical and contemporary data sources utilized.

3.2. Parameters of the study

An important aspect of historical materialist methodology is its emphasis on the conditioning effects of historical processes on class experiences. In this study, the historical dynamic under examination is made up of the dialectical interaction between the capitalist imperative to rationalize and the class practices of the Canadian medical profession. The study begins by focusing on aspects of the professionalization process that occurred during the early history of the medical profession in Canada. The study then examines the effects on physicians of the rationalizing forces associated with the development and implementation of national hospital and health care insurance (Medicare).

In terms of the historical analysis of the professionalization process, it was important to examine *how*—a particular species of the genus “medicine” came to be accorded privileged status within the medical division of labour. Because the linkages between professionalism and the state have had a long history, these relationships are examined in the period between 1800 and 1945. A comprehensive analysis of the ways in which the nascent medical profession became *the* dominant group in a context of

competing health paradigms and practitioners is beyond the scope of the study. The study only sifts out key aspects of the professionalization project in order to provide the reader with some background for the discussion and analysis that will follow in later chapters. Accordingly, data from period medical journals, health care legislation, and especially the work of medical historians was examined from the point of view of understanding the nature of physician's early political and ideological practices, and their role in the process of professionalization.

Only those aspects of the history of the medical profession crucial to the process of class formation are discussed, namely, the transition in the division of labour from a few medical workers to a more intensified dependence on collective labour; the changing structure of ownership and control of the labour process, and the essential elements of the professionalization project, namely, exclusionary practices/social closure, the cultivation of individuals within the state to foster the credential and licensing process, the development of medical schools and hospitals, the creation of a tradition of self-control (collegial control) and the "social construction" of cultural authority based on the rhetoric (and not necessarily the content) of science.

The centrality of the profession's relationship with the state and the importance of this relationship for the process of class formation, requires some appreciation of the changing functions and roles of the state in Canadian society in this period. More specifically, this calls for a discussion of the state's role in responding to and forging political and economic conditions, conceptualized in terms of its role in facilitating the accumulation of capital and legitimating the contradictions arising from this capital

accumulation process. Thus, the analysis of the changing nature of the state spans the time frame within which medicine was professionalizing, and continues into the contemporary phase.

The contemporary time frame for this study spans the early 1960's and the mid 1980's. In Canada, social, political and economic pressures exerted on the state in the post World War Two era fostered the development of policies which changed the context within which medicine was practiced and set the stage for the potential class transformation of the medical profession. For physicians, the most visible indication of potential changes was heralded by the implementation of national hospital and health insurance in the late 1950's and mid to late 1960's respectively.¹

Between 1960 and 1986, three major studies of the medical profession took place, each providing data facilitating the analysis of shifts and continuities in medical ownership and labour processes. The Royal Commission on Health Care (also known as the Hall Commission) study of medical labour power was conducted by Stanislaw Judek between 1962 and 1964, prior to the implementation of Medicare. A similar survey—the Physician Manpower Questionnaire (PMQ)—concerning medical labour power was initiated by the Canadian Medical Association in 1982 and repeated in 1986. The PMQ was designed to collect information on physician's practice patterns and their activities, and, as such, lends itself well (though not perfectly) to comparison with the data from the Royal Commission study. In addition, a third source of empirical information on physician's practice patterns and attitudes was found in the 1986 York University Survey

of Physicians in Canada. The characteristics of each of these historical and contemporary sources are discussed in more detail in the following sections.

3.3. Sources of Historical Data

Historical information had to be gathered on the political, economic and ideological characteristics of the medical profession, in order to provide both a context and a basis for comparison with more contemporary data. The historical sources included secondary literature on the nature of medical practices (Canniff, 1980; Bull, 1934, MacDermot, 1967) as well as new information gleaned from relevant articles in journals such as the Canada Lancet, the Canada Medical Record, Canadian Practitioner, Revue Medicale du Canada and the Canadian Medical Association Journal. All of these were available at the Public Archives of Canada (PAC) and/or at Ottawa and McGill Universities.

McGill had in its possession the personal papers and diaries of many physicians who practiced in the late 19th century. A review of these enabled me to add some "texture" to the information gathered above. For the most part, however, the information from these personal papers only supplemented information gained from already existing sources. To delve into the area of early medical social history would have constituted a project in itself, and for this reason, only some of the original data on practices (i.e. from individual physicians journals, diaries and ledger books) was utilized.

These sources also provide some idea of the political and ideological processes underway in the formation of class. In this respect, the journals mentioned above were examined in relation to political and ideological statements relating to the

professionalization process. As well, secondary literature was examined regarding the political activities of the early, relatively unorganized, medical profession with a view to understanding the formative role of elite British doctors in petitioning the government of Canada to confer professional status.

Primary sources pertaining to the political and ideological dimensions of class formation included various kinds of petitions made to government leaders by the nascent medical profession. I examined relevant government documents of the time, (e.g. Minutes of the Dominion Council of Health 1919-1973), which enabled me to ascertain the nature and extent of the links between government personnel and medical doctors and to understand the strategies utilized by physicians to gain recognition as professionals. In this latter respect, particular attention was paid to the role of the profession's political arm—the Canadian Medical Association—and was documented by reference to documents concerning its history, statistics on membership and polls tapping member's political attitudes.

Between 1919 and 1945, the structure and character of the Canadian state with respect to many issues, not least of which was health care, began to change. The recognition of a link between health, unemployment and poor working conditions, coupled with capital's recognition that "good health pays", began to foster state interest in the continued reproduction of a healthy labour force, and, more broadly, the legitimacy of capitalist relations of production. It began to develop a general policy on health as well as institutions (such as the Department of Health in 1919) that would deal with the problem of public health and welfare. This impact of these structural changes on the

medical profession was minimal, however, in comparison to the impact of political lobbying by the Canadian and provincial medical associations. The success of this political activity is apparent in the degree to which doctors were able to shape the content of an incipient state health care policy. At the same time, labour within the health care sector became increasingly social in nature, while physicians became increasingly dominant within the technical division of labour. To document these developments, I reviewed secondary literature, as well as statistical information (from Health and Welfare Canada's Health Services and Promotions branch) pertaining to doctor's relationships with auxiliary personnel, the nature of "medical work" and supervisory work, and the role of medical practice in hospitals. This information was also used to understand the extent to which physicians engaged in collective work as well as control and surveillance functions within large hospital bureaucracies and other practice modes.

Finally, the historical component of the research called for a discussion of the increasing will of state legislators to impose health insurance legislation which initially contained no or little provisions for physician control. The struggle between the state (both provincial and federal) and the medical profession was analyzed by examining studies undertaken by various provincial governments on the feasibility of health insurance. These were undertaken in British Columbia in 1919 and 1920, in Alberta in 1932, and by the special committee on Social Security of the House of Commons in 1943. Special attention is paid to the tactics used by the CMA to insert the interests of the medical profession into these early attempts at state funded medical care, as well as

their ability to shape the eventual outcome of the debate on health insurance, namely, the Hospital Insurance and Diagnostic Services Act, and the Medical Care Act.

3.4. Sources of Contemporary Data

Changes in the economic aspects of medical practice (functions performed in the labour process and practice ownership and organization patterns) were outlined by compiling statistical data obtained from Health and Welfare Canada, (e.g. Canada's National and Provincial Health Program for the 1980's, and the records of the Department of National Health and Welfare's Health Services and Promotion branch). As mentioned above, the primary source of data came from reports such as Judek's 1964 study of Medical Manpower in Canada. However, supplemental information was gathered from sources such as the accounting firm Hedlin-Menzies study of the Health Services Industry in Canada, which was prepared for the Department of Industry Trade and Commerce (June 1973). In addition, I relied on some irregularly produced although informative publications produced by the Royal and Provincial colleges of Physicians and Surgeons as well as the CMA (e.g. the Report of the Special Committee on Group Practice in Canada, 1967) which provided some insight into the changing structure of practice. The data from these sources was compared with 1986 data from the Physician Manpower Questionnaire (PMQ) and the 1986 York University National Survey of Canadian Physicians. Since the Judek study, the Physician Manpower Questionnaire, and the York University study are the most important of the data sources on ownership relations and the labour process, they deserve some in-depth consideration.

3.5. The Royal Commission Report (Judek, 1964)

In 1964, the Royal Commission on Health Services published a report entitled Medical Manpower in Canada. The report was authored by Stanislaw Judek. Its purpose was to collect information on supply and demand for medical labour power in Canada, its distribution and utilization. This data would assist in the planning of future physician labour power requirements until 1991. Data for this report came from many sources, including "surveys of physicians conducted by the Royal Commission on Health Services in 1962....Provincial Medical Boards and Colleges of Physicians and Surgeons, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and medical schools" (Judek, 1964: iii). Data from two central surveys form the empirical core of Judek's study. In turn, summarized data from these surveys as reported in Judek's study were utilized in this dissertation. Both surveys were conducted by the Department of National Health and Welfare in 1962. One, entitled the Questionnaire on Medical Practice, tapped into the distribution and utilization of physicians in Canada as well as doctors' opinions regarding proposals for national health insurance legislation. The questionnaire was mailed to every physician in Canada (21,000) and 12,000 usable replies were received.

The second survey was entitled the Questionnaire on the Economics of Medical Practice. It gathered data on the earnings of physicians in 1960, type of major work, type of practice, size of community in which the practice was located, years of experience, time spent in various work activities, annual operating expenditures, capital costs of buildings and equipment, and specialty practiced (Judek, 1964: 203). This survey was

also mailed to all physicians in Canada and 7,000 usable replies were received. In both questionnaires, low or spoiled responses reduced the effective response rate for various sections of the analysis. Judek argues however, that “all the evidence available to the Commission suggests that the group of doctors from which averages shown in this study are drawn is fairly representative of the medical profession in Canada” (1964: 204).

3.6. The Physician Manpower Questionnaire (PMQ)

Every four years beginning in 1982, the Canadian Medical Association has conducted a census of licensed physicians in Canada. In 1986, this survey, entitled the Physician Manpower Questionnaire (PMQ), was mailed to approximately 40,000 doctors. The response rate was 78 percent. Not all questions were answered by every physician, thus reducing the effective response rate for various sections of the analysis. However, response rates are high enough in each section of the survey to permit valid comparison with the 1962 Royal Commission survey. The 1986 questionnaire taps into aspects of the economics of medical practice (the questionnaire was designed by the Medical Economics Department of the CMA) as well as information on auspices of practice (ownership), time spent in work activities, specialty and type of practice (solo, partnership etc.). To my knowledge, with the exception of the York University Survey of the Medical Profession in Canada, the PMQ is the only comprehensive statistical profile of Canadian medical practice completed since the Royal Commission study of 1964.²

3.7. The York University Survey of the Medical Profession in Canada

Between 1986 and 1987, the Institute for Social Research at York University conducted a national survey of physicians in Canada. The survey was designed to collect

information about the organization of medical practice and included questions on practice style, workloads, time spent in various professional activities, payment methods and attitudes towards the health care delivery system and professional autonomy.

Questionnaires were mailed to 4100 physicians randomly selected to ensure national representation. More than half (2,397) responded, and, after removing ineligible doctors from the list, the survey had an effective response rate of 67 per cent. It should also be noted that discussions with personnel from the Canadian Medical Association indicated that the findings of the York survey coincide with those of the Physician Manpower Questionnaire, and that from the CMA's perspective, there are no significant differences between the two surveys. For my purposes, however, the York survey asked questions that were not broached in the Physician Manpower Questionnaire. Thus, while the York survey was a useful supplement to the data gathered by the Canadian Medical Association, the reliability of the former is also very high.

3.8. Politics and Ideology: Contemporary Data Sources

Information on the political and ideological practices and perceptions of physicians since the implementation of Medicare came from several sources.

The struggle between the state and the medical profession for the ownership and control of medical practice is highlighted in the political confrontation between provincial and federal governments and the organs of organized medicine. One source of information on the patterns and characteristics of this confrontation came from government documents such as the Hall Commission Report, the Report of the Castonguay-Nepveu Committee, the Hastings Report, and the White Paper on Health

Policy as well as official political pronouncements contained in the annual and interim reports of the provincial and Canadian Medical Associations and the provincial colleges of physicians and surgeons. I also consulted the arguments made in business oriented publications such as the Canadian Doctor and the Medical Post.

A second source of information on the strategies, circumstances and reasons for organized medicine's withdrawal of labour in various provinces were newspaper reports pertaining to the activities of organized medicine and ad hoc physician organizations such as the Keep Our Doctors Committee, as well as each provincial medical association's analysis and perceptions of the "strike" situation.

In order to understand the ways in which physicians conceive of their relations with the state and the changing realities of medical practice, it was important to gather qualitative information on medical perceptions. This was accomplished through semi-structured interviews with 12 physicians in different practice settings in Ottawa and Saskatoon. The PMQ delineates the most common types of practices in Canada as (1) private fee for service which takes the form of solo practices, clinics and partnerships of 2, 3-5 and 6 or more physicians, (2) practice "hybrids" where physicians engage in salaried medical practice within hospitals and clinics in addition to their own fee for service practices, and (3) salaried arrangements where physicians are full salaried employees of hospitals or clinics. Given that the majority of doctors work in the solo, partnership, hybrid and salaried hospital/clinic types, only doctors in these settings were interviewed.

While initial access to these doctors was difficult (due mostly to the demands of time made on the doctors and their initial reluctance to be interviewed by a sociologist), once contacts were made, I found the physicians to be quite forthcoming about their working life, their political perceptions, and their understanding of the doctor's role in society.³

Although time and resources did not permit me to interview as many physicians as I would have liked, these interviews provide some "texture" to the analysis by:

- (1) providing evidence which corroborated the empirical information,
- (2) tapping into their perceptions of continuing state initiatives to control doctors' work, and,
- (3) allowing some insight into their understanding of the future of the medical profession.

Thus, the interviews allowed me to include the real voices of doctors in the analysis of professional ideology undertaken through an analysis of secondary literature and surveys of medical opinion, the most important of which was the York University National Survey of Canadian Physicians. From this source, I constructed some basic scalar measures relating to physicians' attitudes and perceptions of Canada's national health insurance system, their perception of their standing in the eyes of the public, and the tendency of medical practitioners to embrace "free market" or "union" like ideology.

3.9. Operationalization of Concepts

As discussed in Chapter Two, to analyze shifts in the character of physicians' economic class position, it is necessary to analyze changes in their relationship to the means of production conceptualized in terms of rights of ownership over productive

property (the physical capital which exists within clinics, hospitals and group practices), and the character of the medical labour process (control over one's own labour power and the labour power of others, and the ratio of functions of labour to functions of capital).

3.9.1 Ownership Relations

To analyze changing ownership relations, data from the Judek survey was compared with recent information from the Physician Manpower Questionnaire and Statistics Canada. Various supplements, including the Canadian Medical Association and Hall Commission Supplements on group practice were also consulted.

The data are interpreted in terms of the criteria of real and legal ownership/possession of the means of production. Here, real economic ownership refers to the right to appropriate the surplus of the process of production, the right to control labour power, hire and fire, and the right to make tactical (short term) and strategic (long term) decisions regarding operation of the "firm." Legal ownership refers to the rights to the fruits of production and does not necessarily imply involvement in the tactical decision making process. Possession refers to the right to put the means of production into operation through the supervision and control of other labour, and may be distinct from real, economic ownership of the means of production.

3.9.2 The Labour Process

In terms of the labour process, much of the important information regarding functions, time spent in them and various changes over time (between 1966 and 1986) were calculable from the data provided in the PMQ data set and Judek's study. In some

cases, other sources are consulted to substantiate numbers or to find data which was dealt with in one study but not in the other.

Data from the (PMQ) was collected and analyzed in order to identify the types of work functions in which they are engaged and the time they spend in these functions.

The latter were examined and compared in terms of two concepts:

- (1) the individual or global function of capital i.e., the functions of supervision and control; and,
- (2) the functions of collective labour, or unity and coordination of the labour process.

The functions of supervision and control (function of capital) was operationalized as the amount of time devoted to the management of the "firm" (varying types of practices such as solo, income pooling, hospital, salaried etc.) and subordinate labour within this context.

The function of collective labour was operationalized as time spent in the "production" of health care (i.e. direct patient care, research, continuing medical education and teaching.)

These data were then compared with corresponding categories in Judek's survey. Comparing data from these surveys permits me to take stock of variations in the ratio of the function of global capital to collective work in physicians' labour between 1960 and 1986.

Figure 3.1 illustrates ways respondents to the Physician Manpower Questionnaire and the Royal Commission study were asked about the functions they perform in the labour process, and the way these tasks were operationalized in this study. Some difficulties arose due to different operationalization and methodological procedures

used in each data set. In some cases, for example, the definition of “group” was different from that provided in the other survey’s data. In these cases, it was possible through extrapolation to reconstruct the data set to permit valid comparisons. As figure 3.1 illustrates, the Royal Commission study did not ask direct questions pertaining to the time spent in administrative and managerial functions.

Figure 3.1 Operationalized categories from Royal Commission Questionnaire (Judek, 1964) and the 1986 Physician Manpower Questionnaire		
Source	Function of Collective Labour	Function of Capital (Global or Individual)
Royal Commission Report, 1964.	Estimate time spent in; patient care activities, teaching and research.	Estimate time spent in “other” activities which might include some patient care, but which also includes practice management and administration
Physician Manpower Questionnaire, 1986.	Estimate time spent in; patient care, teaching, research and continuing education.	Estimate time spent in practice management, administration and hospital committees.

In contrast, the creators of the 1986 PMQ did feel that time spent in managerial and administrative functions warranted investigation, and therefore included specific questions on this part of the labour process. It is significant that the Royal Commission study chose to include these functions within a catch-all “other” category in that this strategy illustrates the extent to which notions of “management” and “administration” were undervalued (because so few doctors engaged in such work) prior to the early 1960’s.

These are the data sources that were used to portray the shifting class experiences of Canadian physicians. In what follows, I use this data in conjunction with the theoretical framework discussed in Chapter Two to provide a historical portrait of the early Canadian medical profession, and, later, an examination of their more recent circumstances.

ENDNOTES

¹ Medicare, the combination of hospital insurance and medical care insurance, first became a reality in Saskatchewan in 1968. Other provinces followed within a year or two.

² It should be noted that in Physician Manpower Questionnaires since 1986 many questions pertaining to time spent in activities (labour process questions) have been omitted.

³ Interestingly, many of these physicians were more likely to grant interviews when they learned that my father is a practicing physician, probably because they perceived that the interviewer would be more sympathetic to their views

CHAPTER FOUR

A CONSPIRACY AGAINST THE LAITY: THE MAKING OF THE MEDICAL PROFESSION IN CANADA

4.1. Introduction

Contemporary medical power is rooted in a set of historical practices that I have termed the professionalization project. Accordingly, it is important to have a sense of the development of medical professionalism in Canada. In this chapter I present a discussion of the rise to professional status of the Canadian medical profession within the shifting occupational and class structure of early Canadian society.

As implied in the introduction and Chapter Two, the notion that a profession's rise to power is the result of a kind of "cultural authority" deriving purely (in this case) from the doctor's status as a professional is only partially tenable. In his study of the medical profession in the United States, Starr (1982:1-29) argues that physicians were able to gain their power through the development of cultural authority *which was firmly rooted in social conditions*. Similarly, in Canada medicine's professional status and the power which accompanies it, was fought and bargained for, and was the material result of a set of political and ideological struggles by an elite fraction of a nascent medical establishment. It was the profession's successful resolution of these struggles that allowed them to develop and maintain particular privileges in relation to the structure and practice of work, thus providing them with a solid economic basis from which the profession's political and ideological practices flow today.

I examine the process by which medical proponents of one particular kind of medical knowledge in Canada established themselves as a relatively unified profession. In doing so, I wish to interpret the weight of historical evidence in light of the conceptual framework advanced in Chapter Two. Therefore the early aspirations to professional status of medical practitioners in Canada are interpreted in terms of the notion that these ambitions—consisting of successful attempts to impose social closure via inclusion of

similar individuals, and exclusion of others constituted an important strategy for class advancement.

Treatments (particularly of the anecdotal approach) of the history of the medical profession in Canada are relatively abundant and I will not repeat these discussions here. What can be done with existing historical works (and with the help of some under-utilized materials) is to sift out the critical economic, political and ideological practices which constituted the process of professionalization, which in turn can be understood as a "struggle about class."

Historical evidence indicates that between the late 18th and mid 19th centuries, doctors struggled to acquire a set of legally binding rights which gave them enormous power to work as they saw fit and to control the market for their services. This set of rights officially constituted them as a profession in their own eyes as well as in those of the public and the state. Other indicators of this professionalization process are doctors' successful attempts to gain autonomy over the practice of their work, their success in gradually imposing closure over a body of ostensibly scientific knowledge (which in turn restricted access to medical practice), and their control over medical labour power. In this era private medical practices fused real economic ownership and legal ownership thus placing the vast majority of physicians firmly in the old middle class. In the rapidly bureaucratizing hospital, doctors were also coordinating and often supervising subordinate health care workers while only infrequently participating in strategic and tactical decision making—all of this while remaining non-salaried, private businesspersons.

Physicians exerted pressures on the state and often extorted favours in order to establish themselves as a privileged fraction of the old middle class. Early Canadian doctors were able to create a set of conditions which transformed their existence as a set of loosely affiliated trades and institutionalized their position in society as a protected class fraction of independent professionals.

In what follows I highlight the importance of the link between state elites and the medical profession for the latter's achievement of "professional" status. In addition, I provide evidence which allows us to establish that the early practitioners of medicine can be understood as a set of independent professionals who capitalized themselves, worked on their own, in partnerships or in concert with a few assistants, and tended to be independent of the hospital though they used it as a "workshop." Having established themselves as a profession, the rights associated with professional status underscored their role as the dominant "producers of health" at the same time as other health care producers were reduced to relatively subordinate status.

4.2. The professionalization project

In the mid-18th century, an elite group of physicians began the professionalization project. Initially, this activity consisted of attempts to influence parliamentarians to create laws that would sanction those unwilling to join a cadre of "experts." These doctors relied heavily on their connections with the ruling class as well as the fact that they tended to be "in" the state themselves. Yet there were many complications to be overcome in the early stages of the professionalization project. One of the most salient of these obstacles was the apparent disinterest of parliamentarians in the often bombastic claims of physicians. Accordingly, doctors needed to persuade lawmakers of the efficacy of "regular" or "allopathic" medicine.¹

But enlisting state support was not the only important task facing the early physicians. There was also competition from the more recalcitrant practitioners of medicine. Called the "irregulars," these were the heterodox practitioners, the homeopaths, Thomsonians, herbalists and midwives who provided medical relief to the bulk of the population, and particularly the working class. If regular, allopathic medicine was to survive and prosper then the irregular practitioners must be destroyed or controlled. Moreover, the difficulties involved in excluding other practitioners (and thereby

controlling the market for services) were compounded by the fact that there was little unity amongst allopaths themselves. There could be no way of demonstrating the superiority of regular medicine until there was a relatively homogeneous group of regular practitioners.

In effect, in the early 1800's, Canadian practitioners of medicine were a disparate group of argumentative and intensely competitive occupations, vying for the right to call themselves "qualified".

In Upper Canada, a select group of British trained doctors continually argued for the exclusion of "unscrupulous, illiterate and inexperienced practitioners of the art of physic and surgery." Coupled with this indignance was the claim that only a "gentleman's education" would serve to foster the knowledge, skills and cultural sophistication required for the proper practice of medicine. In french-speaking Canada the situation was similar with allopaths complaining to government that licensing requirements were so perfunctory that unlicensed practitioners with "deplorable deficiencies in medical qualifications" were permitted to continue their practices (MacDermot, 1967; Hamowy, 1984).

This fusion of the notion of proper "scientific" practice and knowledge with the cultural milieu of the dominant class is one of the more important aspects of the development of regular medicine into a privileged fraction of the old middle class. As we shall see, the successful attempt to bond to dominant cultural patterns acted as a persuasive catalyst in the gradual rise to dominance of allopathic medicine.

4.2.1. Persuasion and Exclusion

Early attempts to legislate against the homeopaths, naturopaths and eclectics—who made up most of the challenge to orthodox medicine—were geared towards the identification, persecution and prosecution of those practitioners who did not comply with rules set out by elite medical societies. Some of this legislation was quite punitive,

at times setting ridiculously high fines as a deterrent to “illegal” practice. In other cases physicians championed legislation which resorted to the legal (and often lucrative) payment of informers whose function was to expose anyone who was not properly licensed. These political efforts were combined with a public campaign to discredit alternative approaches to healing. Even as early as the 1700’s, an elite group of physicians, mostly ships’ doctors, argued that they should be given professional status so that the public would be protected from the uncontrolled acts of “unscrupulous charlatans.” The most important characteristics of these early bids was the attempt to exclude other forms of health practices from the market for health care and the simultaneous attempt to advance a model of allopathic medicine as “science.” Evidence of the former process is readily found by perusing both the arguments of allopathic physicians in the medical journals of the day and numerous statutes designed to exclude homeopaths and midwives from the practice of medicine. For instance, allopaths were encouraged by their success in influencing the passage of a 1788 ordinance to “prevent persons practicing Physic and Surgery within the province of Quebec, and Midwifery in the towns of Quebec and Montreal without licence.”

Competition between physicians who had been given some form of rudimentary training—often in elite British medical schools—and various herbalists, homeopaths and midwives had resulted in indignant claims regarding the “destruction attending mankind” in parts of the community in which the “wicked pretenders” were practicing (MacDermot, 1935: 1). One doctor, writing to the British American Journal stated that:

Under my own nose lives neighbour B., who bleeds and extracts teeth at exactly half the professional charge. This to you may appear a trifling grievance, yet I assure you the receipts before the infringement of my rights, has helped greatly to condition my horse from a hard midnights ride (MacDermot, 1935: 2)

The desire to exclude such undesireables was founded on the belief that untrained and unqualified men and women were giving what was considered to be scientific medicine a bad name, and that such people were causing more harm than good in the community. While this may have been true of a number of practitioners, it is also clear that many allopaths were by no means innocent of quackery themselves. They were more concerned with persuading the government as well as the public that their knowledge was unique and special, and as such, warranted special political and economic treatment.

And, as Shortt (1983: 60) argues:

what is of paramount importance...is the manner in which physicians used, not the content, but the rhetoric of science. In an analysis of the deployment of science by physicians it will become apparent that the nineteenth century profession, though outwardly demonstrating increasing homogeneity, must be resolved into a series of distinct and frequently competing subgroups.

Despite the high level of indignance and doctors' arguments as to the immoral character of alternatives to allopathic medicine, early attempts to professionalize medicine and exclude other practitioners tended to be ignored by the state. One important reason for this was that allopathic medicine was still considered to be a trade, much like the occupations it was trying to replace, and therefore no more deserving of government protection. In fact, in 1827, one member of parliament suggested that all those who were practicing medicine, surgery or midwifery without licence, should not be liable to any criminal prosecution "except in cases of malpractice, gross ignorance or immoral conduct" (Hamowy, 1984: 58-59). The influential Upper Canada Journal was outraged, arguing that such an amendment amounted to the legalization of quackery. The editors simply could not believe that ostensibly rational parliamentarians were unable to see the clear superiority of allopathic approaches to medical care. To make things worse, in 1846 a powerful free market coalition in the Canadian legislature combined with a generally sceptical public to oppose any legislation which restricted competition and

which would curtail the activities of the heterodox practitioners (Hamowy, 1984: 61). Even as late as 1890, the Patrons of Industry—a political party which enjoyed brief tenure in Ontario’s parliament—opposed the monopolistic tendencies of big business and the professions. They argued that such groups exploited the working classes and farmers and, through their educational and licensing requirements, prevented “poor mens sons from joining their ranks” (McNab, 1970: 29).

To a large extent, state indifference to the demands of the allopathic practitioners is also indicative of a general indifference to health care as a whole. From the late 1700’s to approximately 1857, health care in Upper and Lower Canada was not considered to be a prerogative of the state. Indeed, its only involvement was as a provider of marine hospitals and enforcer of quarantine laws. On occasion, when cholera or small pox epidemics broke out, provincial governments would become involved through the provision of ameliorative public health reforms, but these tended to occur on a crisis basis until at least 1880 (Baldwin, 1983: 374).

While early attempts to professionalize medicine met not only with public but also governmental resistance, continued pressure by physicians and the gradual infiltration of the state by physician-politicians allowed the profession to make slow gains towards professional status. In Upper Canada, demands for regulation of the profession found expression in the provincial act of 1839 which incorporated the College of Physicians and Surgeons of Upper Canada. This body provided the legal means by which the provision of licences and diplomas could be regulated although it was disassembled in 1841 because the colonial English government felt that it impinged upon the rights of the Royal College of Surgeons of London. As a replacement to this body, a previously defunct Medical Board was revived and continued to regulate the profession until the passage of the Parker Act in 1865. By 1869, this licensing legislation was revised to create the College of Physicians and Surgeons of Ontario, and similar legislation was

passed in Quebec in 1847. This Act was subsequently amended to include the eclectics and homeopaths as part of the Medical Council of Ontario.

It is significant that the regular profession eventually decided to bring the irregulars within the ambit of professional regulation. The decision to include them was not so much motivated by a sudden acceptance of their brand of medicine as by the recognition that incorporation under the act would mean that their activities could now be regulated by physicians, who, in the words of one writer, now had the means of “hugging homeopathy and eclecticism to death” (McDermot, 1935: 13).

Esland (1980) argues that it is crucial to understand the social class bias of the production of professional knowledge and the importance of occupational strategies which rely on the cultivation of the socially powerful. Canadian doctors, like their counterparts in other industrializing countries, used their connections with elites in the state to develop and consolidate their power as the only true representatives of the “science of medicine” (Parry and Parry, 1976: 252). The increasing power of the regular professions to determine what constituted the proper and scientific practice of medicine is thus intimately bound up with their connections with state elites. These doctors were “in” the state, but also gained political approbation because they frequently came from the same social backgrounds and attended the same elite educational institutions² (Torrance, 1981; Mandell, 1974).

In addition, the power of these elite doctors to define the proper practice of medicine continued to derive, in part, from their treatment association. The elite doctors tended to treat members of the dominant and middle classes, while the homeopaths and eclectics continued to administer to the needs of the working class (see Mandell, 1974). As well, there were many attempts by the regular practitioners to advance the argument that the public did not know what was good for it. The assumption was, of course, that people would eventually come to the regular practitioner for treatment, and in this way it would be possible to reduce the number of competitors. One regular physician wrote:

Charlatans prey on the public like vampires, and the public as stupid as they are would not know any better if one of their class were to make a cure for some disease, proclaiming its efficiency, even if an angel from heaven pointed out the deception. (British American Journal, Vol 3 1862: 86)

That the use of nostrums, elixirs and other alternatives to the allopathic approach were popular is evidenced by the use of these techniques even amongst the allopaths, and is further testimony to the fact that the profession was far from homogeneous in its approach to care of the sick. Those doctors who were trained in the “proper” scientific tradition yet continued to use “irregular” technique were thought to be causing the profession to suffer:

...a deterioration and a loss of prestige and moral influence, when it is known that among its members men are to be found, who with all the advantages which education and rank can give, can stoop from their high position, and for the sake of a paltry dollar adopt the usages of the veriest charlatan (British American Journal, Vol 1, 1860: 427-8).

Nor were the allopathic elite above using the testimonials and considerable influence of respected and “cultured gentlemen” to advance their case. In a letter to one journal, Sir Benjamin Brodie (a non-physician) was asked to give an opinion on homeopathy by examining some of their books. He found homeopathy to be extremely illogical and infused with:

general principles on the evidence of the most doubtful and scanty facts; and the reasoning on them, for the most part, is thoroughly peurile and illogical...anyone with good sense and versed in the caution with which scientific investigation should be conducted will arrive at the same conclusion (British American Journal, Vol 3, 1862: 18-20).

It is also clear however that as real scientific progress was made, the allopaths were able to gain a great deal of credibility. As Shortt points out, it is essential to appreciate the cultural and non-technical value of science in relation to the contribution

this makes to the status of the profession. Put simply, because allopathic physicians had all along affiliated themselves with the values circumscribing “scientific rationality”, when truly scientific discoveries were made the profession had a ready-made source of legitimacy. This phenomena can be clearly understood in terms of the argument that “invalid modalities” of therapeutics can often lend credence to the stature of the purveyor (Shortt, 1983: 60).

Here, it is worth looking at the work of Shortt in some depth.

Nineteenth century doctors and patients were united in what Charles Rosenberg has labelled ‘a conspiracy to believe’, a willingness to accept medical science’s definition of disease and its prescribed remedies. The body was conceived of as a dynamic balance of vital functions, while disease represented an intrusion which upset the delicate harmony. Treatment was intended to redress the disequilibrium largely through the physician’s ability to ‘regulate the secretions’. Within this theoretical context, ‘unscientific’ procedures such as bleeding, purging, sweating, and blistering did work, for they exerted the expected effect on secretions and frequently showed other evidence of presumably efficacious physiological activity—alterations in pulse, changes in skin colour—as well. Therapy reassured to the degree that it demonstrably acted, and was given added credibility by the self-limited nature of most illnesses. The “physicians ability to understand and intervene in the ongoing physiological process which defined health and disease” was clearly revealed, while “the very severity of the drug action assured the patient and his family that something was indeed being done”. And that something, it appeared, was a product of science. (60)

Thus medicine gained prestige “not through enhanced therapeutic efficacy, but as a result of an increasing public faith in the value of science” (Shortt, 1983: 67).

4.2.2. Development of a Professional Association

Another important development in the professionalization of medicine came when the Canadian Medical Association (CMA) was formed in 1867. Its aims were to advance a monopoly of knowledge, as well as shape public opinion and other occupational interests by:

giving a frequent, united and decided expression of the medical opinion of the country...advance medical knowledge, and elevate the standard of medical education, besides directing and controlling public opinion in regard to the duties and responsibilities of medical men; and serve to excite emulation as well as harmony in the profession (MacDermot, 1967: 54).

As well, the Association began to define the proper role of patients in dealing with the physician, claiming that a patient's first duty was to consult only "regular practitioners....see the doctor even for trivial cases lest 'fatal results' supervene...and a patient should never permit his crude opinion as to their fitness to undercut his obedience to doctor's orders and prescriptions" (Naylor, 1986: 20).

The formation of the CMA signalled the beginning of a uniform system of education and registration whose main purpose was to produce a homogeneous profession with respect to social background and recruitment. In addition, the CMA began to embark upon a policy of public education which would increase public faith in the medical profession by emphasizing the value of science.

According to Mandell (1974: 116) the CMA today has no legal control over health care policy but does function as a powerful pressure group within the political arena, voicing and lobbying for the concerns of organized medicine. While this is certainly the case today, it is clear that in the period between 1867 and 1900, the CMA was a small and (relative to today) not particularly powerful interest group whose members often had fairly direct relationships with state officials. Perhaps the main reason for the relative lack of power of the early Association was its lack of membership. Physician interest in joining the fledgling organization was limited at first; less than 20 percent of the profession had joined as late as 1920. As physicians began to become more homogeneous in terms of political interests (or more precisely, as they had less time to participate directly in the political process and therefore invested this function in the CMA), and especially since the first rumblings about state sponsored health insurance, membership increased dramatically. In 1935 membership had nearly doubled to 35% and

by 1943 it was 60%. As the Second World War approached, the CMA became a "forum for interpreting emergent developments like the health insurance movement and formulating a coherent response from the profession" (Coburn, Torrance and Kaufert, 1983: 416).

4.2.3. The State and Health Care

While allopathic practitioners were gradually attaching themselves to the image of science, the post-Confederation state continued to be indifferent to the health and welfare of Canadians. Between 1867 and 1919, health care was the exclusive prerogative of the provinces, but with growing recognition of the political and economic benefits of an interventionist strategy in the welfare of the population, the federal government began to get involved in the development of health care policy (Swartz, 1977; Wallace, 1950).

Several institutions were established to tend to the needs of the population. The Department of Health was created in 1919 followed in 1928 by the Department of Pensions and National Health and in 1944, the Department of National Health and Welfare. The previously minor health concerns of the federal government (the provision of marine hospitals and quarantine) increased in scope to cover the functions of food and drug control, public health engineering, civil service health and the operation of the Laboratory of Hygiene (McDermott, 1967).

As a whole, this increased activity represented the growing desire of the federal government to maintain the legitimacy and efficiency of capitalist relations of production through the creation and maintenance of social welfare programs. In the early 1900's health insurance was being discussed but little action was being taken due to financing problems and the emerging difficulties *vis a vis* federal and provincial relations. However, in the post-World War Two period, policy goals became more specific. At the heart of the Keynesian revolution was the perception that social programs would relieve the impact of downward troughs of the business cycle (through Unemployment Insurance

and income support programs) and minimize the impact of crises encountered in everyday life (through Hospital Insurance programs and Workers Compensation). Health and welfare programs were also predominant on the list of ameliorative government programs. A nascent industrial capitalism had gradually brought with it fundamental changes in the structure of Canadian society. In particular, there began a transition from rural to urban communities accompanied by an increasingly heterogeneous population due to the increasing use of immigrants to build the country's canals and railways. As Palmer (1983) and others have pointed out, the increasingly oppressive work and social conditions of this period began to take their toll on this population, resulting in increasing health problems and fostering working class militancy. Quebec in particular was the site of many health problems, due to the increasing immiseration and subordination of the working population to anglophone capital in collusion with fractions of the francophone bourgeoisie. Economic subordination led to the development of an increasingly disenfranchised Quebec working class as well as an increasingly poor rural class which found itself drawn into the bottom rungs of the urban proletariat (Torrance, 1981). Recognizing that these developments could have political consequences as well as implications for the accumulation of capital, the federal and provincial governments began to toy with the idea of a state funded health insurance program as one way of addressing some of these problems.³

Royal commission studies were undertaken to consider the feasibility of health insurance in 1919 and 1920 in British Columbia, in Alberta in 1932 and by the special committee on Social Security of the House of Commons in 1943. Predictably, the conclusions of each study were all favourable to the support of a tax-supported system of medical care insurance (MacDermot, 1967). Yet although government officials paid lip service to state supported health insurance, government expenditures on health programs were virtually negligible until nearly 1960. (See table 4.1)

Table 4.1
Government Health Expenditures in Canada 1937-55 (1949 dollars)

Year	<u>Federal Government</u>		<u>Provincial Governments</u>	
	Percent GNP	Dollars per Capita	Percent GNP	Dollars per capita
1937	.02	.15	.5	4.01
1945	.04	.51	.4	4.32
1955	.2	2.69	.9	11.65

Source: Swartz, 1977:317

4.2.4. Medical Schools

As organized medicine gained control over the definition of health and disease through their association and upward assimilation with the dominant class, they also began to attempt to control medical labour power. In addition to the successful exclusion or subsumption of other modes of practice, this meant the control over the “production” of new physicians which was by the 1900’s concentrated in the medical school. Essentially another exclusionary strategy, the ostensible aim was to foster the development of high standards in medical education in order to limit the number of students who could get into medical school, with the long term goal of “reducing the competition which was driving incomes down” (Naylor, 1986: 24).

Early medical schools in Canada were few. In 1890 there were 13 and five of these closed down by 1906. The small number of medical schools also reflects the fact that some doctors were trained in Britain while many were apprenticed to an older and established physician (Hamowy, 1984). Some of the schools were proprietary and drew on the elite members of society for their membership. In addition, because they were proprietary, it was virtually certain that most physicians in training would be recruited from the classes most likely to pay for that training. In effect, the majority of those doctors training in the tradition of “scientific” medicine came from the higher echelons of the old middle class (see Hamowy, 1984; Roland, 1984).⁴ As well, many of the subjects taught in the medical schools (such as Latin or calculus) would more likely be the

“intellectual property” of the propertied classes as opposed to the average working class student, though such skills were often entirely irrelevant to the practice of medicine. In this way, the developing medical curriculum functioned to limit access to upper and middle class aspirants.

The Flexner Report, a survey of the state of medical education in North America, was published in 1910. It found that medical education in the United States was in abysmal condition, owing in part to the lack of enforceable regulations on medical education. However, compared to the United States, Canada’s eight medical schools fared quite well. Two were rated as making good efforts to achieve high standards and two were commended as excellent. But the main impact of the Flexner report was that it provided the political and ideological justification for the further exclusion of unscientific practitioners by arguing that limitations on the membership in the profession was essential to the maintenance of professional standards. Similarly, in 1912, Sir Thomas Roddick (a medical man turned politician) succeeded in “effecting passage of the Canada Medical Act which standardized medical licensing procedures across Canada...resulting in both the upgrading and ‘scientizing’ of medical education,” and a situation in which “fewer but better” doctors would be trained (Coburn, Torrance and Kaufert, 1983: 414).

As the provision of medical education became more financially burdensome, and as it was recognized that only universities would be given degree granting power, these independent schools began to tie themselves to universities. One of Canada’s most famous physicians, Sir William Osler, argued that:

The day has passed in which a small school without full endowment can live a life beneficial to all the students, to the profession or to the public. I know well of the sacrifice of time and money which is freely made by the teachers of those schools, and they will not misunderstand my motives when I urge them to commit suicide, at least so far to change their organizations into clinical schools with affiliation with the central university (quoted in MacDermot, 1967: 109).

As the medical schools gradually affiliated themselves with universities, they began to develop more rigorous and standardized curricula, and slowly removed themselves from the purview of individual professional control. For example, the founder of a school of medicine in Toronto, John Rolph, found that by 1854 his staff had resigned only to continue their functions under the auspices of the larger Toronto School of Medicine. In 1887, this School became part of the University of Toronto. Similarly, the London Medical School which was founded in 1881 and owned and governed by the medical faculty was reorganized in 1913 to become a permanent part of Western University. In total, fourteen out of seventeen medical colleges and schools united, amalgamated or were absorbed by universities (calculated from Hamowy, 1984:80-84). Earlier legislation in relation to medical education had given control over this process to medical practitioners through their representation on the Council of Medical Colleges, but later, universities were given four representatives on the Council. As Coburn et.al. (1983:412) point out:

Practitioners, resentful of this development, eventually reduced university representation, but they were at the same time losing their struggle to control medical education; increasingly, they merely reacted to changes made by the educators rather than controlling the content of the curriculum.

Thus, the most important initial developments in medical education concerned the gradual tightening of entry requirements, association with universities in order to gain the right to grant degrees, the establishment of more formal subjects on the curriculum, and the continued dominance of medical practitioners as formal teaching staff in these universities as opposed to individual owners and controllers of a proprietary medical school.

4.2.5. Lobbying the State: Organized Medicine and Public Policy

Prior to the depression, many physicians (with the exception of public health doctors) had publicly stated that they could have nothing to do with a state run health

insurance scheme since it impinged on their freedom as classical entrepreneurs.⁴ Indeed, the crucial aspect of early studies on health insurance were proposals that such schemes would entail exclusive governmental control of medicine. The perception of the Canadian Medical Association was that this would entail loss of control over the right to carry out the practice of medicine as doctors saw fit (through the sale of their labour power to a third party), and that this would mean a decline in the "quality of health care". If physicians were to retain control over the production of health, their mandate now was to offer alternatives to the systems proposed by the commissions (MacDermot, 1967; Swartz, 1977; Torrance, 1981). Initial attempts at medical health insurance had focused on the provision of services to the indigent population but around the late 1920's, physicians actually began to push for more universal coverage. As the depression of the 1930's began to take its toll on all sectors of the economy, it became increasingly clear to doctors that participation in a state-operated medical insurance scheme would be pragmatic. A survey of Hamilton doctors found that practices had declined in volume by 36.5 percent between 1929 and 1933. In 1929, 77.5 percent of doctors' work was remunerative but by 1932 it had fallen to 50 percent. Almost half of the physicians surveyed claimed that their professional income was insufficient to pay their expenses and provide necessities. Moreover, they estimated that only 30 percent of the population was willing to pay for medical care (CMAJ, Sept. 1934, # 31 Supplement: 51).

Rural areas, and particularly the prairies, were far worse off. One physician described his experiences in this way:

Since 1929, rural areas have many families who cannot pay anything to their doctor. Even farmers, who a few years ago were considered well to do had electricity installed, had motor cars and telephones—cannot pay for medical care today. We are asked to accept all kinds of produce on our accounts. The writer received over twenty chickens, several ducks, geese, a turkey, potatoes and wood on account during last winter. Many country doctors have trouble collecting sufficient to purchase the bare necessities of life (Woolner, 1934: 307).

As Bothwell and English (1981: 482) point out, "Quite suddenly, the CMA began to perceive health insurance not as a threat but rather as an antidote for the economic ills of the profession." The large numbers of unemployed typifying the depression period put a further dent in physicians' incomes leading to the CMA's concern that doctors might fall from their relatively newly forged prestigious position in society. Prime Minister Bennett offered little hope of federal aid which prompted the CMA to present their own proposal entitled "Plan for Health Insurance in Canada" in 1934. In this document, both the federal and provincial governments were indicted for their neglect of the indigent population of Canada. It was argued that the only solution was state health insurance *which would be supervised by the medical profession*, and would cover indigents as well as single persons with incomes below \$1200 and families with incomes below \$2400 (Bothwell and English, 1981).

The desire to maintain control over the production and administrative processes, coupled with the recognition that public health care insurance was both desirable and inevitable, meant that organized medicine would have to pressure the state in order to maintain the fee-for-service relationship with the client. In such a relationship, the state would act as mediator between the client and the producer, rather than a direct buyer of doctors' labour power. One early example of the profession's early inability to create such a relationship is captured in the situation in British Columbia in 1935. There, the government introduced a draft health insurance plan which restricted health insurance coverage to those earning less than \$150 a month. Those most likely not to pay their bills (domestic servants, part-time workers, casual labourers, and recipients of old age pensions and mothers' allowances) were left out of the plan. While there was broad public support for such a plan, it was opposed by organized medicine. Doctors were left out of the administrative aspects of the Act, and were not provided with any manner of determining the rate and manner of payment of fees. The unacceptability of the plan did not however, lead to the profession's out-right rejection of health insurance per se.

Instead, it became clear that the B.C. medical profession would have to temporarily abandon a bargaining strategy and establish some form of insurance scheme which they would administer (Taylor, 1978). In other provinces, the process was similar, with the various provincial medical associations taking the lead in developing proposals for voluntary health care schemes. In 1939, Manitoba installed a voluntary hospital insurance scheme with other provinces following suit (Ontario established Associated Medical Services and Windsor Medical Services in 1937 and a similar scheme was put into operation in Regina in 1939). The task had become to provide medical services to the population (and thereby maintain doctors' incomes) while precluding the possibility of state control of doctors.

Following the establishment of the Rowell-Sirois Commission in 1940, Mackenzie King's government called a Dominion-Provincial conference to discuss the Commission's recommendations, one of which lamented the dismal state of public health. Although the contents of the report were not acted upon, it was becoming increasingly clear to the government that it was once again time to reconsider the possibility of health insurance and once again primarily because of the inability of the existing system to address the health needs of the productive population. In particular, King, who some have called Canada's most class-conscious politician, was convinced that the era of individual responsibility for health was coming to an end and that Canadians needed social welfare legislation to placate fears that the depression of the 1930's would return. Furthermore, those members of the elite who had previously vigorously advocated individual responsibility for health began to realize that diseases such as cholera knew no class boundaries (Wallace, 1950: 68).

Dr. J.J. Heagerty, (M.D.) director of public health for the Department of Pensions and National Health, recommended in 1941 that "public health be an integral part of any health insurance plan, that coverage be universal below a certain income level, and that provincial departments of health administer the plan in consultation with medical

practitioners" (Bothwell & English, 1981: 486). The close relationship between Dr. Heagerty and the government meant that he was able to respond effectively to the concerns of physicians as represented by the CMA and in 1942 a new bill was drafted which recommended an:

....independent Health Insurance Commission in each province, the majority of whom shall be representatives of organized medicine; medical care for indigents paid for by the government; freedom of choice for physician and patient; remuneration according to the method or methods of payment which (doctors) select" (CMAJ vol. 47, Special Supplement: 3-5).

After much debate, it was decided in 1943 that the plan proposed by Heagerty and the CMA would be "filed away" for further consideration.

4.2.6. A Reversal of Fortunes

Slowly but surely, the medical profession's decreasing prosperity of the 1930's and the concomitant desire to achieve paid accounts and security gave way in the more prosperous 1940's to an increasing suspicion and hostility towards a government sponsored health insurance scheme. The scheme was perceived by many as "as plain an example of National Socialism and State control as one could imagine or desire" and it was this perception that was to characterize the climate of professional-governmental relations between the 1940's and the 1950's (Bothwell & English, 1981: 490-491). While doctors understood that some form of health insurance was inevitable, they also felt that they could not allow themselves to become "employees of the state." To preclude such a development, they continued to operate their insurance plans while pressuring governments to include them in the inevitable process of establishing a national health insurance scheme. In effect, the profession had made a conscious separation between the way in which they would be paid—fees-for-service paid for from public coffers—and the employment relationship under which such payment would occur.

They would be independent professionals who would under no circumstances allow themselves to become or be perceived as state employees.

In the 1940's the CMA continued to pursue these interests knowing that their connections with government leaders could still be very useful. In a letter to the executive committee of the CMA, General Secretary T.C. Routley commented that "twenty doctors had sat down to dinner in a private dining room in the House of Commons." The party included four Senators, and 12 members of Parliament all of whom engaged in an "active and interesting discussion...in reference to health insurance." The aim of the meeting was to acquaint these physician/politicians with the CMA's position on health insurance and to underscore their potential in gaining a favourable position from government in the event of a national health insurance scheme. His letter stated:

In looking over the list of Parliamentarians, it might be well if members of the Executive and others would keep in mind the advisability of these gentlemen being contacted by medical colleagues who know them well. When it is remembered that there are twenty doctors in the two Houses, it will be recognized that they can be a powerful force when it comes to dealing with legislation of a health insurance character. It was the opinion of your officers that the group we met were in sympathy with the aims and objects of the Canadian Medical Association and we hope to continue the development of relationships of an informative and friendly character (Routley, 1943).

Even though complications (once again, disagreement over costs and federal-provincial relations) prevented early adoption of federally funded health insurance, doctors tried very hard to influence the policy making process and to shape what they considered to be an inevitability. Thus, from being just another interest group lobbying the state in the early 1800's, the relationship between state leaders and doctors become more intimate (in the mid 1800's) and then more complex from the 1900's on. The close relationship between doctors and the state in which the former were "in" the state

provides good justification for an instrumentalist view of state-elite linkages.⁶ Yet as Canadian society became more complex and as other interests (such as the creation of an infrastructure to facilitate capital accumulation) demanded the attention and favour of government officials, physicians became less able to exert a direct influence in the legislature. In effect, as the state became relatively autonomous, they no longer enjoyed the luxuries associated with the role of policy maker/physician since they could not appear to be blatantly acting in the interests of the profession any more than the state could be seen to be acting solely in the interests of a professional elite.⁷ Rather than establish a health insurance scheme, where doctors would have more than a modicum of control, Mackenzie King's Liberals decided to proceed with a family allowance program, and the original health plans tabled by the profession fell by the wayside.

4.3. Practice patterns of the early doctors

Early in the 19th century, and prior to the development in the 1860's of the "germ theory" of disease, the irregular's conceptions of the body, health and disease were as accurate as the models advanced by allopaths. Yet the allopaths succeeded in either removing the irregular practitioner's rights to practice or bringing them under the control of allopathic medicine. In defining the field of medicine, they were also able to determine its "proper" practice and the kinds of labour processes that were legitimate. In addition while the early practitioners were realizing control over the market for their services, most were also able to establish themselves as private, independent practitioners. In short, they owned and controlled their own means of production.

The geography of Canada in this era played a central role in shaping medical practice. A few physicians in the rugged frontier of Western Canada made their way around camps of miners and railway construction camps. They hired themselves out on a contract basis for a fixed fee, but this kind of practice tended to be relatively temporary

As soon as they could, most of these doctors would settle in more prosperous urban areas where people were less transient, facilities were more developed and where therefore, practices could be more efficient and lucrative (see Rose, 1972).

Detailed data on the ownership and inner workings of early medical practices is difficult to find but anecdotal evidence indicates that the majority of physicians worked in small, self-owned offices by themselves. In many cases, these physicians combined their residence with an office. In the early days of Canada's development, the largely rural character of the country combined with an underdeveloped infrastructure to create conditions which isolated the average doctor. As the horse and buggy days gave way to roads and automobiles, and as the country became more urbanized, the physicians found they were able to expand the scope of practice. In doing so, the combined house/office gave way to the separation of the residence from the workplace, and the modern doctor's office was born. One of the important consequences of this separation, and of the new found ability of doctors to move around the country, was their gradual movement from the rural areas into the urban environment, and the new found requirement to establish the financial security which would maintain both a residence and an office. Those who chose to stay in the country, or were unable to move, found themselves even more isolated than they had been in the past. Moreover, isolated country practitioners found that they had virtually no contact with research and so for the most part were unable to continue their medical education. Isolation also exacerbated differences between the country and urban practitioner. The country doctor feared that as the urban environment became more lucrative, and as licensing and educational requirements became more stringent, there would be a concomitant loss of income and fewer individuals willing to apprentice themselves to the physician (Crichton, Hsu, Tsang, 1990).

Towards the end of the 19th century, medicine began to develop its own internal division of labour as it became increasingly clear that advances in medical knowledge demanded more specialization. In the rural areas, the General Practitioner still "reigned

supreme" but more and more physicians in the urban areas began to study specific areas of medicine. One ramification of this transition was that new standards of qualification became necessary in order to maintain physician control over medicine. This was because as the scope of medicine widened, it was important to ensure that access to specialized knowledge and techniques would be controlled by a central, physician-controlled body. But more importantly, the growth of specialization in combination with the "obvious limitations of the general practitioner" began to lead to the development of group practice and the formation of clinics, the first of which was formed in 1913 in Winnipeg (MacDermot, 1967:45; Bigelow, 1969: xiii). Increasingly, then the physician had begun to rely on other specialists in order to provide a total-care package which once was the function of the general practitioner. In addition, increasing scientific knowledge coupled with technological innovation demanded the purchase of more sophisticated and expensive equipment which tended to be concentrated in the hospital. At the same time, the philosophy of medicine had evolved to a new paradigm in which the body could be split into parts and systems, each of which warranted separate fields of study (see also Foucault, 1973). The profession also began to increasingly rely on the labour of non-physicians whose numbers proliferated. For example, between 1901 and 1911, the number of physicians increased from 5,442 to 7,411 while in the same period the number of nurses increased from 280 to 5,600 (Leacy, 1983: B82-92).

With growth in the number of hospitals as well as expanding knowledge about the etiology, diagnosis and treatment of diseases demanding more capital intensive treatment techniques, the physician became more dependent on the hospital as the locus of work. Some of the larger hospitals began increasingly to resemble disease repair factories, where patients and their illnesses were processed in an increasingly routinized fashion. By the 1930's, surgery had become very well entrenched as a function performed collectively (with the assistance of para-medical personnel) in the hospital. By contrast, until at least the turn of the century, surgery had been learned by the apprentice system,

and it often consisted of emergency work performed by lamplight and assisted by relatives of the patient. The primitive state of medical knowledge and surgical technique lent itself readily to the construction of instruments by the physician himself as well as the compounding and dispensing of drugs—all functions performed by other occupations today. In these cases, doctors not only capitalized themselves, but often invented and created the instruments of their labour (see Connor, 1986; Bigelow, 1969; Rose, 1972).

Thus, the period between the beginning of the 20th century and the 1940's is characterized by a transformation in the labour process of physicians from individualism— in which the physician was responsible for the provision of capital and the supervision of a small number (if any) of employees—to a *combination* of social and individual labour. The physician, working collectively in the hospital, acted in concert with other physicians and increasingly coordinated the labour of a growing number of salaried health workers. Yet at the end of their time spent in the hospital, the physicians could retire to their private practices where they would frequently be the only workers, or at best would supervise and control the labour of a few assistants. Within the theoretical framework of this study, they performed the functions associated with real ownership when in their private practices, but also performed more collective types of work which they coordinated in the hospital, and on their own behalf. In this situation, doctors might also have been involved in making strategic and tactical decisions but in an environment which was a *nascent* bureaucracy, and essentially amounted to a charitably funded doctors' workshop. This somewhat "contradictory functionality" still pervades the physician's labour process, although, with the appearance of the state as "financier", there have been some important changes in this regard (especially since the late 1950's).

In the office, physicians continued to be the masters of their own labour and at most the labour of one assistant, or, in the absence of medical schools and licensing laws, an apprentice. Remuneration tended to be in the form of a cash payment for those patients who could afford to pay, but was often payment in kind. The doctors usually set

up their own fee schedule which would sometimes be competitive with the nearest physician, but frequently was not since for many patients (particularly in rural areas), there was no choice unless one wanted to see an irregular practitioner.

4.4. Early Hospitals: The Doctors Workshop

Prior to the 1900's, hospitals in Canada were mainly charitable organizations in which the physician played a negligible administrative role. These hospitals received support primarily from charitable organizations such as the church, or influential community leaders interested in charitable works, and only erratic government support. Towards the turn of the century, hospitals established and owned by provincial and municipal governments began to flourish and became more sophisticated in terms of the equipment and auxiliary personnel they employed. At the same time, physicians became more central to the bureaucratic operation of the institution.* Not only did doctors use these hospitals more often, but they were also becoming instrumental in managing them. In the late 1800's and early 1900's, hospital administration was often performed by civilians, businessmen or nurses. Most of these administrators learned their skills on the job (Agnew 1970:126). In such circumstances, administrators (or "superintendents") merely carried out directives of the hospital's board of directors which would be composed mainly of its philanthropic sponsors and community leaders whose primary functions were to raise funds for the establishment, physical expansion and maintenance of the institution. Governments appointed members to the board to the extent that the government contributed financially to the hospital. Physicians often sat on these boards, but not as representatives of the physician staff and primarily as the person responsible for attending patients. Insofar as they were board members then physicians could be involved in strategic and tactical decision making processes, but tended to remain somewhat "outside" the hospital bureaucracy. It was not until the 1930's that doctors began to sit on the governing boards as representatives of hospital staff and in this

way formalized their central role in the functionality of the hospital. In addition, the role of hospital administrator was undergoing professionalization as a result of the perception that better organization and increased efficiency demanded specially trained individuals. In the United States, the American College of Surgeons had developed a standardization program to stimulate better staff organization in hospitals, and this gradually led to the development of Medical Advisory Committees (MAC's) made up of the (physician) heads of medical services. This development was watched intently by Canadian legislators, who (following the lead of the Deputy Minister of Health for Ontario) institutionalized doctor's representation on the boards of hospitals by including the regulation that an official representative of the medical staff must be named to the board (Agnew, 1970: 112).

Thus, as the hospital became more bureaucratized and more of a "government" (as opposed to a private, non-profit) institution, doctors necessarily became part of the bureaucracy, and (as Chapter Seven will show) later inserted themselves as unique and important decision-makers within these bureaucracies.

After the Second World War, the Dominion Provincial Conference on Reconstruction proposed that provinces be granted financial assistance in the form of low interest loans to build hospitals. However, as a result of the failure to obtain the approval of all provinces concerning the transfer of taxes, all proposals, including those proposing the financial aid for hospitals, were rejected. By 1958, however, with the adoption of the Hospital Insurance and Diagnostic Services Act, the number of hospitals in Canada increased greatly. As the hospitals became even more sophisticated and productive, and, as they increasingly became the center of health production, physicians continued to powerfully influence their operation. This influence came through the doctor's role as gatekeeper to hospital admission, and as decision-maker in relation to the kinds of treatments which could be dispensed and even the types of equipment which should be purchased, and later, through their role on the various hospital committees. Although

they had little to do with non-clinical hospital workers such as janitors, dietary personnel and clerks, physicians were in control of the labour of paramedical workers—nurses in particular—whose role it was to “see but remain silent.” A hierarchy of labour based on patriarchy and skills developed in the hospital. Coburn (1981: 199) points out that “nurses were socialized to be subordinate to male workers, but as graduates of nursing programs, they were taught to feel superior to aides and practical nurses.” Quoting from the Canadian Nurse, she points not only to the subordinate character of nursing in relation to the medical profession, but also to the by now well entrenched ideological power of physicians:

She (the nurse) owes to the attending physicians absolute silence regarding their professional demerits or blundering. No nurse who has not learned the lesson of implicit obedience to authority and practised it until it has become habit of life, is fitted to command others. (1981:200)

By the early 1960's the profession had come to the stage where it enjoyed the services of a publicly funded labour force as well as publicly funded workshops. At the same time it enjoyed the freedom to control its own labour processes within these workshops as well as their private practices.

4.5. Conclusion

Through the process of professionalization, the Canadian medical profession was able to create for itself a rather unique existence within the old middle class. An elite fraction of the profession had systematically cultivated an ideology of professionalism which acted in a hegemonic way to remove them from the scrutiny of the public and which, through the active patronage of the state, allowed them to develop their technical autonomy and economic independence. Their professional ideology married scientific rationality with a “critique” of competitive alternatives to allopathic medicine, and highlighted their importance as the only valid arbiters of medical knowledge and practice. The basis of this “domination by consent” lay in the physicians’ promulgation of

“science” as valid knowledge. In the public as well as the medical realm, such knowledge was conceived of as a neutral expression of “rationality” and “progress” instead of “an embodiment of science and technique functional for class domination” (Carchedi, 1984: 75). The profession had cultivated their links with state elites and/or *were* the state elites themselves, and as such had been able to influence the policy-making process in important ways.

Politically, and like many members of the old middle class, physicians advanced an ideology of individualism, bound up with the notions of “competitive freedom” and the “free market.” Doctors had managed to achieve a state-sanctioned autonomy based on the argument that their skills and technical knowledge were legitimate, inscrutable and open only to collegial control. They had sufficiently eliminated competition in order to create a near monopoly situation with respect to the market for health services, and had institutionalized their dominance within the medical division of labour—as coordinators and sometimes supervisors of labour in the hospital but making limited strategic decisions, and as controllers, supervisors and always decision-makers in their private practices.

With the creation of the Canadian Medical Association, the profession had a political arm which would take up the task of socializing the public and governments, and which would advance the aims of the profession as a whole. In short, a vignette of the first 100 years of medicine in Canada would show a remarkably successful occupation making a transition from one trade amongst others to a professional monopoly, and would illustrate the process whereby this professionalization project acted as a successful strategy for class advancement.

But the new demands of advanced capitalism, the post-war crisis of legitimacy and the arrival of a state funded health insurance scheme (Medicare) would combine to impinge upon the hard fought privileges of Canadian medicine. It is therefore important to understand the logic and impact of medicare legislation in relation to both the state and

doctors within the socio-economic context within which these new challenges would be met.

A fundamental contradiction was to become more consequential as nationalized health insurance became more reality than rhetoric. On one hand, the private, independent practice of medicine had been founded upon official sanctioning by the state and the construction of public belief in the efficacy of science. Yet as the state began to perceive the importance of state funded health care (in whatever form), there was, from the perspective of the leaders of organized medicine, the possibility of losing all they had struggled for. "State medicine" would create conditions in which doctors would be dependent on government financing, subject to government scrutiny, and challenged by emerging health care occupations who had also been granted licensure.

ENDNOTES

¹ The physicians who are the subject of this chapter, and indeed the whole of this study, can be classified by many terms. Throughout the study, I refer to them as "allopaths" or "regular" practitioners.

² For example, according to Powell (1890), by 1890 there were 10 doctors in the senate, and 23 in the House of Commons. Similarly, the Ontario House of Assembly had 9 physician members while the Quebec Legislative council had 3 and the legislative assembly had 5.

³ Contrary to the argument that welfare state reforms were purely the result of working class militancy, Walters (1982) maintains that class conflict was a relatively mild "shaper" of health care insurance and that more fundamentally, the state was acting in the long term interests of capital and in response to structural problems within the health care sector.

⁴ This is a trend that seems to have continued. In 1962, 52 per cent of all medical students belonged to families in which the father's occupation was identified as "owner/proprietor," "manager/superintendent," or "professional" (Judek, 1962:217-218).

⁵ Bothwell and English (1981: 480) point out that public health doctors, who were already civil servants, "could see few terrors and no degradation in the prospect of universal state medicine."

⁶ As MacDermot (1967:21) points out, the association between the medical profession and politics has persisted in varying degrees. Medical men have always been prominent in Parliament, and two at least—Sir Charles Tupper and Sir Thomas Roddick—were outstanding political figures.

⁷ Moreover, physicians in the state were by no means of one opinion regarding health insurance. One physician-politician who was the liberal member for St. Boniface, argued that "in the opinion of this house, a measure of federal state medicine would be in the best interests of the Canadian people." Another physician-member of parliament, however, stated that state medicine would destroy doctors' initiative and turn them into civil servants. He concluded that "health insurance may be on the way in Canada, but State medicine never" (Wallace, 1950: 260)

⁸ It is also important to note that the public image of hospitals also changed; from a place one went to die, to a relatively de-stigmatized institution which cared for the sick.

CHAPTER FIVE

THE MEDICAL PROFESSION IN CONTEXT

5.1. Introduction

The previous chapter discussed the rise of professional medical power in Canada. The remainder of this dissertation will focus on changes and continuities in the class experiences and practices of the medical profession since the early 1960's—the era of nationalized hospital and health insurance. This chapter discusses the *nature* of the social forces shaping doctor's class relations within this context. Following chapters will explore the impacts of these forces on the profession's class experiences.

The Hospital Insurance and Diagnostic Services Act (HIDSA) of 1957, the Medical Care Act of 1966 and the Canada Health Act of 1984, comprise the set of policies Canadians have come to know as "Medicare." The pivotal role of these policies in the Canadian health care system makes it important to briefly examine their philosophical underpinnings and their significance for the medical profession.

Medicare has not been the only important factor conditioning the class experiences of the medical profession. The evolution of technology (a long-term process pre-dating nationalized health care), the general rise of "administrative rationality," and the changing shape of Canada's political economy have also played a significant part in structuring doctors' class experiences. An in-depth discussion of all the complex forces which have interacted to create the environment within which doctors have "experienced class" deserves a separate study. Nevertheless, it is important to examine the essential nature of these forces to understand the *context* within which class relations have been structured *vis a vis* medicine.

5.2. The Meaning of Medicare

There is much literature chronicling the development of Medicare policy. (see for example, Naylor 1986, Walters, 1982, Goffman 1965, Taylor, 1960, 1986, MacTaggart 1973, Shillington, 1972) Most of these historical discussions have been largely

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atheoretical—focusing on the processes and circumstances under which Medicare developed—or pluralistic in orientation—emphasizing the central role played by “pressure groups” in the development of socialized health care. There are some notable exceptions however. Walters (1982: 159) argues that a nationalized system of health care in Canada did not arise completely out of government fears of the potential power of a radicalized labour movement, nor from the demands of capitalists, whom, one could assume, would support any legislation which might remove expensive areas of fringe benefits from the negotiation table. She contends, (as do some other Marxist writers notably Navarro, 1973) that Canada’s national health insurance system was a result not only of the pressures exerted by interest groups, but also of the role states play in capitalist societies—to assist in the accumulation of capital and the legitimization of contradictions which arise in capitalist society (also see O’Connor, 1973; Bolaria and Dickinson, 1988).

Both federal and provincial governments had some stake in the development and implementation of a national health insurance program. Fundamentally, this interest lay in the human and ideological/political capital to be accrued in introducing legislation designed to minimize the costs of reproducing labour power and couched in terms of the “general interest” of the nation. Thus, in the process of creating a set of policies which would benefit all Canadians by addressing their health care needs the state was also attempting to secure political capital and a healthier workforce.

The general health status of the Canadian population had become of some concern to governments given that the Second World War had highlighted the low level of fitness of military recruits. The Marsh Report, and in Britain the Beveridge Report, had also shown that the general health of the Canadian and British populations was unacceptably low and that a national health system could perhaps address this problem.

A system of public health insurance in Canada was the result not only of public and interest group pressure, but also of fear that labour and its political arm (the C.C.F.)

was becoming restless and was winning the hearts and minds of the people, necessitating containment of their "anti-capitalist" sentiments. In a letter written to the Prime Minister in August of 1943, health minister Ian Mackenzie argued that the Liberal government of the day was unpopular because of the difficulties attending war conditions and general public dissatisfaction with social security policies. The political expression of this antipathy could be found in "the rise of socialism across Canada....for years a British Columbia and Saskatchewan freak [but now] definitely a national political menace" (Taylor, 1978: 35).

The risks to liberal-democracy posed by this rising discontent prompted Prime Minister King to recommend a Dominion Provincial Conference to deal with the conceivable financial and constitutional features of a national health care plan.

Thus, to a large extent, the state's interest in a nationalized health care system reflected a desire to suppress political and social discontent while attaining parity with other industrialized nations that had already embraced nationalized health and welfare systems consistent with the demand-side economics of John Maynard Keynes. In Canada, however, the concept of nationalized health care was not translated into reality until the late 1960's.

5.3. Hospital Insurance: Origins and Impacts

The events leading to the establishment of national health care insurance had their roots in debates concerning the importance and viability of welfare state economies. In Canada, such debates can be traced to discussions about socialized medicine in British Columbia in 1919, in Alberta in 1932, and by the House of Commons special committee on Social Security in 1943. Yet the actual implementation of a health insurance scheme covering hospital and medical services did not occur until 1968 in Saskatchewan. Several factors contributed to the long gestation of Medicare. The federal government was concerned about the potentially prohibitive costs of a national plan given the shortage of tax revenues. It was not until 1940 that it agreed to fund half of the costs for each

province. Moreover, each province had taken different policy approaches to health care which in large part reflected different socio-economic realities and mandates of provincial governments, particularly since the British North America Act specified provincial responsibility for health matters (Mahon, 1977).

The key legislative precursor to the development of Canada's national health insurance plan was the Hospital Insurance and Diagnostic Services Act. As part of his strategy on post-war reconstruction in 1945, Prime Minister King announced a national health grants program with two central components. The first was a "planning and organization" grant to be used to monitor the effective utilization of other health care grants and plan the details of the nascent national health insurance strategy. The second was a hospital construction grant which earmarked 13 million dollars for hospital construction.

Although Saskatchewan, British Columbia and Newfoundland as well as Blue Cross and commercial insurance companies had operated hospital insurance plans for some time, these plans covered a minority of the population. With the increasing use of costly technologies in larger, more expensive to maintain and build hospitals and the rising concentration of health care personnel in these institutions, many hospitals were facing financial problems. Moreover, these financial difficulties were only exacerbated by low utilization rates since only those who could afford to pay could use the system.

At a conference on federal provincial relations in 1955, and at subsequent meetings, the beginnings of a national hospital insurance scheme were fleshed out (Agnew, 1974: 170). Essentially, this legislation was a federal/provincial government cost sharing scheme to be funded from general tax revenues. Provinces wishing to receive assistance had to ensure that hospitals would provide detailed budgets which would be approved by provincial authorities. In addition, the hospitals were to be closely supervised and inspected and requests for new equipment or personnel were to be processed only if a clear need could be demonstrated. The legislation established

federal/provincial responsibility for hospital funding, but also had the immediate impact of increasing costs.

In Saskatchewan, which was the first province to institute a hospital insurance scheme in 1947, total expenditure for the plan increased from \$7,560,763 in that year to \$22,055,360 in 1956, an increase in per capita costs of almost three hundred per cent (Brown, CMAJ, 1958: 750).¹ Following the implementation of HIDS, the proportion of GNP devoted to health care rose from 5.5 per cent in 1960 to 7.3 per cent a decade later (Vayda and Deber, 1992:132). As Agnew (1974: 172) notes, global hospital budgets soon became the norm since;

...by the late sixties it had become clear that despite proven need, some governments simply could not afford to allow hospital costs to climb at such a rapid pace. These provinces then imposed across-the-board maximum rates of expenditure increases.

The provincial and federal governments quickly realized the importance of cost control but had placed themselves in the onerous position where public interest in a social benefit would now conflict with government efforts to contain costs.

Initially, organized medicine had a somewhat conflicting view of hospital insurance. From a purely economic perspective, hospital insurance was largely favoured by the CMA since the hospital had become more than ever the doctor's workshop and state funding meant greater access to expensive technology, personnel and beds.

Politically, however, there was some reticence since doctors were not quite sure as to the implications of hospital insurance. Organized medicine feared that governmental responsibility for hospitals would imply the escalation of "state medicine," in which doctors would become salaried employees of the state. For this reason, they continued to support voluntary insurance schemes while arguing for a partnership (as opposed to dictatorship) with government in the context of "enlightened free enterprise."

Similarly, hospital administrators and the lay boards to whom they were responsible held a cautious perspective on hospital insurance given the potential for government control and administrators' own wishes for autonomy, a mixture of public and private funding and minimal accountability to third parties (Naylor, 1986: 164-166).

Physicians also had good reason for concern since the legislation had imposed "a new era in hospital administration" in which several difficulties would be encountered (Turner, CMAJ, 1958: 768-770). In Alberta the hospital insurance scheme resulted in increased workloads, a decrease in the time spent in house calls and a displacement of the physicians work into the hospital. This seems to have been the case for the entire country (Morgan, CMAJ, Symposium on Hospital Insurance 1958: 748; Young, CMAJ, 1958: 756). In 1951 doctors who were salaried employees of the hospital accounted for 15 per cent of the total number of physicians as compared with 20.3 per cent in 1962. (Judek: 1964)

Since much of their work was now concentrated in hospitals, doctors began to work more collectively with other physicians as well as subordinate personnel. Importantly, their financial standing also improved since "(the physician's) patient has not heavy hospital charges to finance and can more readily pay his doctor" (Young, CMAJ, 1958: 756). Given the displacement of work into the hospital, most doctors, especially general practitioners, would now require hospital privileges, or face a dramatic decrease in practice volume. As well, doctors assumed that patients who had been reluctant to enter the hospital because of a lack of economic resources would now have the opportunity to do so while the scarcity of out-patient programs meant that the number of patients entering the hospital would also increase. Until more hospitals and beds became available, the increase in hospital utilization would put a great deal of strain upon existing bed facilities and the load of laboratories, implying that physicians and hospital staff would have less time to spend with patients and thereby reduce the quality of care.

Furthermore, for many physicians, the shift from premium paying days to costs paid from taxation had created a sense of irresponsibility amongst the citizenry (Watson, CMAJ, 1958: 752). Patients would be more tempted to abuse what they now perceived to be a "free" system while doctors might be tempted to admit patients who really did not need to be admitted. A survey of Saskatchewan physicians reported that fifty per cent had witnessed a large increase in "frivolous demands" from patients. One doctor stated that he had seen "as many as 10 patients a day who did not require medical treatment, but a humidifier", and some were also bitter about patient attitudes that suggested that "it is all paid for and we might as well get the attention" (CMAJ, 1963: Vol 93 974). Thus, the need to manage patient flow promoted the establishment of hospital review committees composed mainly of doctors who would regulate and discipline the incidence of such abuse, in addition to the already existing committees designed to exert collegial control over physicians practicing in the hospital. To a large extent as well, doctors were successful in obtaining influence on hospital boards. Nevertheless, a new set of conflicts between hospital boards of trustees and doctors gradually emerged, especially in cases where the doctors demanded new equipment which the lay-board of trustees thought unnecessary or prohibitively expensive (Watson, CMAJ, 1958: 753).

Hospital insurance increased the importance of hospitals as a site of medical practice subject to the administrative and fiscal authority of the state, making it in many ways like any other factory with one important distinction. While hospital managers would be responsible to the legal owners of the institution (in most cases the state) and would experience pressures to rationalize, doctors—the primary workers in the hospital—would now enjoy the capacity to use the production facilities free of charge in order to sustain and maximize their own incomes and without the irritation of having to collect on "bad debts."

5.4. Health Insurance

As pointed out in the previous chapter, between 1938 and 1942, the Canadian Medical Association was suspicious of proposals for health care insurance that excluded doctors from administration of the program and did not provide them with any control over the rate and manner of fee payment. Recognizing that health insurance was inevitable, physicians attempted to lobby for a "fair" system—a subsidized approach that would provide health insurance to the "genuinely" needy while preserving professional autonomy. Accordingly doctors campaigned vigorously in favour of a national health insurance system that would be controlled by physicians arguing that such a system would serve the "best interests of the Canadian people."

The events leading to socialized medicine in Saskatchewan are important to examine in some detail because they are widely regarded as the catalyst for a national health insurance scheme and clearly illustrate organized medicine's more conspicuous objections to socialized medicine. Indeed, analysis of the developments in Saskatchewan between 1958 and 1967 show that both the Canadian Medical Association and the federal government viewed the unfolding events in Saskatchewan with profound interest. Federal leaders wanted to monitor the declared intention of the social-democratic C.C.F. to lobby for the introduction of health insurance on a national basis, a particularly important issue in light of anti-communist sentiment generated by the cold war. Similarly, the Canadian Medical Association was also carefully monitoring the situation in order to determine the possible impact of socialized medicine on the province's doctors and to develop a strategy of resistance should the program translate to the national stage.

In 1947, the Saskatchewan government had gone alone in the development of a hospital insurance scheme (British Columbia soon followed in 1949). By the time that Diefenbaker's Conservatives arrived in power in 1957, a provincial-federal fund sharing initiative had been put in place in order to share the costs of hospital insurance with all

provinces. Saskatchewan now had the opportunity to use some of this money to also pay doctors bills which they began to do in 1959.²

In his 1959 proposal to the people of Saskatchewan, C.C.F. Premier T.C. Douglas argued that his proposed health insurance legislation would include the key elements of prepayment, universal coverage, high quality of service, government sponsorship administered by a public body responsible to the legislature, and, importantly for doctors, that the service must be in a form acceptable both to those providing the service and those receiving it (Badgely and Wolfe, 1967: 1-22). The profession's central objection to the Act centred on some rather broad interpretations which suggested that the government agency to administer the Act (the Medical Care Insurance Commission - MCIC) would have the power to make regulations concerning the control of finances which might entail the control of medical practices (Naylor, 1986: 197). Accordingly doctors supported a scheme that would maintain and extend already existing indemnity and service plans. Predictably, they were also concerned about the relationship between state funded medicine and issues of "professional control" and "freedom" (See Blishen, 1969: 152).

However, the profession's views were almost completely ignored. Although Douglas had stated publicly that any form of health insurance should be acceptable to both producers and consumers, the actual legislation was virtually imposed on the profession in spite of the existence of ongoing consultations between the profession and government representatives.³ Marjorie Shearon, a writer and vociferous opponent of anything smacking of "socialism" was commissioned by the Saskatchewan Medical Association to produce a pamphlet which would convey the position of the medical profession to the general public. In this document, she argued that Douglas had paid scant attention to the medical profession and had instead implemented his own plan. Moreover, she maintained that:

The issue of compulsory health insurance...is purely political and has little or nothing to do with health, (and) is invariably isolated from genuine considerations of health and is promoted unilaterally for the dual purpose of buying votes and justifying more taxes (Shearon, 1962: 13).

In general, the reactions of Shearon and other apologists for the doctors of Saskatchewan reflected a more general opposition to the principle of the welfare state, a sentiment that was not confined specifically to Saskatchewan. At the national level, the Canadian Medical Association offered both financial and ideological support for the arguments against Medicare. Between 1960 and 1962, The Canadian Medical Association Journal is replete with discussions supporting the struggle of the Saskatchewan College of Physicians and Surgeons (SCPS) against a state-controlled system of medical insurance. However, the CMA suppressed the results of a survey of doctors which indicated overwhelming support by members of the profession for a state aided form of medical insurance in which the profession would bargain with the state regarding terms of remuneration (Naylor, 1986: 187-8). In addition, a Gallup poll taken in 1960 had shown that nearly sixty per cent of Canadians supported a comprehensive state Medicare plan. With these facts in mind the CMA decided to attempt to stem the tide of pro health insurance sentiment by appealing to Prime Minister Diefenbaker to call a Royal Commission which would "assess the health needs and resources of Canada with a view to recommending methods of ensuring the highest standard of health care for all Canadians" (Naylor, 1986: 191).

In the meantime, Saskatchewan doctors reacted to the imposition of Medicare by staging the 21 day doctors strike of 1962, undoubtedly the most obstreperous example of physician resistance in Canada this century. During this strike, the medical profession withdrew all but emergency services to patients and sponsored newspaper ads proclaiming the demise of quality medicine, and the imminence of communism. In addition, ten per cent of doctors left the province prompting the government to invite foreign medical graduates to practice in Saskatchewan.⁴

The Canadian Medical Association was caught in a difficult situation. Its leaders knew that Manitoba, Alberta and Ontario favoured a subsidization approach suggested by the CMA. The outcome of the difficulties in Saskatchewan were sure to influence these provinces in addition to the federal government and the now active Royal Commission on Health Services headed by Emmett Hall (Naylor, 1986: 205).

At the annual meeting of the Canadian Medical Association, in June of 1962, it was argued that:

...Saskatchewan doctors are standing in the place of each one of you. They are fighting your fight as well as their own. Whatever happens in Saskatchewan will have an ultimate effect on every doctor in this room.

Though the CMA rallied behind the Saskatchewan doctors, it was clear that not everyone supported the strike. The tone of media reports varied considerably, with provincial newspapers taking a definite pro-doctor stand (which might also be read as an anti-CCF stand) while other papers took a much more anti-doctor position arguing that the legislation should be accepted simply because it had been derived by a democratically elected government. (Naylor, 1986: 207; Taylor, 198: 307-14)

Support from other countries also varied. The American Medical Association was most notably in support of the Saskatchewan doctors and provided financial support as well as re-location for those doctors who left the province. But the British medical profession tended to disagree with the concept of the strike, arguing that it was essentially unethical (Naylor, 1986: 208).

Although the initial relationship between government and organized medicine regarding national health insurance was confrontational, as it became increasingly clear to the SCPS that health insurance was here to stay, they adopted a more compromising strategy. This was partly facilitated by the arrival upon the scene of a go-between, Lord Stephen Taylor (a physician himself), who, in reminiscing about the political climate at the time, has stated that he:

...suspected that we were now witnessing a test-case, as it were, in North America, of the conversion of a powerful and reluctant profession into a social service (CMAJ, Vol 110).

Taylor was a superb mediator who managed to get the two sides to agree to an amended version of the legislation. Importantly, however, the new agreement (called the Saskatoon Agreement) was also the product of some considerable acquiescence on the part of organized medicine within the province.

In addition to strengthening the wording of some clauses in the Act, the profession was also able to get an agreement on the way in which they would be paid. They were allowed to bill patients directly who could then bill the insurance commission for up to 85 per cent of the services rendered, while the doctor had the option to extra bill the patient for the remainder. Or, the doctor could enter the plan directly and simply make do with the 85 per cent of the SCPS fee schedule. Lastly, the doctor could simply deal with one of the existing doctor sponsored insurance plans at 85 per cent of the full tariff and deal with an intermediary rather than the government (Naylor, 1986: 210).

Later, the editor of Canadian Medical Association Journal News and Views Column (Oct 27, 1962) evaluated the impact of the Saskatchewan events on the rest of the medical profession. Several issues were deemed important. The public had become more aware of health insurance provided by governments. Furthermore, the "harsh glare of publicity" had affected the public image of the profession. But most importantly, the compromising nature of the Saskatchewan agreement would, it was felt, tempt politicians to introduce similar programs in other provinces. Indeed, the Saskatchewan experience provided an important indication of the need for the profession as a whole to be alert, for as far as they were concerned, public demand for a national health insurance system would be artificially created by politicians anxious for re-election, and encouraged by the labour movement. The latter would of course stand to gain much from health insurance, most importantly the elimination of medical insurance from fringe benefits packages and

political prestige for the labour dominated NDP. For these reasons, organized medicine continued to recommend that the profession should not support any kind of health insurance scheme which resembled the Saskatchewan format. This, however, is exactly what happened when the Hall Commission recommended that a universal, publicly administered, accessible and portable health insurance scheme be established.

The events in Saskatchewan illustrate the initial willingness of organized medicine to use confrontational tactics and later a more compromising approach to achieve their goals—the claim to freedom of practice style and the attempt to counteract socialized medicine which, it was felt, would undermine the free enterprise approach to medical care. But the situation also reflects a genuine fear within the profession of medicine as a whole, namely that the entity that controls the purse strings might also control, at some point, some or all of the technical aspects of work. There was some ominous evidence that this might happen. Speaking at a conference on medical labour power and health insurance in 1967, H. A. Crewson (an accountant) stated that “increased demand brought on by health insurance (had) created a crisis of manpower throughout the health field, for which we are all scrambling to find remedies” (1967: 225) and that:

we (the government) desperately need leadership, and look to the medical profession for this in relation to studies which will look into the technical aspect of doctors labour which hitherto have been their sole prerogative....(and) also to define those procedures which could be delegated to other people, such that the profession is still in control of what constitutes satisfactory care.

In the meantime, public support for a publicly funded medical insurance scheme was gradually increasing. A survey on the public's view of a national medical care insurance scheme was conducted by the Canadian Institute of Public Opinion and showed that the “overwhelming majority” supported some form of Medicare. The only question was whether the plan should be compulsory or voluntary (*Toronto Daily Star*, Feb 10, 1966).

There was further impetus from Saskatchewan physicians who by 1965 had changed their opinions regarding the health plan. In that year, 72 per cent of 222 practicing doctors stated that they would vote to continue the Medicare plan. Furthermore, 73 per cent reported that they regarded the program a success, and 83 per cent felt that the health care needs of Saskatchewan citizens were being met as well or better than before the plan was adopted.⁵ (Thompson, Canadian Medical Association Journal, 1965: 976)

What the Saskatchewan profession had openly been bargaining for was to be the same thing as the other provincial divisions. The main issue was the preservation of their traditional freedom to decide payment methods—their fiscal autonomy. But the loss of fiscal, or entrepreneurial autonomy was interpreted by some as the harbinger of interference in technical autonomy as well. Although the profession had managed to gain a concession in the form of a financial relationship which removed the government from immediate dealings with the profession, in reality the government now controlled the financial resources from which the profession would be paid.

In 1967, at a conference on health manpower and health insurance, Lester Pearson whose Liberal Party had committed to the idea of federally subsidized and provincially administered Medicare since 1961, stated:

I believe the social welfare progress we have made strengthens the foundations of our private enterprise system by broadening the whole basis of our prosperity and making our system more just and fair; more supportable by all Canadians.

Moreover, the success of the Medicare system was to be:

gained only by co-operation rather than conflict; co-operation between neighbours, between employees and employers, between governments, between business and government, between doctors and politicians, between nations....all the different interests in our population must give priority to the general welfare, as opposed to the particular, the sectional or the occupational good.

In these quotations we can see that the notion of Medicare was now couched in a not so subtle rhetoric of the "national interest" stressing free enterprise and the relocation of particularistic interests within the context of cooperation. In effect, the state was pursuing its relative autonomy by engaging in the "isolation and unity effects discussed in Chapter Two. Moreover, the creation of health security for Canadians also represented a shift in the content of state policy—from an ideology of individualism in the stages of capitalist development prior to the depression of 1929, to an ideology of "collectivism" in the years that followed.⁶

At the national level, the CMA realized that the majority of the public wished for a policy that would enable them to prepay all of their health care bills, and therefore, that the organization controlling fee payment would also be the organization controlling the medical profession. This overall dependence upon the fiscal exigency of the state constitutes an important issue for the profession to this day and has prompted the CMA to call for effective bargaining strategies including unionization. In 1986, while the Federal government was implementing the new Canada Health Act (which forbids extra billing and entrenches the original principles of medicare), the CMA issued a policy statement on physician remuneration arguing that the doctors "deserve an income commensurate with their training and their professional contribution to society," and that collective bargaining, mandatory binding arbitration and conciliation should be employed to determine the level of this remuneration. This was claimed in light of the fact that "increasingly, physicians are bound by provincial legislation to accept government payment as payment in full without the advantages of collective bargaining....The result is an inequitable balance of power in favour of government" (CMAJ, 1986: 207).

Physicians in Quebec, which implemented Medicare in 1970, were by and large in favour of health insurance provided the prestige of the profession did not suffer (Wallace, 1950: 261). They argued that the program might hinder their right to negotiate with the government over issues such as participation in the planning of health services, and might

involve the possibility that the state would unilaterally impose fee levels which in turn would run counter to the principles of individual liberty and remuneration proportional to work performed. Clearly these sentiments implied that national health insurance was here to stay and that doctors should therefore attempt to retain the right to negotiate with governments (Robillard, 1970).

To summarize, the development of national health insurance in Canada witnessed see-saw reactions from the medical profession, ranging from full acceptance during the depression, to outright rejection in the period of the cold war, to gradual acquiescence tempered by the belief that well articulated mechanisms should be built into the system to protect doctors against the arbitrary will of the state regarding matters of fiscal and technical autonomy. As Crichton (1976: 61) notes;

Medicare was introduced at a bargained price: the maintenance of the fee-for-service payment system and the maintenance of the non-profit insurance principle.

Gradually, the initially confrontational nature of Medicare was, from the government's perspective, to be replaced by a strategy of co-optation.⁷ In effect, governments had established the conditions whereby "value for money" would become the overriding principle of a publicly financed system within which most physicians would practice privately. Viewed more broadly, the state had intervened in the health care sector under the ideological umbrella of the national interest, a process that entailed working out an unstable equilibrium of compromise with the working class, the medical profession and capital, all within the context of maintaining the long term interests of capital. But as the economic climate has worsened, the state has more recently been obliged to cut costs and, ultimately, restructure the welfare state. This in turn entails the "reworking" of the compromise established in earlier times.

5.5. Health Care Costs

One of the central debates currently associated with Medicare revolves around the perception that health care costs are "spiralling out of control." From a purely economic perspective, there can be no question that the costs of health care have indeed increased since Medicare came into force. While this increase is small relative to the proportion of taxes spent on health care in other countries, the socio-economic context within which these costs have increased has created a perception that there is a fiscal crisis in health care.

Though it is becoming less true today, traditionally physicians have not agreed wholly with the perception that health care costs are out of control, claiming instead that there is a crisis of underfunding in the system. This is not surprising given their reliance on expensive technologies which are inextricably linked with modern medical practice and the conviction that such technologies ought to be used.

Moreover, to view them for a moment as "rational self maximizers," doctors are more likely to order and perform expensive procedures which may not be "necessary" in order to maximize their income, particularly in systems where fee-for-service remuneration dominates.⁸ Indeed, it has been suggested that as much as 30 per cent of what doctors do is of little value to the patient (Towers Perrin, 1993: 1). In addition, the vast majority of medical procedures have never been subject to any "cost-benefit" analysis. Moreover, economists have noted that holding down fee schedules results in increased utilization levels thereby lending further credence to the argument that "supplier induced demand" is a significant method by which physicians can retain high incomes (Evans, 1984: 84-88, Tuohy, 1976).

Thus, as the public continues to perceive health services as a "free" service while manifesting a cultural propensity towards technological solutions, the demand for health care services, particularly those grounded in expensive technologies, has grown ever higher. In these kinds of conditions, fee-for-service remuneration flourishes because

physicians can increase the number of "pieces" produced in order to meet a demand which they help to create, which in turn maximizes income. This is exactly what has occurred in the years since the implementation of Medicare. Between 1947 and 1971, physician's average incomes increased from 3.26 times that of the general taxpayer to 5.57 times. This increase was due mostly to increases in the price and volume of services but also to improved collection procedures arising from the public health insurance program.

In the early 1970's, doctor's incomes dropped below the rate of inflation despite increased fees and billings. The late 1970's, however, saw fee increases almost to the inflation rate, and, since 1980, fee increases have consistently exceeded the inflation rate (Evans, 1984; Barer & Evans, 1989: 146).

Government perspectives on the relationship between Medicare and health care costs differ significantly from that of physicians. The costs of social programming associated with deepening contradictions of the welfare state have escalated significantly as have public demands for ameliorative social programming. Yet cutbacks, clawbacks, and the gradual impoverishment of existing social programs such as unemployment insurance and government sponsored pension plans have become the order of the day as governments struggle to deal with high debt, an eroding tax base, and an economic structure ill prepared to deal with current trends towards the global restructuring of capital and the transition to an economy characterized by "good and bad jobs" (see Maxwell, 1994).

In this context, Canada's health care delivery system has come under increasingly severe fiscal pressures. Overall, the impact of universal health insurance on per capita expenditures was substantial in every province almost immediately after implementation (Barer and Evans, 1989: 79). In 1965 the total costs of health care in Canada were \$3.3 billion. By 1985, the figure was close to \$40 billion. Health care costs now account for a third of provincial tax dollars of which 52 per cent go to pay for institutional (primarily

hospital) services while 22 per cent are earmarked for physician's services. Whereas Canada spent 5.5 per cent of its GNP on health expenditures in 1960, by 1990, it was spending 9.5 per cent of GNP. As figure 5.A shows, physicians enjoyed a slight increase in the amount of finances allocated to paying for their services immediately after the implementation of Medicare. More striking is the increasing financial resources devoted to paying for hospital care and "other" services. The trend line for "other" services is difficult to disaggregate since it encompasses more items over time. For instance, in 1956 these costs could be accounted for mainly by prescription drugs. By 1961, however, they also accounted for non-prescribed drugs, eyeglasses, hearing aids, other prostheses, nursing homes, public health, health research, health insurance administration and a few other sundry items.

Source: Brown, 1987: 172

As well, the costs attributable to care delivered by physicians seem to have stabilized, while the costs of hospital care (where physicians work) have increased substantially. At the same time, physician/patient contacts continue to rise as do laboratory, radiological and surgical procedures and ambulatory and out patient care

(Fulton, 1993: 3). It is expected that demand for health care can only increase as Canada's population ages (because the elderly typically require more services and they are often very expensive) while tax revenues drop.

Transfers of federal money to assist in the creation and maintenance of health care programs has gradually withered away with the creation of the Established Programming and Financing (EPF) Act of 1977. This legislation was designed to help the federal government control and predict the costs of health services to a greater degree, to establish greater equity between the rich and "have not" provinces, and to give the provinces greater flexibility in allocating resources to different health care priorities. It is widely accepted that by the end of this century, federal contributions to provincial health care will be eliminated making it difficult if not impossible for the federal government to enforce the terms of the Canada Health Act (universality, comprehensiveness, accessibility etc.) via financial sanctions (Fulton, 1993: 27, Battle & Torjman, 1993). As a result, fiscal responsibility for health care matters will increasingly be transferred to provincial and municipal governments and a relatively new "player" in the health care scenario—employers—who collectively will be forced to find ways to make up the 33 percent of health care revenues now transferred from the federal purse.

In such a context, it is not surprising that governments have attempted to control these rising costs. This raises questions regarding the nature of existing and contemplated strategies used by governments to control health care costs.

5.6. Cost Cutting Strategies and the Challenge to Medical Authority

Canadian governments have been caught in the contradictory position of maintaining political face *vis a vis* the sanctity of Medicare's original principles while facilitating capital accumulation in a rapidly declining economy. Both federal and provincial governments have attempted to work out this contradiction by imposing controls on less powerful actors within the health care sector, by imposing structural

limits on health care costs (for example, through the imposition of global hospital budgets), or by transferring the costs of health care to new payers.

Governments recognized early in the Medicare era that annual above inflation increases in health care expenditures would require some intervention. Initial attempts to deal with the cost issue were no more than efforts to control the rate of increase. The strategies employed were based on the assumption that overall efficiency could be improved via the transformation of in-patient to out-patient care, substitution of paramedical labour for elements of physician's labour, reduction in hospital beds and the creation of community health centres. The 1969 *Task Force Reports on the Costs of Health Services in Canada* recommended that strategies to increase system-wide efficiency needed to be pursued. Failure to do so was to invite reduced standards of care, increased taxes or premiums and/or the introduction of deterrent fees. The *Hastings Report* of 1973 recommended the construction of community clinics or health service centres. At the same time, a somewhat contradictory ideology emphasizing the individual's responsibility for health but recognizing (and paying lip service to) the socio-economic determinants of well-being was emerging. The Hall commission report (Canada 1964: 12) had recommended that

efforts to improve the quality and availability of health services must be supplemented by a wide range of other measures concerned with such matters as housing, nutrition, cigarette smoking, water and air pollution, motor vehicle and other accidents, alcoholism and drug addiction

Similarly, with the publication in 1973 of the Lalonde Report, governments have continued to argue that the costs of health care can be controlled by shifting the emphasis in medical care from curative invasive approaches to preventative methods. This was based on the notion that the curative mode of medical care has marginal utility and that a better standard of health as well as lowered costs would best be achieved through

reallocation of resources and the displacement of responsibility for health onto the individual through lifestyle modification. As Lalonde (1974:18) argued:

When the full impact of environment and lifestyle has been assessed...there can be no doubt that the traditional view of equating the level of health in Canada with the availability of physicians and hospitals is inadequate...future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology

Importantly, he also stated that:

individual blame must be accepted by many of the deleterious effect on health of their respective lifestyles. Sedentary living, smoking, over-eating, driving while impaired by alcohol, drug abuse and failure to wear seat-belts are among the many contributors to physical or mental illnesses for which the individual must accept some responsibility and for which he should seek correction (1974: 26).

It is significant that both the Lalonde and Royal commission statements (and others like it since), mentioned the cost (both human and monetary) of industrial disease and inadequate or unsafe working conditions. Lalonde cited "rapid social change", "working conditions including the deadening effect of repetitive production line tasks", and "economic deprivation" as a far greater threat to health than any present inadequacy of the health care system. Yet very little has been done to alleviate the structural and organizational causes of ill-health while increased attention has been focused on "blame the victim" ideologies such as "lifestyle modification."

With respect to governmental attempts to control physician's incomes, since the implementation of Medicare an income pattern of growth-stabilization-growth suggests that initially, the provincial medical colleges were organizationally unprepared to bargain with governments over fee schedules particularly since physicians had just come through a period where incomes had increased dramatically and public support for their income demands was likely to be minimal. Wage and price controls exerted in the 1970's contributed to the stabilization of physician's incomes. However, since the percentage of

GNP spent on health care in the 1970's remained relatively constant at 7 per cent, physicians and other health care providers argued that the system was underfunded and that more funding should be injected into the system via private insurance and user fees. Extra billing increased and some doctors began to "opt out" of the system resulting in acrimonious negotiations between provincial colleges and governments as well as work stoppages and rotating strikes. More recently, provincial medical associations have successfully negotiated increases in doctors' fee schedules, suggesting that governments are less willing to impose stringent controls over this component of the total health bill (Barer & Evans, 1989: 147).

A strategy of substituting physicians' labour power has also been evolving. By 1967, some 30 new categories of paramedical occupations had come into existence. It has been estimated that savings in the order of 10 to 15 per cent to the entire Canadian health care system could have been made in 1980 if nurse-practitioner technology (the use of paramedical staff) would have been implemented (Denton, Gafni, Spencer & Stoddart, 1985). Within hospitals, Lomas and Barer (1989) have shown that with the exception of nursing assistants there has been a steady increase in the number of complementary occupations relative to the growth of physician supply between 1968 and 1982.⁹ These occupations are increasingly being recognized as capable of replacing much doctor's work but continue to be regulated by physicians. They are also becoming more vocal in their demands for legal recognition as professional and legitimate alternatives to the traditional health care professions of medicine and nursing. In addition, Ontario has proposed that some emerging health care occupations be allowed to write limited numbers of prescriptions within their scope of practice, thereby removing some of this authority from doctors.

Another key development related to cost control in the health care environment has been the trend towards centralization of legal responsibility for health through regionalization of health care management and administration. Whereas health care

programs were once autonomous in terms of raising money and creating their own planning strategies, many are now subject to the authority of multi-agency or regional arrangements. One example of this trend can be seen clearly in the hospital sector, where one regional board of directors will be responsible for administering a number of local hospitals through one budget and one executive director or president. According to Fulton (1993:14) it is very difficult to identify outcome patterns of this trend in Canada since each region has taken varying degrees of responsibility with respect to administration and delivery of services. The key issue here is that attempts to regionalize have often been met with resistance by key players including patients (through advocacy groups) and professionals (including doctors) because centralization is often perceived as increased control in the hands of a few.

Provincial governments have also capped hospital budgets forcing the closure of hospital beds and fostering attempts to utilize "business principles" to improve the efficiency of hospital health care delivery processes. In hospitals, this is manifested in the increasing demand by governments for accountability and the use of measurable objectives for different departments. Amongst the most recent of these is the current interest amongst hospital administrators in the principles of "Total Quality Management" (TQM)—also known as Continuous Quality Improvement (CQI). Essentially, TQM involves the application of statistical process management methodologies, including the setting of stringent "production targets." It employs "employee empowerment" ideology within the context of a focus on the customer—in this case, patients. Largely Taylorism in a new guise, this approach to hospital management is increasingly gaining favour because it is assumed that the strategy increases control over what is produced and how, while entrenching the power of largely non-physician managers. At the same time, doctors are vulnerable to such strategies because they essentially work on a "piece rate" basis. Needless to say, most physicians have been sceptical and even hostile to TQM, particularly when they learn that more stringent evaluation of their clinical performance is

part and parcel of the new management ideology in hospitals. On another level, it is becoming clear that the application of these principles within hospitals and larger group practices is consistent with the entrenchment of "factory style" medicine. Recognizing that hospitals are different from factories, one management consultant promoting the TQM concept nevertheless argues that:

....the workers assembling the inpatient food trays differ in no material respect from assembly line workers in other settings; the pharmacist preparing an intravenous solution is also engaged in a simple manufacturing task (Warner, 1991: 42).

In addition to representing an intensification of rationalization within health care, the TQM/CQI ideology also represents a shift towards the notion that quality health care is defined by the customer/patient, thereby diluting the supposition that physicians and other health care professionals are best qualified to judge what is best for the patient.

Efforts to control costs are also spawning challenges to the historically given authority of medicine from other directions. More recently, pressure to control costs has come from the private sector, which (as shown earlier) once welcomed the idea of health insurance. However, in Ontario, Manitoba, Quebec and Newfoundland, health insurance premiums are now paid by employers who have increasingly come to believe that these costs are having a negative impact on their competitiveness, particularly in light of U.S. company claims that a substantial portion of the costs of a product can be accounted for by health care costs.¹⁰ Additionally, within the context of the North American Free Trade Agreement (NAFTA), U.S. capitalists are lobbying for a "level playing field" which includes pressure to eliminate or reduce health care benefits provided by Canadian employers. Amongst the most frequently cited causes for concern in the Canadian context are the rising costs of extended health premiums, Workers Compensation claims, eye care, and prescription drugs. Accordingly, some of these employers are now lobbying provincial governments for rebates on the Employer Health Tax (EHT) on the

basis of claims that health care initiatives within their organizations (such as Employee Assistance Programs and Occupational Health programs) are saving money in the long run by reducing employee utilization of the system. More importantly, if business is to pay increasingly for health care, it is likely to mobilize its resources and considerable lobbying power to join with those who wish to make the system "more efficient" by utilizing "good management" practices with a proven track record in the private sector. In addition to strategies involving cut backs in benefits (or managed benefits approaches), businesses are recognizing the key role of physicians as gatekeepers of the health care system and calling for a "process of shifting health care decision making from the medical profession to employers, insurers and other buyers of health care" (Crouse, 1993). As such, this involves an attempt to lobby governments to move away from a health care system where doctors receive traditional fee-for-service reimbursement towards cost containment and eventually "total managed care" where consumers would be making more informed decisions based on better knowledge of treatment options and providers such as physicians would be more "service" oriented, acting as "teachers" providing the "right" service at the "right" place while acting in the community interest as opposed to their own. Ultimately, this trend may represent the beginning of the demise of physicians' monopoly position within the economics of health care. Whereas they have traditionally been responsible for choosing the right product for the consumer-patient, attempts are being made to place those purchasing decisions in the hands of non-physicians and increasingly, patients.

5.7. Trends in Medical Labour Power

Prompted by the fear that universal health insurance would create a shortage of physicians, the Hall Commission Report of 1964 estimated that by 1986 Canada would have a population of 30 million, requiring approximately 44,000 doctors to service the nation and the construction of five new medical schools to train new doctors. By 1987,

Canada had a population of 25.6 million and 55,000 physicians. The physician to population ratio has increased since 1961 when it was 1:857 to 1:538 in 1981 and now stands at 1:542 (Taylor, 1989:9; CMA, 1989: i). It is now widely accepted that Canada has too many doctors and that the distribution of doctors according to region and specialty is unbalanced.¹¹

The perception that Canada has too many physicians has led to increasing pressure from governments to cut back on the number of practicing doctors by restricting medical school enrollment, access to billing numbers, physician immigration and redistributing physicians into underserved areas.

Specialization is another significant labour market trend. Specialization has flourished in Canada since formalized specialty training was implemented in 1929. Since the early 1960's there has been an increase in the number of specialties and the number of doctors entering into these specialties. In 1951, 27 per cent of doctors in Canada were certified specialists. By 1961, specialists accounted for 37.3 per cent of the physician population, and they now represent half of all doctors (Judek, 1964: 157, CMA, 1989). The growth in specialization is due mostly to the increase in medical knowledge which is now far too great to be mastered by any one doctor (Judek, 1964: 152; CMA 1989:43).

Specialization entails the fragmentation of the whole body into discrete parts and therefore bears some resemblance to the deskilling process experienced by other occupations in capitalist societies. However, it is difficult to equate highly skilled surgical labour and the work of an assembly line auto worker. If medical labour is viewed from the perspective of treating the whole body/person, the fragmentation of the person into parts and subsystems does entail a deskilling from the point of view of the alleged efficacy of "total care." However, specialization also means that the knowledge base of specialists is deepened. Specialists often spend many years learning exclusive skills and developing knowledge which will make them more in demand as highly skilled labour—the anti-thesis of the effect of specialization within many other types of work.

The results of this deepened knowledge base are readily apparent in the higher fees specialists command relative to family and general practitioners, and in the higher prestige accorded them by the general public (Blishen, 1991: 157).

The key to understanding the different consequences of specialization in these types of work lies in the fact that because of its indeterminate quality much medical knowledge cannot be distilled to its constituent elements. Whereas the work of the auto maker or the office worker can be understood by managerial staff whose job it is to break down this work into discrete components, the work of medicine is not so readily fragmented. Partially this is because the profession itself has had great success in resisting those who would take over elements of their work. But it is also because of the undeniable fact that medicine has not yet, and may never be, completely "knowable." Thus, as physicians and scientists continue to attempt to understand the human body, they are likely to discover (or invent) and monopolize new forms of knowledge.

As in other occupations, specialization often fosters "increased productivity by separating tasks, (facilitates) the acquisition of accuracy speed and skill, better distribution of tasks among doctors endowed with specific abilities, economy in utilization of material and equipment, and, increases the dissemination of knowledge and provides opportunities for development of new techniques" (Judek, 1964: 152). In addition, consumer demand for increased expertise to meet their perceived needs is likely to have encouraged specialization. Finally, particularly recently, physicians may choose to limit the scope of their activity because they are concerned about liability issues.

5.8. Medical Technologies

Popular conceptions of medical technology conjure up visions of expensive computerized machines and procedures such as Computerized Axial Tomography (CAT) scans, radioactive scanning or Magnetic Resonance Imaging (MRI) machines. While such machinery receives the most attention, technological medicine is here defined more broadly as the hardware and pharmaceutical products which make up the physical

components of diagnosis and treatment as well as the knowledge, skills, techniques and organizational patterns which accompany the use of these instruments of health care production. To be sure, advances in medical technology have produced positive effects in terms of lives and time saved. However, technology has also had important impacts on doctors particularly in relation to the expense and efficacy of "high tech medicine."

There are two broad types of medical technology; those that are low cost and those that are high cost—or "big ticket"—technologies. High cost technologies would include the examples noted above in addition to procedures such as cardiac surgery, kidney dialysis, transplantation and *in vitro* fertilization. While medical technologies of all sorts have proliferated in the last 30 years, the assessment of technology, particularly "big ticket" items, has only recently become an issue in the Canadian health care system. One reason for the interest in technology's costs and benefits is that technology is impersonal and lends itself to scrutiny more readily than people or processes. As well, the expense and high visibility of high technology medicine makes it an easy target in cost cutting schemes, even as physicians continue to claim that more high technology is needed and that in general, the health care system is underfunded (CMAJ, 1986: 207). This is not surprising, since doctors have primarily been responsible for the rise of big technology within the Canadian health care system primarily because modern medicine tends to be dominated by:

a technological imperative wherein tradition demands that all patients be given the best possible care and the principal constraint is not the cost but rather the state of the art....the physician seems to be fighting a war against disease and debility in which the latest technology matters the most and cost is subordinated to winning the war (Auer, 1987:56).

However, as the efficacy of this technology comes under increasing scrutiny, physicians have found themselves engaging in acrimonious battles with the non-physician managers of hospitals, their boards as well as government personnel, over the

need to buy or increase use of equipment which, from management's perspective, is unproven.¹²

In addition, the use of such machinery requires highly skilled workers, many of whom are laying claims to professional status. These claims involve demands to expand their current roles and responsibilities, in many cases into the domain of physicians. At the same time, because physicians *initiate* the patient's contact with technology they are increasingly being asked to take responsibility for the expense associated with high technology solutions and to internalize the notion that such procedures involve a cost to the hospital/institution in which it is used and ultimately to the health care system (and therefore other patients and taxpayers).

Thus, physicians increasingly face the contention that medical technology is supplanting the traditional hands-on approach to medicine, that doctors are too quick to establish the usefulness of technologies, that these technologies involve considerable expense and that it is the doctor's responsibility to understand the economic consequences of an over-reliance on high technology. These developments have created an environment in which physicians may either lose control over aspects of the medical production process or attempt to suppress or control technology to retain their autonomy.

To make the point concrete, we have only to look at the relationship between modern medicine and drug therapy. It has become impossible to discuss the changing context of medical practice without paying some attention to the critical role played by pharmaceutical companies in shaping the health care context and the nature of medical practice. In 1992, Canadians used over \$7 billion worth of prescription and non-prescription drugs. There are currently 16,000 pharmaceutical products on the market, and approximately 500 new drugs are approved each year. Perhaps more than ever, modern medicine has struck a symbiotic relationship with the pharmaceutical industry. According to a poll conducted in 1991 by the *Medical Post*, physicians receive information on prescription drugs directly from the pharmaceutical industry through

advertising and direct sales visits 66 per cent of the time, despite the fact that 59 per cent of advertisements would not lead to proper prescribing while another half of all ads were judged to have little or no educational value (*Annals of Internal Medicine*, June 1992). In Canada, the combined expenditures of the industry on these attempts to influence physician's prescribing patterns ranges from \$6000 to \$10000 per year, per physician. Canadian physicians have the highest prescription rate in the world, but also spend the least time interviewing patients. On average, they write 4000 to 5000 prescriptions per year with the highest average amongst family physicians (most often the first point of contact in the medical system) who write 6,000 to 8,000 prescriptions per year—or 25 to 30 prescriptions each working day (Drug Programs Reform Secretariat, 1992). The tendency towards "prescription medicine" has had several important implications.

Most notable of course is the effect on patients who often have neither the knowledge or temerity to query their doctor's decisions regarding the use of certain types of medication. The effects of this phenomena can readily be seen. In Ontario, for instance, over 17,000 individuals are treated each year for problems related to prescription drug use. On another level, the fact that doctors in Canada spend the least amount of time interviewing patients before writing "scrips" again highlights the tendency towards "income maximizing behaviour" on their part—a situation which has prompted governments to further indict the private practice-public payment system.

Governments are prepared to utilize methods to encourage the physician to use efficient and effective drug therapy via Drug Utilization Review Programs (DUR). According to the Ontario Drug Programs Reform Secretariat (1992:8), this system of "rational pharmacotherapy" will entail the implementation of step-by-step guidelines which physicians will be required to follow when writing a prescription.

The process encourages physicians to involve the patient in shared decision-making and informed consent. Using a continuous quality improvement approach, reviewing and

monitoring the quality of the service provided to the patient would occur on a continual basis.

It would appear then that governments are attempting to address the over-medication issue by imposing controls on the way doctors dispense drugs. At the same time, they are less aggressive in their approach to controlling rising pharmaceutical costs given that this industry is seen to be a "valuable contributor" to the economy.¹³ While rational pharmacotherapy may well benefit patients while reducing costs, it most certainly constitutes another example of pressure to control a hitherto unassailable domain—that of the physician's decision making powers *vis a vis* a critical component of the health care delivery process.

5.9. The Doctor's Workshop

Though they were once charitable institutions where the sick were taken to die, hospitals have entrenched their positions as institutions of medical science run increasingly like businesses. Moreover, the modern hospital is more than ever the doctors' workshop. Huge sums of money were directed at building new hospitals in Canada during the late 1940's and early 1950's. Within five years of the Hospital Construction Grant Program announced in 1948, 46,000 new beds had been built (Taylor, 1989: 7). Between 1947 and 1982, the number of hospitals in Canada grew from 666 to 1,028 (Barer & Evans in Barer, Evans and Stoddart, 1989: 101), while the decade between 1961 and 1971 witnessed an increase in the number of hospital beds twice the rate of population growth (Vayda and Deber, 1993: 127). However, despite the fact that universal insurance provided the public with increased opportunities to use the system, increases in hospital utilization rates were, and have continued to be, remarkably low, increasing from 143.4 per 1000 population in the mid 1950's to just 154.7 per 1000 in 1960 and 155.5 per 1000 in 1980. Among the factors that may have played a role in maintaining lower rates of utilization are the provision of facilities in under-serviced areas, the use of technology to reduce the length of stay in hospitals and the general trend

(discussed above) towards the emphasis on individual responsibility for health and preventative behaviour (Taylor, 1989: 8).

However, during the 1970's, the costs of operating hospitals continued to increase at an average annual rate of 15 per cent, doubling every five years. About four-fifths of this cost increase can be attributed to inflation and population growth while the remainder are accounted for by increases in wages, hospital prices and service intensity (Auer, 1987:63).¹⁴ These escalations in costs coupled with continued growth in the number of physicians have contributed to government perceptions of a health care cost crisis (Taylor, 1989: 13). Government attempts to control this situation have involved increasing political pressure on hospital managers to heighten the efficiency of hospital procedures and personnel (particularly nurses), adjust funding priorities, modernize facilities and substitute expensive with cheaper labour. While it is difficult to say to what extent these initiatives have been successful in reducing costs, one important effect has been to lower the availability of hospital beds and more recently, to close hospitals, particularly in rural areas. As well, state encouraged perceptions of Canada's need to eliminate the national deficit have lent credibility to the claim that hospitals need to be closed and/or corresponding efficiencies accumulated if Canada is to "compete in the global market." Particularly in the context of Canada's recent neo-conservative regime, this process corresponds well with an agenda to divest government of the fiscal burden of health care in order to open the health care system to free enterprise, especially since governments are the primary owners of hospitals.¹⁵

Hospital ownership has changed significantly from private to publicly owned and operated institutions. By far the most common hospital type are those owned and operated by community (lay) boards, although there are also hospitals owned and operated by religious institutions, provincial and federal governments, municipalities and private individuals/groups (see Table 5.2). Municipal hospitals, which make up approximately one-quarter of all hospitals, are owned by municipalities but are generally

not operated by them. Their boards have full executive responsibility and do not report to the municipality in any meaningful way. (Sutherland and Fulton, 1988: 238-40)

Table 5.2 Hospitals and Beds By Ownership:1986				
Ownership	Hospitals		Beds	
	Number	Per cent	Number	Per cent
Lay	509	41.1	94,449	50.8
Religious	130	10.5	23,116	12.4
Municipal	331	26.7	23,991	12.9
Provincial	160	12.9	37,849	20.4
Federal	50	4.0	2,673	1.4
For Profit	58	4.7	3,679	2.0
Total	1,238	100	185,757	100

Source: Sutherland and Fulton, 1988:81

While it has been suggested by some that the physicians who work within the hospital are primarily responsible for 85 per cent of hospital costs (York, 1987), ultimate financial leverage rests with the provincial Ministry of Health. Ministries can and have established financial ceilings with respect to the running of hospitals. Doctors, in concert with the hospital committees on which they sit, control the allocation of resources contained within global budgets handed down from government to the hospital.

According to Fulton and Sutherland (1988:240-2) the Ministry of Health has final authority over the range of services the hospital provides, the wording of hospital by-laws, changes in physical size, capital and operating expenditures, information and record keeping, admission practices, volume and price of preferred accommodation, medical staff appointment and appeal procedures, patient consent, quality review and "whatever other things the Minister chooses."

Despite the ostensible power of hospital trustees who sit on the board of directors, the Ministry is also empowered to transfer the powers and functions of these people to a ministry appointee whenever this is considered appropriate. Not surprisingly, conflict between hospital boards and government has escalated notably in recent years. By far the

most important reason for this is fiscal. As hospital costs have increased, governments have demanded accountability on matters relating to finances and quality of service. In Ontario, governments balked when hospitals decided to set their anticipated budgets at 15 to 20 million dollars over government budgets, and despite the political and ideological rhetoric of hospital boards, the government remained firm in its stance. Similar events across the country have prompted hospitals to realize that they have to operate within the financial constraints imposed on publicly funded institutions (Sutherland & Fulton, 1988: 241).

5.10. Conclusion

This chapter has provided a brief discussion of the changing political, economic and ideological environment in which doctors have worked over the last 30 years. I have argued that the profession initially saw Medicare as a threat to their economic and technical freedom but gradually shifted their concerns to maintaining control over the medical production process (technical control over the labour process) as socialized health insurance became a *fait accompli*. Since their incomes had increased substantially, and no real short term problems had been found under the new arrangements, this further dampened their desire for conflict with government. The foundation for a politics of negotiation and accommodation between the profession and government had been laid.

The state was compelled to initiate Medicare as a way of attracting and holding votes but also, and perhaps more fundamentally, of socializing the costs of reproducing labour power. This reproduction, which can be understood as part of the accumulation function of the state, is also tied to a need to appear legitimate in the public conscience. Particular interests (including those of political parties, insurance companies and organized medicine) were subsumed under the rubric of "the general interest of the nation" - which was defined as universal and "free" health care for all citizens. Because consumers would now never see a doctor's bill, the perception that health care is "free"

became entrenched. At the same time, physicians, prompted by the profit making interests of pharmaceutical and equipment manufacturers, continued to utilize and promulgate new and expensive medical technologies. Driven by these factors, and within the context of a fiscal crisis of the state, interest in cost containment intensified, leading to the creation of various cost control strategies. The pressure to control costs is largely located in government, but has more recently come from the private sector.

In general, then, the health care environment since the establishment of Medicare has embodied a number of key developments as follows: 1) An initially specious but later more genuine concern with health policies oriented to healthy outcomes (a proactive approach) as opposed to post hoc (curative) intervention. 2) The ostensible entrenchment of the Medicare principle of equal access to all via the banning of extra billing. 3) An attempt to foster greater participation by consumers, providers and other stakeholders in managing and planning the system. 4) Increased accountability of hospitals and providers due to limited resources with a concomitant implementation of management technologies and philosophies. 5) An attempt to match provincial resources to "legitimate" health requirements. 6) Government sanctioning of the "substitution" approach whereby elements of health care can be delivered by less costly labour power. 7) An ongoing attempt to achieve economies of scale via regionalization of health care delivery, and contemplation of "deterrents" such as user fees. 8) Pressures to scrutinize well established practice styles, that is, medically controlled, high technology, hospital based treatment patterns. 9) The initial concentration of financial responsibility for health care matters in the hands of the state and more recently, the attempt to divest this accountability.

These developments lend support to the notion that with the implementation of Medicare and the subsequent economic crisis of the welfare state, the Canadian state has found itself in a contradictory position *vis a vis* health care. On one hand, it has attempted to gain political capital by constructing a socialized health care policy that

exists under the rubric of the best interests of the nation. On the other, it has now to deal with escalating costs without appearing to kill the "sacred cow" of Medicare. It has done this by focusing less on physicians and more on the structure and number of hospitals, individual responsibility for health, the implementation of private sector management methods, and on other health care personnel. Moreover, Medicare while entrenching physicians' financial autonomy, also laid the foundation for increasing intrusion into doctors' technical autonomy primarily because hospitals are controlled by the state. In effect, the potential for challenges to physicians' dominance within the health care sector has never been greater.

With this background in mind, the next chapter examines shifts in the class position of the Canadian medical profession viewed in terms of economic criteria.

ENDNOTES

¹ It should be noted that this increase would be accounted for partly by increase in the number of people covered by insurance, as well as an increase in the percentage of elderly people and the costs of wages and materials

² Medicare is often cited as the outcome of the attitudes and aspirations of T. C. Douglas, the socialist founder of the Cooperative Commonwealth Federation (C.C.F.). To a large extent, the actions of this man and his party ought to be counted as central to the initiation of the legislation. It is also important to view the events in Saskatchewan as the outcome of definite political visions held by the C.C.F., concerning the eventual spread of socialism to the rest of the country. In addition, a health insurance scheme constituted something of a political "mission" for Douglas. As a boy, in his native Scotland, he had suffered from osteomyelitis and had been unable to receive adequate medical care due to his family's indigence.

³ Part of the reason why this act was virtually forced through was because of Douglas's transition to federal politics where he planned to lead the fledgling NDP party. By ensuring that the act was a *fait accompli*, Douglas was attempting to make political capital which would lend legitimacy to his tenure in federal politics.

⁴ For a complete analysis see: Badgely and Wolfe, 1967

⁵ It is significant however, that the author of the survey was chastised in a barrage of letters to the CMAJ, which argued against his "flawed methodology" and intrinsic biases in determining the sample. The author was however, able to reply successfully to his critics.

⁶ Recently of course, Canada has shifted back to this "New Right" ideology of individualism.

⁷ The strategy was typical of the approaches used in most countries with national health insurance schemes; governments slowly implement the program in order to gain physician's grudging acceptance and co-operation, then, as incomes go up, controls are slowly enacted (Mechanic, 1976).

⁸ There are considerable difficulties with the notion of what constitutes a "necessary" medical procedure. Some physicians argue that the technical complexities of modern medicine and the ever changing level of sophistication required to master them requires the use of many new technologies and procedures. They view these technologies as optimal solutions to difficult problems in a context where the consumer is increasingly demanding "the latest" in medico-technological solutions. Nevertheless, there is also a substantial body of literature which argues that many medical interventions and diagnostic procedures are unnecessary. This argument is particularly compelling in light of evidence that only 1 in 1000 magnetic resonance imaging procedures (MRI) actually detect anything out of the ordinary, and that overtreatment is frequently reported in the management of hypertension (interview with J. Fulton, 1992).

⁹ Evans and Stoddart (1989) explain the reason for this as being that nursing assistants are probably more accurately viewed as complementary to the nursing profession.

¹⁰ For instance, Chrysler Motor Corporation claims that health care adds more than \$600 (U.S.) to the cost of every car made in the U.S.A. Similarly, Ontario's former deputy minister of health Dr. Martin Barkin, argues that "rising health care costs threaten Canada's economic growth and ability to become a global business competitor" (Hassen, 1991: 34).

¹¹ For instance, it is difficult to find certain specialities in rural areas or some of the "have not" provinces while British Columbia has a physician to population ratio double that of Newfoundland.

¹² For instance, many hospitals have invested heavily in lithotripter machines used to shatter gallstones despite the fact that there is insufficient data on its performance and efficacy as compared to traditional treatment of this ailment. It is also significant that as with pharmaceuticals, the main source of information used in making decisions regarding capital acquisition of new technologies is the manufacturer (Deber & Thompson, 1992: 214)

¹³ In Ontario, whose share of the prescription drug market is 46per cent of Canada's total, the pharmaceutical industry contributed \$377 million in wages and salaries in 1988. This represents 1.25per cent of Ontario's total manufacturing wages.

¹⁴ Service intensity refers to the number of tasks (e.g., nursing hours and materials required per procedure, per day of nursing care etc.) required per patient stay as well as personnel hours and materials required per service unit.

¹⁵ Of course, it could be argued convincingly that amputating large components of the health care system falls within orbit of a larger strategy to eliminate publicly financed programs of all sorts.

CHAPTER SIX

THE CHANGING SHAPE OF MEDICAL PRACTICE: OWNERSHIP, CONTROL AND THE LABOUR PROCESS.

6.1. Introduction:

Property relations and the labour processes embedded in these relations are central to the analysis of class relationships. This chapter explores general changes in patterns of ownership and organization of medical practice between 1964 and 1986, and also examines functional changes in physician's labour process. The following two chapters examine respectively these key *economic* factors in the class transformation process for doctors working in solo and group practices, and in relation to their experiences in hospitals.

6.2. Ownership Relations

As conceptualized in Chapter Two, ownership can be divided into two categories—legal (or juridical) and real. Legal ownership is formal in that it may entail the right to derive revenue from the enterprise, but it can also be the *basis* of real ownership of the means of production. Real ownership has an *economic* component which entails exercising rights associated with accumulation, distribution, investment control over what is produced and the strategic decision making process. A second component of real ownership—*possession*—refers to the rights associated with putting the means of production into operation including directing the labour process and controlling how things are produced as well as tactical (day-to-day operational) decision making. These distinctions are essential for understanding the process of the production and reproduction of the new and old middle classes (Chandler, 1962; Clement, 1990).

The historical pattern experienced by other components of the old middle class (such as farming and fishing) has been characterized by the loss of ownership of the means of production (accompanied in some cases by the gradual concentration of work in

the factory and the subsequent transition to full scale manufacture) and the transition to wage labour resulting in their economic proletarianization. The key factor in this transformation is the purchase of labour power by capitalists for the purpose of producing surplus value or labour, such that legal and real ownership are vested in the hands of the capitalist. Additionally, while many occupations within the old middle class have resisted economic proletarianization by taking political action, their efforts have been largely unsuccessful in the long run.

The categories of legal and real ownership also have implications for the transformation of the new middle class in that the latter may retain elements of legal and real ownership while still performing the obligations of labour—thus placing them in “contradictory” class locations. One of the tasks of this chapter is to explore if (and if so how) Canadian physicians have progressively lost the rights associated with legal and real ownership.

6.3. Forms of Ownership in Medicine

Usually, the degree to which members of a class exercise the rights of property versus the obligations of labour is closely connected to the method by which those individuals are remunerated. Some Marxist approaches to the question of who owns the means of production have relied on the criterion of whether someone is an “employee” or not. In this conceptualization, it is possible to assign individuals or groups to the category of “non-owners” of the means of production on the basis of whether those individuals receive a salary or wage. However while the wage/salary relation criterion is important in specifying classes at the more abstract level of analysis, unpacking the relations of control requires a wider understanding of the pattern of authority relations prevailing within the way labour power is structured and organized. As Clegg et. al. (1986:77) argue, it is critical to examine the scale and organizational complexity of productive environments since “...even when a business appears not to have any employees it may still be the case that exploitation occurs.” Similarly, it is possible that a

salaried employee could exercise power and authority associated with legal and real ownership.

As Chapter Five showed, during the debate on Medicare many doctors feared a state sponsored system of universal health care would mean the de facto salarization of all physicians and an associated loss of control over the technical aspects of work. However, in Canada the fee-for-service relation has persisted and is best described by Naylor's (1986) term "private practice, public payment." In this relationship, doctors are "paid" by the state only in the sense that the latter collects and disburses the doctor's fee via taxation.¹ Moreover, even though doctors negotiate remuneration rates with the state in much the same way as unions do, the state *administers* the payment for services rendered. Accordingly Canada's doctors are not in the same position as the waged workers many unions represent. Since the wage relation is often a weak indicator of the extent to which individuals and groups wield power within firms and organizations, it becomes important to analyze "ownership" in terms of both the method of remuneration (the presence, absence and attributes of the wage relation) and the configuration of practice (organizational structure) within which physicians work. (see also Walters, 1982; Field, 1966; Daniels, 1975).

In taking this approach it becomes clear that contemporary ownership relations within medical practice in Canada are complex, highly variable and not readily comparable to the historical experiences of other occupations within the old and new middle classes. Moreover, because of the often subtle and complex nature of the organization of medical practice it is virtually impossible to accurately describe all possible permutations of ownership relations (see Freidson, 1970). It is possible, however, to offer a broad typology to help us make sense of these complexities.

Recent investigations of the way physicians organize their practices have charged that the distinction between "solo" and "group" practices is somewhat outdated (Williams et.al 1989). Part of the reason for this criticism is that this distinction—while adequate

as a description of the structure of medical practice in the pre-Medicare era—no longer captures the realities of modern medical practice. In fact, today there are a number of ways in which physicians can organize themselves, and each organizational mode can have particular implications for authority and control relations. Williams et.al. (1989) identify six distinct types of practice organization;

- Solo practices: in which doctors work primarily outside institutional settings, working mostly alone with no income/expense sharing arrangements and no sharing of patient records
- Group Practices: in which doctors again work primarily outside institutional settings but work mostly with other physicians, sharing income/expense arrangements or partnerships with other physicians and sharing patient records
- Associate Practice: another non-institutional type involving doctors with economic associations such as office and/or overhead costs but with no sharing of patient records. In effect, these practitioners share “bricks and mortar” but little else.
- Hospital physicians: doctors who spend most of their time on hospital and academic staff.
- Community Health Clinics/Health Services Organizations: doctors working in these institutions receive salaries.
- Hybrid or Mixed: Doctors who spend significant proportions of time in both solo and group organizations.

Table 6.1 presents a typology which expands upon the distinctions made by Williams and his colleagues in order to capture the range of ways doctors in Canada organize themselves and the corresponding range of possibilities for method of remuneration attached to these modes of practice. Each of these types is also linked to a type of ownership. The typology illustrates the point that for contemporary medical practice in Canada, different practice and payment modes are associated with different possibilities *vis a vis* the rights flowing from different forms of ownership and, by extension, for the nature of the labour process performed within such sites.² In addition, it illustrates the “fuzzy middle ground between one firm and many” characterizing

Table 6.1
A Typology of Medical Ownership, Practice and Payment Modes and the Relations Implied

<u>Ownership status and example</u>	<u>Practice Mode</u>	<u>Primary Payment Mode</u>	<u>Relations Implied</u>
Owner (traditional solo practice)	Solo	fee-for-service	Legal and full real ownership. Control over medical and non-medical labour power
Non-owner (company doctor)	Solo	salaried	Possession. If it exists, would have control over medical/non-medical labour power
Co-Owners (Clinic)	Group	pooled income from fee-for-service	Shared economic and legal ownership/possession. Control over medical and non-medical labour power.
Owners (Associate Practice: association of solo practitioners sharing building, facilities, operating costs)	Group—minimal formal/legal association	fee-for-service	Legal and real ownership of individual practice; sharing of economic ownership rights regarding building, facilities and operating costs/possession. Control over the labour power of ones own employees
Non-Owners (Health Maintenance Organization or Community Clinic)	Group—formal/legal association	Capitation (fixed rate per patient per annum) or salary	Degree of economic ownership only via influence on board of directors/possession. Limited control over medical and non-medical labour power
Co-Owners (small co-owned practice)	Partnership	fee-for-service	Shared Legal and real ownership. Control over medical and non-medical labour
Non-owner (one doctor working for another)	Partnership	salaried	Possibly possession, elements of economic ownership. Control over subordinate medical and non-medical labour.
Non-Owners (hospital staff physicians)	Hospital based	salaried	Possession/elements of economic ownership, depending on role in hospital. No or very limited control over medical or non-medical labour
Non-Owners (doctors with hospital privileges working primarily in the hospital)	Hospital based	fee-for-service	Possession/elements of economic ownership depending on role in hospital. No or very limited control over medical or non-medical labour

practice associations of "solo practices, all located in a building owned jointly by their principals, with shared diagnostic services and active inter-practice referrals" (Evans, 1984: 125). The following sections examine aggregate changes in the way physicians have organized their practices as well as general shifts in the content of the labour processes they perform.

6.4. General Shifts in the Structure of Medical Practice

In general, the most important shift in the organization of medical practice since the implementation of Medicare is physician's increased choice of and dependence on modes of practice which are *institutional and collective*—a trend that has been interpreted as a long term structural movement towards the bureaucratization of medical practice (McKinlay 1982; McKinlay and Arches, 1985). This shift can be seen in two parallel processes;

1. the ongoing significance of the hospital as the predominant site of health care production (also discussed in Chapter Five) and,
2. the growth (sustained from the pre-Medicare era) of the group practice.

In examining changes in the practice structure of active civilian physicians between 1962 and 1986, the most important shift occurring is the relative decline of the solo and partnership practice modes and the concomitant substantial growth of group practices (Table 6.2).³ Other research also suggests that group practice is becoming increasingly popular. A study by Vayda (1977) estimated that in 1976, 30 per cent of physicians were in some form of group practice. More recently, a study of a representative sample of Canadian physicians found 22 per cent were in some form of group practice, while more than one-third were working either as salaried hospital staff or in a mixed practice (a combination of solo and group organizations) (Williams et.al. 1989).⁴

Table 6.2 Shifts in the Organization of Practice Structure: Canadian Active Civilian Physicians 1962 and 1986 (per cent)			
<u>Practice Mode</u>	<u>1962</u>	<u>1986</u>	<u>Percentage Point Change</u>
Solo	47	34	-13
Group	10	35	+25
Partnership	13	7	-6
Other (Institutions)	30	24	-6

Source: Judek, 1962:144, 146 & Thorlakson and CMA Physician Manpower Questionnaire (PMQ)

Group practices have not only become more prevalent but have become larger—showing a trend towards the formation of larger groups with 6 or more physicians. Data from 1962 (Judek: Appendix 6-2) shows that physicians in group practice chose to join or create small group practices ranging in size from 3-5 doctors (74 %) while comparatively few doctors chose to work in larger practices of six doctors or more (26 %). By contrast, the 1986 PMQ data indicates that there has been a major shift towards group practices containing six or more physicians (54 %) and a concomitant decrease in the number of doctors willing or able to work in smaller practices (46 %).

Younger physicians, who are less likely to have the financial means to practice on their own, are choosing to join group practices. Figure 6.A shows that younger doctors just graduating from medical school (under the age of 30) are more likely to choose to work in groups than in solo practice modes compared to older doctors in the peak producing years (between 31 and 54 years) who are more likely to practice solo.

While medical work is increasingly performed in group practices, the likelihood of being a salaried physician in group practice has decreased. Table 6.3 reports on the shifts occurring between 1954 and 1986 for doctors working in different practice modes and receiving either all or a portion of their income from salary.

As a whole, the proportion of physicians receiving partial or full salary has actually declined slightly from the early 1960's to 1986. In addition, viewed in terms of the structure of practice, the proportion of physicians receiving partial or full salary income has increased only slightly in small practices (solo and partnership), while group practices show a marked decline. Moreover, in both time frames, as practice size grows from solo to partnerships to increasing sizes of group practices, physicians are more likely to receive a salary for part or all of the work they perform.

Figure 6.A
Physicians Practice Mode by Age Group: 1986

Source: CMA Physician Manpower Questionnaire: 1986

Table 6.3
Percent of physicians within non-institutional practice modes receiving partial or full remuneration as salary, 1954, 1962 and 1986. (N=21,015 for 1986 7,000 for 1962, and 15,655 for 1954)

Year	Practice Mode				
	Solo	2 Physicians	Groups 3-5	Groups >6	Average
1954** & 1962*	14*	15**	26**	36**	23
1986	15	18	22	24	20

Source: CMA Physician Manpower Questionnaire 1986

* Derived from Judek, 1962: 224

** Derived from Canada, National Health and Welfare, 1958: 47

Thus group practices have become more prevalent as the method of practice structure at the expense of smaller solo and partnership practices, while the likelihood of working in the latter two modes as a fully or partially salaried employee is only slightly greater today than in the early 1960's. Physicians reporting being salaried in solo practice would be combining income from their fee-for-service practices with salaried arrangements elsewhere (to supplement their income), whereas partnerships would more likely involve one individual receiving either full or partial salary. In effect, since Medicare, the extent to which the salaried wage relation permeates solo and partnership practices (traditionally private methods of organizing medical work) has only slightly increased, and, in group settings, the likelihood of being salaried has decreased.

With respect to institutional settings, private industry and hospitals are now employing slightly more doctors compared to 1962, while governments at all levels show a marked decrease in employing physicians (Table 6.4).

Salaried arrangements in institutional practices can be very complex. For instance, some doctors working as "salaried" employees of hospitals (and reporting themselves as such) might actually work on a fee-for-service basis—billing the provincial health insurance commission for services rendered, then pooling the income from these billings and drawing a salary from that pool. Any revenues that augment the salary pool—called the overage—are reinvested in the hospital for research and/or teaching purposes, but cannot be captured as additional income in the hands of physicians. It is likely that many of the physicians working in institutional settings in both time periods and reporting themselves not to be in private practice *combined* salaried appointments with income from private practice.

Table 6.4 Shifts in the Organization of Practice: Canadian Physicians reported to be not in private practice 1962 and 1986 (per cent)			
Location	1962	1986	Percentage Point Change
Federal Govt.	3	1	-2
Provincial Govt.	5	3	-2
County/Municipality	2	.5	-1.5
University	4	—*	—*
Industry	1	3	2
Hospitals	14	16	2
Other	1	3	2
Total	30	26.5	-3.5

* These doctors are included in a "residual" category in the 1986 questionnaire.

Source: Judek:144 and PRDB

The tendency to combine practice forms with different modes of remuneration has some important implications for a class analysis. To the extent that some physicians actually *vary* their practice location from one part of the day to the next, their experience of the rights deriving from ownership has become dependent on the "place" within which their work occurs, so that they may enjoy complete control over their own practice in the morning, while being subject to bureaucratic protocol in the afternoon (also see Williams et.al 1989). Moreover, although most doctors are dependent on hospital settings to some degree, they may spend much of their time in a practice they own, or a portion of their time as a partner with shares in a group practice or as a salaried employee in a community clinic. Similarly, a physician reporting that she is in "solo, fee-for-service practice" may also work part-time in a large bureaucracy (as a company doctor) in which her capacity to make strategic or operational decisions is diminished or even non-existent. Thus, physicians today may alternatively control or be highly dependent upon bureaucratic, formal organizations which they may or may not own. This variability in terms of the experience and exercise of authority relations, associated with the tendency towards hybrid forms of practice represents an important break from the relatively more homogeneous shape of medical practice some 30 years ago.

What, then, is the character of the authority and control relations permeating the labour process of the physicians who work within these different practice forms?

6.5. The Medical Labour Process: What do doctors do?

The content of the labour process of old and new middle class members is composed of the unity of two functions: the function of capital (both global and individual) and the function of collective labour.

This section examines data on doctors' labour process in order to determine whether there has been a shift in the ratio of the functions of collective labour to the functions of capital within doctors' work between 1962 and 1986. It also examines the nature of the work physicians do in order to determine to what extent there has been a shift in the *kinds* of work comprising collective labour, and whether there has been a diversification of the functions of capital.

The process of economic proletarianization of the new middle class involves the gradual stripping away of the functions of global capital and an increase in the functions of the collective labourer. If physicians are spending less time (compared to 1962) managing their practices, supervising both medical and non-medical subordinate labour, and making both strategic and tactical decisions we might expect that they would be performing more of the function of collective labour (operationalized as time spent in direct patient care, teaching and research). Accordingly, we could surmise that at least in terms of the economic dimension of class, physicians are being proletarianized

Doctors in the Judek and PMQ surveys were asked to report on the time they spend performing tasks that can be assigned to the two functions.⁵ In the York University sample survey of physicians in Canada, doctors were asked to report the number of hours they spend performing various "professional activities" during the typical work week. Unfortunately, the survey did not provide a separate set of response categories to capture management functions-choosing instead to "bundle" such activities

into existing categories (most likely within the categories of patient care, Medicare paperwork and committee work/compulsory staff meetings).⁶ By contrast, the Canadian Medical Association's Physician Manpower Questionnaire for 1986 questioned doctors in some detail regarding the time they spend in *direct patient care* while providing response categories for the management functions of committee work, practice management and administration. In Judek's 1962 survey physicians were asked to report on the time spent in patient care functions while an "other" category was provided to capture administrative and managerial work.

Although results should be interpreted with a degree of caution, the best possible analysis of changes that have occurred in what doctors do is provided by comparing Judek's data with the 1986 Physician Manpower Questionnaire.

Figure 6B describes the categories utilized to capture what doctors do in the Royal Commission questionnaire as well as relevant categories from the Physician Manpower Questionnaire. Each of these categories is also assigned, as appropriate, to the functions of labour or capital.

Figure 6B

Operationalization of the functions of capital and labour: Categories from the Canadian Medical Association 1986 Physician Manpower Questionnaire and The Royal Commission on Health Services: Questionnaire on Medical Practice, 1962 (Judek).

Functions	Categories in Royal Commission on Health Services: Questionnaire on Medical Practice 1962 (N=12000)	Categories in Canadian Medical Association Physician Manpower Questionnaire 1986 (N=29983)
FUNCTIONS OF LABOUR	Time Spent in:	Time Spent in
Time spent in direct patient care regardless of setting (office, Hospital etc.) Involves coordination and unity of the labour process. Time spent in formal consultation with colleagues (collective labour)	<ul style="list-style-type: none"> • Office Calls • Hospital Calls • Home visits (night and day) 	<ul style="list-style-type: none"> • Direct Patient Care regardless of setting • Formal consultation with colleagues
Time spent teaching would usually involve working for universities. Therefore includes coordination and unity of the labour process. Time spent in research may be an individual task or may involve coordination and unity of a collective labour process involving research staff	<ul style="list-style-type: none"> • Teaching and/or Research 	<ul style="list-style-type: none"> • Research • Classroom Instruction
FUNCTIONS OF CAPITAL		
<ul style="list-style-type: none"> • Time spent participating on Hospital Committees: Involves making short term (lower level managerial decisions) and long term (strategic) decisions on the functioning of the hospital. • Time spent in management of practice Involves making decisions as an owner of the medical practice; supervision, hiring, firing and promotion, office management, and makes binding tactical and strategic decisions either as member of a group of doctors or by oneself. • Time spent in administrative duties. Involves making strategic and tactical decisions within bureaucratic and/or institutional settings 	<ul style="list-style-type: none"> • Captured by "Other activities" category which included work at clinics, preparation of medical papers, attendance at medical meetings, telephone consultations, work connected with medical insurance, keeping medical records, participation on hospital committees and office supervision 	<ul style="list-style-type: none"> • "administration", • "hospital committees" • "managing your practice"
OTHER ACTIVITIES		
Time spent in Continuing Medical Education (CME). Though still voluntary for some specialties, a certain number of hours of continued education is mandated for other physicians. Includes time spent attending Conferences and in formal courses and/or workshops	<ul style="list-style-type: none"> • Captured by "Other activities" category 	<ul style="list-style-type: none"> • Time spent on continuing medical education as follows: listening to audio tapes Reading Viewing videos Formal Consultations with colleagues Conferences Formal Courses and Workshops

6.6. Changes in the Labour Process: General Practitioners and Specialists

The data on the average time spent performing the functions of labour and capital for all physicians regardless of practice style and by specialist/G.P. status for 1962 and 1986 is presented in Table 6.5.

Table 6.5 Per cent of weekly time spent performing functions: Canadian fee-for-service Specialists and General Practitioners: 1962 and 1986.						
	Specialists			General Practitioners		
	1962	1986	Percent Change	1962	1986	Per cent Change
Function of Labour (Patient Care)	83	60	-23	95	68	-27
Research/Teaching	7	18	+11	1	14	+13
Total Function of Labour	90	78	-12	96	82	-14
Hospital Committees	—	5	—	—	3	—
Administration	—	11	—	—	8	—
Practice Management	—	6	—	—	7	—
Total Function of Capital	less than 10*	22	greater than 12	less than 5*	18	greater than 13

Sources: Physician Manpower Questionnaire: 1986; Judek: 174 (all percentages rounded)

* In Judek's survey, all functions of capital were included in one category along with "other" activities. Hence, less than 10 and 5 per cent of all time worked by specialists and general practitioners respectively was spent performing the functions of capital. In addition, this category captured the time doctors spent on continuing medical education.

The data show that compared to fee-for-service general practitioners and specialists in 1962, there has been an increase in the proportion of time spent performing the function of capital and a concomitant decrease in the time devoted to patient care for physicians in 1986. In addition, as a whole, doctors in 1986 were much more likely to undertake some teaching or research work than they were in the early 1960's.

This data show that rather than losing more of the functions of capital to non-physician managers, as a whole, physicians are performing *more* of the functions of capital than they did in the 1960's. In light of the evidence pointing to the growth of groups organized along bureaucratic lines, it is likely that doctors in this practice mode

are retaining managerial prerogatives though they may be performing these functions on behalf of another physician. The general increases in all the components making up the function of capital—administration, practice management and hospital committee work—are best explained by the rise of administrative rationality permeating all practice forms. In bureaucratic forms such as the hospital and group practice, the imperative to assure accountability for costs and quality of care has probably contributed greatly to the time spent by physicians in these activities. Even in solo practices, increases in Medicare paperwork, increasing staff ratios and the need to manage paramedical and administrative staff have contributed to the rise in time spent performing management activities, as Chapter Seven will show. It is likely, then, that in addition to a decrease in the time spent performing the functions of labour, there has been a slight shift in the kinds of work comprising the function of labour, primarily towards teaching and research work. Similarly, the functions of capital are more diverse now than they were in the past, with physicians having (or choosing) to take on more management activities that previously may not have existed or may have been performed by others.

The distinctions between general practitioners and specialists evident in the early 1960's regarding teaching, research and performance of the functions of capital appear to be disappearing. Specialists in 1962 were more likely to be performing management activities than their counterparts in general practice and were far more likely to engage in teaching and research activities. By 1986, the gap in time spent in these activities between general practitioners and specialists had narrowed substantially, although the latter still spend more time in management, teaching and research activities.

In addition, it is significant that in 1962 the time spent by general practitioners and specialists performing the functions of capital would also have included time spent in continuing medical education (CME) according to the categories used in Judek's survey. Thus, specialists probably spent far less than 10 per cent of their weekly time in CME while general practitioners would also have spent much less than 5 per cent of their time

per week in this activity. By contrast, in 1986 General practitioners were spending an average of 3.2 hours per week in CME activities alone (approximately 5 per cent of their work week), and nearly half were taking 9 days per year to attend medical conferences. Specialists were spending 3.8 hours per week in CME activities (7 per cent of their work week) and took an average of 7 days per year to attend conferences (York University National Survey of Canadian Physicians Data, 1986; Physician Manpower Questionnaire, 1986). Thus, although it is impossible to disaggregate the data falling into the "catch-all" category in Judek's census, it is highly probable that CME activities have increased for both specialists and general practitioners. Thus, physicians today are spending more time keeping up with the knowledge base of medicine by engaging in reading, listening to tapes, and attending conferences—probably because of the tremendous growth of knowledge and the fact that CME is now mandated for physicians.

Both specialists and general practitioners are spending less time in patient care activities and more time in the functions of capital than they have in the past.

Importantly, there has also been a shift in the work of general practitioners. Judek (1964: 153-4) cites several experts who state that general practice can diagnose and treat "85 per cent of the illnesses of mankind, and this includes the knowledge of when and where to obtain help for the remaining 15 per cent." In effect, general practitioners in the era prior to Medicare were really the bulwark of the medical profession—the "repository" of all medical knowledge "able to provide a range of specific services—surgical, obstetrical, pediatric, psychiatric, pharmaceutical—all based on the existing corpus of medical knowledge" (Blishen, 1969: 47). Today, although many general practitioners provide anesthetic, obstetric and surgical services, (thus placing them in a realm that would have been considered specialist practice in the 1960's (CMA, 1989:25)), the existing corpus of medical knowledge has expanded sufficiently to make it very difficult for general practitioners to be as effective as specialists in the treatment of some illnesses. More than ever, the general practitioner has become the "gatekeeper" to the

health care system—a role which entails a large number of relatively brief first contacts with patients primarily for diagnostic purposes and redirection of more serious problems to the appropriate specialist. This may help to explain the displacement of the general practitioners' work into the realms of teaching and research and away from patient care. As well, whereas the decline of general practice was lamented in the early 1960's because of the trend towards specialization, according to the Canadian Medical Association, there has been a dramatic resurgence in the general and family practice since the 1970's, and the proportion of individuals entering specialist training has stabilized at around 50 per cent. Thus, although the *content* of labour in general practice has changed since the 1960's, it would seem that some form of "general practice" is here to stay.

6.7. Conclusion

In this chapter, the exploration of general shifts in practice mode and the labour process have provided some understanding of the basic transformations that have occurred within medical practice. Although ownership relations and the labour processes attending these relations have become more complex in thirty years of Medicare, it is clear that physicians are spending more time engaging in management activities tangentially related to patient care. In addition, while the wage relation continues to characterize some medical practices, as a whole, the likelihood of being a salaried physician has actually declined in the case of group practices and only slightly increased in solo and partnership practices.

Viewing practices in terms of their size and structure, as practices get larger, the likelihood of being salaried increases, a phenomena that was also evident in the early 1960's.

On a global level, the majority of physicians continue to practice within a piece work framework paid for through taxes and administered by the state. Yet complex and dynamic systems of remuneration and ownership have evolved which make it very difficult to place some doctors in any given class situation with any degree of certainty.

At the same time, earlier differences between specialists and general practitioners appear to be disappearing as general practice has become redefined as a kind of specialty in its own right. In addition, it is clear that group practice has increasingly become a dominant practice mode.

So far we have only examined these shifts at a broad level with little attention paid to intra-professional differences (excepting the differences between specialists and general practitioners). However, it is important to examine differences in labour process functions and authority relations along the dimensions of solo and group practices for both salaried and non-salaried physicians. This is the subject of the next chapter.

ENDNOTES

¹ This of course is one of the main distinctions between the Canadian health care system and that of the United States, where, in the context of a free-market, medical labour power is increasingly purchased by capitalists and is becoming concentrated in Health Maintenance Organizations (HMO's) and for-profit hospitals.

² Note that this typology does not take into account the possibility that physicians could be working in more than two sites i.e., combining solo with associate *and* group practice.

³ As Williams (1989) and others have argued, because of the lack of agreement as to how a group practice should be defined, it is difficult to precisely estimate the extent to which group practices have superseded solo practice. However, the closest match in terms of definitions of group practice within available data sources occur within the data derived from Judek and that of the Physician Manpower Questionnaire. These are the primary data sources used in this dissertation, because they provide the best possible comparison for the period under study. In any case, Williams' estimate that 30 per cent of physicians are in some form of group practice coincides with the findings of this study.

⁴ It should be noted that the Williams study only looked at physicians working more than 30 hours per week and therefore—on this dimension at least—cannot be compared properly with either Judek's survey or the Physician Manpower Questionnaire. Nevertheless, the study does suggest that group practice has become a preferred form of practice structure.

⁵ However, the functions are only analytically distinct and may not necessarily occur in different parts of the day (although they might in other types of work). In his earlier work, Carchedi argues that the two functions (global capital and collective labour) are performed in different parts of the day. But as Carter (1985:70) points out, this claim cannot be empirically verified, and it is possible that many occupations perform both tasks at the same time. Carchedi (1987) later concedes this point.

⁶ While most findings from the York University data set were nearly identical with those of the Physician Manpower Questionnaire they differed on one important set of variables—time spent in various activities. The total hours worked by physicians reported in the PMQ coincides with the findings of the York study. However, in looking only at those physicians who had replied in all categories of activity within the PMQ that they had spent time greater than or equal to zero on all activities, the "total hours worked" no longer added up to the average reported in the CMA's findings and hence do not match the hours reported in the York study. I have utilized this data because we are interested only in those doctors who provided valid responses to all questions on the issue of time spent in various tasks.

CHAPTER SEVEN

THE CHANGING NATURE OF SOLO AND GROUP PRACTICE

7.1. Introduction

The previous chapter dealt with general shifts in the structure of medical practice. This chapter provides a more detailed examination of the nature and implications of shifts in the structures of group and solo practices with particular attention paid to the experiences of salaried and non-salaried (fee-for-service) practitioners in both practice forms. In particular, it explores the implications of variability in the structure of salaried and non-salaried group and solo practices for physicians' rights relating to ownership, authority and control relations.

The ideal-typical solo practitioner embodies the quintessence of private medical practice. Traditionally, most solo physicians worked mostly out of their own offices and would be considered as having real and legal ownership over the primary means of production. They would therefore belong to the old middle class. In the past, these doctors have had full ownership of capital assets in the form of office, diagnostic and treatment equipment, and have traditionally employed a small number of workers. In addition to the technical autonomy it affords the practitioner, the doctor's preference for solo practice has been buttressed by the ideology that it is the embodiment of entrepreneurialism (Freidson, 1970). This certitude in the value of the practice "as small business" has nourished the reproduction of solo fee-for-service practice as the dominant form, both prior to and after the implementation of Medicare, despite the fact that it is increasingly less likely to be the typical practice structure.

The predominance of solo practice is remarkable in a context where vast shifts in medical knowledge and technology have contributed to the perception that the efficiency and quality of medical service can be improved in group practices. Even in 1962, nearly half of all solo physicians responding to Judek's survey felt that group practice could improve the quality of medical services, while 88 per cent agreed that group practice

could improve physicians' working conditions. Not surprisingly, 91 per cent of physicians in group practice felt that this practice form afforded improved quality and nearly all agreed that it could improve working conditions. Yet, as we have seen, the demise of solo practice has not been as accelerated as one might expect given these attitudes.

Part of the reason for this may be that at least for some physicians, there is still some ambiguity as to the advantages of group versus solo practice. According to data from the York University National Survey of Canadian Physicians, of those doctors reporting that they had changed practice type from one to another in the past ten years, 38 per cent had switched from solo to group practice while a similar proportion (34 per cent) had switched the opposite way—from group to solo. This suggests that some doctors are entering group practice to build the clientele, experience and capital necessary to ensure the viability of the relatively more expensive (and risky) solo ventures they hope to establish later in their careers. At the same time, a similar proportion of physicians are probably giving up their solo practice in favour of joining group practices because of the perceived advantages of these arrangements.

Several physicians interviewed for this study indicated that were it not for their involvement in some kind of group arrangement they would very likely not be practicing medicine today. The main reason for this was the high cost of solo practice (which includes rental of buildings, salaries to employees, investments in technology and taxes). Some even went so far as to describe the solo practitioner as an "anachronism", a "dinosaur" or "likely (in the future) to be practicing in a basement with one light bulb and a chair." By contrast, physicians who were currently in solo practice argued that while "making ends meet" was an increasingly difficult task, they would not give up the technical autonomy and small business milieu characterizing their practices.

As a practice mode, solo practice faces numerous challenges. This begs the question as to if, and, if so to what extent, forces such as the imperative towards

economies of scale, the financial burden associated with starting and maintaining one's own business, and the entrepreneurial ideology, have changed the structure and/or nature of modern solo practice. Is solo practice taking on a new shape? If so, what kinds of authority and control relations do these new solo practices entail and what are the implications for solo physicians' economic class relations?

7.2. The New Shape of Solo Practice

Ironically, the change of greatest significance for solo practice has been its increasingly collective nature. Solo practices have become larger primarily in terms of a trend towards the employment of greater numbers of support and professional ancillary staff. It is likely that increasing workloads and more administrative duties have contributed to this trend. In 1960, the mean number of paramedical and clerical workers employed by solo physicians was 0.8. One study of solo general practice showed that about two-thirds of solo physicians generally employed one or two assistants—either secretaries or nurses—while the remainder “had no secretarial or nursing assistance, except such sporadic help as some of their wives were able to give” (Clute, 1963: 66). By 1971, the mean number of staff in solo practitioners offices had increased to 2.8 per physician, and data from the York university 1986 survey of physicians shows that 50 percent of solo practitioners now employ at least one full-time nurse, while over 90 percent employ at least one two secretary, receptionist or clerk. Only one-third employ an office administrator, suggesting that many solo physicians prefer to manage their own business affairs.¹ In these practice arrangements, the physician would have the power to hire and fire his employees as well as control and supervise the nature and pace of their work. Accordingly, as some solo physicians begin to employ more employees, they are increasingly making a transition from old middle class “small businesses” to small scale capitalists.

The increase in the size of the team delivering services in a typical solo practice is also related to increases in patient volume, which requires more ancillary personnel to take responsibility for various tasks within the office. In 1962 the average solo practitioner saw an average of 99 patients per week (Judek, 1964). By 1986 their patient loads had increased to an average of 106 patients per week (York University National Survey of Canadian Physicians Data, 1986). In addition, the number of physician contacts per person per year in Canada has increased from less than three, 30 years ago to around 10 to 12 in recent years (Fulton, 1993:41).

There are other related reasons for the physical expansion of solo practice. The large amounts of paperwork entailed by Medicare, and the need to maintain adequate incomes in the face of increased competition by other physicians are perceived by physicians in solo practice to be important sources of stress (Table 7.1). The growth of the "team based" approach in solo practices is therefore likely to be related to the perception that efficiency (and income) can be amplified by creating a division of labour.

Table 7.1
Per cent of solo and group practitioners reporting activity as "important" or "very important"
source of stress: 1986

<u>Source of Stress</u>	<u>Solo Physicians</u>	<u>Group Physicians</u>	<u>Percent Difference</u>
Medicare paperwork	54	33	-21
Need to maintain adequate income	51	43	-8
Profession/government relations	46	41	-5
Office management problems	21	27	+6
Need to maintain own knowledge	40	44	+4
Coordinating services for patients	26	28	+2

Source: York University National Survey of Canadian Physicians Data, 1986

The fact that modern solo practices are larger and more complex affairs than those of the 1960's, is illustrated by data on the time spent in tasks comprising the functions of capital and labour. Today's solo physician is much more likely to be involved in management tasks than their counterparts of the 1960's, and is not spending as much time

in patient care activities (Table 7.2). Importantly, practice management—which would consist of Medicare paperwork, hiring, firing and supervision of personnel and other office management activities—appears to be a fairly significant portion of the solo physician's work week. In addition, these doctors spend nearly as much time on administrative tasks within hospital settings though they tend to spend less time on hospital committees. Teaching and research have also become much more prevalent activities, perhaps reflecting the need for these doctors to supplement their income with non-traditional work.

Table 7.2 Per cent of weekly time spent performing functions: Canadian Physicians in Solo practice: 1962 and 1986.			
Function	Solo Physicians 1962	Solo Physicians 1986	Percent Difference
Patient Care	95	65	-30
Teaching & Research	1	14	+13
Total Function of Labour	96	79	-17
Hospital Committees	—	4	—
Practice Management	—	8	—
Administration	—	9	—
Total Function of Capital	less than 5	21	greater than 16

sources: Judek: 344; PMQ, 1986.

As a whole, the increased time spent on management by solo physicians compared to doctors in the 1960's illustrates the more bureaucratic nature of practice as well as the increasing resemblance of solo practice to collective practices like groups but with one owner and a number of employees. Once again, this provides evidence of the extent to which many a solo practitioner of old who owned a "small business" in which management was directed at oneself, has become the sole proprietor of a "larger business" in which management is directed at staff. Since movement from the old middle class to the capitalist class is based on the extraction of surplus value or labour from

others, it appears that some solo physicians are making a transition from old middle class to the capitalist class.

7.3. Salaried and Non-Salaried Solo Physicians

As documented earlier, a substantial proportion of solo physicians *combine* fee-for-service income with a salary. These doctors have moved out of teaching and public health jobs and into salaried work in hospital and clinical settings although the proportion of income earned from combined practice in the latter has remained constant (Table 7.3). In addition, some of these physicians are finding employment in industrial medicine, usually as full time employees in larger companies or as contract doctors in smaller organizations.

The industrial environment (in which 16 per cent of solo practitioners perform part of their work) is particularly interesting for its implications regarding authority. As provincial governments increasingly shift the burden of meeting health care costs onto employers, many industrial or "company" doctors in large organizations are finding that their work is subject to accountability pressures similar to those experienced by other workers within the enterprise (also see Walters, 1984). Interviews with three full-time company doctors working for large organizations indicated that while the technical aspects of medicine and physician-patient confidentiality are, in theory, held to be inviolable, these doctors are increasingly being asked to account for the "effectiveness" and cost-efficiency of treatments, primarily because job related injuries and illnesses affect productivity (e.g., through high rates of absenteeism, and use of sick-day leave) and

because of the employer's concern over the increasing costs of workers compensation claims, extended health benefits and drug costs.

At the same time, these (full-time) company doctors stated that they are being given some responsibility for defining corporate objectives in the domain of health standards and employee wellness. They are therefore involved in strategic decision making but in a very limited way.² On the other hand, doctors working for smaller organizations, or those working on a part-time basis, seem to have correspondingly little involvement (if any) in corporate decision-making.

Table 7.3 Percentage of solo physicians receiving part of income from salary by location of salaried medical practice: 1962 and 1986				
	1962		1986	
	% of solo doctors combining salary with fee-for-service	Salary as % of total income (average)	% of solo doctors combining salary with fee-for-service	Salary as % of total income (average)
Hospital staff—Specialist	11	42	—	—
Hospital staff—Other	3	59	—	—
Other (mostly clinics)	12	31	—	—
Sub Total—Hospital/Clinic work	26	44 (average)	58*	44*
Research	4	66	—	—
Teaching	19	59	15	11
Public Health	3	51	1.10	29.4
Industrial Medicine	9	63	16	25

Sources: derived from Judek, 1962: 224 & PMQ

* For 1986, this figure includes doctors working in clinics and hospitals

Solo physicians working within salaried and non-salaried arrangements in hospitals experience fewer constraints than their industrial peers. Because of the nature of modern Canadian hospitals (discussed in the next chapter) and since the hospital is a domain in which physicians are sovereign, many solo physicians working in hospitals exercise power regarding strategic and tactical issues in relation to the operation of the

hospital—maintaining a great deal of control over their own labour processes as well as the labour of others. Given that the wage/salary relation implies less control over the means of production, we might expect that salaried solo physicians would have less control over their own labour and the labour of others. Put simply, a comparison between fee-for-service and solo physicians who are salaried at least part of the time ought to yield some differences in the times spent performing the functions of capital versus the functions of labour.

However, salaried physicians actually spend slightly *more* time carrying out the function of capital than their non-salaried counterparts (Table 7.4). Although they spend less time in managing the practice, they spend as much time on hospital committees as their fee-for-service counterparts, and far more time in administrative work which again would be concentrated in the hospital. This suggests that physicians in full or partially salaried positions in hospitals are taking on more managerial tasks in an effort to become part of the administrative or managerial hierarchy, rather than being subject to it.

Table 7.4 Per cent of time spent in activities by solo fee-for-service, and salaried doctors: 1986			
	<u>Fee-for-service solo</u>	<u>Salaried solo</u>	<u>Percent Difference</u>
Patient Care	67	63	-4
Teaching/Research	13	14	+1
Total Function of Labour	80	77	-3
Hospital committees	4	4	0
Managing Practice	8	7	-1
Administration	7	11	+4
Total Function of Capital	19	22	+3
Hours Per Week CME*	3	4	+1

Sources: PMQ, 1986 & York University National Survey of Canadian Physicians Data, 1986 (*).
Figures are rounded

The full one hour more per week spent on continuing medical education (CME) by salaried practitioners is understandable given that solo fee-for-service practitioners probably find it more difficult to leave their practice to take courses or attend conferences. Indeed, one of the main reasons doctors choose to go on salary is because their compensation packages often allow them paid time off to attend conferences, seminars and other CME activities.

While some efficiencies can be obtained within solo practices by employing ancillary personnel and creating a division of labour, computer technology is also being utilized to increase productivity in solo practices. It is significant however that salaried solo physicians are nearly twice as likely as fee-for-service solo doctors to utilize computers to maintain patient records, and three times more likely to employ computers in diagnostic procedures (see Table 7.5). The use of computers to automate diagnosis and patient records implies that doctors in salaried practice modes are more inclined (or feel more pressure) to become efficient in their practices. Particularly in relation to diagnostic procedures, computer technology implies that there is greater potential in these practice forms for a process of deskilling to occur as well as possibilities for the routinization, codification and evaluation of physician's work.

Table 7.5 Use of Computers by Solo Fee-for-Service and Salaried Physicians (per cent)		
<u>Use computers for:</u>	<u>Fee for Service Solo</u>	<u>Salaried Solo</u>
Patient Records	10	18
Billings	19	21
Diagnosis	5	15

source York University National Survey of Canadian Physicians Data, 1986

To summarize, more solo physicians have become dependent on salaried arrangements, primarily in hospitals and in industrial medicine. Industrial physicians, the majority of whom contract their services to companies, have very little influence over

organizational strategy although full-time salaried physicians in large organizations are gaining power over limited aspects of corporate decision making. In contrast, and despite their dependence on the wage relation for at least a portion of their work, full and partially salaried solo physicians in hospitals spend more time than their fee-for-service counterparts in management activities. Accordingly, we can assume that they would have a great deal of say in the strategic and operational activities of these institutions.

Thus, while most solo practitioners are undertaking more managerial activities than physicians in the 1960's, today's salaried solo practitioners are slightly more liable to perform the functions of capital compared to fee-for-service doctors. Understandably, these management activities are primarily concentrated in bureaucratic settings where these doctors would coordinate and perform medical labour processes, but would also supervise other medical and non-medical workers. Accordingly, it may be that salaried solo physicians are becoming the new middle class decision makers in these work environments while their non-salaried peers are increasingly managing large (by 1960's standards) practices in which they are Chief Executive Officer, worker and middle manager. Yet these class locations are not as simple as they may seem since solo, partially salaried doctors will be in different practice forms in different parts of the day. Therefore, they may not uniformly "belong" to one class (economically defined) but will instead belong to different classes at different times and in different circumstances, a phenomena that lends support to the contention that the middle class tends to be in a state of flux. To determine the eventual class trajectory of these doctors will require an analysis, in the future, of the tendency for such physicians to have become either full or partially salaried workers within bureaucratic practice forms.³

7.4. Group Practice: Bureaucratic Control or the Reproduction of Professional Power?

From the beginning, group practices were organized in ways that entrenched and reproduced doctor's autonomy and control over the labour process while achieving

economies of scale. Group practices began forming in Canada prior to 1920 but their numbers accelerated markedly during the late 1950's with the implementation of the Hospital Insurance and Diagnostic Services Act. Nearly half of Canada's doctors had served during the Second World War and, upon their return to Canada, were often anxious to re-assert their independence having spent the war years working in highly organized (and disciplined) "groups," and learning first hand the efficiencies to be gained by applying the concept of triage⁴ (Morton: 1992).

Many doctors began to perceive clear advantages in the construction of practices based on cooperative arrangements. In theory, it was hoped that the group practice would "bring together doctors trained in the different disciplines of medicine (in order to) provide for the patient a well rounded opinion on his 'ailment' by the collaboration of specialists." (Lyon, 1967: 254) In addition, there was a perception that group practice would offer other advantages, namely; better co-operation and co-ordination between physicians, a higher production rate, and major benefits in relation to financial and working conditions. Writing in 1962, Thorlakson argued that the practitioner of the future would increasingly opt to join group practices for all these reasons including the ability to work a regulated work week, with dependable opportunities for leisure and/or other non-work activities.

The promise of group practice was largely an illusion however. Today, physicians in group practices tend to work only slightly fewer hours than their counterparts in other practice forms. Moreover, there is virtually no difference between solo and group practitioners on issues of degree of satisfaction with "working conditions" and "time available for family and personal life" (See Table 7.6). Even women, who are more likely to experience stress juggling a demanding career with family life, (see Williams, Domnick-Pierre, Vayda, Stevenson and Burke, 1990) indicate similar levels of satisfaction with their practice arrangements compared to men. However, female physicians in group versus solo practice do show some differences in practice

satisfaction. For instance, more women in group practice tend to be satisfied with their ability to maintain personal health compared to women in solo practice, while slightly more female solo practitioners are satisfied with that practice mode's capacity to provide them with time for family and personal activities.

Table 7.6 Percent of Male and Female Physicians indicating Satisfaction with working conditions, time available for family and/or personal life and ability to maintain personal health: 1986				
<u>Satisfied or Highly Satisfied</u>	<u>Group Practitioners</u>		<u>Solo Practitioners</u>	
	<u>Males</u>	<u>Females</u>	<u>Males</u>	<u>Females</u>
With working conditions	54	56	55	58
With time available for family/personal life	38	37	39	41
With ability to maintain own personal health	48	48	46	41

Source: York University National Survey of Canadian Physicians Data, 1986

In the 1950's and 1960's, group practice was also thought to enhance professional and economic security by offering "a comforting check on the possibility of error and a friendly support in adversity," and by offering easy access to consultation through the professional stimulus of group relationships in maintaining high quality and improving performance. Ostensibly, working collectively would be advantageous because it would spread economic and professional risks. It is clear, however, that the extent to which such advantages can be obtained will depend on the way in which group practice is organized. Indeed, the level of collegial control, the degree to which knowledge is shared and the opportunity to advance one's medical career depends greatly on the form of group practice. For instance, in group practices with senior and junior partners, advancement for junior partners depends greatly on the perceived quality of their work as well as the rate at which they "turnover" patients. Thus, supervision in these types of group practices

is quite structured relative to "bricks and mortar" arrangements where supervisory contact is minimal and only the joint ownership of physical capital binds physicians together.

In addition, there is some evidence to suggest that physicians working in fee-for-service group practices gain very little in terms of efficiency and/or productivity. Evans (1984) argues that "apparent income and output advantages of professionals in (fee-for-service) groups have been shown to be largely a result of differences in product line rather than choice of production technique." Essentially, physicians in fee-for-service groups make gains in productivity because diagnostic and treatment services (offered by other specialists) and other services (such as x-ray, urinalysis and pharmaceuticals), which ordinarily would be referred out, are often available in-house. Thus, "solo practitioners with a well-functioning referral network may be just as efficient as a formal group." It would seem that while group practices have grown in Canada it is difficult to conclude that they have done so primarily for the gains they might entail with respect to efficiency and working conditions. Why then has group practice become so popular? To what extent has there been a transformation in the structure and authority relations of group practice? Furthermore, do variations in the structure of group practice entail significant differences in authority and control relations within group practices? The answers to these questions requires an analysis of changes and continuities in the ownership patterns of group practice.

7.5. Ownership Patterns in Group Practice

The little information that exists on the ownership patterns characterizing group practices in the 1960's indicates it could take a variety of forms. One type consisted of a doctor and his or her partners owning the capital assets of a group practice while other physicians and ancillary personnel worked on salary for these physician "owners" (Judek, 1964: 208). Other doctors were sole proprietors who owned capital assets and employed other physicians in the group. The Canadian Medical Association stated in 1967 that

many groups were started by solo practitioners who gradually added staff (including doctors) as the practice develops. In such situations, the original solo practitioner often remained the head of the group—making all upper level management decisions but often delegating the tasks of office management to a group manager (1967:67).

Finally, group “corporations” were associations of doctors in which a few physicians would form a corporation owning buildings and equipment while also practicing medicine. Additional physician non-owners involved in such corporate arrangements would conduct and control their own practices while leasing office space and equipment from the corporation. The members who founded the group would be the main shareholders of the corporation and other doctors would be governed by bylaws and management selected by the corporation. According to Boan (1964:11) in the 1960’s groups often organized by creating two distinct entities; a partnership to carry out the joint practice of medicine, and a joint stock company which owned the premises with shares being held by some or all of the doctors.

In a study of 246 Canadian medical groups in 1967, 54 per cent had some “medical members who were employed rather than being partners, particularly in the earlier stages of having joined the group.” To become fully fledged partners in these groups, physicians in two-fifths of groups had to make some investment although three quarters of all groups gave all partners a share in profits (Canadian Medical Association, 1967: 18-19). The physician employees of these groups would receive a salary with yearly increments for a period of time defined by the group’s owners. After a specified number of years, the physician would have attained his or her maximum salary but would share in the total profits with other physicians who had completed the specified term of service (McFarlane, 1967: 56-8). These salaried doctors would gradually attain more of the privileges associated with full ownership of the group, most notably a share in accounts receivable over time, or through gains in productivity and/or via capital investments. After achieving the status of partner, the doctor could look forward to an

equitable distribution of revenue with built in annual increments based on seniority and productivity.⁵ The average group physician achieved the status of junior partner after one to two years, and senior partnership two to three years beyond that. It took a relatively short time then for group practice doctors to make a transition from salaried employees with little say in the operation of the group, to partners in which they would be the “men [sic] who dictate its policies and control its affairs” (Canadian Medical Association, 1967: 54).

Thus, the typical group practice in the pre-Medicare era was characterized by fairly informal relations between federations of “quasi-independent shopkeepers” in which the group serviced rather than controlled the physicians (Madison & Konrad, 1988).

While the foregoing discussion provides a glimpse of the ownership relations characterizing group practice in the early 1960's, it is difficult to provide a completely accurate comparison of the differences between these groups and those in the '80's because of differences in the operationalization of group practice within existing data and a lack of substantive information on the exact nature of ownership relations in today's group practices. Moreover, when asked to place themselves in practice categories, physicians are often unsure as to what constitutes a group, a problem that is exacerbated by the fact that existing surveys have been inconsistent in defining categories of practice for the respondent.⁶ In part, these methodological difficulties reflect the ever-changing shape of group practices themselves. Notwithstanding these difficulties, an approximate comparison can be made using available data by inferring that “pooled income” groups—a category from 1954 data collected by Health and Welfare Canada—are comparable to the “private group” operationalization in the 1986 data set from the York University National Survey of Canadian Physicians. Similarly, physicians in groups claiming to work solely on a fee-for-service basis in 1954 would likely match with “associate” groups in 1986.⁷ With some caution then, data on methods of remuneration received by

physicians in group practice from a 1954 survey of medical groups reveals that about half of all groups were of the pooled income variety—entailing the creation of joint stock partnerships discussed earlier (Table 7.7). About one-seventh were involved in association practices (no sharing of patient files but sharing of expenses), while the remainder combined salary with other methods of remuneration.

Table 7.7
Changes in types of group practice : Canadian Physicians, 1954 and 1986 (Percentage)

Type of Group Practice	1954	1986	Percent Difference
Private Group, Pooled income, Fee-for service	53	44	-19
Associate Groups, Fee for Service (Bricks and Mortar arrangements)	15	36	+21
Other (combinations such as pooled and salaried, capitation etc.)*	32	20**	-12

Source: Survey of medical groups in Canada 1954: 64, Williams et.al. 1989

1986 figures for physicians receiving more than two-thirds of income from fee-for-service and excludes physicians working fewer than 30 hours per week. 1954 data excludes two person "partnerships."

* These doctors obtain between 0 and 66 per cent of their income from fee-for-service and mix this mode of remuneration with salary and/or capitation.

** Includes physicians combining other practice forms (solo, hospital) with group practice as well as physicians in CHC's/HSO's

By comparison, physicians in 1986 have moved more towards associate practices while the proportion engaged in formal pooled income/patient sharing arrangements has declined. This observation, while circumspect, indicates that doctors have entered into relationships with other physicians which essentially distribute the costs of medical practice while assuring individual autonomy. The latter is ensured because it is extremely difficult and often impractical for doctors in associate practices to have the time or proximity to observe the work of their "colleagues" (Scott, 1982: 217). Taken together with the observation that group practices (of both kinds) have become a more prevalent form of practice organization as a whole, it is likely that physicians in group practice have sustained the privileges of legal and real ownership found in pure solo practice by joining group practices which are actually "loose federations of solo practitioners" (see Burke,

1989). Aside from the advantage of autonomy, this kind of association affords physicians the ability to maintain an "entrepreneurial" approach to practice while increasing patient throughput. Burke (1989) suggests that patient volume (the number of patients seen over a given period) ranks as the most important determinant of physician income, surpassing factors such as the time invested in the group, dollar investments and administrative responsibility. To some extent then, associate group practice does afford economies of scale while entrenching the individual doctor's autonomy.

Group practice also offers physicians the opportunity to enter practice without a heavy professional investment while providing reasonable assurance of a stable income. This factor is important given the high entry costs of an independent solo practice and the obvious economies of scale achievable through group purchase of equipment for administrative functions, diagnosis, therapy, and for research. Moreover, by hiring ancillary staff and implementing a division of labour, groups sharing patient files and pooling incomes can utilize "competent business management to assist in these relationships" while increasing the availability of technical aids and facilities.

In Thorlakson's (1962) terminology, the division of labour within group practice was to have contributed to the "privilege of devoting ones energies to purely professional problems, without concern for administrative matters." Indeed, most early commentaries on group practice postulated that physicians would gain clear advantages via the existence of office managers and other clerical staff who could not only handle the day-to-day paper work associated with practice, but who could take care of human resources issues such as hiring and firing. However, this picture of the physician working purely on technical/medical matters is rather idealistic since it is clear that contemporary doctors in group practice spend far more time on management activities than their counterparts in 1964 (Table 7.8).

Table 7.8
Per cent of time Spent in Activities, Fee for Service and Salaried General Practitioners and Specialists in Group Practice: 1964 & 1986

Activity	Fee-for-service G.P.'s & (Specialists): 1964	Fee-for-service G.P.'s & (Specialists): 1986			Salaried G.P.'s & (Specialists): 1986		
		Partner-ships	Small Group	Large Group	Partner-ships	Small Group	Large Group
Patient Care	95 (88)	72 (60)	57 (59)	74 (59)	66 (68)	57 (59)	71 (57)
Teaching and Research	0.55 (6)	5 (15)	14 (20)	7 (19)	10 (13)	15 (20)	9 (22)
Total Function of Labour	96 (94)	77 (75)	71 (79)	81 (78)	77 (81)	72 (79)	80 (79)
Hospital Committees	—	3 (7)	3 (5)	3 (6)	4 (4)	4 (6)	4 (5)
Managing Practice	—	7 (5)	5 (6)	6 (6)	6 (6)	5 (5)	5 (7)
Administration	—	13 (14)	22 (10)	10 (11)	14 (9)	18 (11)	11 (9)
Total Function of Capital	less than 4 (less than 6)	23 (26)	30 (21)	19 (23)	24 (19)	27 (22)	20 (21)

Sources: Judek 1964 and Physician Manpower Questionnaire. 1964 data for salaried group practitioners unavailable.

Thus, the overall pattern discussed in Chapter Six in relation to the decrease of patient care activities (function of labour) and the concomitant increase in management activities also pertains to physicians in group practices in 1964 compared to 1986. With the exception of time spent in research and teaching activities, there appears to be very little difference in time spent in other functions for group practitioners in 1986. In addition, whether they are specialists or general practitioners, doctors working in salaried group practices spend approximately the same number of hours on patient care and approximately the same amount of time on practice management as non-salaried group physicians.

As well, physicians employed in larger groups tend to be slightly more involved in patient care activities than doctors in either small groups or partnerships, suggesting that larger organizations might offer advantages in relation to the physician's ability to practice more medical as opposed to administrative/managerial tasks. Moreover, group

size appears to make no difference for specialists *vis a vis* time spent on the functions of labour and capital compared to General Practitioners.

The use of labour saving computer technology to automate the administrative and technical components of medical practice becomes more pronounced as group practices become larger although the extent to which computers are being used by the physicians themselves is unknown (Table 7.9).⁸

Table 7.9 Per cent of groups using computers to automate medical practice by size of group practice and function				
Function	Partnerships	Small groups (3-5)	Medium groups (6-15)	Large groups (> 16)
Patient Records	17	19	30	43
Billings	22	38	53	81
Diagnosis	7	8	15	19

Source: York University National Survey of Canadian Physicians Data, 1986.

Interestingly, data from the York survey of physicians show that doctors in large group practices (six or more physicians) see fewer patients than their counterparts in partnerships or smaller groups (see Table 7.10)

Table 7.10 Number of patients seen by physicians, percentages of patients receiving insufficient time with physician and per cent of physicians who would increase, decrease or not change number of patients seen per week, by size of group practice.					
	Number of Patients seen per physician in average week	Estimated per cent of patients not getting sufficient time	Per cent who would increase number of patients seen	Per cent who would decrease number of patients seen	Per cent who would not change number of patients seen
Partnerships	118	13	26	46	28
Small Groups	118	16	20	49	31
Medium Groups	113	18	15	39	46
Large Groups	100	17	12	39	49

Source: York University National Survey of Canadian Physicians Data, 1986

Yet doctors in all group forms felt that they were unable to give sufficient time to a similar proportion of patients (ranging from 13 to 18 per cent), and physicians in the largest groups were most satisfied with the number of patients they were now seeing. Conversely, those working in smaller practices were more willing to increase their patient load, a finding which lends some support to the argument that doctors in smaller groups are more likely to feel that the viability of their practice depends on increasing patient throughput while physicians working in larger group practices perceive their practices to be more efficient.⁹

As with solo physicians, salaried doctors in group practices owned by other physicians are as involved in decision making processes as non-salaried owners of groups. This is in direct contrast with the experience of physicians working for salary or on capitation in Community Health Clinics (CHC's) and Health Services Organizations (HSO's) where ownership is vested in non-physicians.¹⁰ A recent study of group practices in Ontario showed that doctors in private groups had the greatest influence over decisions in a number of areas concerning group management and operation (Burke et.al. 1989). Doctors in private group practice continue to retain the prerogatives associated with legal and real ownership via control over purchasing of major equipment, operation of the premises, hours of work and hiring (and presumably firing) other doctors. By contrast, salaried doctors working in CHC's and HSO's have considerably less decision making power in these areas, though they retain a modicum of power over decisions within their domain, i.e., those activities requiring medical knowledge such as supervision of other physicians and the range or type of services to be offered (Table 7.11).

Table 7.11
Per cent of Groups with Physicians Having Greatest Influence over Decisions Regarding
various issues: Groups in Ontario with Lay Administrators/Managers, 1987

Type of Decision	Type of Group		
	Private	CHC/HSO	Percent Difference
Premises	75	27	-48
Range of Services	83	44	-39
Hiring M.D.'s	77	38	-39
Major Equipment	75	39	-36
Administrative Policies	35	12	-23
Hiring non-M.D.'s	34	12	-22
Work Hours	55	42	-13
Hiring Clerks	17	4	-13
Supervising M.D.'s	63	50	-13
Supervising non-M.D.'s	27	25	-2
Supervising Clerks	13	13	0
Number of Groups	55	26	

Source: Burke, Williams, Stevenson and Vayda, October 1989, Table 5

The reduced capacity of doctors within Health Services Organizations and Community Health Clinics to make decisions regarding the control (i.e., hiring, firing and supervision) of other physicians reflects the likelihood that physicians in these organizations are seen as providers of medical labour only with no "rights" of management. Diminished rights of management *vis a vis* hiring non-medical labour is also evident in HSO/CHC settings relative to private groups, although the right to supervise non-medical workers appears to be a prerogative of doctors in both settings. This suggests that physicians in CHC's and HSO's tend to be accorded management rights associated with the new middle class, while doctors in private groups are more likely to be given management rights associated with the capitalist/executive class because, in addition to supervising, hiring and firing, they are more likely to make decisions regarding services, premises and administrative policies. Accordingly, it would be very difficult for doctors in CHC's or HSO's to capture the prerogatives of the capitalist/executive class unless they became part of management proper.

In summary then, within group practices in the 1960's, senior partners made major strategic decisions on issues such as: investment in technology, control of assets, and decisions over what kind of medicine will be practiced in the group (i.e. whether it will be primarily specialist or general medicine, an "open" or private clinic etc.(Boan, 1964)). Senior partners were also more likely to make decisions regarding the hiring, firing and supervision of junior doctors, technical and clerical personnel. Junior partners participated to a limited extent in the determination of business and professional policies, while employee physicians were usually restricted from management and received straight salaries only (Judek, 1964:208).

The 1980's have witnessed a gradual shift away from private groups consisting of employer/employee relations between physicians, but in many of those practices which still maintain such relations, salaried physicians appear to be exercising some of the rights of ownership, often as voting members of the group. The increased popularity of associate practice relations indicates that physicians in such arrangements are enjoying a modicum of efficiency due to the presence of ancillary and associated medical services within the same location. In addition, these doctors essentially control their own "practice" and participate in "corporate" decision making (in relation to issues such as building maintenance, adding physicians to the group etc.) also as voting members of the group.

Given the fact that both major types of group arrangement offer opportunities to participate in management (and in effect to control ones destiny) it is not surprising that group practices have become more popular as a whole. Moreover, it is likely that the trend towards group practice, particularly associate forms, will continue in the future, particularly since nearly half of all doctors approve or strongly approve of government granted low interest loans to physicians establishing group practices, while more than a third feel similarly about the establishment of financial incentives for groups delegating

“routine primary tasks” to ancillary personnel (York University National Survey of Canadian Physicians Data, 1986).

For many elements of the old middle class the development of industrial capitalism was associated with a transformation of the labour process organized along bureaucratic lines and the concentration of collective labour within factories. In such organizations, hierarchical managerial frameworks evolved to maximize the productivity of labour via the separation of conception and execution. In this context, many members of the old middle class experienced a transformation to new class “locations”—as capitalists, executives, or members of the new middle or working classes.

For professional workers, the imperative towards the maximization of productivity inherent in the bureaucracy is in direct contradiction with the tradition of autonomy associated with professional status. A classical statement of the inherent strains in the role of professionals within bureaucracies can be found in the work of Scott (1966) and has been summarized by Davies (See Figure 7.A)

Figure 7.A		
A model of professional/bureaucracy conflict		
	<u>Bureaucracy</u>	<u>Professionalism</u>
Task	partial, independent with others	complete, sole work
Training	short, within the organization, a specialized skill	long, outside the organization, a total skill
Legitimation for Act	is following the rules	is doing what is to the best of his/her knowledge correct
Compliance	is supervised	is socialized
Loyalty	to the organization	to the profession
Career	ascent in the organizational hierarchy	often no further career steps in the organization

Source: Davies 1978

As this figure illustrates, bureaucracies imply the existence of rule based, specialized tasks organized hierarchically and performed collectively. Within such organizational structures, professional authority will be based on expertise but elements of work will be subject to rationalization and control. Although one possible outcome of the interaction between professionals and bureaucracies is outright conflict, another possible outcome is accommodation to the roles expected in bureaucracies via an "acceptance" of the rules and even participation in the rule making process. The latter outcome seems to have been the experience of most Canadian physicians working in group arrangements. Contrary to the "proletarianization by bureaucratization" argument (McKinlay and Arches, 1985), it would seem that in Canada, a significant proportion of doctors working in group practices are much more likely to be either part of the new middle class (because they participate in management activities on behalf of others but still perform patient care) or part of the capitalist/executive class (because they are responsible for the overall direction of the group as "firm" and in fact are the primary shareholders in such arrangements).

Finally, those physicians who are purely on salary in groups owned by non-physicians (e.g., community clinics run by lay boards) are perhaps the most "proletarian" of all doctors since even though they exercise a good deal of technical autonomy in their work they play less of a role in the functions of management. Moreover, there appears to be a continuum of privilege with respect to the exercise of authority, ranging from high in bricks and mortar/associate relations, through private, pooled income groups to pure salaried arrangements (in the case of Community Clinics and Health Services Organizations).

Thus, while there has clearly been a trend towards group practice in medicine, it would be mistaken to suggest that all physicians in group practice are subject to the impersonal managerial authority associated with bureaucracy. Indeed, "group practice" in Canada encompasses several kinds of ownership and control associations, each with its

own implications for physician's capacity to make technical and administrative decisions and to control their own and others work. Today's group practitioners perform many different activities, occupy various formal and informal roles and maintain different kinds of relations with each other and with the organizations that employ them (Madison & Konrad, 1988).

Doctors can join these different group practices for a number of reasons. Some may do so because they wish to forego the right to make tactical and strategic decisions, opting instead for the security and relatively hassle free world of salaried practice. Other physicians might be more inclined to join group practices where there is a clear career path from salaried, non-decision maker to full partner with management responsibilities.

7.6. Conclusions

Several important points in relation to solo and group practice arrangements in Canada point to the ambiguous nature of the class fragmentation of medicine. Solo practice has become a larger and more complex affair with many solo physicians taking on the role of manager of their own and other (medical and non-medical) labour, and chief practitioner within the firm. These developments represent a tendency for these physicians to become small scale capitalists. Other solo physicians have, however, remained in the old middle class by virtue of the "small" nature of their practices, and the fact that they control and supervise a small number of employees.

As more solo physicians have become partially dependent on salaried arrangements located primarily in industry and hospitals, they appear to be taking on more management activities within these sites of labour. Despite their dependence on the wage relation, these doctors are really in two class locations. As salaried workers they are part of the new middle class since they perform management related activities in bureaucracies. Yet for partially salaried physicians, in that portion of the work period

where they are in their own practices, they belong to the old middle class, and may even tend towards the capitalist executive class as their practices grow in scope and size.

The proportion of physicians choosing (or being forced into) group practice has grown relative to those opting for solo or partnership forms; and there have been some important shifts in relation to the size and complexity of groups. The most important implications of these shifts for the class analysis of doctors are that depending on the arrangements, physicians working in groups could "belong" to any of the capitalist class, the executive fraction of the capitalist class, the working class or the new or old middle classes. Moreover, doctors class position could shift according to developments in their career as they gain more experience, accumulate capital (with which they may start their own practices), or move up within the hierarchy of the group practice.

There have been both shifts and continuities in the roles played by physicians within group practices, but in general the majority of doctors in group arrangements are enjoying technical autonomy while reaping the economic benefits associated with the close proximity of other doctors and related medical services.

The fact that doctors have a high level of control over their own labour and high involvement in decision making at strategic levels flies in the face of the assumption that salaried physicians in large bureaucracies are likely to be economically more working class in character than their private fee-for-service counterparts. On the contrary, many doctors in group and solo salaried arrangements are becoming part of management *per se* while continuing to enjoy technical autonomy. As Konrad (1988) argues, their authority as "individual" practitioners has been "preserved by the absence of strong executive authority within the clinics (and group practices) in favour of various forms of administration by consensus."

Group practice will more than likely continue to grow in popularity and within these configurations, doctors will likely remain as senior members of work teams in which, at the very least, they coordinate and unify the labour process. In addition, and

with the exception of Health Services Organizations and Community Clinics, they will tend also to perform the work of supervision and management either for themselves or on someone else's behalf. The overall degree to which they perform the function of capital will vary according to the extent to which they are dependent on the type of practice they join and whether they work in other practice forms as well.

Given that class relations are fluid and dynamic, and in the context of a theoretical perspective which emphasizes the formation, reproduction and dissolution of classes, it should be emphasized that the shifting class relations experienced by physicians in solo and group practices have been the result of their own self interested assertion in conjunction with structural and political change, both of which are ongoing processes. Accordingly, the future shape of authority and control relations within group and solo practices will be interesting to watch in the future. As group practices develop in organizational complexity under competitive pressures, and as the plentiful supply of physicians makes it less attractive to retain doctors by offering them share holding tenure in the group practice, some physician owned group practices may well hire doctors on a purely performance basis which might in turn entail a loss of autonomy and managerial authority for salaried physicians in these practices. The growth of associate practices suggests therefore that this practice form may offer some refuge from the threats associated with third party ownership, whether this be by a non-physician entity or physician capitalist-executives.

Similarly, in light of the gradual abrogation of solo practice and its concomitant transformation towards larger "businesses," solo practitioners may well be on the cusp of changes in class location from old middle class to new middle or capitalist executive class.

ENDNOTES

- ¹ It should be noted that many solo physicians also employ these workers on a part-time basis
- ² This finding coincides with those reported in Walters' (1984: 814) work but seemed to be considerably more pronounced in that employee wellness has, according to the doctors interviewed, become more of a corporate concern in recent years. The main reason for the increased interest in employee's well-being has more to do with increased productivity, reduced absenteeism and lowered (employer paid) health care premiums, than with humanitarian concern for employees. This represents another way that the work of physicians tends to be harnessed to fulfill the requirements of capital
- ³ Another possibility of course may be that these doctors may become employers themselves
- ⁴ In military hospitals, triage developed as a way of determining which patients were in need of immediate attention, which ones could wait and which ones were beyond hope. As such, it represented one of the first attempts by physicians to apply a theory of patient management in the field
- ⁵ In 1967, 43 per cent of group practices divided income equally, while 30 per cent took productivity into account and another 39 per cent considered the doctor's seniority (CMA, 1967: 20)
- ⁶ For instance, some doctors may see their practice in a hospital as a form of "group practice," while others are unsure as to whether an association of two physicians constitutes a group
- ⁷ The logic motivating this comparison is as follows. In the 1954 Health and Welfare data, doctors in group practices are defined according to the method of remuneration prevalent within that group. I extracted those physicians in group practices who were identified as receiving payment from pooled income. It was assumed that physicians receiving income from pooled resources would also be sharing patient files and expenses. These physicians were compared to the doctors in the York University data who were sharing patient files, expenses and income. Only doctors working primarily (more than 95 per cent) in fee for service practice were included in this category so as to provide the best possible fit with the 1954 data. Similarly, some physicians in the 1954 data set identified themselves as "receiving receipts from their own practice" although they still worked in "groups." Therefore, it was assumed that they were practicing in associations sharing expenses but neither income or patient files. These physicians were compared with doctors from the York data who were identified as "associate" practitioners sharing expenses but not income or patient files and who for all intensive purposes "appeared to be solo practitioners" although working in group arrangements. Again, for this year and category, only those physicians receiving 95 per cent of their income from fee-for-service were included to ensure the best possible comparison with the 1954 data
- ⁸ For instance, administrative tasks such as billing and patient record keeping are likely to be performed by administrative personnel, but it is more likely that computerized diagnosis will be performed by doctors. However there is no way of telling to what extent the latter tasks are being performed by non-physicians with knowledge of the diagnostic software
- ⁹ This conclusion is tentative however and requires further research
- ¹⁰ There are many names for these "community health centres." In British Columbia they are called Health and Human Resource Centres (HHRC's), in Saskatchewan they are known as Community Clinics (CC's), while Ontario has CHC's and HSO's. In Québec, they are called Centre Local des Services de Santé (CLSC's) or Local Community Health Centres (LCHC's). With the exception of Québec, these centres have grown slowly throughout Canada, and, even in that province, the vast majority of doctors are

on fee-for-service. Moreover, although they integrate social services with some medical care, the CLSCs' provide little in the way of physicians' services (Fulton, 1993, 19-22, 54)

CHAPTER EIGHT

PHYSICIANS, HOSPITALS AND THE MANAGERIAL DEMIURGE

8.1. Introduction

Hospitals have become one of the central institutions of industrialized societies, even supplanting the church and parliament (Anderson & Gevitz, 1984; Holzner and Marx, 1979). As transformations in the nature and functions of the hospital have occurred, its structure has changed fundamentally. These shifts in hospital structure and function, coupled with its accentuated role and increasingly bureaucratic nature, has had (and continues to have) implications for the economic class relations of physicians.

In terms of their functions, hospitals have made a transition from charitable "death houses for the poor" to prominent sites of health production which essentially facilitate the practice of modern medicine. As the central site of health production, the authority and control relations of the hospital have come under increasing scrutiny by those interested in the links between hospital structure and cost control, and the role of physicians in hospital management. From a sociological point of view, several commentators have focused on the relationship between physician, hospital structure and non-physician actors within the hospital (such as hospital management and para-medical personnel) as a means of determining to what extent, if any, doctors are being proletarianized.¹ These inquiries generally focus on the level of physician's subordination to administrative control and the effects of challenges to physician authority and autonomy represented by subordinate occupations and the rise of technology. This chapter provides a historical analysis of the changing relationships

between physicians and hospitals. It focuses on doctors' role in the management of hospitals and the implications of this role for physician's economic class relations.

8.2. The Hospital, Physician Dependency and the Rationalization Imperative

The historical tendency of the labour process to become increasingly appropriated by capital and concentrated within the factory have been well documented by numerous scholars. Although the production of health has come to be concentrated within the hospital, there are in reality few similarities between physicians (as people who work in hospitals) and the factory worker. These contrasts are based on some fundamental differences between the hospital and the factory. Unlike the typical goods-producing factory, hospitals (like many other services producing enterprises) are industries in which:

1. Defining and measuring output is difficult.
2. The work involved is felt to be more highly variable and complex than in other organizations.
3. More of the work is of an emergency and nondeferrable nature.
4. The work permits little tolerance for ambiguity or error
5. The work activities are highly interdependent, requiring a high degree of co-ordination among diverse professional groups.
6. The work involves an extremely high degree of specialization.
7. Organizational participants are highly professionalized, and their primary loyalty belongs to the profession rather than to the organization.
8. There exists little effective organizational or management control over the group most responsible for generating work and expenditures: physicians.
9. Hospitals (particularly in Canada and the United States) exhibit dual lines of authority, which creates problems of co-ordination and accountability and confusion of roles (Shortell and Kaluzny, 1983)

As will be shown, some of these points have important relationships to the way in which physicians carry out their work, yet, despite the differences between goods and services producing industries, there is one important similarity. Like factory workers, Canada's physicians have gradually become more dependent on their own factories —

hospitals—as centralized sites of production. In the Royal Commission Report on Medical Manpower in Canada, Judek (1964: 176) wrote:

In recent decades, there has been a trend towards the increased utilization of hospitals by private medical practitioners because of superior facilities, equipment and paramedical personnel in hospitals and also because family nursing care has decreasingly become available.

Since Judek's analysis of the characteristics of physicians in 1964, there have been few systematic and comprehensive Canadian studies of the time doctors spend in the hospital as a proportion of the time they spend in other work settings. However, we do know that there has been a steady increase in doctor's use of hospitals to provide medical services and a corresponding decline in the number of services provided in the physician's office. In 1974-75, services delivered by physicians occurred in their offices 75 per cent of the time, with the remaining one-quarter of services performed in the hospital. By 1987, the number of services delivered in the hospital accounted for one-half of all services delivered by doctors, with the remainder performed in offices (Health Information Division, Health and Welfare Canada). As well, in 1986 only 15 per cent of all physicians worked exclusively outside the hospital, indicating a high level of inter-dependence between hospitals and doctors (York University National Survey of Canadian Physicians Data, 1986).

The physician's dependency on the hospital is heightened by the "technological imperative" which permeates modern medical practice in that the latter's capital intensive nature has compelled the doctor to use prohibitively expensive hospital-based technologies which are virtually impossible to purchase privately. Thus even though there are now fewer acute hospital beds (for which doctors must compete), and trends

towards more day surgery, shorter hospital stays and fewer hospital patients overall, the number of services performed by physicians in hospital settings has increased relative to those performed in private practices (Shapiro, 1993: 88).

Cost cutting is the most fundamental challenge facing hospitals today, particularly in light of the perception that these costs are out of control, that future public funding is limited and that few hospitals have been accountable for costs until relatively recently (Rachlis and Kushner, 1989). The goal of making hospitals more cost effective and efficient has important implications for doctors.

In terms of the functions of labour within the hospital, there is substantial evidence that the physicians' dominance in many technical fields is being challenged by formerly subordinate workers. Canadian governments have long been aware of the potential gains in efficiency to be made via the substitution of physicians labour by less costly and (allegedly) equally efficient para-medical professions; most notably, midwives and nurse practitioners (NPs). A study conducted by the Canadian Hospital Association in 1985 concluded that hospitals of the future would have:

increasingly important duties for nurse practitioners and alternative providers, using intelligence systems to extend their capacity to treat people. (Moreover) The systems would make a wide range of knowledge available to various health professionals. Even some of today's software is able to diagnose better than a general practitioner can in some areas (CMAJ, 1985: 1319).

Although there are still relatively few nurse practitioners in Canada, between 1975 and 1983 the number of qualified nurse practitioners in Ontario almost doubled, from 79 to 131. More recently, claims regarding the cost-effectiveness of these and other paramedical workers as well as the potential gains in efficiency to be had through the use

of computers, continue to animate health care debates and will continue to challenge the medical profession's historical claim to dominance in the hierarchy of health care delivery (Lomas and Barer, 1989: 256).

At the same time, as pointed out in Chapter Five, the "managerial demiurge" is proceeding, largely unimpeded in the hospital. Protocols, paperwork and accountability permeate the hospital environment, and efforts to directly or indirectly control the pace and content of doctors' labour are increasingly evident.²

It is clear then that while doctors perform a significant proportion of the function of labour in hospitals they are not completely immune to challenges to their dominance within the hospital from "labour-saving technology," or traditionally subordinate professions and occupations. Nor are they immune to cost-control and efficiency initiatives (such as Total Quality Management) which has the potential of reducing control over their own work.

The key question becomes, how have physicians responded to attempts to rationalize the hospital? If doctors are the passive subjects of the "efficiency paradigm," then clearly a good case can be made for the argument that at least within hospitals, physicians are being proletarianized. But are physicians quiescent subjects? Are they in some way resisting these imperatives? Or have they in some sense embraced the objectives of hospital management? Clearly, these questions are linked by a common thread, namely, the nature of the relationship between doctors' roles in the hospital and hospital management. To understand this relationship, the rest of the chapter provides a historical analysis of the extent to which doctors perform the functions of management in

hospitals, the nature of this management, and the extent to which they are the subjects of management.

8.3. Changing Management Roles and Functions in Canadian Hospitals

Though they were once little more than warehouses for the sick poor, the hospital's transformation into a care giving institution and its capacity to deliver quality care was greatly enhanced by new techniques and concepts brought home by physicians and nurses returning from the First World War. Having seen first hand the advantages of a planned and systematic approach to patient treatment, when they returned from the war a few of these personnel took on administrative roles in hospitals and attempted to implement what they had learned. At the same time, this period witnessed the growth of the scientific medical model as well as significant advances in the overall health of the Canadian population, both of which lent increased credibility to physicians as a whole.³ Initially, however, hospitals remained relatively disorganized and were largely free of any government (or other) controls.

After World War Two, the growing functional importance of hospitals and their concurrent expansion created greater physician dependence on hospital technologies and personnel. Hospitals were rapidly becoming legitimate institutions of care as developments in antiseptic and aseptic techniques made it more likely that patients would actually leave the hospital better off than when they had arrived. Growth in the volume of surgery and its acceptance as a valid method of treating patients also invoked greater legitimacy for the hospital. As this occurred, refinements in diagnostic and treatment facilities (such as intensive care units) also developed, all of which were concentrated in

the hospital. The increased legitimacy and efficacy of the hospital, in conjunction with the growth of prosperity, also increased the willingness of patients from all sectors of the community (especially the middle class) to use the hospital. Nursing—which provided the bulk of labour necessary to the operation of increasingly busy hospitals on a day-to-day basis—was expanding and professionalizing. Doctors began to recognize the importance of the hospital not only to patient care but also to their own financial well-being. As they began to work more often within these institutions, the income they generated slowly began to replace the philanthropic donations that had previously functioned as the hospital's chief source of income (see Starr, 1982: 145-179; Agnew, 1976).

Because the hospital was becoming the central site of health production, efforts to improve efficiency and to accurately measure hospital output in terms of quality and quantity generated “the need for full-time managers (who) became more critical to the survival and success of the hospital” (Storch, 1987: 31-32; Smith, 1907). However, unlike the case of ideal typical factory workers, these developments did not *immediately* entail the development of an administrative hierarchy to which physician's would be subjugated.

Rather, the transformation of the hospital into a bureaucratic and accountable organization witnessed a *gradual* transformation of the relations between hospital administration and physicians. Their respective roles have gone through successive phases within which doctors have held a variety of perspectives on hospital management ranging from disinterest (and even disdain) to active participation. Writing about the

organizational history of one American hospital, Perrow (1963) characterized the development of these management relations in stages as follows:

1. Trustee domination: where hospitals were charities serving the poor
2. Medical domination: where physicians were becoming powerful actors in the hospital because medical knowledge was becoming more complex.
3. The administrative challenge: where a new breed of manager challenged physicians' authority based on the need for sound management practices and cost control, and;
4. Multiple leadership: in which trustees, physicians and hospital managers represent a co-operative triad of power within the hospital

This chapter utilizes the essential elements of Perrow's historical stages but collapses them into three phases that better capture the character of the Canadian experience⁴:

1. A phase of trustee domination in which the relationship between doctors and hospital management was virtually non-existent.
2. A phase characterized by the initial, though brief domination of hospital management by physicians and followed by the development of dual authority structures.
3. The contemporary phase in which doctors are encouraged to learn, practice and participate in the functions of management within hospitals. Because the dual authority structure still exists, and since new pressures are impinging on the organization of health care delivery, this phase is transitory.

8.4. Trustee Domination

The phase of trustee domination coincides with a period of Canadian history between the colonial era and the end of the 19th century. At this time:

Medicine had a limited basis in science and seriously ill patients were treated in the home whenever possible. Nursing care was given by friends and family according to the doctor's instructions. Hospitals were primarily charitable institutions for those who could not afford a private physician (Agnew, 1974:1).

Various religious and secular groups motivated by a humanitarian concern for the poor, or by philanthropy and charitable works, established non-profit hospital corporations. Essentially free from government control, conditions in these hospitals were often atrocious by today's standards and funding was a perpetual concern. These hospital conditions are vividly described in Agnew's history of Canadian hospitals (1974: 3):

In those days (1867) it was with the greatest difficulty patients could be induced to go into a hospital. It was the popular belief that if they went in they would never come out alive. No records were kept. The clinical thermometer had not come into use; the patients had to look after themselves; fresh air was not thought necessary. Armies of rats disported themselves about the wards. Instruments were looked after by a man who assisted in the operating room and at post mortems in the dead-house. Nothing was known of sepsis or antisepsis. Surgeons operated with dirty instruments and septic hands and wore coats which had been for years baptized with the blood of victims.

The administrative functions of the hospital were the prerogative of boards of trustees (or directors) while some nurses provided day-to-day management in their role as superintendents. Physicians merely worked in these institutions and had little to do with management issues. In addition, most procedures, including minor ones, were performed by the doctors themselves as nurses were not permitted to undertake any but the most menial tasks.

8.5. Dual Management Structures and the Relative Autonomy of Physicians

The beginning of the second phase of medical-hospital relations (1900-present), occurred in a context characterized initially by the development of medical knowledge accompanied by the changing functions of the hospital mentioned above. Physicians had

started to pay more attention to clinical as well as non-clinical management issues because they recognized that the hospital was becoming an undeniable fact of life in medical practice. By extension, ignoring the hospital would be tantamount to jeopardizing one's financial well-being. As well, the rise of positivist scientific methodology had reinforced the realization that there were important medical uses for statistics on factors such as patient mortality, the number of services delivered and in particular, on the effectiveness of doctors' colleagues. Thus if physicians had any concerns regarding management they were directed first and foremost at maintaining their own dominant position within the hospital as exclusive keepers of "valid" knowledge, and, from a clinical point of view, at making the hospital more effective in the treatment of patients.

It is in the beginning of this era, then, that physicians can be thought of as old middle class entrepreneurs using the hospital, its facilities and labour power as their own workshop. Within this context, doctors had already established the tradition of collegial control, in which it was understood that *self* management *vis a vis* clinical issues was essential to getting work done while maintaining one's independence. At the same time, somehow this had to be reconciled with growing non-medical management concerns that had the potential to conflict and overlap with doctors' objectives. By 1929 provincial governments were funding the majority of Canada's hospitals and they, along with the new profession of hospital administration, were rapidly coming to the conclusion that hospitals required better staff organization and more clinical controls (Agnew, 1974: 32). Doctors knew that if they were to continue as the prime actors in the hospital hierarchy,

they would have to embrace or co-opt management campaigns that potentially impinged upon their independence. Ultimately, the solution was found in the committee structure which now characterizes the modern hospital.

By implementing "control committees" physicians found a way to create a separate management structure within hospitals which functioned to police doctors and their colleagues in relation to clinical matters, while responsibility for non-clinical issues remained in the hands of non-physicians.

Although some doctors initially balked at the prospect of serving on committees because they were unremunerative and represented the practice of "judging" ones' colleagues, they eventually embraced the committee structure since it had evolved in response to demands for standardization emanating from the self-interest of assertions of organized medicine itself.

Prior to the 1950's, The American College of Surgeons, which for some time had provided standards for the Canadian medical profession, had stipulated standards of review for physician's clinical performance. However, they did not suggest administrative provisions for the actual implementation of these standards. In 1952, the American College of Surgeons, the American Medical Association, the American Hospital Association and the Canadian Medical Association formed the Joint Commission on the Accreditation of Hospitals (JCAH). In addition to fulfilling the function of standardizing hospitals, this organization specified that two committees -- the medical records committee and the tissue committee--be established in hospitals as a condition of accreditation (Roemer & Friedman, 1971: 40-41). In 1959, a Canadian

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equivalent of the JCAH, called the Canadian Council on Hospital Accreditation, was formed from an alliance of The Royal College of Physicians, The Canadian Medical Association and l'Association des Medecins de Langue Francaise du Canada (Agnew, 1974). Through these agencies, physicians were able to exercise control over hospital standards, and, as demands for homogeneity and standardization of services increased, the medical profession was able to exercise collegial control over physicians practicing in hospitals via the committee structure while remaining outside the authoritative scope of non-clinical managers. The latter, in the persona of hospital superintendents and bookkeepers, were generally responsible for the day-to-day hospital operations including purchasing, personnel relations, public relations, medical records, payroll and bookkeeping. At another level, the hospital board, composed of volunteers with "altruistic interests (and who had demonstrated) success in their personal careers" was responsible for initiating hospital policy which the superintendent would carry out (Agnew, 1974: 127). The resulting *dual structure of management*—with physicians making clinical decisions and policing themselves, and administrators and boards handling non-clinical matters—has characterized most Canadian hospitals since the 1950's.

Relations between these two spheres of authority were not always peaceful because in practice, the functions of these two management structures often overlap. Since the 1970's, the major areas of contention have been admitting privileges, payment arrangements of doctors working exclusively within the hospital, and medical staff representation on the board (Agnew, 1974: 108). Early attempts to make the hospital

more efficient resulted in demands from administrators for better efficiency from doctors. Most doctors complied with these requirements, but those who did not were denied hospital privileges. With the evolution of committees, granting admitting privileges became the sole right of physicians, with hospital boards essentially rubber-stamping these decisions.⁵ More recently, government perceptions of a surplus of physicians have created pressures on hospitals to carefully evaluate which doctors are to obtain hospital privileges. Restrictions have occurred accordingly.

Prior to hospital insurance, staff physicians working almost exclusively within the hospital, (such as radiologists, staff pathologists, psychiatrists and anaesthetists) frequently came into conflict over compensation issues. Because these doctors worked in areas that generated profit sorely needed by the hospital to operate its public wards and out-patient departments, the division of profit between the hospital and these in-house practitioners was often a contentious matter. These doctors were perhaps the first to acknowledge that while they spent most of their time in the hospital, they should be allowed to act as independent contractors within those hospitals. However, when the Hospital Insurance and Diagnostic Services Act (1957) came into effect, it guaranteed funding for hospitals under the conditions that hospitals "have legislation providing for the licensure, inspection and supervision of hospitals....(in return) the federal government agreed to pay approximately 50 per cent of authorized charges" (Agnew, 1974: 170). Hospitals receiving federal assistance were able to offset losses on low-income services, thereby making irrelevant discussions between hospital doctors and administration over rights to revenue.

As the hospital became more bureaucratic, medical staff representation on hospital boards gradually became more common as physicians began to see such positions as opportunities to influence the general direction of the hospital. But their participation in board activities was not without controversy. Detractors argued that medical staff membership on hospital governing boards would disrupt the efficient management of the hospital, rob it of its independence and damage its public image. Implicit in this argument was a perception that physicians were little more than hospital employees who, unlike the governing board, were not ultimately responsible for the well-being of the patient (Rozovsky, 1972). Although doctors had previously sat on these boards in advisory capacities, until the 1930's most did not sit as representatives of the medical staff. Eventually, as hospitals developed more medical committees made up of the heads of each medical service, many hospitals asked that the chair of these committees be a member of the board in either a voting or non-voting capacity. In this way, doctors could now influence the hospital's strategic direction. In this way, a small cadre of physicians now began to exert powers associated with the executive fraction of the capitalist-executive class.

Today, hospital committees have evolved into the most important vehicle by which doctors influence the operation of the hospital. Physicians participate in hospital management primarily through the committee structure, however, many of these committee's functions entail overlaps between clinical and non-clinical issues (Figure 8.A).⁶ Thus, doctors using the hospital are still working within the context of a dual authority structure—where one structure is associated with the hierarchy of the formal

hospital organization—administrative control—and the other is based on the authority and power of the physicians who work there—collegial control (Kralewski, Pitt & Shatin, 1985: 34-5; Blishen, 1991).

The main source of collegial control¹ derives from the hospital committee structure. For instance, non-staff doctors must obtain hospital privileges from the hospital board of directors in conjunction with the recommendations of the Medical Advisory Committee (MAC). This committee is usually composed of all chiefs of clinical departments and major sub-departments and divisions, and in some cases also includes members of administration, nursing departments and other departments. The non-physician members of a MAC have no voting privileges, effectively leaving control over the decision as to which physicians may obtain hospital privileges in the hands of other doctors. Other committees are charged with the responsibility to review the technical qualitative elements of physician's work. A Tissues Committee would be

Figure 8 A

responsible for examining the tissues removed by surgeons; the Medical audit committee would assess the overall quality of medical care provided by doctors while the Medical Records committee would evaluate the patient records kept by physicians (Blishen, 1991: 127). Staff physicians are also expected to participate in committee work (for which they are not paid) so that there is physician input into the short term functioning of the hospital.

Collegial control also acts to buffer the intrusive efforts of third parties and thus helps professionals to maintain their class position. The hospital affords the greatest opportunity for collegial control to be effective because physicians work in close proximity to one another.⁷ Within hospitals, however, a structure of peer control has evolved in which physicians are given administrative duties that entail the evaluation of performance *prior* to granting hospital privileges (i.e., in relation to the skills, training, and past performance of a physician applying and in the context of current labour power requirements within the hospital) and *after* the performance of medical work (i.e., through the evaluation of medical records and pathological evidence). Accordingly, the performance of day-to-day clinical activities is left relatively unscrutinized. As well, although most hospitals do conduct annual performance appraisals of physicians (see Table 8.1) where the board of directors most frequently reviews the physician's performance, in the past, the latitude for physician independence tends to be very wide.

Table 8.1	
Annual Review of Medical Staff Performance: Per cent of Canadian Hospitals 1987	
	<u>Per cent of Hospitals with</u>
Annual Performance Review	74
Formally Documented	67
Evaluation Includes	
Continuing Medical Education	83
Clinical	60
Mental	40
Physical	39
Other	21
Reviewed By	
Board	78
Chief of Staff	76
CEO	74
Credentials Committee	61
Medical Advisory Committee	56
President of Medical Staff	51
Chair of Department	32

Source: Derived from Leatt, Vayda, Evans & Barnsley, 1987: 38

Collegial control has also facilitated doctors' ability to extend independent, fee-for-service practice into the hospital to the extent that now, more than ever, hospitals can be viewed as "firms" in which there are clients, staff and a managerial structure. Indeed, some have argued that the hospital can be viewed as a physician co-operative, "run by and for its physician staff members" (Pauly and Redisch 1973). This contention is rather extravagant, however, since it implies that physicians in hospitals are highly organized and that they have a high degree of control over the administrative functioning of the institution. It is far more likely that physicians using the hospital as a site of production demonstrate a kind of relative autonomy with respect to the authority and decision-making structure of the typical hospital characterized by relative independence from managerial constraint but a capacity to influence the way in which the hospital operates. They have varying degrees of control over their own and subordinate labour, capital costs

and technology depending on the level of accountability required as to the quantity and quality of care delivered in the hospital. It is in this sense that the majority of physicians are *in* the hospital, but not *of* it.

Recently, a trend towards greater physician participation in hospital management and policy development has become evident—both the number of medical staff committees and the physician participants on these committees has increased and many of these committee responsibilities are directly related to non-clinical issues (see Leatt et. al. 1983; Noie, Shortell and Morrissey, 1983). The Total Quality Management initiatives now underway in a number of Canadian hospitals have helped to facilitate the process of co-opting doctors into management, or at least coercing them to agree with the need to rationalize hospital operations. Generally, this process of co-optation has been characterized by attempts on the part of hospital managers to emphasize the supposed “congruence of values” between Total Quality Management and medical science (Hassen, 1993: 63). Yet some physicians may be amenable to this equation if only because they feel that rationalization is inevitable. Indeed, according to an Angus Reid survey of physicians in Canada, 87 per cent feel that “in 10 years, funding bodies will scrutinize treatment patterns and require (doctors) to follow standard protocols” (quoted in Hassen, 1993: 58). It is not surprising, then, that some physicians while enjoying considerable influence in their clinical roles have also become an important part of the hospital’s strategic management team by taking on greater executive powers than most other doctors. At the same time, fewer than 10 per cent of all doctors spend no time participating in hospital committee and administrative work and the remaining 90 per

cent spend between one and ten hours a week (or an average of 12 per cent of their total work time per week) on this managerial function (Physician Manpower Questionnaire Data). A good portion of the work of these committees is directed at non-clinical issues requiring attention in order to fulfil medical obligations to the quality of services. In addition, however, increasingly many doctors participate in hospital management through their involvement in committees devoted *exclusively* to the non-clinical administrative operations of the hospital (Table 8.2).

Table 8.2 Physician Involvement on Hospital Management Committees by Province: 1987 A= Percentage hospitals indicating committee exists B= Percentage physicians share of committee membership							
	BC	Alberta	Sask.	Man	Ont.	Que.	Atlantic
<u>Long Range Planning</u>							
Has Committee (A)	52	56	47	39	55	49	36
Physicians share (B)	36	23	44	17	25	55	21
<u>Capital Budget</u>							
Has Committee (A)	47	48	43	39	55	38	31
Physicians share (B)	30	14	13	12	32	28	22
<u>Cost Containment</u>							
Has Committee (A)	21	14	17	18	15	13	17
Physicians share (B)	32	19	0	26	21	18	23
<u>Joint Conference</u>							
Has Committee (A)	90	90	93	80	90	83	83
Physicians share (B)	45	42	41	47	45	11	49
<u>Management</u>							
Has Committee (A)	53	45	35	53	77	66	44
Physicians share (B)	12	12	8	15	10	18	10
<u>Executive of the Board</u>							
Has Committee (A)	87	77	62	80	79	91	82
Physicians share (B)	3	5	3	3	13	15	5

source: Leatt, Vayda, Evans & Barnsley, 1987

Fewer physicians participate in the long-term strategic operations of the hospital (Table 8.3). Only about 3 per cent of all hospital CEO's are physicians, while Chief's of medical staff, who represent physicians and are therefore not as involved in strategic operations, are primarily physicians.

Table 8.3		
Medical Staff Involvement in Governance of the Hospital: Canadian Hospitals, 1987		
	<u>Position exists</u>	<u>Physician occupies position</u>
Chief of Medical Staff	88	87
President of Medical Staff	68	64
Director of Medical Education	19	16
Medical Director	18	15
CEO	90	3

Source: Derived from Leatt, Vayda, Evans & Barnsley, 1987: 45 (figures rounded)

Medical directors play an intermediary role, representing physicians' interests to the board of directors. In effect, there are various levels of physician executives. Ruelas and Leatt (1984) provide a framework for understanding these different levels. Top physician executives (such as CEO's) make decisions directly affecting the hospital and/or the staff and are responsible for all clinical and managerial activities performed by all physicians in the hospital. In class terms, they would therefore be considered to be part of the executive fraction of the capitalist/executive class. A second level, middle physician-executives, make decisions directly affecting activities at a departmental level, and are generally responsible for one or more departments, services or divisions. These doctors would also belong to the executive component of the capitalist/executive class, although they would have diminished powers relative to the top physician-executives. At another level, there are "first line" physician executives who make decisions directly affecting

specific programs or managerial decisions within a department for which they would be responsible. Importantly, these doctors are likely managing but without a commensurate reduction in clinical responsibilities.

Although they can make strategic and operational decisions to different degrees according to their level in the management hierarchy, these physician executives possess limited control over medical and non-medical labour power within hospitals is limited since the majority of these workers belong to unions. As Crichton et.al. (1990: 85) point out, hospital staff working in laboratories, rehabilitation services, food, linen and cleaning services are unionized and “managers have to observe contractual agreements carefully.”

Although a dual management structure has evolved in Canadian hospitals, these structures cannot be considered as “two solitudes.” When they work in the hospital, doctors play a double role. They are the clients of hospitals because they must earn and retain the privilege to work within them. Yet they are also managers of hospitals in the sense that they often direct the labour processes central to health care, make important meso-level management decisions (because so much committee work involves an overlap between clinical and non-clinical functions), and increasingly, macro level managerial decisions through their participation in non-clinical committees.

8.6. The New Managerialism—Physicians In and Of the Hospital

The outcome of the cost control imperative has not, so far, yielded the proletarianization of physicians *vis a vis* hospital work. Rather, the managerial functions performed by doctors in the hospital have shifted from self-directed *clinical management*

to more wide-ranging responsibilities directed at the administration of the hospital, and incorporating clinical issues.

At the same time the modern hospital continues to increasingly resemble a business organization complete with protocols, codified procedures and heightened demands for worker accountability. Administrative hierarchies have developed apace with the ongoing division of labour so that specific and diverse occupational positions (with equally specific interests) have evolved. In addition, as Chapter Five showed, the perception that health care costs cannot be funded in the context of the current fiscal crisis has heightened pressures on hospital administrators to control costs, thereby placing them in roles similar if not identical (in many respects) to those occupied by managers in the private sector.

The crystallization of the hospital as “firm” has been presided over by a cadre of health services executives trained in the techniques and perspectives promulgated in Masters of Business Administration programs. This new breed of manager is well trained in the roles and functions of modern management and espouses a discourse of “corporate rationalization.” In effect, hospital administration has become a profession itself. Between 1975 and 1985, for example, the number of graduates from programs for health service executives increased from 55 to 425. More recently, Statistics Canada has noted a 67 per cent increase in medical administrators between 1981 and 1986. In terms of their content, health administration programs have moved from:

an institution-based, vocationally-oriented focus in hospital administration to a broader, more academic focus on health care administration. The basic cognitive foundation for these broadened programs has been identified as policy evaluation and planning, applied social sciences and quantitative techniques (Storch, 1987: 47).

In conjunction with these developments, a new trend—regionalization—has important implications for physicians' ability to control hospitals. Despite the fact that hospitals have been dependent on governmental funding for years, they have traditionally been quite independent in terms of planning issues. Now, in another effort to streamline costs, improve efficiency and heighten accountability, many provinces are either planning or have already regionalized the boards of existing hospitals by creating one "super" board, with one budget and one executive director administering a number of institutions (see Fulton, 1993: 13-18). One implication of this trend is that the control and autonomy physicians now wield will depend in the future on the extent to which they are able to influence the controlling regional entity. Such control may be difficult to attain as board members will generally be elected or appointed by designated agencies. In this organizational scheme, physicians will be seen more as equal partners in health care delivery because they will merely be part of a "pool of players" who may be consulted, elected or appointed to regional boards. Their success will depend on the extent of their political acumen.

We have seen that because of their historically derived ability to construct a separate yet influential sphere of management (through the committee structure), and since the management of clinical and non-clinical issues so often overlap, physicians are successfully participating in the non-clinical functions of management.⁸ Yet the ongoing development of the hospital, an environment of fiscal restraint and the rising corporatization of hospital management, makes it likely that doctors will be faced with new challenges to their authority very soon.

The most recent phase in hospital-physician relations represents an attempt to integrate physicians into management by winning their loyalty and convincing them that cost-efficient hospitals are in their best interests. To achieve this managers and even the Canadian Medical Association are calling for physician training in management science, while those hospitals preaching the new religion of Total Quality Management are striving to “empower” doctors by increasing their involvement in strategic management, benchmarking and cost-benefit analysis practices. As one author puts it

Physicians should not feel they are without power. They have a great deal of it. They need not feel they will be ignored, but they should recognize that their advice will not be taken if it is inconsistent with the evidence, or is unacceptable to too many of the other major players. ...Even if physicians live in the past, the system will continue to examine the future and respond to new data (without physician input). If however, physicians develop a cadre of informed and respected leaders and staff, they will be able to significantly influence the rules and protocols that will continue to affect every physician....It remains for physicians to decide whether they will be among the users of existing data and of the data of the future, and among the major participants in the writing of new policy (Fulton, 1993 73-73)

Clearly, physicians are being asked to participate in the future creation of health care policy both inside and outside the hospital. Whether they will do so remains to be seen. In the interim, the doctor will remain the prime hospital actor since it is physicians who still decide on administration and procedures regarding treatment, who will give it, who will implement their prescriptions and what functions will be delegated and to whom.

8.7. Summary and Conclusion

Technically, the hospital does not employ most physicians. Rather, the key relationship between doctors and hospitals is in relation to access to the use or benefit of

the latter's equipment, facilities and ancillary personnel. This relationship places the hospital at arms length from most physicians as far as the employer-employee relation is concerned, and suggests that while doctors may increasingly be forced to act *as if* they are employees, most are in fact self-employed but dependent on the hospital. Accordingly, when they work in hospitals, and in terms of economic criteria, many doctors would belong to the new or old middle classes. Other physicians who take on greater management responsibilities within the hospital are in effect appropriating executive powers, although the proportion of those with higher level executive powers tends to be rather small.

At the same time, it is indisputable that the crisis of the welfare state has created heightened demands for accountability, cost control and efficiency within the hospital and that these forces constitute proletarianization pressures on physicians. But by simultaneously separating themselves from the non-medical structure of management while integrating themselves into a related but self-disciplined medical management structure, most doctors have so far been remarkably successful in maintaining autonomy and control over their own labour within the hospital.

In phase one of the historical relationship between doctors and the hospital, physicians trivialized non-clinical hospital management issues because they did not exist in any coherent form. In the intermediate phase, as the role and functions of hospitals widened, non-clinical management grew and at the same time attempted to "curb doctors' discretionary decision making" (Hunter, 1992: 557). The data that physicians were gathering in an effort to improve their clinical efficiency meant that they could create

their own, collegial management via the committee structure. At the same time it became clear that a significant component of the functions of the hospital would always be determined and controlled by physicians since so much of their clinical knowledge was essential to quality care, which, for the hospital manager is a *sine qua non*.

In the current phase, it remains to be seen whether and to what extent the dual authority structure will persist in Canadian hospitals in light of attempts to "co-opt" physicians to take part in non-clinical management activities and as pressure to control costs and ensure efficiency intensify. It is unclear to what extent these efforts to make physicians "buy in" to the managerial demiurge will be successful, given that doctors' individualistic ideology has meant that they traditionally do not see themselves as managers, nor as part of a responsibility structure (Gelmon & Mickevicius, 1984: 63). Moreover, despite the fact that two-thirds of doctors believe that there should be more emphasis in medical schools on business administration and office management, physicians are still not taught about budgets and cost controls, tend to be loyal first to the patient (not the institution), and, for those deriving income through fee-for-service, do not get paid (yet) to participate in management activities (York University National Survey of Canadian Physicians Data, 1986; Fulton, 1993: 114-115).

As developments in this phase of hospital-physician relations play themselves out, physician stratification (along class lines) within the hospital may become evident. Different groups of doctors may find that they have very different relations to the control structure of hospitals. Some may continue to utilize it purely as a "workshop" and will not concern themselves with administrative matters though they will likely be subject to

rules imposed by administrators, other physicians (in terms of collegial control) and physician-managers. The extent to which such rules come to dominate the health care scenario will play a role in the class relations of the medical profession. If rationalization is directed at areas of the hospital that do not impinge upon the work of physicians, they will likely continue to be new middle class because they will be dependently self-employed *vis a vis* the hospital. If on the other hand the rationalization process is applied to all components of the health delivery system, including physicians, (as is likely to be the case) doctors could well experience proletarianization.

The degree to which doctors recognize the inevitability of rationalization, and the way in which they respond to this will be critical to their class experiences. If doctors embrace managerialism they could become, in a much more formal way than they are now, managers themselves—thereby strengthening their position within the new middle class. We may soon see more CEO's and hospital administrators who are also trained physicians—thus placing a fraction of the profession within the executive component of the capitalist/executive class. Other doctors may also appropriate executive powers as senior managers within hospitals, while wielding small capitalist powers in their own practices. On the other hand, if doctors view the managerial demiurge as a threat to their incomes and autonomy, it will be difficult to convince them to become part of the rationalization process. In this scenario, we may see some physicians withdrawing their labour, protesting their loss of autonomy and resisting in otherwise typical “working class ways”

ENDNOTES

¹ For example, those leaning towards some variant of the proletarianization thesis include McKinlay, 1985, Coburn, Torrance and Kaufert, 1983, and Wahn, 1987, while Friedson, 1970, 1985, represents the most notable opponent of this view

² For instance, a computerized system called Medcomp has been available for nearly a decade and allows physicians and others to access information on virtually every aspect of internal medicine. "The doctor can enter a given patient's medical record into the computer and have it respond by laying out a variety of preliminary diagnoses with suggestions as to which are most likely to be relevant to this particular case" (reported in Woods, CMAJ: 1985a). The critical issue with technologies like this relates to its ability to be appropriated by non-physicians, particularly technicians, nurses and even lay persons, thereby reducing the importance of the doctor and certainly de-skilling his or her labour. There are now dozens of these programs available.

³ For example, between 1871 and 1921, the death rate per million in Canada dropped for many diseases including: tuberculosis (62 per cent), scarlet fever (86 per cent), typhoid (79 per cent), measles (79 per cent) and smallpox (89 per cent) (see Hamowy, 1984: 280)

⁴ It should be noted that by collapsing the rich and complex history of Canadian hospitals into three phases, some liberty has been taken in this chapter. Hospitals are extremely complex institutions and their history can be quite diverse. Nevertheless taking an abstract and essentialist view of the process of hospital development and physicians' role in this unfolding is the only way of determining the inter-relations between physicians and hospitals without undertaking a separate study

⁵ For an ethnographic account of this phenomenon and other issues of hospital governance, see Regan, 1991.

⁶ Deriving general organization charts of hospitals is difficult because no hospital organizes its staff exactly the same way. Nevertheless, this chart, which is a composite of several hospital organization charts, illustrates the typical structure of hospitals and doctors' roles within them

⁷ As previous chapters showed, in privately owned practices, whether group or solo, collegial control is less evident because physicians will generally lack the specialized competence to evaluate another's work, do not have opportunities to observe and evaluate that work and lack effective sanctions to reinforce their evaluations (Scott, 1982).

⁸ It should be noted however, that physicians who are given non-clinical management duties have traditionally been "reluctant managers" because they see such responsibilities as conflicting with clinical responsibilities. This reluctance is exacerbated by the fact that when physicians are given management responsibilities they are usually term positions which they are only too happy to relinquish when the term is over. At the moment, doctors simply do not see themselves as managers of the hospital. Moreover, the temporary nature of physician-administrator jobs implies that these doctors are continually learning the job or preparing to leave it (Scott, 1982; Storch, 1987; Gelmon and Mickevicius, 1984)

CHAPTER NINE

THE ROLE OF MEDICAL POLITICS AND IDEOLOGY

9.1. Introduction

Previous chapters have focused on the changing nature of physician's economic relations conceptualized in terms of the functions performed in the labour process and ownership relations. In terms of the economic definition of class, these changes represent a transformation of the medical profession from virtually uniform membership in the Old Middle Class, to a position where many members of the profession either are or are in the process of becoming part of the New Middle Class, the Capitalist/Executive Class or the Working Class. Thus, in terms of the economic dimension of class, the profession of medicine is not only in flux, it has become increasingly fragmented.

As Chapter Two argued, the class formation process consists of the dialectical interaction between politics and ideology on the one hand, and economic relations on the other. Accordingly, this chapter examines the nature of the ideological and political relations between governments and the medical profession between 1966 and 1986 as well as elements of medical professional ideology. I examine the shifting balance between compromise and confrontation characterizing the relationship between Canadian doctors and governments between the early years of Medicare (1962) and the mid 1980's. This 20 year time span also provides the context for an analysis of a number of job actions which occurred within factions of medicine as well as the profession as a whole, in response to various state initiatives to further control the costs of health production. It

will be shown that the strike as a strategy of resistance places many doctors in an ideological quandary since many physicians see strike action as either “unethical” or as a strictly working class (and therefore “unprofessional”) strategy. However, as doctors became less able to sway public and state opinion towards their cause, they became more amenable to the possibility of the strike as a weapon of resistance. More recently, the strike has become less desirable as a mode of resistance as many in the profession have realized the limitations of confrontational tactics. In understanding this, they have become more inclined to compromise with governments through collective bargaining clauses in their contracts.

It will also be argued that whereas the medical profession has traditionally and successfully used the ideology of science to reproduce their (economic) class position, the declining stature of the profession in general as well as the reduced allure of “scientific medicine” has made this increasingly difficult.

9.2. Doctor's Relations with Government and the Bases of Contemporary Political and Ideological Struggles

We have already seen that federal and provincial governments have applied economic constraints to the health care system because of the assumption that health care costs are “spiralling out of control.”

This chapter takes the position that the issue of whether or not health care costs are “spiralling out of control” is not as important as the political and ideological discourse which surrounds such debates. Put differently, what is important is the perception by governments that health costs are increasingly prohibitive. By the same token, the

medical associations that ostensibly speak for physicians have traditionally perceived that the health care system is under-funded. I will not deal with the issue of who is correct in the debate, since the issue of health costs would necessitate a separate study. Taken up here are the various political actions and strategies used by governments and physicians' associations in relation to the perception that costs are escalating out of control or that funding is inadequate.

Put simply, these perceptions are based on the fact that governments and physicians have different needs and interests. Government interpretations of data on health care costs are *prima facie* evidence of the need to monitor and control health care spending. They also serve to legitimate government's desire to act in a managerial capacity with respect to the health care system, since it is funded from the public purse. Caught in the bind of maintaining political face (in terms of their unwillingness to tamper with the five original principles of Medicare) while simultaneously facilitating capital accumulation, both federal and provincial governments have attempted to work out the uneasy balance between capital accumulation and legitimation by attacking less powerful components of the health care sector, or by imposing structural limits on health care costs (through the imposition of global hospital budgets for instance), or by transferring the costs of health care production to provinces, municipalities or employers.

A second key point of conflict between medical profession and the state arises from the problem of regulation. It will be recalled that initially many physicians bitterly opposed Medicare because it not only meant third party intervention in the relationship between patients and their physicians, but could entail the latter's loss of status as a

"rational self maximizer" in the free market. According to Evans, however, (1984:69), the regulation of health care professions, including medicine, does not really encompass the issue of a conflict between "state control" and "private enterprise." In his view, there has never been a free market, or free enterprise in medical practice in Canada, nor have private for-profit hospitals ever played any significant role. Since the state has been involved in the regulation of medical practice since its earliest days, the issue of regulation—or the determination of who is legally a physician, whom she may treat, and how they shall behave in the economic/professional market—has always rested with the state. And, in the case of medicine, the state has historically determined that physicians would be one group of professionals who would have the right to determine their own fate in these matters. This may be changing. According to Ostry (1978), there has gradually been a significant change in the public attitudes towards self-regulation. In addition "to a greater extent than ever before, people are making invidious comparisons, and questioning whether it is necessary and desirable to endow some groups with special powers" (Ostry, 1978: 466). One important expression of this phenomenon occurred in 1983, when the Health Services Legislation Review Committee of the Ontario Ministry of Health decided to strengthen the leverage of the state in terms of deciding who shall be legally considered a physician, and what kinds of activities they shall be allowed to perform. In their overview of recommendations, the committee stated their overall objective as being "the design of a new regulatory framework that will more effectively advance the public interest." The framework had four aspects:

1. The public must be protected from unqualified, incompetent and unfit health care providers to the extent possible.

2. Mechanisms must be in place to encourage the provision of high quality care.
3. The public should have freedom of choice within a range of safe health care options.
4. There should be scope for evolution in the roles played by individual professions, and flexibility in how individual professionals can be utilized so that the system operates with maximum efficiency. (my emphasis)

These recent guidelines are not that profoundly different from the old with the exception of the fourth aspect, which institutionalizes the concept of efficiency and opens the door to government intervention by allowing for the allocation of different health care workers to certain tasks previously performed exclusively by doctors. These rules have had major implications for physicians as well as other members of the health care professions. They allowed, for the first time, that doctors could be scrutinized by the Health Professions Board if patients were dissatisfied with the governing body's (usually the provincial College of Physicians and Surgeons) investigation of a complaint against a member. In addition, the number of lay persons on councils and committees of the College of Physicians and Surgeons were increased, hearings were made open to the public, colleges were required to file annual reports with the Minister of Health, and the College must publish disciplinary decisions and reasons. Finally, and perhaps most importantly, the Act lists specific licensed tasks and operations which may be performed by doctors. One of the main reasons this legislation was developed was to curb the "unnecessarily wide and ill-defined monopolies" resulting from self-regulation of the medical profession. In constructing the new laws, the members of the review created a situation in which other health professions that compete with medicine can now theoretically practice without limitation. In the past, this limitation has come from the

medical profession's definition of scope of practice, which has been very wide. Thus, any other care givers would be subject to the control of doctors since doctors decide what treatment can be given and how it should be supervised. In analysing the previous legislative model, the authors of the new recommendations stated that:

It necessitates hierarchical and therefore unequal relationships between licensed and registered professions. This produces tensions between professions and tends to inhibit cooperation...It inhibits innovation in how the various health professionals can be utilized: this makes it difficult for institutions like hospitals and community health centres to use combinations of health professionals that will provide the best service at the lowest cost (Schwartz, 1989: 14).

In sum, the new act gives the consumer as well as governments more power over the doctor than ever before. Nearly 30 years after doctors expressed concern over the technical aspects of medical practice stemming from political intervention by the state, their fears appear justified. At the time of this writing, the CMA is studying ways to respond to the legislation.

In summary, the bases of contemporary political and ideological conflicts between organized medicine and governments lie in the disjuncture between government's need to ameliorate the contradictions of capitalism by socializing health care costs while sustaining the legitimacy of capitalist relations in a context of fiscal crisis, and the profession's interests in sustaining their economic and technical autonomy.

9.3. Professional Ideology and Political Action

This chapter proceeds from a "critical conception" of ideology, in which the latter is essentially linked to the process of sustaining asymmetrical relations of power (Thompson, 1984: 4). Though it is not "pure illusion," (because it is partially constitutive

of what is real in society) ideology is fundamentally a *distortion* serving ultimately to justify and defend relations of domination. Accordingly, it especially assumes significance when relations of dominance are threatened.

Moving from this abstract conceptualization of ideology, we now need to look at elements of ideal-typical professional ideology. I have taken the position that professionalism is a “project” viewed as an attempt to produce and reproduce certain production relations between skilled labour (the professional) and the state/client. “Professionalism” amongst Canadian doctors is probably most adequately conceptualized as a process (the professionalization project) by which a “service ethic” ideology is constructed, and which, as chapter two argued, is ultimately a “sheer mystification of status claims and a device to silence the critics of monopoly, privilege and power to which professionals are alleged to cling” (Halmos, 1973: 6; and see Oppenheimer 1980). Significantly, the process of professionalization involves the sometimes successful attempt to impose closure over a body of esoteric knowledge in order to control the market for services. This, of course, cannot be accomplished without the willful compliance of the state. Similarly, the state is also instrumental in the granting of autonomy over such things as payment of fees, training and curricula, validation of credentials and ultimately over the exercise of work itself.

Typically, we might expect that professionals would espouse an ideology captured by the notion of “private competitive self interest”—an ideology which includes an aversion to big business and big government (even though there is a dependency relation

between the profession and the state), belief in the importance of competition within a free market context, and a high priority on financial and technical autonomy.

Before proceeding to examine the concrete translation of these notions into the lives of physicians, several caveats should be kept in mind. First, it should be noted that doctors' ideological beliefs are not homogeneous. As Stevenson and Williams note, there will be significant differences according to personal and occupational experience, subjective perceptions of threats to the role and status of physicians, their personal understanding of the meaning and priorities of health care and stress encountered in the practice of medicine (1989: 508). While such subjective and experiential differences are important correlates of physicians' ideology, this study is more concerned with broader notions of ideology as expressed in the political pronouncements of organized medicine (The Canadian Medical Association, the Colleges of Physicians and Surgeons) and in surveys of physicians' attitudes. Recognizing that this approach will not generally reflect the myriad individual perceptions and beliefs of the rank and file, in the absence of other kinds of data, it is difficult to do more. Moreover, as one physician put it

Our leaders (in the Canadian Medical Association) say a lot of crazy things sometimes. But if some idiot starts saying things publicly that many of us disagree with, we have to remember, he's our idiot....

Second, I am not suggesting that the elements of ideology examined here represent the totality of doctors' beliefs or the way in which they make sense of the world. Lack of data on elements such as perspectives on civil liberties, civil rights, tolerance, morality and other issues preclude a detailed (and therefore more comprehensive) examination of physicians' ideologies. However, the data that are

available permits a examination of some important dimensions of physician ideology, as follows:

Economic Autonomy

- The degree to which doctors experience and express “economic well being,” defined in terms of the achievement and maintenance of what they consider to be a reasonable income, and their perceptions/experiences of obstacles to such freedom. (e.g., “excessive” taxation.)
- The extent to which doctors feel they have “economic freedom”; to practice where they wish, and to treat whom they wish. The degree to which they value the “free market.”
- The extent to which they feel they have control over the supply of doctors

Technical Autonomy

- The extent to which physicians feel they have control over the quality of their work
- Their perception of the role of government and other third party intervention in the technical aspects of medicine.
- The extent to which they feel control over the way in which labour is carried out i.e., control over the labour process

Professional Status

- Their perception of their own status as professionals. The extent to which they are able to create a favourable public perception of the medical profession.
- Their perceptions of unionization, withdrawing services and other traditionally “working class” modes of resistance.

These aspects of physician ideology are important “lenses” through which physician’s make sense of the world. In the remaining sections I examine these beliefs as well as their political expressions.

9.4. Medical School and the Explicit Curriculum.

Beliefs do not develop in a vacuum, and for physicians, it is formal medical education that creates the basis of medical ideology (See Blishen, 1991: 77, Shapiro,

1978). Indeed, in comparison to the notion that there is a hidden curriculum in capitalist schools whose function is to create docile, compliant workers, the curriculum in medical schools *explicitly* promulgates “professional” values and principles of conduct centering on the notions of economic and technical autonomy and fostering a sense of entitlement.¹

As Blishen (1991:85-86) argues:

Should the students' role models, their teachers, stress the values of independence and autonomy in medical practice, particularly as they affect the content and socio-economic conditions of practice, there is a strong possibility that the graduating student will exhibit these characteristics as well. Thus, physicians entering practice will tend to filter their perceptions of the prevailing socio-economic conditions of practice through this ideology....The clinical-science perspective directs the physician to believe what he or she sees; the ideological perspective directs the physician to see what he or she believes.

The strength of these beliefs was further corroborated by the comments of three of the doctors interviewed for this study.

We are taught all our lives that we are at the top of the heap, and we literally make life and death decisions...it's no wonder that we think we are correct about everything, especially politics. Doctors have a kind of professional arrogance which comes from our training and our work.

Medical school teaches you to value hard work, and to make the correct choices (for patients) in a very stressful environment...it (medical school) deliberately puts tremendous stresses on the student...that's why when we get out into the real world we don't like to be told how to do our jobs or what they're worth....

We are the only people who can legally cut into your body....we have to be right about that (clinical matters), and (this) often translates into our lives...

It should also be noted that medical students tend to demonstrate a degree of similarity in terms of social background that also “provides them with some similarity of interests, values and attitudes, which is the basis of group support....”(Blishen, 1991: 83).

Thus, medical school not only teaches students how to be good physicians, but also teaches them the elements of professionalism which will underpin much of how they perceive the working world. Having developed a strong sense of these values in medical school, what shape do these beliefs take in the world of work?

9.5. The Politics and Ideology of Economic Autonomy

As noted earlier, physicians do not often quarrel with the data provided by governments, only with governments' interpretation of this data. They contend that the health care system is based fundamentally on the concept of "needed services." What is needed, they argue, is more services, more technology and more facilities to respond to the growing demand which they perceive to be characteristic of modern medicine. In part, their arguments about needs are very much related to their ties to the new technological breakthroughs characterizing twentieth century medicine as well as their genuine concern over the welfare of patients. But it cannot be denied that the concept of needed care is also an income maximizing strategy. Not surprisingly, medical political discourse rarely acknowledges the fact that it is the medical profession itself which identifies and generates this need.

Doctors have earned approximately three to four times the average industrial wage since 1941. (Table 9.1) Despite this continuing trend in high incomes, provincial medical associations as well as the CMA argue that both academic and governmental estimates of physicians' incomes are not only grossly misrepresentative but also foster public misunderstanding of doctors' real situation. This construction of the "big lie" as one doctor put it, is creating a situation in which the medical profession is rapidly losing

its public esteem. Moreover, 81 per cent of physicians feel that other professional incomes are increasing at a significantly faster pace than the incomes of physicians, a claim which does not seem to be substantiated by data on the earnings of other professional groups (Table 9.1) (York University National Survey of Canadian Physicians Data, 1986). The data also clearly show, however, that while physicians' incomes have been high relative to other professional groups, there has been an overall decline in incomes since the 1970's. It is not surprising then that much of the political and ideological activity of medical associations has focused on wage issues since this time.

Table 9.1
Earnings of Selected Self Employed Professionals Relative to Average Weekly Wages and Salaries: 1946-1981

<u>Year</u>	<u>Doctors</u>	<u>Dentists</u>	<u>Lawyers</u>	<u>Engineers</u>	<u>Avg. weekly wage x 50 (\$)</u>
1946	4.60	3.26	4.02	3.68	1624
1956	4.05	2.85	3.92	4.23	3222
1966	5.19	3.57	4.37	4.40	4817
1976	4.32	3.80	3.93	3.56	11402
1981	3.87	3.52	3.20	2.47	17736

Source: Evans, 1984:138

There are other reasons for doctor's defensive posture in terms of income levels. First, doctors claim that they tend to enter the labour force later than any other occupation, and therefore their total lifetime earning potential is shortened. Moreover, in their study of medical attitudes, Stevenson and Williams (1985: 510) found that on a five point scale, with a score of five representing "strongly agree", doctors scored 4.34 in response to the statement that physicians are losing economic ground. However,

although this general perception is obviously held by many doctors, it tends not to be substantiated by data on income levels. Ruderman (1973: 4) has found that

not only do (doctors) earn more than the members of other independent professions, but their earnings are high enough to compensate for a later start and result in the highest level of lifetime earnings as well.

Second, a consistent theme amongst the physicians I interviewed was that the high costs of practice overhead do not permit them to earn a reasonable standard of living. The Health Services Review (chaired by Emmett Hall) in 1980 reported that "it is accepted by the Income Tax authorities that the gross income of physicians includes some 40 per cent of expenses incurred in earning that income (Hall, 1980:27). The York University National Survey of Canadian Physicians data tends to corroborate the difficulty of sustaining private practice in that 37 per cent of salaried physicians feel that the need to maintain an adequate income is a significant source of stress, while fully one-half of fee-for-service physicians feel the same way.

Third, doctors argue that the tax system in Canada does not allow them enough leeway to permit the accumulation of wealth. In several interviews with physicians, I determined that the source of much frustration with the taxation system is rooted in attitudes which are best described as "private, competitive, and self-interested," which can be further linked to the belief in self-dependency, individualism and ultimately laissez-faire capitalism (see also Colombotos et. al 1975; Mechanic, 1974). Others have substantiated the existence of this attitude in their studies of medical perceptions of the Medicare system. For example, Stevenson and Williams (1985: 512) surveyed the attitudes towards Medicare of more than 2,000 physicians and found that:

Professional criticism of Medicare is grounded more in a principled opposition to government involvement in health insurance than in negative evaluations of the conditions of professional practice or the standards of medical services under Medicare, and there is strong support for the increase in proportion of private financing of the health care system.

Physicians tend to support some important *elements* of free market ideology while recognizing that Medicare, as a program firmly entrenched in the politics of the welfare state, is of critical importance to their economic well-being and that of their patients (Table 9.2). Sixty-one per cent of physicians believe that Medicare has positively affected the health of Canadians (York University National Survey of Canadian Physicians Data, 1986). Even though 40 per cent of all physicians feel that "Medicare has resulted in a direct loss of physician control over medical decisions," doctors nevertheless support the principle of Medicare (statements 1-3), but are not as supportive of government involvement (statement 4). In particular, fee-for-service practitioners are more supportive of the involvement by third party private insurance carriers as the payors for medical care. As well, physicians indicate greater support for the use of private for-profit management firms in hospitals (statement 5) although salaried physicians, many of whom work in hospitals, are less supportive on this issue because it entails losing the authority they presently enjoy. Finally, few doctors are willing to allow competition from midwives or nurse practitioners. Taken together, the data on these beliefs paint a contradictory picture of physician ideology and corroborates theoretical arguments that ideologies are in themselves quite contradictory. In effect, doctors support a centralized

Table 9.2
Salaried and Fee-For-Service Physician's Opinions on Dimensions of Free-Market Ideology: Canada, 1986 (Per cent)

Statement	<u>Disagree/Strongly disagree</u>		<u>Agree/Strongly agree</u>	
	Salaried	fee-for-service	Salaried	fee-for-service
1. Centralized planning of health care is necessary to determine an optimal distribution of services and resources	14	30	52	44
2. Market forces alone should determine the mix and distribution of health care services and facilities	70	48	14	29
3. The Medicare system should be returned to voluntary and commercial control	70	45	13	33
4. Private insurance carriers should be allowed to cover services now covered by Medicare	40	22	41	64
5. Hospital management by private for-profit management firms should be permitted	58	36	22	44
6. Medicare regulations should be changed to allow nurse practitioners and midwives to be paid on a fee-for-service basis	51	61	22	15

Source: York University National Survey of Canadian Physicians Data, 1986
 Percentages do not add to 100 due to "neutral" responses.

health care delivery system not only because they believe that this system positively affects the health of Canadians but also because it ensures physicians are paid. At the same time, however, they support privatization of at least some aspects of the health care system indicating some appreciation of free-market ideology. Yet this appreciation is only piecemeal, as indicated by their strong *opposition* to competition and a concomitant appreciation of the monopoly over the "legitimate" medical services they now hold.

In terms of practice mode, fee-for-service physicians are more likely to indicate opposition to centralized planning, show more support for free market forces, voluntary

and commercial control and privatization (in the form of private insurance and for profit hospital management) and less support for competition which might threaten their monopoly position. Accordingly, it can be convincingly argued that at least on these dimensions, fee-for-service doctors are more "conservative" than their salaried counterparts.

Doctors also espouse an ideology of professional individualism in which technical autonomy and some aspects of economic autonomy are highly esteemed. One important illustration of the latter is evident in the physician's traditional concern, since the legislation of Medicare, that the right to extra-bill should be preserved, even though most physicians claim they did not extra bill.² However, many continue to argue that the extra-billing component of health regulations allowed doctors a kind of safety valve, which enabled them to opt out of socialized medicine if their conscience did not permit them to agree with the principles of Medicare, lest those principles entail the establishment of a real wage-labour relation with the state. Importantly, the fact that one-third of doctors believe that the ban on extra-billing has resulted in a deterioration in the quality of medical care also illustrates the extent to which physicians have internalized the notion that there are linkages between financial autonomy and quality of the "product." Accordingly, for a great many physicians, the right to extra-bill was justifiable because it not only represented economic freedom but also had an impact on the public's health.

The extra-billing luxury was eventually withdrawn as a result of the recommendations of the second Hall commission report in 1980. An open letter from W.D.S. Thomas, then president of the Canadian Medical Association, to all members

argued that organized medicine was generally in support of the recommendations of the Hall study in terms of the fact that provinces were clearly spending federal money earmarked for health care on other things; that Established Programming Financing was essentially a good funding mechanism, and that the “have-not” provinces could deal with financial shortfalls by a 50/50 cost sharing mechanism as Hall had recommended, or by some other mechanism; and importantly, that Hall agreed with the profession on a position “we have held for years, that health care costs are not out of control—indeed the programs have been underfunded; lack of portability has caused serious problems for patients and physicians, and that the health insurance system should have a national character”

Thomas also argued that physician payment levels have been suppressed, that physician incomes in comparison with other professional groups had been dropping; and that a medical manpower study was essential. The important issue the CMA disagreed with, however, pertained to the issue of extra billing (which Hall himself called the dominant issue) in which it was argued that banning extra-billing would create a profession of *de facto* civil servants. All 193 members of the CMA general council unanimously rejected the proposal that all direct personal responsibility for the payment of health care costs should be eliminated, that all health care costs be paid by government from taxation revenues, that payment for physicians services come from that one source and if necessary be determined by compulsory arbitration. They argued that such proposals would not be in the best interests of the public or the profession. The implementation of such a program would move the doctor from an “independent”

employee legally and otherwise responsible to his or her patients, to a government retained independent contractor. In an interesting repetition of the arguments made more than two decades ago, the president stated that:

In a very real sense Mr. Hall is recommending that *health care insurance*, which the medical profession of Canada has pioneered and strongly supports, should be abandoned in favour of *state medicine*. (Message from the President, October 1980: 2)

Significantly, the president also felt that if Hall's recommendations were to become law, physicians would inevitably seek the protection of unionization rather than the "current voluntary association of self employed professionals". He said:

In case that unfortunate decision is made by governments, CMA general council has directed the board to explore the potential benefits of unionization of the profession, with attention to such issues as defined hours of work, premiums for hours on call, overtime, weekend and holiday service, standardized working conditions and grievance procedures, indexed pensions and other fringe benefits that are available to state employees. (Message from the President, October 1980: 3)

The conflict over extra-billing illustrates clearly some of the key elements of physician's professional ideology in relation to economic issues, and in particular its contradictory nature. They express a commitment to the ideals of individualism and "free market ideology" but also a general acceptance of the economic benefits to be gained from a publicly funded health care system and a willingness, at least in rhetoric, to utilize a proven form of (working class) resistance if push comes to shove.

Whatever the efficacy of medical care may really be, and despite any real attachment doctors may have to an ethic of responsibility towards patients, many doctors are also fundamentally interested in preserving what they consider to be an unambiguous although threatened status as self-employed businessmen and women. Economic issues

are couched in terms like “freedom of the individual”, “free enterprise” and “independence,” and are expressed in terms of the potentially negative impact on public health of doctors’ diminished economic freedom. It would seem that many doctors espouse the norms and values which comprise this ideology of “rugged individualism,” to attempt to reproduce or increase their economic advantages relative to other occupations and professions.

9.5.1 Physicians, Unionization and The Strike

To address both economic and technical autonomy issues, Canadian doctors have increasingly engaged in open conflict with governments and hospital management over the level and delivery mechanisms of fees, the freedom to choose where to practice and whom to treat, as well as perceived interventions into their technical domain. In the majority of cases the outcomes of these struggles have, from the point of view of physicians, been successful—resulting in the reproduction or supercession of their economic class position.

Before Medicare, the profession relied on a loosely drawn up schedule of fees which gradually and in an ad hoc manner became acceptable to the profession on a nationwide basis. Since governmental involvement in health care, the profession has had to bargain with the state over the level of fees and types of services for which they can legitimately charge. Bargaining sessions in which governmental representatives sit down with a provincial medical negotiating committee to hammer out a bargain typify recent sites of conflict.

Importantly, the state has seen these negotiations as ways to control physicians incomes first, and costs of health care second, a strategy which doctors clearly understand and recognize.³ Indeed, at a 1985 conference sponsored by the CMA on Negotiations Policy, the British Columbia delegation argued that health care costs are not out of control and that increased utilization is really the main issue. Moreover, they argued that meaningful negotiation between governments and the profession would not be possible without both sides sharing “factual information” (Canadian Medical Association 1985:5) In effect, the government’s strategy was seen to be:

1. Absolute control over the costs incurred by hospitals through global budgets and quarterly reviews
2. Control over labour power via the claim that there was a surplus of doctors and the use of billing numbers as the mechanism of control
3. Little or no increase in fees
4. Making doctors responsible for utilization, and,
5. The threat of legislation if these mechanisms failed or were contested.

In Table 9.3, recent uses of these kinds of mechanisms to control costs is broken down by province for various years between 1985 and 1987.

It is significant that doctors agreed with government that increased utilization was mostly to blame for the increased costs of health care in Canada, but that patients, not physicians were responsible for these increases. This disavowal of responsibility was justified by attributing increasing utilization to population increases, increases in the

Table 9.3
Recent methods of cost control by provinces, various years

Province	Government Strategy
Newfoundland	Post 1979: low fees relative to other provinces resulted in successful negotiations over fees
Prince Edward Island	1987: threat of billing number restrictions. Averted for time being
Nova Scotia	post 1985: successful negotiations over fees
New Brunswick	1987: selective opting out allowed
Quebec	Post 1987: Income controls placed on doctors
Ontario	1987: successful negotiations
Ontario	1993-4: caps on physician's fees
Manitoba	1987: possible restriction of billing numbers. Medical Association is suggesting alternatives.
Saskatchewan	1987: cap on global budgets, 10% roll back in fees
Alberta	1987: possible restriction of billing numbers.
British Columbia	1987: attempted restriction of billing numbers

Source: Proceedings of an Invitational Meeting on Negotiating Strategies and Utilization: CMA, October 25, 1987, Ottawa.

number of doctors and "natural" increases of about 2.5 percent per year in utilization by patients. What is significant about these kinds of disputes is that doctors tend to forget that their income is in actuality a public cost. Much of the rhetoric surrounding often shrill cries from physicians that the government is attempting to hold down doctors incomes often ignores that increasingly, governments do not see doctors as quasi-self-employed professionals, but as employees whose services are costing the "firm" too much.

The nature of conflicts between Canadian physicians and their "employers" is an important indicator of the extent to which doctors can be seen not only as "rational self maximizers," but perhaps also as concerned to protect their technical autonomy by securing the economic terms of practice (Naylor, 1986: 246). It also indicates that increasingly, the state has become more comfortable with the notion that doctors are state employees.

Since the 1962 doctors' strike in Saskatchewan, there have been a number of clashes between the organized profession and the state (Table 9.4). The vast majority of conflicts between the medical profession and "management" involves doctors' economic autonomy. Even in those cases where technical autonomy was an issue, the question of remuneration, or control over fee schedules, also figured prominently. There also appears to be an important pattern to the outcomes of conflict between governments and the profession. In all cases except for Quebec in 1970, governments have either completely capitulated to professional demands, or have attempted to work out a compromise with the profession.

In most cases where there has been a compromise between the profession and the state, doctors have been able to negotiate resolutions which ultimately favour the profession in some important ways. For example, the outcome of the 1986 strike over Bill 94 which banned extra billing in Ontario should not only be viewed as a "public" victory (in the sense that the government refused to back down and doctors eventually went back to work) but also as a "private" victory for the medical profession. The Ontario physicians were able to maintain their incomes and virtually all their traditional

powers, and most importantly, won guaranteed freedom from future government action from the Liberal government in relation to choice of practice location and volume of services. In effect, the outcome of the strike was to severely limit the effective capacity of the government to control costs by regulating physicians (York, 1987:31-33).

When pressed for information about doctors' strikes, some provincial medical association authorities were very reluctant to admit that such action had ever occurred. They preferred to redefine physicians' actions at moments of crisis as relatively benign protests rather than strikes, job actions or sanctions against government. The Manitoba Medical Association simply stated that I was "misinformed" and that "doctors have never gone on strike in Manitoba," even though they did in 1981 and 1982.

Similarly, the Saskatchewan Medical Association reported that:

In 1986, there was some talk by the physicians of Saskatchewan for the "withdrawal of medical services," but the word "strike" was a news media ploy which was an anathema to the medical profession here. One may argue that they are both one and the same thing but anyone who can really grasp the situation could but conclude that in reality they are indeed not the same. (personal communication with Communications Director, SMA, 1989)

In these quotations we see that some evidence that the medical profession is often ideologically unable to support the notion of the strike as it is usually understood—as a strictly working class form of action. Indeed, doctors' adherence to the position that they are taking "job action" rather than striking is revealing in its indication of the extent to which they embrace an ideology which is between (in some sense) capital and labour. Understanding that they are financially dependent on the state (as *de facto* piece work employers) while at the same time in many ways "different" from organized labour,

medical associations have been placed in a contradictory situation when it comes to bargaining over economic and technical issues.

Indeed, in the past, medical associations have taken the position that the strike as such is unethical, not to mention unprofessional. For example, in 1965, the Ontario Medical Association stated that doctors and other professionals had historically formed professional associations to lay down qualifications of entry into the profession, but did not act as trade unions or enter into collective bargaining mainly because most of their members worked in private practice receiving fees from clients or patients, and essentially having no employer with whom they could bargain. But with the new medical relations of production accompanying Medicare, medical associations have represented doctors interests and bargaining resembling that between unions and manual workers and employers has taken place. That doctors' participation in collective bargaining is a question of status is illustrated by the advice given by one contributor to an Ontario Medical Association document on Collective bargaining:

....the real question over the issue of collective bargaining is one of attitude, of personal values and inclinations...you cannot have collective bargaining unless you are prepared to surrender a measure of personal independence. The interest of the individual must be subordinated to the interest of the group, or group action will not be meaningful. Second, you may not want to belong to a group which calls itself a trade union and includes in its membership persons who are not professionally trained. (Ontario Medical Association, 1965: 31)

Table 9.4
Selected Strikes and Sanctions by Canadian Doctors: Issues Involved and Outcomes, 1962-1986⁵

<u>Actors Involved and Year</u>	<u>Issue</u>	<u>Action</u>	<u>Outcome</u>
Saskatchewan M.D.s 1952 / PG	EA / TA	23 day strike	Agreement compromise
Quebec Radiologists 1967 / PG	EA	resignation of 205 doctors	Agreement compromise
Quebec Specialists 1970 / PG	EA	all on strike for 10 days	Government legislated doctors back to work October Crisis played important role
Quebec General Practitioners 1975 / PG	EA/TA	Rotating strikes for 7 months	Profession won concessions
Manitoba Salaried M.D.s 1975 / PG	EA	70 M.D.s on strike for 2 weeks	Profession won concessions
Lunenburg Hospital Staff 1980 / HA	TA	strike for 10 days	Profession won concessions
Surrey Memorial Hospital B.C. 1980 / HA	TA	withdrawal of service on hospital committees 3-4 months	Agreement compromise
Ontario Interns and Residents 1980 / HA	EA/TA	withdrawal of services in varying degrees	Profession won concessions
Quebec Specialists Chicoutimi 1981 / PG	TA	153 M.D.s on strike for two weeks	Profession won concessions
British Columbia Medical Association 1981 / PG	EA	Withdrawal of services recommended by BCMA. Physicians balance bill for 10 days	Agreement/compromise
Manitoba Physicians, 1981 / PG	EA	One day study session by one-third of province's physicians 40 M.D.s close offices for 6 days	Agreement/compromise
Quebec G.P.s 1982 / PG	EA	walkouts, no weekend or evening hours kept. boycott of hospital committee/administrative work. resignations from hospital staff	Government ordered doctors back to work
Ontario Physicians 1982/PG	EA	Rotating office closures (three months), withdrawal of routine services (two days)	Agreement/Compromise
Manitoba 1982 / PG	EA	Rotating office closures for 4 weeks	Agreement/compromise
Ontario Psychiatrists (in public Hospitals) 1985 / PG	EA	Withdrawal of services	Agreement/compromise
Ontario Physicians 1986 / PG	EA	24 day walk out	Agreement/compromise
Saskatchewan, Prince Albert Anesthetists, 1986 / PG	EA/TA	Withdrawal of non-emergency services	Agreement/compromise

Source: Derived from Alföldi, 1981 and unpublished documents, Department of Medical Economics, Canadian Medical Association, 1983

KEY		
PG : Provincial Government	EA : Economic Autonomy	
HA : Hospital Administration	TA : Technical Autonomy	

In terms of the tendency for doctors to exhibit “union-like” behaviour, physicians tend to eschew what they consider to be “labour union style” actions to produce more favourable income settlements (Table 9.5, and also see Stevenson and Williams, 1989: 512). In addition to an aversion to all out strikes or job action, doctors in various provinces are seriously considering the merits of collective bargaining and support binding arbitration as ways of resolving disputes between government and medical associations over fees.

Table 9.5 Tendency Towards Union-Like Behaviour: Salaried and Fee-for-Service Physicians in Canada, 1986				
Support for....	<u>Salaried Physicians</u>		<u>Fee-For-Service Physicians</u>	
	Approve	Disapprove	Approve	Disapprove
Binding Arbitration in event of deadlocks in fee negotiations	78	7	71	13
Withdrawal of non-emergency services in event of inadequate income settlements	18	71	31	56
Reconstitution of medical associations as labour unions	23	45	31	49

Source: (York University National Survey of Canadian Physicians Data, 1986)

Viewed in terms of mode of remuneration, fee-for-service and salaried physicians both tend to approve of binding arbitration as a method of dispute resolution. Curiously, salaried doctors (whom one would expect to be less adverse to strike action because of their more “proletarian” condition), are less likely to favour withdrawal of services than their fee-for-service counterparts. Similarly, salaried doctors are less likely to approve of the reconstitution of medical associations as labour unions. While there is no ready

explanation for this, it is possible that as "organization men and women" salaried doctors have greater commitment and loyalty to their employers and enjoy a greater sense of stability *vis a vis* job and income security. Moreover, because many of these individuals practice in bureaucracies, they are more likely to ascend in management (or at least internalize the objectives of the organization) and advance the aims of the organization (McKinlay and Arches, 1985). Accordingly, they may be less likely to see unionization and striking as valid methods of resistance compared to their fee-for-service counterparts because they are more comfortable in their roles and less uncertain about their future. At the same time, because they may feel greater pressure to defend their economic condition, fee-for-service doctors may be more prepared to surrender personal independence to be part of meaningful collective action.

As for methods of dispute resolution, doctors are more inclined to favour binding arbitration than collective bargaining, primarily for ideological reasons. Collective bargaining is seen to involve negotiation between an association of members (employees) and a set of representatives from these members who are authorized to bargain on behalf of the membership, over issues such as job conditions, wages etc. But importantly it is also seen to be typical of union behaviour. Arbitration on the other hand involves the appointment (preferably neutral) of a third party who weighs the pros and cons of each party's arguments, and then arrives at a decision binding on both parties. It tends to be the way that professionals like to have disputes solved, despite the fact that a recent survey of 30 physician-negotiators revealed that collective bargaining is favoured slightly

higher than binding arbitration as the negotiating mechanism of choice (Adams, CMA Survey, 1985).

9.6. How Many Doctors?: The Politics and Ideology of Patient Choice, Practice Location, and Labour Power Planning

Doctors have always exercised great discretion in terms of who they treat.

However, as we have seen in Chapters Six and Seven, recent developments in the organization of practice have slightly altered this situation. Some salaried doctors, especially those in community clinics, have less opportunity to choose their clientele. In community and other types of clinics where doctors are paid on a capitation basis, the remuneration of doctors is not dependent on the number of patients he or she treats. Instead, a fixed amount of money (a salary) is advanced to the physician who must treat whomever walks through the door of the practice. As we have seen in previous chapters, the degree of economic and technical discretion is lowest for those physicians working in community clinics. It is not surprising that physicians are reluctant to approve proposals for the funding of such community-based alternative models of health care delivery (Williams, 1987:17).

As shown earlier in this study, despite the slight increase in the absolute number of physicians who are involved in this form of practice, the overall percentage of doctors who are salaried has remained approximately the same as it was in 1962. For the remaining 70 percent of doctors, and unless all physicians were to be placed on salary, the issue of who they may treat is essentially a non-issue in terms of their political or ideological activity.

The same cannot be said for the issue of where doctors may practice. As Canada's population has increased, the availability of physicians has also grown, although there are some important provincial differences. In British Columbia, for example, there has always been above average physician availability relative to the rest of Canada.

To a large extent, the low physician to population ratio in that province has meant that the government has had to redirect doctors to rural areas. Consequently, there has been some political resistance by B.C. doctors who have argued that such tactics violate fundamental rights accorded to every other kind of worker. In the late 1980's physicians in this province took the issue to the B.C. Supreme Court which decided that such government action was "manifestly unfair in substance" (Ottawa Citizen, Aug. 5, 1988).

In Ontario, which also has a low physician/population ratio, there have been some rumblings that restriction of billing numbers could be used to control where physicians practice, but the government has so far declined to antagonize the profession.

Since the 1970's governments have also attempted to increase their control over the supply of doctors, an initiative underpinned by the recognition that the original Hall Commission Report of 1964 had grossly overestimated the number of doctors needed in Canada. However, in granting the profession the right to self governance, governments have effectively left control over the supply of physicians in the hands of professional colleges. In effect, labour power policy has led to the "significant growth and ongoing dominance" of the primary professions (of which medicine is the most primary), including their continued control and in some cases suppression of complementary

occupations perceived to be a threat (Lomas and Barer, 1989: 242). Nevertheless, as Taylor (1987: 474) has noted, by the year 2000 there will be a huge physician surplus and this recognition has generated some pressures from governments to reduce the surplus.

According to the Federal Provincial Advisory Committee on Health Manpower (1982) there are four general policy areas in which options are available. (1) Reduce the number of foreign medical graduates who can practice in Canada, both as immigrants and Canadian citizens. (2) The output from Canadian postgraduate training into the stock of general practitioners should be reduced by encouraging trainees to proceed to surgical and laboratory specialties, and there should be a reduction in output from Canadian postgraduate training of general practitioners and medical specialties. (3) Reduce medical school enrollment by 125 per cent per year into general practice and by 145 per cent in specialties. (4) Restriction of billing numbers in order to redistribute physicians in areas which demonstrate need for medical services (Taylor, 1987: 475-8).

These latter recommendations constitute what Lomas and Barer (1989: 251-260) call harsher and direct policies which are aimed at overcoming the deficiencies of the softer approach to dealing with the supply of physicians characterizing the 1970's. In that decade, governments recognized that there were too many doctors, but were reluctant to constrain supply because of the "Medicare pact"; i.e. if physicians would become part of Medicare, government would not interfere with either the profession or the 'practice of medicine'" (Taylor, 1978). With the exception of controls on physician immigration introduced in 1975, governments took an indirect approach to the control of health costs. Instead of focusing on physician supply, they concentrated on indirect policy levers that

could affect the expenditures generated by physicians; hospital bed supply and budgets were restricted, and medical school capacity was left unchanged or allowed to increase slightly (Lomas and Barer, 1989: 255). Today, although 61 per cent of physicians feel that the number of physicians is "about right," it is likely that the number of new entrants into the medical labour market will be legislated down.

The emergence of greater economic problems as expressed in fiscal crises and couched in terms of a "new right" ideology has meant that the covenant between government and physicians has worn thin. As economic realities continue to upstage other factors in determining government policies, the privileges of physician self-government in relation to practice location and labour power requirements has gradually been eroded.

9.7. Scientific Ideology and Technical Autonomy

Doctors have continued to control the extent to which the product of their labour (the definition of health and disease) is appropriated as valid by the public. This is illustrated by the continued dominance of the medical model of disease. As noted earlier in the study, this model assumes that the causes of ill health and mortality are diseases, for which a "cure" is required. Indeed, the "causes" of illness are generally seen to be *within* the body itself. The "cure" entails, more often than not, a technical intervention into the body through the use of drugs, therapy and surgery. In addition, this model "defines health and illness in individual terms, independent of the social context in which they occur" (Bolaria, 1988: 538-9).⁶ Despite the fact that this model completely ignores

that social issues like poverty and the organization of work are highly correlated with ill-health⁷ (Rachlis, 1989:182), it continues to be the theoretical lens through which physicians understand their work and is illustrated by the fact that although 73 per cent of physicians feel there should be more emphasis on health promotion and disease prevention in medical schools, only 40 per cent feel the same way about training in social and political problems. Ultimately:

....a mechanistic-individualistic conception of disease, which engenders a disease-centred, high technology, medical orientation is pervasive in medical practice and research, absolving economic and political systems from the responsibility for disease, and denying its social foundations (Bolaria, 1988: 540)

A good part of doctors' acceptance (and indeed their promulgation) of this conception is born of the educational system which has socialized them to understand medicine in specific terms. Crucially this paradigm of medical knowledge is also perceived as something to be guarded—as knowledge which cannot be had by others without specific training. Moreover, because there is a knowledge gap between the consumers of health and their doctors, and because both parties see themselves as united in a “common fight” against the common enemy of disease, the public (and the state) continues to support medicine's claim to esoteric knowledge (Horobin, 1983:94). It is in this sense that doctors have managed to create the impression that what they do is “mysterious.” In sum, as Chapter Four showed, medical knowledge was a social construction (involving interactions between the state, the public, allopathic and irregular practitioners) and continues to be so, particularly since there have as yet been no important challenges to the way doctors view health and disease. Allopathic physicians'

knowledge continues to dominate the discourse and practice of health and disease, and, perhaps as important, their continued overall emphasis on individual responsibility and their tendency to engage in the “normalization” of “deviant” behaviour are qualities which harness their work to the imperatives of capital. As such, this perspective is “consistent with the basic tenets of bourgeois individualism and freedom of choice (in that) its singular emphasis on health obscures the social nature of ill health” (Dickinson and Stobbe, 1988: 545).

Other important factors have contributed to the continued control by doctors over the product of medical work. One is the lack of market power of the consumer/patient. Traditionally, when people see physicians, they give over their complete confidence and trust to an authority figure they perceive as having all the answers. Generally, people continue to trust their physician’s knowledge and ability to deal with ailments although to some extent, the perception of medical care as free has generated a shift in public attitudes towards doctors from “credat emptor” (let the taker (patient) believe in us) to “caveat emptor” (let the buyer beware).

A second element concerns the fact that policy makers have never really expressed any cogent interest in intruding upon the actual medical work of the physician. Rather, what we have seen is the partitioning of medical work into what Jamous and Pelloile (1970) and Johnson (1972, 1977) call components of indeterminacy and technicality. Those aspects of medical work which are defined as amenable to rationalization, or substitution with lesser skilled labour are defined as technical aspects of the labour process. These technical aspects are open to the ministrations of anyone

who can understand the data generated in such work. If the data can be interpreted, then the work is amenable to rationalization. By contrast, many aspects of doctors work are left to the discretion and “better judgment” of the physician. These aspects are indeterminate; they cannot be understood without specialized knowledge. Thus, the physician of today continues to dominate a certain domain of medical knowledge although clearly, parts of this knowledge and skill are open to challenge. Ironically, the very process of “science” as applied to management is responsible for the fragmentation of medical knowledge into hitherto “unknowable” pieces now more readily appropriated by non-physicians.

The physician’s dominance of the medical knowledge base is not without the potential for continued challenge however, as illustrated by the continued existence of alternatives to the medical model of disease and health. Chapter Four showed that physicians acted successfully to exclude homeopaths, eclectics, midwives and chiropractors from practicing their skills. Yet chiropractic has become even more established although there is still a lack of medical awareness or willingness to understand and accept it as a legitimate form of medicine. The improbable conciliation of medicine and chiropractic is illustrated by the comment of one physician, who said he “wouldn’t even take his cat to a chiropractor.” Another doctor (an osteopath) said:

Frankly, I think chiropractors are stuck in the dark ages. Their concept of disease is very backward ...everything is related to the spine, everything is a “subluxation”. Some of them are calling themselves sports medicine doctors, but they aren’t trained for it. If their initial premises (about disease) were correct then there would be some value in what they do, but all that flies out the window if their premises are incorrect.

Another doctor (in general practice) took a more positive approach, but still denigrated chiropractic compared to medical knowledge:

My prediction is that chiropractic will come around to a more conventional approach to disease...look at osteopaths. There are no schools of osteopath in Canada so they are coming from the States and there aren't many of them here. But they are really a new breed...much of what they do is close to what medical doctors do...and that's because of the scientific training that they are getting. The fund of medical knowledge is overwhelming, and compared to medicine, chiropractic has a minuscule knowledge base. They have been around as long as medicine but they haven't developed their knowledge at all. Some of these guys who have been practicing for years got into chiropractic school with a grade 12 education in science. But I think things will change fairly soon...In the meantime, they should stick to the things they know, which is a pretty narrow field...they do have some value with respect to some aspects of health.

The aversion to real competition for medical services is not restricted to chiropractic. We have seen that doctors espouse a competitive market for services yet do not wish to compete with nurse practitioners and midwives. Although nearly two-thirds of all doctors are satisfied with their relations with non-physician personnel, this probably reflects their dominant position over these personnel more than a willingness to accept them as competitors in the health care delivery market (York University National Survey of Canadian Physicians Data, 1986). Furthermore, most of the allied health professions are directly controlled by doctors because they accept doctors' orders to guide their work (Crichton et. al., 1990: 59). Physiotherapists, for example, cannot legally diagnose and prescribe without the express permission of doctors, and midwives, who have only recently won the right to practice, must (in hospitals) do so under the general supervision of a physician. The doctor's domination in the health care arena is also well entrenched

in the doctrine of “physician as leader” espoused by organized medicine. For instance, in reference to nursing, the Canadian Medical Association maintains that:

physicians recognize the importance and independence of nursing care, but under the overall supervision of a doctor because nurses can only describe when they diagnose, whereas physicians evaluate....physicians are the leaders of the team. The essential contribution of other members of the health care team is recognized but the principle of physician leadership is emphasized (Canadian Medical Association, 1986)

Despite the emergence of challenges to the medical conception of disease and health, the critical issue is that such paradigms and the actors who practice them continue to be dominated by physicians and the bio-medical model.

Despite ongoing challenges, the definition of health and disease (the ends of physician's labour) continues to be the prerogative of the medical profession. It is reasonable to expect that such challenges will continue to occur in the future, particularly on the fringe between work which is defined as technical and indeterminate. This is likely to occur as new computerized technologies allow for procedures to become gradually viewed as less indeterminate and more technical in nature, thus allowing for some degree of control over the end purposes of work by other workers. Doctor's perceptions of the impact of this likelihood are rather optimistic. In my interviews with physicians it was quite clear that technological developments were not seen as an immediate threat to the medical profession, but rather as enhancements to the medical labour process, which *physicians would be able to control*.

For example, in response to questions about the uses to which computers were being put in their medical practices, all the physicians interviewed agreed that they served

to enhance their ability to diagnose quickly, look up medical histories, cross-reference cases with recent medical research data-bases, and most importantly, to speed up billing and office procedures. But in all of these cases with the exception of the last, (which in group practices tended to be performed by receptionists) physicians felt they were in control of the technology, and that it presented no threat to their technical autonomy.

Yet, as Fulton (1993:100) argues:

Computer-based simulations have, for some time, been a major part of medical teaching, but future diagnosis and prescribing will almost surely become partly a computer function. The computer will process data and evaluate alternative diagnoses and therapies with a skill equal to or greater than that of most health workers in many complex circumstances. The machine age is here, and many health workers, especially physicians, will have their work altered by it.

Finally, in relation to doctor's perceptions regarding supervision of their daily work, all of the physicians interviewed expressed surprise at questions dealing with the nature of supervision and control over their own labour. It was quite clear that many of them thought that *because they were professionals*, the concept of supervision should not even be considered let alone discussed. However, there were some important differences between the doctors on this point which were related to the type of practice style in which the doctor was engaged. Physicians who were in group practices where they shared patient files were often likely to respond that they were supervised by the senior doctors in the group, but this did not appear to present a problem for them. The fact that their labour was more formally collective and that they were supervised was justified by the argument that professional behaviour demanded such close inter-relations and that there

was nothing unnatural, insidious or exploitative about supervision by older, more experienced physicians.

9.8. Public Image and Professional Status

One of the key elements of professionalism is the ability to influence the public to sustain their "generalized influence on everyday life" (Island, 1980: 214).

We have seen that challenges from other medical occupations have created pressures impinging on the physician's status as "generalized wise man" (McKinlay, 1982). Now, and particularly in times when physicians have engaged in disputes with governments, the public believes that "physicians make too much money." While challenges to the medical model are becoming more common, so too are challenges to the doctor's authority itself. The extent of this challenge can be seen in public opinion polls which show that the Ontario Medical Association's withdrawal of medical services in 1986 to protest legislation banning extra billing was opposed by 66 per cent of the public in Ontario, and 80 per cent of Canadians. Moreover, this strike damaged the public image of the Ontario medical profession. Nearly half of Ontarians indicated a diminished opinion of the medical profession since the extra-billing dispute began (The Reid Report, July, 1986).⁸ The political implications for physicians were clearly that any public defense of their position that centred on financial remuneration would fail miserably. Conversely, one-half of Ontarians showed support for doctors' arguments that banning extra-billing would infringe on their ability to carry out the practice of quality medicine. According to an Angus Reid poll taken at the time of the dispute

Here, the doctors have some strong cards to play since Canadians still have a great deal of respect for the medical profession and for the health services they receive....Any deterioration in the quality of service will lead them to become less preoccupied with costs and more sympathetic to those who are putting forward the case that the quality of their health care is at risk. The task facing the doctors, therefore, is to ensure that future debates take place around issues of quality and not around money.

Another dimension of physician's declining status is the extent to which the public are willing to challenge physician's authority. For instance, in 1986, 27 per cent of physicians had sought legal advice in response to an actual or threatened malpractice suit in the past three years (York University National Survey of Canadian Physicians Data, 1986). In addition, the increase in total litigation costs (the sum of legal, administrative costs and fees paid to experts) as reported by the Canadian Medical Protective Association has increased by 331.5 per cent between 1980 and 1986 alone (Fulton, 1993: 78). The incidence of threats or writs against the 90 per cent of physicians who are members of this association (which provides insurance and legal advice for Canadian physicians) has increased significantly (Table 9.6).

Table 9.6			
Incidence of threats or writs per 1,000 members of the Canadian Medical Protective Association			
	1972	1977	1981
Advice about threats or matters that could result in claims	15.7	26.2	28.7
Threats - members referred to counsel for advice	4.4	4.3	7.1
Writs served	6.1	8.5	14.2

source: Canadian Medical Protective Association, *Annual Reports*, 1972-1982 cited in Blishen, 1991: 152

The declining status of the physician in Canadian society has had important effects on doctor's perceptions of their own standing in society. In terms of physician's

perceptions of the public's view of the medical profession, 38 per cent of salaried physicians felt dissatisfied with this image compared to 21 per cent who were satisfied, while fee-for-service physicians were even more dissatisfied (56 per cent) compared to those who were happy with their image (19 per cent) (York University National Survey of Canadian Physicians Data, 1986).

Slowly, and in a fragmented way, the medical profession's capacity to positively influence the public to accept their status has eroded. Particularly in today's economic climate, and as experience with the Ontario doctor's strike of 1986 has shown, the public is unlikely to look favourably on political and ideological pronouncements centering on physicians' economic hardships. However, doctors still command a great deal of power based on the possession of knowledge still considered to be valid by the bulk of the population. In the future, it will be interesting to observe how this contradiction is played out particularly in relation to doctors' economic aims, and ultimately their class ambitions.

9.9. Conclusion: Politics, Ideology and Physicians Economic Class Location.

It is the *articulation* of politics, ideology and economics which are central to the constitution and reconstitution of class relations. This chapter has focused on some of physicians' key political and ideological strategies to illustrate the nature of this articulation.

Doctors have been successful in controlling the market for medical services and in lobbying for the right to regulate their access to and conduct in the health care market.

They continue to enjoy a monopoly in terms of the product of their labour since they are the sole providers of "legitimate" health care, determine how "clients" should be treated, as well as the level and kinds of technology which should be used in doing so.

However, as governments and third parties (attempting to implement the will of governments) continue to attempt to control the non-clinical aspects of medicine under the rubric of "the public interest," and given the decline of medical status, doctors will find it increasingly difficult to use old ideologies based on the inviolability of issues affecting their autonomy to justify their position (Blishen, 1991:144).

And, it should not be surprising that the components of physician's political activity and ideology examined here tend to follow the kinds of patterns which some have argued to be *typical* of the new and old middle classes. What is significant about these interests is that they tend to favour neither the interests of capital or the interests of labour (Poulantzas, 1978: 290). Like the working class, the new middle class tends to be exploited but tends to react to this by demanding higher wages and a more rational system of pay determination. Moreover, the new middle class tends to avoid questions of the ownership and control of the means of production. As Carter (1985:204) notes:

It (the new middle class) seeks not to replace the hierarchical organization of work but rather to reorganize it in order to enhance its own position, leaving the position of subordination of the working class unchanged. The attachment to hierarchy likewise manifests itself in its aspirations for promotion and career.

Previous chapters dealing with the economic aspects of medical practice have shown that many physicians have reorganized work in ways that enhance or reproduce their economic class positions. Essentially, the profession has undergone a process of

class fragmentation . By examining some of the key political and ideological issues since the implementation of Medicare this chapter supports the contention that physicians—bolstered by a sense of entitlement, the appeal of science, and successful political maneuvering—have stemmed the tendency in capitalist societies to reduce skilled labour to a common denominator. Recognizing that there is no necessary correspondence between political, ideological and economic activities, it would nevertheless seem safe to argue that the political and ideological practices of physicians in their initial rise to professional power tended to underpin their reproduction as members of the old middle class. More recently, the somewhat ambiguous nature of these practices underscore the fluctuating nature of their economic class positions.

ENDNOTES

¹ In addition to the clear emphasis on financial and technical autonomy medical schools also teach doctors to dissociate themselves from the patient, a phenomena that Foucault associates with the concept of the "medical gaze" (See *Birth of the Clinic*).

² Only 17 per cent of all physicians admitted to "balance" or "extra-billing" billing practices in the York University National Survey of Canadian Physicians with the majority doing so in 1986. In addition, 31 per cent of physicians "extra-bill" by charging patients for time spent in uninsured activities such as telephone calls, medical certificates paperwork, etc. Thus, in some respects extra billing has taken a new form

³ Such direct control is not the only way that physicians' incomes are controlled. The imposition of global budgets (in hospitals and clinics), prorated payments, prorated individual fees and benefits and the overhead differential are all ways in which the state is attempting to control the incomes of doctors. (Canadian Medical Association, 1985: 6)

⁴ The Quebec case is unique only insofar as the government was able to legislate doctors back to work because of the 1970 October crisis involving a situation of "apprehended insurrection."

⁵ It should be noted that there were other strikes and sanctions in the period. However, to my knowledge, the details and outcomes of these sanctions are not adequately documented anywhere.

⁶ Moreover, Bolaria (1988: 539) notes that a great deal of medical intervention, particularly in relation to psychological disorders, is geared towards restoring "normalcy," as opposed to identifying the socio-economic correlates of "deviant" behaviour.

⁷ As Dickinson and Stobbe argue (1988: 425) "Work is one of the leading causes of injury, disease, and death in Canada. Every 30 seconds in this country, a worker is injured on the job. Each year, nearly 1000 people are killed on the job, and several thousand more die as a result of diseases caused by their work. Work trails only heart disease and cancer as a cause of death in Canada (and contributes to many cases of these diseases). Canadian workers are twice as likely to die from their work as from automobile accidents (attributed to Reasons et al., 1981: 4)"

⁸ Importantly, those voting for the Conservative party supported doctors on this issue, while Liberal and NDP supporters were firmly opposed to this practice (The Reid Report, 1986)

CHAPTER TEN

SUMMARY AND CONCLUSION

10.1. Summary of the Study

This study has addressed the relationship between transformative pressures associated with the capitalist mode of production and the class relations and practices of one profession within the middle classes. Specifically it has focused on questions of “where” the Canadian medical profession has gone in terms of economic class relations, “how” physicians have responded and inserted themselves within the changing nature of Canada’s health care system, and under what conditions these transformations have occurred.

The study has shown that despite increasing proletarianization pressures associated with the logics of capitalist development in Canada, many Canadian physicians have either made a successful transition from old to new middle class or to part of the capitalist/executive class, or have entrenched their position within the old middle class as independent professionals. Moreover, these class locations are in *flux* and *ambiguous* because doctors increasingly work in different circumstances (i.e., hospitals and private practices) with correspondingly different relations of production. As members of the old middle class physicians control their own labour as well as the labour of a small number of medical and non-medical staff in self-owned practices. As new middle class doctors, they perform the functions of capital and labour but on behalf of others in sites of labour they do not legally own. Importantly, within hospitals, they may also perform the functions of capital on behalf of the “owner” (the state) while

performing the functions of labour as independent practitioners (i.e., for themselves).

Finally, physicians belonging to the capitalist/executive class would own and/or control large practices or institutions (such as hospitals) and are part of the formal management hierarchy within these organizations.

Contrary to the arguments of some theorists (McKinlay and Arches, 1982; Derber, 1982; Coburn, 1987; Oppenheimer, 1973; Chernomas) correspondingly few physicians have truly become proletarianized. Nevertheless, physicians in Canada are working in an environment in which proletarianizing forces have heightened since the implementation of Medicare. Moreover, these pressures are likely to intensify in the future. In part, the failure of the proletarianization thesis to adequately capture the Canadian experience is related to the fact that its advocates tend to focus on the medical profession's experiences in other countries, notably the United States. There the relations of medical production have been characterized by a free-market for professional services where the role of the state as payor for medical assistance has been minimal and where entrepreneurial forces have fostered a true, albeit slow, decline in physician's autonomy as well as the transformation of some doctors into working class locations (see Starr, 1982).¹ Indeed, American physicians work in a system where the profit motive has prevailed, so that pressures to rationalize the system are openly implemented and even embraced. It is not surprising then that the proletarianization of physicians has been a focus of theorists interested in the fate of professional segments of the middle class.

In Canada, as this study has shown, the situation has been markedly different. Since the implementation of Medicare, the state has played an important role in

sustaining the power of the medical profession by first guaranteeing their position within the division of labour as licensed practitioners, and second, by guaranteeing that they are paid. It is *because* the state has granted the medical profession autonomy that it continues to be powerful today. The “private practice, public payment” nature of the Canadian health care system has actually contributed to and helped reproduce Canadian physicians’ autonomy. Yet the state has not acted entirely on its own to guarantee and protect the doctors’ rights as members of the new and old middle classes. Physicians’ own political, ideological and economic practices have played an important role in constituting their class experiences.

In Canada, medicine’s professional status and the power which accompanies it, was fought and bargained for, and was the material result of a set of political and ideological struggles between the state, competing factions of the health care community and an elite fraction of a nascent medical establishment (Chapter Two). It was the profession’s successful resolution of these struggles that allowed them to develop and maintain particular privileges in relation to the structure and practice of work, thus providing them with a solid economic basis from which the profession’s political and ideological practices ebb and flow today. The early medical profession developed close links with members of the state and were in fact “in” the state as politicians and civil servants. These direct links should not be underestimated as important factors contributing to organized medicine’s success in creating a privileged space within the then highly competitive but unregulated milieu of health care occupations.

It was the profession's successful fusion of the notion of proper "scientific" practice and knowledge with the cultural milieu of the dominant class that was central to the construction of allopathic medicine as a "moral imperative" and ultimately its development into a privileged fraction of the old middle class. The profession's use of the rhetoric rather than the content of science was instrumental in persuading the government and the public that their knowledge was unique and special, and, as such, warranted special political and economic considerations. While the profession's basin of knowledge was, in fact, quite shallow, it has until recently been able to hide this fact from the public. Taken together—and until Medicare created the conditions for another set of transformations—these factors underpin physicians' rise in status and prestige in society, and the transformation of the majority of doctors from a set of semi-organized trades into a middle class profession.

Initial fear that a state funded health care system would transform physicians into civil servants gradually gave way to acceptance that such a system was financially lucrative, more beneficial for Canadians and inevitable. Though they grudgingly accepted the terms and conditions of the new medical relations of production associated with Medicare, physicians also made sure their technical autonomy was protected. At the same time, their dependence on Medicare grew to the point that now, if the system were ever abolished, up to 50 per cent of all practitioners would be out of work (Richter, 1986: 524).

Medicare also created the legal, political and economic framework for the rise of proletarianizing forces within the system of health production—forces that are themselves

an inevitable part of the logics of capitalist development. As the once burgeoning welfare state began to develop the structural gaps associated with chronic fiscal crises, provincial and federal governments began to seek ways in which to relieve the pressure of rising health costs—a disposition that continues today, though certainly with more urgency (Chapter Five). At the same time, health care has become a 70 billion dollar industry that increasingly behaves like the manufacturing sector. In both sectors work has gradually been concentrated in centralized institutions, cost control has become the central policy driving organizational behaviour and labour processes have increasingly come under managerial scrutiny. The medical profession's increased dependency on high technology medicine concentrated in hospitals and other bureaucratic institutions has also opened the door to increased accountability and third party control because many of these technologies can be operated and appropriated by non-physicians.

Although governments had long ago recognized the central role played by doctors in the creation of demand and overhead costs they were both unwilling and unable to target physicians in their attempts to control the costs of health care. As the forces of medical production expanded at the behest of physicians via technological innovation, new and expensive techniques, drugs and heightened dependence on the “curative” medical model, both provincial and federal governments seemed unwilling to place controls on the profession as a whole. Instead, they focused on the labour processes and supply of other less expensive components of the health care sector—nurses, technicians and paramedicals. In the latter half of the period under examination, the perception that “costs are escalating” has had increasing economic, ideological and political significance.

In the past, governments have attempted to control the costs incurred by doctors but these methods have largely been indirect and symbolic (Tuohy, 1988). More recently, pressures have intensified to the point where physicians are no longer as immune to the cold eye of administrative efficiency.

Under increasing pressure for accountability and recognizing that they are no longer masters of their own destiny, the profession's economic response has been to create larger, more stable practice forms. Practice forms have not only become more heterogeneous, they have become more institutional and collective in nature (Chapter Six). Group practices have grown by 25 per cent since the pre-Medicare era and these practices are larger than they used to be. A new generation of physicians is choosing or being forced to work in group practices while older, more established doctors continue to work in solo practices. However, many solo practitioners exist in the grey area between small group and solo practice. Similarly, many "group" practices are in fact "loose confederations of solo practices." Within the latter, the likelihood of being salaried has actually decreased since the beginning of the Medicare era.

As for the labour process within these different practice modes, physicians are clearly acting more like managers than ever before, while at the same time spending less time in the functions of medical labour. This increase in the functions of management is being performed at the same time as patients volume has increased, suggesting that as there is an increase in medical work, a good portion of the functions associated with such work are being performed by ancillary medical personnel (e.g., nurses) who (in Canada) are managed by doctors.

Compared to the pre-medicare era, slightly more solo physicians have become dependent on salaried arrangements, primarily in hospitals and in industrial medicine (Chapter Seven). Industrial physicians, the majority of whom contract their services to companies, have very little influence over organizational strategy although full-time salaried physicians in large organizations are gaining power over limited aspects of corporate decision making. In contrast, and despite their dependence on the wage relation for at least a portion of their work, salaried solo physicians in hospitals tend to have a great deal of say in the strategic and operational activities of these institutions. Even today's salaried solo practitioners are slightly more likely to perform the functions of capital compared to fee-for-service doctors. Accordingly, salaried solo physicians may be becoming key decision makers in these work environments while their non-salaried peers are increasingly managing larger and more complex (by 1960's standards) practices in which they are Chief Executive Officer, worker and middle manager.

Physicians in 1986 have moved more towards associate practices while the proportion engaged in formal pooled income/patient sharing arrangements has declined. Although provisional, this observation indicates that doctors have entered into relationships with other physicians which essentially distribute the costs of medical practice while assuring individual autonomy.

As more solo physicians have become partially dependent on salaried arrangements located primarily in industry and hospitals, they are taking on more management activities. Despite their dependence on the wage relation, these doctors are really in two class locations. As salaried workers, they are part of the new middle class

since they perform management related activities in bureaucracies. Yet in that portion of the work period where they are in their own practices, they belong to the old middle class, and may even tend towards the capitalist executive class as their practices grow in scope and size.

There have been both shifts and continuities in the roles played by physicians within group practices, but in general the majority of doctors in group arrangements are enjoying technical autonomy while reaping the economic benefits associated with the close proximity of other doctors and related medical services. The fact that doctors have a high level of control over their own labour and high involvement in decision making at strategic levels flies in the face of the assumption that salaried physicians in large bureaucracies are likely to be economically more working class in character than their private fee-for-service counterparts. On the contrary, many doctors in group and solo salaried arrangements are becoming part of management per se while continuing to enjoy technical autonomy. Their authority as "individual" practitioners has been preserved by the absence of strong executive authority within the clinics (and group practices) in favour of various forms of administration by consensus (Konrad, 1988).

Group practice will more than likely continue to grow in popularity, and, within these configurations, doctors will likely remain as senior members of work teams in which they coordinate and unify the labour process. In addition, and with the possible exception of Health Services Organizations and Community Clinics, they will perform the work of supervision and management either for themselves or on someone else's behalf. The degree to which they perform the function of capital will vary according to

the extent to which they are dependent on the type of practice they join and whether they work in other practice forms as well.

Given that class relations are fluid and dynamic, and in the context of a theoretical perspective which emphasizes the formation, reproduction and dissolution of classes, it should be emphasized that the shifting class relations experienced by physicians in solo and group practices have been the result of their own self interested assertion in the context of political and economic change, all of which are ongoing processes.

Accordingly, the future shape of authority and control relations within group and solo practices will be interesting to watch. As group practices develop in organizational complexity under competitive pressures, and as the plentiful supply of physicians makes it less attractive to retain doctors by offering them share holding tenure in the group practice, some physician owned group practices may well hire doctors on a purely performance basis which might in turn entail a loss of autonomy and managerial authority for salaried physicians in these practices. The growth of associate practices suggests therefore that this practice form may offer some refuge from the threats associated with third party ownership, whether this be by a non-physician entity or physician capitalist-executives.

Similarly, in light of the gradual abrogation of solo practice and its concomitant transformation towards larger "businesses," solo practitioners may well be on the cusp of changes in class location from old middle class to new middle or capitalist executive class.

We have also seen that while hospitals have increasingly become "factory-like," unlike craftworkers and artisans over 100 years ago and despite their dependence on the hospital, physicians have not for the most part become salaried wage workers within these institutions. Instead, they have succeeded in establishing and maintaining a dual management structure through their participation in the committee structure so essential to hospital functioning. However, as hospitals become more accountable to the health care managers who increasingly control them, and in the context of heightened pressures to control costs and improve efficiencies, doctors are likely to be increasingly subject to rationalization pressures. As well, if hospitals continue to regionalize their functions and authority, physician authority within the hospital may gradually become lost amongst the myriad voices who will then speak for large hospital "systems." The extent to which physicians will be successful in inserting themselves into these new relations of power remains to be seen.

Finally, it has been shown that the economic dimensions of the class practices and experiences of physicians articulate with their political and ideological practices. Indeed, the latter set of practices played an important historic role in justifying and reproducing their economic class position by creating the conditions for their rise to professional power and by acting in political ways to sustain technical autonomy. The bases of contemporary political conflict between the state and physicians lie in the disjuncture between the state's need to sustain legitimacy over the course of a fiscal crisis and the profession's need to sustain economic and technical autonomy. Over time, physicians have moved from a confrontational political stance *vis a vis* the state to one that is more

accommodative. This shift to an accommodative perspective is likely to be rooted in the recognition that while welfare state economies are, in principle, anti laissez-faire, they are also critically important to the way health care is financed, particularly in Canada. In other words, physicians recognize they have little choice when it comes to the "public payment" character of the system. Accordingly, they have chosen to embrace the model while exercising as much control as possible within its parameters, even though they are struggling against a general decline in their public image and a concomitant increase in the willingness of the public to challenge their authority. At the same time, significant variations *in*, and the somewhat contradictory nature *of* contemporary physician ideology may reflect their fluctuating economic class positions.

10.2. Conclusions

At the outset of this study, the following questions were posed: *under the transformative pressures that characterize capitalism, what happens to professionals within the middle class? i.e., as the old middle class faces pressures that might force its decline, where does it go; to capital, labour or the new middle class, and under what conditions?* This study has documented the experiences of one professional component of the old middle class—physicians—to provide answers to these questions. These answers, however, are contingent upon the unique circumstances of the Canadian medical profession within historically specific political and economic conditions making up the development of the Canadian health care system. Accordingly any attempt to generalize the experiences of Canadian physicians to the experiences of other established

professions (such as law or accounting) within class structures will require specific historical analysis of these professions' experiences and practices.

The examination of the class transformation and reproduction process *vis a vis* the Canadian medical profession has pointed out the "inexorable" nature of capitalist forces that set parameters of development. De-industrialization and the working out of the capitalist mode of production in Canada, has been responsible for the disappearance of certain kinds of jobs, and the transformation of others. It has also been responsible for a host of other outcomes including the polarization of incomes and the crisis of the welfare state. As this study has shown, in comparison to formerly independent occupations such as farming and fishing the Canadian medical profession has been able to sustain and in many cases supercede their privileged position within the hierarchy of the "welfare state professions." The analysis has also illustrated the effectiveness and difficulties associated with the unique strategies employed by this group of professionals for counteracting or resisting these forces. Physicians' ideology and their political practices tend to reflect an emphasis on technical and entrepreneurial autonomy within the context of an unregulated (read "free enterprise") medical marketplace despite the fact that Medicare has both regulated the market and helped to create a monopoly for physicians' services (also see Williams, 1987). Moreover, historically these political and ideological practices have been at the core of a successful strategy by which the majority have made successful transitions to new class "locations." While the laws of motion of capitalist development have worked themselves out for the medical profession as they have for other occupations, the critical difference for physicians has been that they have successfully

intervened in this process. Indeed, the medical profession's success in counteracting the proletarianization process illustrates the importance of historically derived authority. In the case of physicians this authority has been sustainable because it is based in the ideology of science and, historically, close personal ties with the dominant political and cultural milieu. Medicine's historical resilience in the face of proletarianizing pressures has played (and will continue to play) a crucial role in assisting physicians in their efforts to sustain a position within the old and new middle classes. In effect the study has provided further evidence for the claim that political and ideological relations are tied to the economic relations in that the former tend to sanction and legitimize the latter (Poulantzas 1975: 21).

The study has also shown that the relatively disinterested approach of the state *vis a vis* the rationalization of the labour process of established (as opposed to marginal) professions is due to the latter's well established integration into the dominant ideology espoused by capital (see Clegg Boreham and Dow, 1986). Indeed, as Johnson (1982) has argued, professionalism can only emerge when the ideological and political conditions for sustaining indetermination coincide with the requirements of capital. In Canada, the medical profession has always performed such functions including the reproduction of healthy labour power, and more generally, the reproduction of the ideology of individual as opposed to structural responsibility for illness and disease. The performance of the latter function is expressed in the medical profession's general failure to identify and critique the contradictions of capitalist development as the central factor in most health problems in the last century, a linkage so salient that some health economists now argue

the correlation between social problems and ill-health is more dependable than that between smoking and lung cancer (Conference Board of Canada, 1994). Even in those cases where doctors have supported public health and anti-pollution measures, the basic structure of medical political and technical dominance remains unchanged since these issues have little or no effect on the structure of medical practice. Finally, physicians have always performed social control functions as many critical sociologists of medicine have pointed out. (Illich, 1976; Navarro, 1986). In these ways then, medicine shares much in common with capitalist ideology and it is perhaps because of this reciprocity that they have so successfully reproduced or superceded their class position.

Nevertheless, the pressures on the state to rationalize the health care system are now outweighing the allegiance it has traditionally given to organized medicine. It is likely that state managers will intensify their attempts to control the work that physicians do within locations not controlled by physicians, such as hospitals and community clinics. The extent to which they will be successful will depend on their ability to make doctors' indeterminate knowledge more open to control. At the same time, doctors will likely continue to resist attempts to impinge upon their technical and financial autonomy although the extent to which they will employ tried and true strategies remains to be seen.

In terms of its implications for class analysis, the most salient finding in this study is the extent to which the medical profession has become fragmented as opposed to *homogeneously* new middle class or old middle class. In economic terms (i.e., in terms of ownership relations and the labour process performed within these relations) as well as in terms of their political and ideological practices, doctors seem to be in a state of flux. At

the theoretical level, this finding suggests that the class transformation of the middle classes can be a far more subtle process than a simple “disappearance into the proletariat” model would suggest. Indeed, the structural (economic), political and ideological ambiguity of this particular profession and its heterogeneity *vis a vis* class location make it difficult to determine “where,” in terms of the class structure, they may end up (see Clegg et.al., 1986)

As we approach the fourth decade of Medicare, more research will be required to understand the extent to which the fragmentation process has continued (or solidified into more concrete class locations) with respect to the medical profession. As this dissertation has shown, the Canadian medical profession is splitting up into entrepreneurial (old middle class/capitalist executive class) and bureaucratized middle classes (new middle class) each possessing objectively different interests, but cemented together by an unstable ideology of professionalism. In the future it will be interesting to see to what extent old middle class doctors are able to defend their traditional prerogatives against the imperative to rationalize. It will also be interesting to see whether this struggle might be against other, new middle class physicians who may in the future be the new “organization men and women” of the health care system.

Finally, as for the proletarianization thesis, it is clear that viewed in the long term, proletarianization processes have been occurring since the inception of Medicare—proletarianization is a process, not a condition. At the same time, this study has pointed out that the proletarianization of professionals may take a very different form than that experienced by other occupations. By extension, it is clear that an orthodox theory of proletarianization (in which all labour is tendentially reduced to a common denominator)

needs to be modified if it is to shed light on the range of possible class experiences of professionals. It is equally clear that for Canadian physicians, their historically cultivated authority, based in the ideology of scientific reasoning and reproduced by direct linkages with the state, has laid the foundation for hitherto successful resistance to this process. It is likely that this success will be short lived in historical terms. The march of managerialism within the welfare state in general and in the practice of medicine in particular will constitute the context within which the medical profession will be challenged to sustain their historically struggled for economic, political and ideological hegemony. For Canadian physicians, the process consisting of the dialectical relationship between proletarianization and professional resistance is far from complete.

ENDNOTES

¹ Indeed, the United States is one of only a handful of industrialized nations that has no national health insurance scheme.

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