MEDICAL CARE AND CONFLICT IN SASKATCHEWAN

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At 12:01 A.M. on July 1, 1962, the Saskatchewan Medical Care Insurance Act became law.[1] At that moment most of the doctors in the province went on strike. Twenty-three days later, with the help of a flamboyant and hyperactive mediator, Lord Stephen Taylor, an agreement was reached between the doctors and the government. As the Canadian Press reported: "Doctors say they had to give way on at least one key principle to reach Monday's agreement ending the medical care dispute. This was acceptance of a universal, compulsory medical care plan, long opposed by organized medicine as a threat to doctors' freedom."[2]

The doctors' strike in Saskatchewan provides an unusual case study of government in conflict with a profession. The inability of the profession to tolerate internal dissent by its members resulted in the development of a competing form of medical practice and an influx of doctors with attitudes favorable to Medicare. The medical profession, accustomed to exercising its prerogatives without external constraint, opposed legislation enacted by a government elected by the people. As the struggle continued the issues at stake became secondary to a test of strength between the profession and its powerful allies and the government. These issues could have been resolved before the strike as the government made many attempts at conciliation. These were consistently rejected by the

doctors. By withholding vital services to the population the medical profession tried to overthrow the government. The doctors lost the battle. But the strike mobilized majority interest groups antagonistic to the government which previously had been unrelated or only loosely aligned. This temporary coalition of interests may have subsequently contributed to the narrow defeat of the Cooperative Commonwealth Federation (C.C.F.) government.

Our purpose here is to analyze the reasons for the conflict. In doing this we will review what has happened since the strike and, in particular, attempt to place the roles of the government, the medical profession, and the public in perspective.

THE PRESENT SITUATION

Since the doctors' strike[3] the report of the Royal Commission on Health Services has been tabled in Parliament. Aside from its sweeping proposals concerning a universal medical care program, it is significant that the Commission, on which sat a past president of the Canadian Medical Association, unanimously rejected the views of the Association and of the health insurance industry concerning voluntary health insurance. In other words, the Commission rejected the basic position to which the medical profession had adhered and which had led to the doctors' strike. More recently the doctors' position has been further challenged by Prime Minister Lester B. Pearson's announcement, on July 19, 1965, that his Liberal Government expects to introduce a national medical care plan.

Have the fears voiced by the doctors about the Saskatchewan medical care plan come to pass? Objecting to the C.C.F. government's proposals in 1960, a leading Saskatchewan physician said:

> . . . we have good reason to know that it leads to a deterioration in medical services—because of centralized authority—because of cumbersome administration—because of demands for services beyond reasonable needs—its increased staggering costs—with increased taxation—and its necessary regulation of the individual—and the sacrifice on the part of the patient of his present freedom and privacies. . . .[4]

The consequences of the government's act anticipated by this physician have not occurred. What has happened?

First, no meaningful studies of quality of service have been carried out to determine if the quality of services rendered has changed. Second, total administrative costs for the Saskatchewan plan are the lowest of any medical care insurance plan in Canada. Third, demands for service have risen slowly, and evidence suggests that increased services may be due more to doctors' decisions than to patients' demands. Fourth, the costs of the plan have risen more slowly than have the per capita costs of the voluntary plans during the past three years.[5] Fifth, the plan since its inception has permitted free selection of doctor by patient and of patient by doctor. Sixth, the patient's privacy has been interfered with not by government but as a result of a traditional system of payment preferred by the doctors which requires them to submit a diagnosis as part of the account sent to various paying agencies. In the province, then, to date none of the doctors' expressed fears seem to have been justified.

This case study may have relevance for the medical profession in Canada, where new medical care legislation is being considered, and in the United States, where legislation providing medical care for the aged has just been enacted. It is doubtful if organized medicine elsewhere in Canada will again seek to test the power of a democratically elected government. Not only was the attempt unsuccessful but it tainted the reputation of a great profession in the eyes of the public and forced it to reassess both its ideals and its role in society. A profession situated in the midst of advancing knowledge in technology and administrative complexity must learn to cope with the necessary social changes in order to deal with both effectively.

THE CONCEPT OF CONFLICT

Perception and conflict are concepts which appear relevant in an analysis of the doctors' strike. From studies in social psychology we know that the interpretation of threats varies with the breadth of an individual's experience. Frustration may make it more difficult for men to adapt to social change.

Conflict is essentially a struggle over values or resources by two or more groups. The aim of those involved in conflict is to render their opponents ineffective or to get rid of them. Simmel viewed conflict as necessary in the process of growing up, of learning to become a member of a group, and, indeed, he emphasized that group stability requires both harmony and disharmony. Conflict sharpens group identity and sets out clearly the boundaries between groups which may have become blurred. Conflict affecting many individuals may produce coalitions between groups which normally may not have basic mutual interests. The extent to which the group is inflexible, its size, its prestige and status, the degree to which its members are committed to the organizations and issues involved, all may serve to intensify conflict. Conflict is more intense if ideology is involved and if there is little or no contact between the disputants.

When two groups are opposed, each attempts to build up the loyalty of its own members and to downgrade the opposition. Hostility may be expressed by making scapegoats of dangerous insiders as well as opponents. When opportunities for the release of hostility do not exist, deep structural and emotional cleavages may be expected to occur.

A group in conflict is intolerant of dissenters. As a result, heretics and renegades often emerge. Renegades or apostates usually become open enemies. But heretics, by adhering to some of its objectives while dissenting on other vital issues, prevent the group from achieving complete harmony and provide a constant, internal stimulus for social change. Indeed, once open conflict has been resolved, "the enemy within" may help to strengthen the unity of the group by continued questioning of accepted values and interests.

Conflict may breed social hatred of those thought to threaten the existence of the group. If this hatred is returned in kind, conflict is intensified. By definition, the so-called renegade, or person who leaves the group and crosses to the other side during conflict, is easier to deal with than is the heretic. After all, we can say of the renegade, "To hell with him! Good riddance!"

But, in Simmel's words, "It is fearful to be at enmity with a

person to whom one is nevertheless bound, from whom one cannot be freed, whether externally or subjectively, even if one will, so there is increased bitterness if one will not detach himself from the community [for several reasons] . . ."[6]

THE ISSUES AND THE PROTAGONISTS

We are not going to review here the merits or the reasons for the decision of the government of Saskatchewan to proceed with a tax-financed medical insurance plan. Suffice it to say that in the provincial election of 1960 the party in power campaigned on this issue, and was re-elected to a fifth term in office, with 38 of the 55 seats in the provincial legislature.

During the 1960 election campaign, the medical profession spent tens of thousands of dollars trying to defeat the party that proposed the medical care plan. Doctors took to the hustings. A "key-man" system was set up, and each key man was responsible for a small cell of doctors. Plans were passed from the hierarchy and its hired public relations experts to the key men and then down to the troops manning the barricades. Potential medical heretics were excluded from the communications system, and if they held positions on any committees of the profession, they were purged.[7] However, the profession was on the horns of a dilemma. While it could control the behavior of, say, specialists, by threatening to withdraw referrals of patients, still it could not excommunicate the heretics. But its social hatred for these was even greater than that for the C.C.F. itself.

The behavior of the medical profession in the 1960 election campaign was out of keeping with a profession that considers its first ethical imperative to be altruistic service to the patient. The doctor has almost universally been accorded high status in society. Dealing with one of man's most basic concerns, he often sets an exemplary role by his humane and unselfish devotion to his patients. The doctors of Saskatchewan share this heritage. Their organization in its *Brief to the Advisory Planning Committee on Medical Care* in late 1960, months after the election, formally and publicly rededicated itself to the provision of a high quality of medical practice

and reaffirmed the doctors' obligations of trust to their patients.[8] Yet in 1962 the doctors were embroiled in a fight for their "professional freedom" over a decision that had apparently been decided by the electorate in 1960.

From the point of view of the government, the issues were clear. The government had been elected to govern. A fundamental tenet of its ideology was the organization of tax-financed health services, including a system for paying doctors' bills. It placed great reliance on collective and co-operative action for the public's good. In this matter the government had the support of the farm unions, of trade unionists, and of many co-operative organizations.

The doctors, for their part, contended they were safeguarding the rights of the individual against the intrusion of the welfare state. They controlled a monopoly in determining their fees, and in their relationships with agencies that pay doctors' bills, and they refused to negotiate a change which might threaten their monopoly. There is no doubt that the members of the profession were free to decide whether or not to practice, but a withdrawal of services was a serious breach of jurisdictional and moral responsibility. As the solicitor for the Ontario Medical Association noted:

> A doctor can't say "I'm through" when there is no other doctor available. Under law he has a continuing obligation to patients under treatment. If he leaves them he will be considered to have abandoned them and would be liable for damages.[9]

A professor of law summed up the issue succinctly:

> . . . There are certain fundamental rights, the infringement of which would justify the use of force even in a democracy; but great care must be taken to avoid confusing fundamental rights with self-interest or the preservation of the economic or professional status quo.[10]

By their own standards, the doctors' strike may have been professionally unethical. One of the principles approved of by the Canadian Medical Association (C.M.A.) specifically dealt with a doctor's behavior if a conflict of interest were to arise over insur-

ance programs. This principle, approved by the C.M.A. in session, stated: "... that the duty of the physician to his individual patient takes precedence over his obligations to any medical services insurance programs."[11]

There are several alternatives from which a profession may choose if it opposes specific legislation affecting its interests. These include: 1. negotiation, 2. court action, 3. seeking the political defeat of the government, and 4. strike. All of these procedures were tried by the medical profession in Saskatchewan, although court action was attempted only eight days before the strike and then not by the College but by two private physicians. They asked the court to declare the medical care act unconstitutional and the 1960 provincial election null and void. Implicitly, the medical profession recognized the legality of the act by not challenging it in court.

With this range of alternatives, why did the profession choose to strike against the government? Repeated attempts at negotiation by government were turned down by the profession. In retrospect, it appears probable that in 1962 the leaders of the profession believed they could successfully force the government to repeal the medical care act. This position was strengthened by the emotional fervor with which the dispute was fought and by the support received from segments of the public and medical associations elsewhere, and their chief supporters, including the Keep Our Doctors Committee, other professional groups, the political opposition, and the Chamber of Commerce. The doctors' position was further strengthened by the insulation provided by a partisan press which, for the most part, supported the doctors' stand within the province. In other parts of the Dominion most editors condemned the strike. The combination of these forces created a momentum within the profession which outweighed other considerations. The profession at this point had many of the characteristics of a religious sect—or a minority political party—a fanatical zeal in pursuing its mission, a position based on faith, and the exclusion of nonbelievers.

Like a patient in the throes of an illness, the profession's attention during the dispute focused increasingly inward, and this concern

superseded in importance the place of the patient and the community. One Saskatchewan doctor, writing during the strike, reflected this reversal of the usual order of professional interests:

> What casualties have the doctors suffered in these twelve days? Perhaps 80 or 90 irrevocably lost to the province. The others are torn by one of the great tortures of the soul, the agony of those who face exile, who face the decision to leave the patients who are his friends, to tear himself from all the ties of home and community. Day after day, I have watched the sorrow of Saskatchewan doctors as they make their personal decisions. Their decision seems always based on one question, "Is there any hope of immediate relief from this arrogant government dictatorship?"[12]

Before, during, and after the strike, the heretics of the profession were dealt with in a manner that differed sharply from the usual professional behavior of doctors to one another. British training was downgraded, even though over 500 such doctors had come to Saskatchewan in the preceding decade. Hospital privileges were refused certain doctors. Co-operation was denied the heretics and consultations were refused. And yet the same doctors who refused co-operation sat in judgment on the heretics in matters concerning their rights to practice. On a Canadian Broadcasting Company program, one doctor, the president of a district medical society, was asked if he would co-operate with the newly arrived (heretic) doctors. His reply was clearly a breach of professional ethics:

> . . . It would take a great many years for me to overcome my resentment at the—what shall I use, a rather strong term—scab labour—which is what most doctors in Saskatchewan feel towards these immigrants. . . .
>
> They came here specifically for financial gain, quick financial gain. . . . I cannot but feel antagonistic to any doctor who would . . . embarrass medical confreres in another part of the world strictly for financial gain.[13]

It is clear that the profession had a poor knowledge of the processes of democratic government, and lacked scientific knowledge about social and economic matters. Small wonder! As we under-

stand it, there are virtually no full-time social scientists on the staffs of any medical schools in Canada. Nor are doctors in training taught very much about the complexities of medical organization and administration, and about systems of financing health care.

Further, the profession was already in crisis within itself. Jurisdictional conflicts existed between general practitioners and specialists. The field of work of the general practitioner was increasingly restricted. Income disparities between general practitioners and specialists were apparently increasing. Hospitals, or doctors' workshops, were increasingly financed, owned, and operated by the public. But at the same time, most doctors continued to operate their own little, singlehanded offices, and defended this arrangement as representing the best of all medical worlds. Thus the doctors acted like nineteenth century laissez-faire private entrepreneurs in economic affairs, while spending parts of their lives applying the technology of the 1960s in publicly owned workshops.

The decision of the government to pay doctors' bills enabled the profession to bury, albeit temporarily, its inner cleavages, and to unite to protect both its prestige and its power to set its own prices without negotiation.

But it was too late. Medicine is experiencing its industrial revolution. And the doctors attempted—as have other workers in other places, during their industrial revolutions—to prevent the machinery from working. But like it or not, the doctor has to face up to the fact that he must come to terms with the whole "health factory," including his workshop, the hospital, and the whole complex organization for the provision of health services. Like other workers in the past, the doctor must discover that wrecking the machinery—rather than learning to work with it—may have just as dire consequences for him in the 1960s and 1970s as it had for the Luddites a century and a half ago.[14]

The doctors' strike was an attempt to obstruct the machinery. Before the strike, the doctors refused even to meet for four months, and on several occasions rejected major concessions made by the government. This approach maintained the intensity of their crusade against the government but hindered any fruitful attempts

at successful compromises which would still have allowed the government to carry out its electoral and legal mandate. This type of conflict was one in which "the intrusion of primary group attitudes when secondary group attitudes are institutionally demanded,"[15] precluded logical decision-making by the profession's leadership.

But what of the government's role? The government clearly had wide breadth of experience concerning the organization and financing of health services. It had the administrators. It had the economists. But it left its flanks wide open for attack. Not only did it fail to neutralize the anxieties of a proud profession, but it also lacked administrative foresight on key issues. As a result, the government failed to render its opponents ineffective.

Some of the wording of the act was inept, and stirred up the anxieties of already anxious men. In addition, though the plan had been long heralded by the C.C.F., it represented a major innovation for both the government and the profession.

The innovator faces many risks. And the more his program departs from what is customary, the greater the opposition he may expect. In an insightful essay on the hazards of being an innovator, Dexter has described the fate of the reformer. Semmelweiss, who tried to reduce the maternal mortality rate by simple hygienic procedures, was ostracized by his fellow physicians, and Hanway was mobbed for introducing the umbrella into England. Dexter suggests that the innovator must consider the various hazards which his proposals may encounter:

> The innovator must know—after the first shot is fired—what is to be done next; *and what is to be next;* who in relevant professions or organizations can be expected or persuaded, for *whatever motives,* to support the new departure. Who can understand what is actually being attempted? What alternative means of winning a livelihood are open to those who take risks? What friendships may be lost, what temptations to unhappiness or bitterness must be adjured?[16]

For many years the C.C.F. had contemplated introducing a medical care act, but it had to wait until the federal government began to share in hospital costs before it became economically

feasible to do so. Despite a great deal of planning during the early phases of introducing a medical care act it appears that a comparable amount of planning had not gone into the strategy of both introducing the act, and of negotiating with the medical profession.

When the government introduced its medical care legislation, its leaders misjudged the rigid position taken by the doctors. Indeed, it would appear that the government assumed its representatives would be dealing with a group accustomed to bargaining for contracts. As a former teacher, the Premier was accustomed to the negotiations between teachers and their school boards. This assumption was further strengthened by the appointment of a Minister of Public Health who was a trade unionist. These assumptions were inaccurate on several points.

The doctors were not accustomed to bargaining for their wages like members of a trade union, and no rules for such negotiations existed. Only part of their livelihood depended on income governed by contracts, and the doctors, in fact, prided themselves on being professional private entrepreneurs. Further, the C.C.F. leaders assumed that, in the final analysis, the medical leaders would consider the act rationally and dispassionately, and would bargain in good faith.

Even though the government and the profession had bargained annually for years on segments of public medical care in payment for special groups or for special disease problems, it had never given thought to the development of arbitration methods for settling disputes with the medical profession.

It is virtually impossible to determine the extent to which the decisions of the medical profession's executive on the basic issue of the government's right to pay doctors' bills represented their own opinions or those of their fellow physicians. That many doctors opposed the government's plan is indisputable. It is not so clear, however, whether all who opposed the legislation favored the course of action followed by their executive. Once the doctors' plan of action had become charged, no opposition would be brooked. At an open convention only a handful of heretics dared even to vote against the majority. Their professional lives were at stake. Moder-

ate voices were not heard, and the medical academic community did not show signs of recognizing that these social issues were important. As a result, the profession's basic decisions were made by a tiny group of highly organized, angry, and committed men.

Simultaneously there was a crisis of leadership in the Saskatchewan C.C.F. at the time of the intense social conflict. One cannot change leaders with impunity during a period of crisis. However, not only did the premiership change, but also the key personnel in the health department. A new Minister of Health was appointed, and the deputy minister chose to leave his post during the heat of the battle. Thus, the key persons directing strategy not only had to learn new roles, but also had to engage in intense social conflict almost from the moment they assumed their new jobs.

Another problem had never been dealt with by the government. A group of social scientists had commented on the matter to the Advisory Committee that had studied the medical care issue:

> One and the same body is responsible, on the one hand, to receive public protest and screen professional standards, and on the other to protect the vested interests of the profession. This is surely a rare example of judge, jury, prosecution and defense rolled into one, and operating *in camera*.[17]

Years earlier, the government should have separated out the functions of licensing, setting standards, and self-discipline, from the profession's trade union or negotiating role regarding economic matters. Since all of these powers rested in the same body, with the same paid official executing policy on all of these matters, the profession was in a much stronger position to enforce conformity. It is significant that the federal Royal Commission on Health Services was explicit in recommending separation of these powers in all provinces.[18]

The dual functions of the profession undoubtedly increased the intensity of the hostility between the majority and those doctors who became identified with pro-Medicare views. But since these competing interest groups had to achieve at least a minimal level of harmony, the profession inadvertently retained within itself the

seeds for social change in its form of organization and the manner in which doctors treated patients.

Finally, during the conflict local leaders were a potential, largely untapped source of outspoken support for the government's program. At no point did the Premier or members of his Cabinet seek to arouse the enthusiasm of their political and other pro-Medicare supporters. Indeed, quite the opposite approach seems to have been taken.

For the most part, the government's plea for restraint was followed, and in a sense it is an indirect measure of the support which the government was given by the population. Many assumed the issue had been settled in 1960. And a law is a law. However, by listening to the radio or by reading local papers, a visitor to the province might have assumed that the majority of the population supported the doctors' position. Although the 1960 provincial election had been fought on the issue of medical care, at the time of the strike the government did not know to what extent its position was supported by the population, nor did it attempt to measure its popularity. Its failure to do so undoubtedly contributed to its willingness to agree to settlement terms that created great confusion in the minds of the public.

By not seeking public support in the form of rallies, marches, or public statements, the government inadvertently contributed to the doctors' contention that they were supported by the majority of the population. And, indeed, on the surface the doctors were right, for the campaign which they supported and which was mounted on their behalf dominated public attention in the partisan anti-Medicare press. The government's restraint probably dampened the spirits of its supporters and may well have alienated others.

CONCLUSIONS

In a democracy regular constitutional opportunities are provided for changing governing officials. They permit the resolution of decision-making among groups with conflicting interests.

It was an abuse of the democratic process for pressure groups, and in particular for a coalition such as the one that arose in Saskatchewan during the conflict—consisting of the medical profession, the Chamber of Commerce, and other professionals, representing the upper socio-economic and educational groupings in our society—to attempt to subvert legislation to which a duly elected government had been committed. At the time of the strike these leaders attempted to reject the concept of legitimacy—the belief that our existing system of parliamentary democracy was appropriate for Canadian society.

In restrospect, the subsequent defeat of the C.C.F. after 20 years in power may have been a blessing in disguise for the party. The defeat which followed a fundamental debate concerning social policy undoubtedly created a stronger rededication to the party than ever before by its key adherents. The departure of dissidents, including a downgraded Cabinet minister, during the crisis also strengthened the party. This was an advantage the C.C.F. had that the profession did not share. It was not able to rid itself of its dissenters.

It is significant that in losing the 1964 election, the C.C.F. retained its percentage share of the popular vote. Further, the controversy had resulted in a temporary coalition of essentially diverse elements. This polarization of views, while intensifying the position of the extremes, served the purpose of enabling clearer differences in ideology to be observed than are usually apparent in our system of government, as the result of the election of a right-wing government in Saskatchewan.

We also feel that for the profession the results of the conflict may be viewed as useful rather than otherwise. Since the heretics have to be lived with, the social hatred directed at them cannot be a long-term thing. But by their continued presence within the profession (and, indeed, their numbers have increased) they will continue to maintain forces for disharmony within it which will constantly alert the profession to the problems of social change.

Even more important than having to live with heretics though, is the need for the profession to live in partial harmony with society.

There is little doubt that the great majority of Canadians are in favor of tax-financed health services. This means that the profession now must face up to the need to negotiate its fees with the elected representatives of the people. It also means that both profession and government must design arbitration procedures that will safeguard the interests of both the public and the profession.

A change in strategy by the C.C.F. government in introducing its legislation or in rewording sections of the medical care act would not, however, have necessarily averted the 23-day impasse. The profession seemed intent on maintaining its monopoly.

The supposed virtues of conformity may reduce and inhibit the acceptance of social change. And we know from the coalition which emerged in Saskatchewan that major social change affecting the status quo must result in conflict, which is distasteful and produces anxiety for many. Yet, government in the pursuit of its responsibilities should not be directed or intimidated by those who would threaten it with conflict or violence. In defense of human or civil rights, government should pursue its objectives in spite of organized resistance.

The propriety of the course taken by the government of Saskatchewan has been confirmed by the report of the federal Royal Commission on Health Services, and by the Canadian government's proposal to implement a Saskatchewan-type medical care plan for all Canadians by 1967. The conflict engendered over medical care also made an obvious contribution by accelerating widespread acceptance of the need to reform the organization and financing of health services in Canada.

REFERENCES

[1] This paper was read at the Thirty-seventh Annual Meeting of the Canadian Political Science Association, Vancouver, B.C., June 11, 1965.

[2] *Regina Leader-Post,* July 25, 1962, as reported by Canadian Press. The headline read "Doctors Say They Gave Way on a Key Principle."

[3] We regarded the doctors' action as a strike. Many may not like the word used in connection with a profession, but that is what it was. The chief spokesman for the profession, Dr. Harold Dalgleish, as quoted in the *Saskatoon Star-Phoenix,* July 5, 1962, p. 1, said: "A strike is a work stoppage and the doctors did not stop work but made provisions for the care of their patients." But milkmen deliver milk to hospitals when they go on strike, which is analogous to the limited though efficient emergency service that the doctors provided in July 1962.
A strike is the concerted collective withholding of their labor by a group of workers for the purposes of extracting certain concessions; in this case the concession sought by professional health workers was the prevention of the government of Saskatchewan's becoming "the monopoly buyer and seller of all medical services." This definition of a strike is from Andras, Andrew, LABOR UNIONS, Ottawa, Woodsworth House Publishers, 1948. The concession sought by the profession was included in a memorandum from the Council of the medical profession of Saskatchewan to the Honorable Woodrow S. Lloyd, Premier of Saskatchewan, dated April 12, 1962.

[4] Anderson, Jack F. C., Government in Medicine in Saskatchewan in 1960, p. 13 (mimeographed). Dr. Anderson is a past president of the Canadian Medical Association.

[5] The statements in this paragraph are based on comparative reviews of the annual reports of the Saskatchewan Medical Care Insurance Commission, including the 1964 report, and statistics from several of the voluntary prepayment plans in both Canada and the United States.

[6] *See* Simmel, Georg, CONFLICT AND THE WEB OF GROUP AFFILIATIONS (translated by Kurt H. Wolff), Glencoe, Ill., The Free Press of Glencoe, 1955; *see also* Coser, Lewis A., THE FUNCTIONS OF SOCIAL CONFLICT, Glencoe, Ill., The Free Press of Glencoe, 1956, pp. 70–71. Coser makes the following distinction between the heretic and the apostate: "At times the reaction of the group against the heretic is even more hostile than [it is] against the apostate. Whereas the latter deserts the group in order to go over [to] the enemy, the heretic presents a more insidious danger: By upholding the group's central values and goals, he threatens to split it into factions that will differ as to the means of implementing its goal. Unlike the apostate, the heretic claims to uphold the group's values and interests, only proposing different means to this end or variant interpretations of the official creed. . . . The heretic proposes alternatives where the group wants no alternative to exist. As Robert Michels wrote, 'The hatred of the party is directed not in the first place against the opponents of its own view of the world order, but against the dreaded rivals in the political field, *against* those who are competing for the same end. In this respect, the heretic calls forth all the more hostility in that he still has much in common with his former fellow-members in sharing their goals.' "

For concepts from social psychological sources, *see* Bruner, Jerome S., Social Psychology and Perception, in MacCoby, Eleanor, READINGS IN SOCIAL PSYCHOLOGY, ed. 3, New York, Holt, Rinehart & Winston, Inc., 1958, pp. 85–94; Bruner, Jerome S., Neural Mechanisms in Perception, *Psychological Review,* 64, 340–358, 1957; Bruner, Jerome S., Perceptual Readiness, *Psychological Review,* 64, 123–152, 1957; *see also* Solley, Charles M., and Murphy, Gardiner, DEVELOPMENT OF THE PERCEPTUAL WORLD, New York, Basic Books, Inc., Publishers, 1960. An earlier writer who commented on the way people distort the world around them was Walter Lippmann, writing on stereotyping; *see* his book, PUBLIC OPINION, New York, The MacMillan Company, 1922, 1960.

[7] *Saskatoon Star-Phoenix,* June 21, 1960, p. 3. Other references concerning the attitudes of individual doctors and of the organized profession to dissenters are available.

[8] The College of Physicians and Surgeons of Saskatchewan, Saskatchewan Division of the Canadian Medical Association, BRIEF TO THE ADVISORY PLANNING COMMITTEE ON MEDICAL CARE, December, 1960, Saskatoon, Mercury Printers Ltd, 1960.

[9] As reported in the *Saskatoon Star-Phoenix,* June 30, 1962, and based on a paper published by the Ontario Medical Review in June 1962, written by Edson L. Haines.

[10] Tollefson, Edwin A., BITTER MEDICINE: THE SASKATCHEWAN MEDICARE FEUD, Saskatoon, Modern Press, 1963, p. 149.

[11] College of Physicians and Surgeons of Saskatchewan, *op. cit.,* p. 23.

[12] *Saskatoon Star-Phoenix,* July 18, 1962.

[13] Canadian Broadcasting Corporation radio broadcast "News Magazine," September 2, 1962.

[14] Rosen, George, The Impact of the Hospital on the Physician, the Patient, and the Community, *Hospital Administration,* 9, 15–33, 1964.

[15] Merton, Robert K., Bureaucratic Structure and Personality, in Gouldner, Alvin W. (editor), STUDIES IN LEADERSHIP: LEADERSHIP AND DEMOCRATIC ACTION, New York, Harper & Brothers, 1950, p. 78.

[16] Dexter, Lewis A., Some Strategic Considerations in Innovating Leadership, in Gouldner, Alvin W., *op. cit.,* p. 600.

[17] A Brief Submitted by the Saskatoon Social Science Group to the Advisory Planning Committee on Medical Care, Saskatoon, December 27, 1960, p. 21 (mimeographed).

[18] This was Recommendation Number 38 in the report of THE ROYAL COMMISSION ON HEALTH SERVICES, Ottawa, Queen's Printer and Controller of Stationery, 1964.