

Canadian Medicine: Dominance or Proletarianization?

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HOW CAN THE DEVELOPMENT OF MEDICINE IN Canada be described? Has it been and is it now dominant in the health care system? Is it being deprofessionalized or proletarianized? Before analyzing the Canadian experience, a background on the issues involved will be provided.

There are both substantive and conceptual disagreements regarding the social position of medicine. Substantively, some authors claim that medicine is declining in dominance (Coburn, Torrance, and Kaufert 1983); is being deprofessionalized (Haug 1975, 1976); or is being proletarianized (McKinlay and Arches 1985); others feel that medicine is either stable (Freidson 1984, 1986) or is actually increasing in power. Writers on the development of the profession in the United States, Britain, and Australia are equivocal about the current role of medicine, although they are perhaps leaning toward decline (Larkin 1983; Starr 1982; Willis 1983).

Conceptual difficulties involve the similarities and differences among medical dominance, professionalization, and proletarianization. There is also argument about the best way to theorize the role of medicine, through a non-Marxian approach, the neo-Weberian version of which emphasizes social closure and market relationships, or through neo-Marxian theory which focuses more on ownership/control over the means of production and the labor process.

I leave theoretical exegesis to others. It must be noted that a decline

in dominance, deprofessionalization, and proletarianization cannot simply be assumed to be on the same theoretical terrain. While there may or may not be overlap between the notion of (a decline in) dominance and that of proletarianization (the criteria for dominance bearing a great similarity to, for example, Wright's (1978) criteria for assessing class position), certainly deprofessionalization often centers on such matters as increases/declines in physicians incomes/occupational prestige, which, from a proletarianization perspective, are largely derivative.

Freidson (1970) has described dominance as consisting of control over the content of care, over clients, over other health occupations, and over the context of care. But Freidson's early contention that medicine is dominant in the health division of labor failed to explain adequately the reasons for that dominance and to situate the concept of dominance within a broader theory capable of explaining change in the role of medicine. Freidson's latest claims that medicine is not declining in power are somewhat contradicted by his own disavowal of the dominance concept and his implicit admission that, compared with the salaried professions, the self-employed professions may, in fact, be suffering some loss of control.

Marxist writings on medicine have claimed that medicine could only be adequately analyzed by situating it within the larger social formation (Derber 1982, 1984; Navarro 1976, 1978, 1983; Waitzkin 1983; McKinlay 1984). Medicine was viewed as the intermediate rather than ultimate controller of health care events. More important were the logic of the capitalist system and the class struggle.

One stream within Marxism was the assertion that recent changes in the United States had produced the proletarianization of medicine (McKinlay and Arches 1985). This follows earlier Marxist analyses of occupational/class trends as exemplified in Braverman's *Monopoly Capital* (1974). The claim is that twentieth-century medicine is beginning to suffer the same fate that had overtaken nineteenth-century crafts workers, a fate facing all or most (skilled) workers under capitalism.

The proletarianization concept itself poses difficulties, however. The concept implies movement from one class to another. This movement would demand both an a priori view of class structure/class relationships/the class struggle and suggests that there are specific criteria, related to the picture of the class structure used, to assess the degree to which medicine is being proletarianized. Few writers are explicit

about both of these matters. At the margins, proletarianization becomes little more than a contention that medicine is losing status and power.

It is not the task here to settle the conceptual issues mentioned. Rather, I want to describe briefly the historical development of medicine in Canada and its changing power in the past two or three decades, before commenting on the implications of the findings.

Medicine in Canada

In an earlier article (Torrance, Coburn, and Kaufert 1983), the social history of Canadian medicine was described in three stages: a rise to dominance (to the end of World War I); the consolidation of that dominance (World War I to the 1960s); and since about 1962 (the year of the Saskatchewan doctor's strike) the beginnings of a decline in dominance. This article updates that analysis.

In describing Canadian medicine it must be noted that Canada did not exist as a nation until 1867 and that Alberta and Saskatchewan, for example, only became provinces in 1905. And because health is a provincial rather than a federal responsibility, there has been provincial variation within a broadly similar stream of development. Ontario is used as the major example.

The Emergence of Medical Dominance

The emergence of medical dominance in Canada took place between the nineteenth century, when medicine lacked power and status, and the early twentieth century, by which time it largely controlled the emerging health means of production.

Two problems faced Canadian medicine in the nineteenth century: restricting or eliminating competition from the irregulars who had enough popular support to resist attempts to make their practice illegal, and actually convincing the "regulars" to become licensed themselves. The main divisions within medicine were between allopathic medicine and the homeopaths, Thompsonians or eclectics; between an elite group of urban physicians and the lower-status doctors in the towns and in the countryside; and, in Lower Canada (Quebec), between Anglophone and Francophone doctors. Finally, there was conflict between

the medical schools (which had an incentive to produce students) and practitioners (who wanted to avoid competition).

There were repeated attempts by the regulars to gain legislation in Upper and Lower Canada to license practitioners and suppress irregular healers. Licensing in Quebec dates from 1788. A medical board to license physicians had existed in Upper Canada since 1795, but enforcement of licensing was minimal. The public, legislative, and irregular opposition to medicine is indicated by the rejection by the Ontario Legislature around mid-century of numerous attempts by the profession to pass legislation which would establish a monopoly for the regulars.

Even so, as Kett (1981) has noted, medicine in Canada has never been as uncontrolled as it was in the United States in the mid-nineteenth century. Regulatory institutions in Canada have a more or less continuous history from the early nineteenth century on. In particular, the number of medical schools in Canada was always limited by the number that could obtain university affiliation. There was never the proliferation of proprietary schools as in the United States and, hence, never the same sharp decline in schools in the early 1900s.

After mid-century the major challenge to medicine came from the homeopaths and eclectics, who had spread to Canada from the United States and gained a considerable popular following. The irregulars were strong, partly because they were often the only source of care, while homeopathy, with its much less drastic treatments than allopathy, recommended it to some influential citizens. A strong antimonopoly sentiment was reinforced by orthodox medicine's lack of a curative advantage over other forms of healing.

While some doctors were socially prominent (the first president of the Canadian Medical Association later became prime minister) the status of the profession as a whole was dubious at best. Newspapers delighted in reporting the vituperative attacks by one doctor on another. Educated laypersons displayed their contempt for bleeding, blistering, and purging—the main treatments of the time. The disjunction between personal and professional standing gave the impetus to a professionalizing elite to push for higher educational and practice standards, an aim that coincided with the goals of practitioners to reduce competition.

Competition was the major concern (Hamowy 1984). The 1861 Ontario census lists 974 physicians, while by 1871 the total was 1,574, an increase of 60 percent as compared to a population increase

of only 16 percent (McCaughey 1984). One doctor noted in the *Canada Lancet* (1873) that he settled in a village of 400 in which the justice of the peace practiced medicine, a local dentist advertised himself as knowing eye and ear problems, and another member of the college advertised cures for many incurable disease (*Canada Lancet* 1873–1874a). Another doctor complained about midwives in a county already “flooded with trained practitioners.” His competition got about 60 cases a year “which would amount in my hands to a very decent living for my small family” (*Canada Lancet* 1873–1874b).

The legislature repeatedly rejected bills for a medical monopoly for the regulars. Then, the legislature confounded orthodox medicine by authorizing a board for homeopaths in 1859 and one for eclectics in 1861. Finally, in response to one of many medical petitions, the politicians stunned the “regulars” by including both homeopaths and eclectics along with the orthodox practitioners in the act establishing the College of Physicians and Surgeons (Gidney and Millar 1984). But the embrace of regular medicine quickly proved fatal for the eclectics; they had disappeared by the 1880’s and, though homeopathy still lingers on in the 1980s, it has not been a serious threat to orthodox medicine for nearly a century.

By the middle of the 1870s, there was no universally valid principle for therapeutics and “active interventionism thus gave way to an emphasis on restoring constitutional powers (often by the use of stimulants such as alcohol)” (Howell 1984, 118) and by “the healing power of nature.” The major advances in treatment came in the last third of the century with the revolutions in surgery made possible by the use of anaesthetics and disinfectants and discovery of the germ theory.

Toward the turn of the century, the rise of medicine was aided by the development of public health, part of the broader Progressive movement (the “Social Gospel” movement, roughly from 1890 to 1920). The Progressives (Allen 1973) saw in the new industrial cities the antithesis of an idealized clean, healthy, rural environment they felt characterized their own past.

In the “public health” movement, medical science saw its first victories. It was the successful legacy of public health in reducing mortality and morbidity, rather than the results of ordinary medical practice, that medicine gave as evidence of its efficacy and of the power of the germ theory on which it was based. When public health

advocates began to attack the inequities of capitalism as the source of illness, however, the limits of public health acceptable to the new industrial elite was reached (Bator 1979). The public health movement was diverted toward education of the public rather than change in the social and physical environment (Biggs 1984), completely lost its dynamism and, in the 1920s, was superseded by curative medicine.

During the early part of the century, the health care system was in transition from a home-based to the beginnings of hospital-based care. With its new scientific respectability medicine attained equal status in the hospital with administrators and philanthropic trustees. The rise of health care occupations, such as nursing, to numerical predominance occurred simultaneously, and many types of auxiliary or paramedical occupations in the hospital, were brought into being under medical control (Torrance 1987).

The main roots of present-day medicine were thus established in the nineteenth and early twentieth century. The first licensing acts, the first schools of medicine, the first associations, the first journals all came mainly in the second half of the nineteenth century. Medicine already controlled the content of medical practice. By the end of World War I it had also attained control over the burgeoning health means of production in the hospital and over other health occupations and clients. Self-care was attacked through control over patent and prescription medicines. Doctors had a monopoly over the provision of care, even though there were still disputes with midwives (Biggs 1983), pharmacists, and nonallopathic healers such as homeopaths and chiropractors (Coburn and Biggs 1986).

But, in a market economy, doctors were far from controlling the context of care completely. Within the profession there was concern over competition. Medicine was still opposed by those in fledgling municipal, provincial, and federal bureaucracies and, most especially, by populist and working-class organizations and politicians. Indications of opposition included vaccination riots, attacks on the medical monopoly by the "Patrons of Industry" (an agrarian populist movement at times allied with labor), and other antimonopoly groups, and rejection, by judges, newspapers, and legislatures, of medical attempts to eliminate competition.

These events occurred as Canada moved from a purely subsistence economy to one characterized by production of a surplus and then of increasing industrialization. Both farmers and labor had antimonopoly

interests (although they were divided in other respects) and regularly attacked the professions in general and medicine in particular. In the 1920s, agrarian parties did form a number of provincial governments and the Progressive (agrarian) party won the second-largest number of seats in the federal parliament in 1921 (but refused to be the official opposition). Though populist movements had prevented medicine from attaining a complete monopoly of care, agrarian/labor governments did not directly touch the work or status of physicians, which by the 1920s was entrenched and surrounded by the mystifying aura of medical "science." With the decline of subsistence farming, agrarian radicalism was increasingly confined to particular regions and was more and more replaced as an oppositional force by the urban working class.

After the turbulent years of World War I, the postwar period was initiated by labor unrest, particularly in the West, and the Winnipeg general strike of 1919. Petrified by the Bolshevik revolution, the Canadian bourgeoisie suppressed dissent through suspending civil rights, intimidating unionists and strikers, jailings, beatings, and deportations (Cruikshank and Kealey 1987; Palmer 1983; Robin 1968). But efforts to unite discontented farmers and labor in an anticapitalist crusade failed.

In the nineteenth century the medical elite had allied itself with the lingering colonial aristocrat (the "Family Compact") and then with the rising (but quickly superseded) petite bourgeoisie. In tandem, its justificatory ideology switched from an emphasis on classical learning to a focus on "science" (see Shortt 1983). Although early in the nineteenth century there were political reformers in the medical profession, as an organized occupation medicine never identified with the working class and always felt threatened by the labor movement, although it had more ambivalent relations with agrarian populism, some of whose sentiments it shared. In the early twentieth century a minority within medicine, particularly public health physicians, did, for a time, agree with labor's anticapitalist aims.

Consolidation of Medicine

The importance of associations in the rise and maintenance of medical power has often been stressed. The Canadian Medical Association (CMA) was founded in 1867 but by the 1920s was in a parlous state,

threatened for Canadian members by more developed organizations in Britain and the United States. A suggestion to disband at the 1920 annual meetings was rejected, however, and, after that, the association never looked back either in membership or in finances (much of its increasing affluence due to drug advertisements in its journal). By the 1930s the CMA (outside of Quebec which developed its own associations loosely affiliated with those in English Canada) was a strong national voice, and all provincial associations were divisions of the national group (though the Ontario Medical Association was frequently stronger than its parent) (MacDermot 1935, 1958).

Despite medical power, medicine failed to completely suppress new unorthodox intruders such as chiropractic. Even though provincial commissions recommended their disappearance, in the 1920s the "drugless practitioners" obtained a foothold they have fought hard to make more secure ever since.

The social unrest of the postwar years and the relative prosperity of the 1920s gave way to the Depression. Doctors, especially those in the hard-hit prairies, suffered a drastic loss of income. Medicine adopted a more open attitude to schemes to hire doctors on salary, and to plans which promised to pay at least some of the bills for the poor. Provincial governments in four provinces ceded to organized medicine the administration of plans to pay for medical care for indigents (Taylor 1960).

Various provincial commissions were set up to examine the issues of health services and health insurance. All of these came to nought, partly, but not completely, because of medical opposition (Naylor, 1986). Medicine wanted health insurance but only their own form of health insurance on their own terms.

The medical elite made an increasingly sharp distinction between a national health service—which they saw as payment by salary and state ownership of health facilities, i.e., "state medicine"—and national health insurance. Totally opposed to the former the profession was not as completely against the latter, provided they retained control of payment and administration.

The 1930s and 1940s were also a time of social unrest. The unemployed marched on Ottawa only to be brutally halted by the police. Despite "camps" for the unemployed, desperate men marched and rioted in Vancouver and elsewhere. Political protest parties arose. The most notable was the Co-operative Commonwealth Federation (the

CCF), an avowedly anticapitalist working-class party, which, however, received a great deal of support from prairie farmers. And Social Credit, a populist party and one with, at least initially, an antimonopoly capital theme (it later became highly conservative), contested the political terrain in some western provinces. The 1930s and 1940s, not coincidentally, also brought moves toward the building of the welfare state in Canada (Guest 1980; Moscovitch and Albert 1987; Palmer 1987). Doctors became amenable to some form of health insurance, if only for their nonpaying customers.

During the war years the reform rhetoric grew more prominent, especially during times of CCF strength, as in 1943. Of four federal by-elections in that year, one seat was won by the communists and two by the CCF. In the same month the CCF became the official opposition in Ontario, winning 32 percent of the vote. In September of 1943 an opinion poll indicated that the CCF was the most popular party in the whole country, with 29 percent, followed by the Liberals and Progressive Conservatives, both at 28 percent. In 1944 the CCF attained power in Saskatchewan. The need to legitimate the war effort, fears of the CCF and a postwar depression, and fear of disorder, all contributed to a reform push by the Liberal party (Swartz 1977). Even the federal Conservative party, in 1942, changed its name to Progressive Conservative.

The wartime pressure for reforms in health and health care continued. The Heagerty (1943) report on health insurance (March, 1943) was quickly followed by the Report on Social Security in Canada (the Marsh report [1943]). There was movement on family allowances and on old age pensions. But, with the re-election of the Liberals in 1945, the beginnings of the Cold War, the postwar economic boom, the fading of the socialist "threat" and conservative governments in such provinces as Alberta (Social Credit), British Columbia (Social Credit), but most important, Ontario (Conservative), and Quebec (Union Nationale), the pressure for reform was undermined.

Although it had made some policy concessions because of the Depression, the medical profession survived the 1930s intact and influenced all subsequent developments in health care. During the war, government practically integrated its policy and planning with that of the profession. The recommendations of the federal government's Haegerty Committee on Health Insurance directly reflected the aims of the CMA's "Committee of Seven." Military manpower planning

was largely left to the profession. By the end of the war a medical official of the Department of Health could unabashedly state that "we do our utmost to maintain at every turn the interests of the practitioners of Canada as well as organized medicine" (McGinnis 1980, 285). Still, the federal and provincial governments were much more powerful after than before the war.

The wartime schemes for medical care insurance came to nought, foundering partly on federal/provincial wrangling, but the federal government did announce, in 1948, a series of grants for training personnel, health surveys, and construction of hospitals as "fundamental prerequisites to . . . health insurance" (*Canadian Medical Association Journal* 1949). There were other developments. Doctor-sponsored medical plans spread to a number of provinces, leading to a decline in any previous medical enthusiasm for government health insurance, except for the poor.

Though health insurance had foundered, hospital insurance survived and was implemented by the CCF in Saskatchewan in 1947 with little opposition. Partly in response to the parlous financial condition of hospitals, hospital insurance, generally welcomed by medicine, was put in force across Canada in 1957.

The Decline of Medicine?

The major battle for medicine came in Saskatchewan where a CCF government had been re-elected in 1960 on a platform which included a provincial medical care plan. The story of the war waged by doctors against Medicare in Saskatchewan has been told elsewhere (Badgley and Wolfe 1967). Medical care insurance was implemented, but only after a twenty-day strike by doctors, accompanied by vicious attacks by medicine and anti-CCF forces on the government, and with significant government compromises.

Medicine in the 1960s and 1970s had two strategies in combatting the spread of government-sponsored medical insurance outside of Saskatchewan. The first was to push the doctor-sponsored voluntary plans as an alternative to government-administered schemes. The second was to influence those provincial governments that were ideologically opposed to national health insurance to implement programs which conformed to the CMA's own aims. In Alberta, Ontario, and British Columbia, conservative provincial governments went along with

profession-designed plans. A draft health insurance plan in Ontario "incorporated the basic principles which the Ontario Division supports—the noncompulsory aspect, universal coverage by multiple carriers, and subsidy by Government for those individuals who require assistance for coverage" (*Canadian Medical Association Journal* 1963).

But, the profession was faced with a Royal Commission on Health Services, set up at its own suggestion as an apparent tactic both to stall government health insurance on a national scale and to give medicine possible influence over government policy. Despite strong medical representation and briefs from dozens of medical organizations opposing universal health insurance, the commission's report in 1964 recommended a national health insurance plan (Hall 1964) which, after many delays, was finally implemented in 1966 by a minority Liberal government propped up by the New Democratic Party (NDP) (the CCF had combined with labor in 1961 to become the NDP). All provinces were part of the plan by 1971; they could hardly resist 50 percent funding by the federal government.

Some writers claim that health insurance, itself an indication of medical power in opposing "state medicine," leaves the basic structure of health care untouched. But events in Canada show that while health insurance had little immediate impact on the structure of health care the consequences of health insurance are still reverberating in the health care system, greatly influencing the role of medicine.

Medical insurance, and its consequences for the public purse and the health of Canadians, prompted a huge number of provincial and federal studies of health "problems," from the early and sweeping Castonguay-Nepveu Commission in Quebec (1967–1971) to the Ontario Committee on the Healing Arts (1970), and a large number of other provincial and federal studies (e.g., federally, the Task Forces on the Costs of Health Services (1970), the Community Health Center Project (the Hastings [1972] report, the Lalonde [1976] report, and many others). All of these reports concerned the interrelations among health care personnel and the reorganization of health care services in the name of effectiveness and efficiency. Prominent in the reports were calls for a more integrated system of social and health services, community health centers, and the necessity of administering and "rationalizing" health care services. Implicit in most of the reports, and explicit in some, was the desire to reduce the overwhelming power of medicine to control health and health care.

But medicine still had the power either to prevent completely suggested reforms—for example, the Hastings report which recommended community health centers was shelved—or to negate these once implemented. For example, the medical profession in Quebec successfully bypassed a proposed system of government/lay health and social services centers by setting up hundreds of doctor-controlled polyclinics (Lesemann 1984; Renaud 1987). Schemes for nurse-practitioners came to nought. However, doctors could not halt the organizational consequences of government concern with costs and the politicization of health care.

With government health insurance, medicine immediately lost its control over the terms of the provision of health insurance. And the fee-for-service system, along with the use of computers and central payment, permitted complete documentation and surveillance of the work and income patterns of Canadian doctors (Charles 1976; Tuohy 1976). Medicine also now had to negotiate its fees with increasingly cost-conscious provincial governments rather than set these unilaterally.

The documenting of practice patterns led to concern with those physicians billing unusually large numbers of procedures. In most provinces, joint government/profession medical review committees were set up to investigate overservicing. In cases of abuse, payment could be reduced or refused. But relatively few physicians were disciplined.

Faced with a relative decline in income from a 1971 high, doctors in the 1970s began to support their demands for fee increases with threats to “withhold services” or by outright strikes. In Quebec, even before health insurance, specialists struck to preserve opting-out and extra-billing. Significantly, they were not supported by the general practitioners. The strike failed. As the decades wore on, withdrawal of services and strikes were no longer isolated events. On the government side came tough bargaining, including the publishing of the incomes of all doctors (in British Columbia).

A major aim of government was to control hospital costs, the most expensive portion of health care. Hospital budgets were given line-by-line scrutiny or hospitals were placed on strictly controlled global budgets. Pressure was exerted to intensify the work of hospital employees and to restrict the right of hospital workers (including, in some provinces, nurses) to strike. The strong pressure for the “rationalization” of hospital care resulted in a strengthening of hospital management, though still constrained by the parallel medical structure.

Wahn (1987) provides a number of instances in which the drive for efficiency directly affected medical control in hospitals in all three of the areas mentioned by Larson (1980), i.e., economic, organizational, and technical alienation. Wahn notes that although not many doctors are on salary they are being treated *as if* they were employees. And governments did apply pressure to institute salaried work in some instances, e.g., compelling some hospitals to put emergency room physicians on salary.

There were greater organizational controls. In one hospital, budgetary constraints forced the hospital administration to divert neurosurgery cases to another hospital, in the face of violent opposition of the medical staff in neurosurgery which ultimately admitted defeat. Similarly, studies of differential surgical rates provided ammunition for governments to control various surgical procedures. And doctors faced competition for power in the hospital from militant nurses and technical workers.

On the labor process level, government had to approve any new facilities. The increased use of research and clinical trials, computer protocols, and computer diagnosis and treatment also impinged on the day-to-day work of physicians in hospitals. The power of studies to influence what doctors do is being transmitted partially through doctors' own organizations: "Doctors are becoming active participants in the processes that are taking away their autonomy and power" (Wahn 1987, 431).

Physician as well as hospital costs were a problem. At first, governments concentrated on strict negotiations over fees with provincial medical associations. But fees are not incomes. Medical economists found that, regardless of fee levels, physicians tended to attain self-set income levels by manipulating utilization and mix of procedures (Barer, Evans, and Labelle 1988). It was a common insight that each additional doctor generated high levels of costs in the system. Both the numbers and the (mal)distribution of physicians became salient issues. Though some provinces attracted physicians to undeserved areas by offering financial inducements, Quebec simply refused to pay full fees to those moving into overserved areas. British Columbia now controls the issuance of all new government insurance billing numbers in the province and where they will be issued, thus effectively controlling all medical practices.

In 1975 the profession had successfully persuaded the federal government to restrict the immigration of physicians. In the 1970s new medical schools opened and older ones expanded. But this expansion

was short-lived. Burgeoning costs and lower government revenues turned physician "shortages" into "over-supply." As a consequence, in the late 1970s governments reduced the number of funded post-graduate training places, and influenced universities and medical schools to reduce their student intake and to maintain general practitioner graduates at about 50 percent of the total. Government funding of universities and hospitals and control of immigration gave them great influence, if not complete control, over medical manpower.

Finally, there were vast increases in government health care bureaucracies. The few physicians in government service soon were swamped with the new tide of "corporate rationalizers"—lay planners, accountants, and managers. Medicine, which had never completely controlled politicians but had had much greater influence in health care bureaucracies, lost the intimate association with officials it had previously had. As one doctor noted in Quebec, with the institution of health insurance doctors simply reacted to what emanated from government rather than being on the ground floor of planning from the beginning—even though this control varied by province (in Alberta there was close CMA/government cooperation).

Although health insurance brought a long-range decrease in power, it was immediately preceded and accompanied by a rapid rise in income, reaching a high in 1971. Doctors' incomes rose so high they became something of an embarrassment. But initial increases were followed by relative declines in the 1970s; in the 1980s physician's incomes are again on the upswing, while average wages have declined relative to inflation since 1981 (Barer and Evans 1986).

By the middle of the 1970s, although medicine had other concerns—abortion, foreign-born versus Canadian medical graduates, control of the proliferating allied health occupations, and negotiations with provincial governments—the issues which dominated the era were extra-billing and user fees, issues with strong overtones of a fight for control over health care.

Extra-billing, charging patients more than government insurance would pay, was effectively banned in Quebec. In the other provinces, most commonly, physicians billed government and accepted this payment as their full fee. But, even in Ontario where less than 15 percent of doctors extra-billed some patients and only 5 percent of claims concerned extra-billing, there were problems. Extra-billing was concentrated in

particular specialties, such as obstetrics and anaesthesia, and, often, in particular localities.

A Liberal federal government asked Justice Emmett Hall, the chairman of the original Royal Commission on Health Services, to study the situation. The profession went to extraordinary lengths to persuade Justice Hall that extra-billing and user fees were necessary, and that the main problem in health care was underfunding. But Hall recommended that extra-billing should be forbidden (Hall 1980).

The Hall Commission led directly to the Canada Health Act to ban extra-billing. The act produced open and acrimonious debate between Medicare supporters and the medical profession. Medicine, along with conservative provinces, faced a health care coalition of hundreds of public groups and health occupations, largely organized by labor, but aided by the federal government. The enactment of the Canada Health Act, in 1984, an election year, supported by all parties, was a bitter blow, yet another defeat for medicine and led directly to the doctors' strike in Ontario.

In Ontario, a Conservative government in power for over forty years, had been replaced in 1985 by a minority Liberal government supported by the New Democratic Party. The banning of extra-billing had been one of the conditions under which the NDP agreed to support the Liberal government. Bill 94, to ban extra-billing, provoked the most vicious and public reaction from medicine since the Saskatchewan doctors' strike nearly twenty-five years earlier. In the summer of 1986, doctors stormed the legislative buildings, publicly castigated the government as Nazis and/or Communists, and eventually went on a twenty-day strike in which they withdrew all but essential services (in some areas, even hospital emergency rooms were closed). But even at its height less than 60 percent of doctors took part in the strike, many were against it or provided only lukewarm support, and it turned into a costly and complete failure. With public opinion firmly against the strike, the hysterical reaction of the minority of right-wing doctors and their supporters backfired. Physicians trickled back to work; extra-billing in Ontario, and in Canada, was at an end (York 1987).

Though the power of medicine is indicated by the caution with which the government treated the strikers (in contrast, a few years earlier hospital workers and union leaders had been jailed because of

an illegal strike), still, the most powerful provincial association in Canada had been humiliated. Medicine's image was in tatters as a result of the wild behavior and the exaggerated rhetoric of some of its members.

Medicine was also facing challenges from other directions. Previously subordinate health occupations were struggling for independence and encroaching on medical territory. Nursing, at one time completely subordinate to medicine, now seeks to be "separate but equal" to medicine and to practice independently in the community. Nursing strongly and publicly opposed extra-billing and even suggested that all health workers be put on salary. Midwives are gaining recognition. Similarly, other healers, such as chiropractors, have been gaining in legitimacy (if at the expense of a narrowing of their scope of practice) despite medical opposition (Baer 1984; Coburn and Biggs 1986). Midwifery is in the process of re-emerging as an autonomous occupation in Ontario (see Task Force on the Implementation of Midwifery 1987). Even occupations such as physiotherapy, which medicine once used as a weapon against chiropractic, sought independence from its original sponsor. The burgeoning system of health occupations is increasingly out of medicine's direct control.

The efficacy of medicine and its right to determine the form under which medical care is delivered are being questioned, as is the emphasis on cure rather than prevention. The public now seeks to recover both birth (alternative birthing centers and home births) and death (the living will) from medical control. From the women's movements have come challenges to medical control over childbirth. Expsychiatric patients contest medical legal prerogatives; patients' rights groups challenge the adequacy of medical self-regulation. Though nowhere near as prevalent as in the United States, malpractice cases are increasing in number. And, in legal precedent, Canadian courts have, over the years, more and more moved to a patient-centered rather than a doctor-centered view of what constitutes adequate "informed consent" regarding medical treatments. From the state, from other health occupations, from the public, and from law, medicine is faced with encroachment on its previous unchallenged domain: even its clinical methods are questioned.

And, internally, medicine is changing. There are more physicians than previously in administrative posts, in community health or public health, and in the medical/educational complex. These often have

quite different views than their confreres in practice. Though one of Freidson's (1986) arguments is that medical power has been preserved through physicians controlling physicians, this view assumes all physicians are alike and have similar interests, and overemphasizes socialization as opposed to social structure as a determinant of physician behavior. There is an incipient split between general practitioners (who have formed 50 percent of the profession in Canada for many years) and specialists. The CMA and the College of Family Practice argue over who has the mandate to put forward medicine's political and economic views. General practitioners fight for more equitable fees relative to specialists. Medicine is also being rapidly "feminized." Females now form over 40 percent of medical school enrollments.

In Quebec the medical associations are in all respects like trade unions, with an annual dues check-off, a clear focus on the self-interests of the profession, and many of the rights and duties of a union. The provincial colleges and associations are now clearly separate organizations, with the former, though medically dominated, having lay representation and some duties to protect the public, the latter, more clearly representing the economic and political interests of doctors, without the automatic claim to represent the public interest they once had.

All this while the political discourse was largely dominated by a mildly liberal Liberal party in an economy increasingly controlled from the United States. During the decades following health insurance, however, politics was characterized by a revival of neoconservatism. By 1984, a Conservative prime minister, pro-business and pro-American, boasted to Margaret Thatcher that Canada had business governments from coast to coast. This did not last long as both Ontario and Quebec turned Liberal, and currently (1988) the three parties are about tied in popularity at the federal level. In the middle 1980s, however, the NDP narrowly lost crucial provincial elections in Saskatchewan and British Columbia to neoconservative parties. While big business became more American, unions shed their American ties.

Throughout Canada social services were being cutback, business was ideologically dominant, and there were attempts not only to roll-back wages, but to attack the very existence of unions. These efforts were not entirely successful, as the percentage of the labor force unionized remained nearly 40 percent, well above that in the United States (to some degree because of the high degree of unionization

among white-collar state workers). The claim was no longer that welfare measures ameliorated capitalism. Business now said that Social Security measures destroyed initiative. Inequality was no longer excused but was declared a necessary part of capitalism. Throughout, organized medicine supported any measures that would weaken government control over health and health care.

The Proletarianization of Medicine?

Viewed in terms of medical dominance regarding the content of work, and control over clients, other occupations, and the context of care, there has been a definite decline in medical power. This has been most pronounced in the context of care, but has been evident in all areas.

Even so, some Canadian observers contend that many reforms have been negated by medical power and that medicine's basic control over health and health care is largely untouched (see, e.g., Contandriopoulos, Laurier, and Trottier 1986; Lomas and Barer 1986; Renaud 1987; Swartz 1977; York 1987). How to account for these differences? Partly, it is a question of viewing the glass as half full or half empty. Certainly, medicine is still powerful; it has successfully opposed many potential reforms. The point is that it is not as powerful as it once was. And it is a mistake to view every frustrated reform as due solely to medical opposition. There are numerous health institutions with vested interests. For example, hospitals, and not only doctors, strenuously opposed the idea of community health centers. Medicine is not the only actor in the health care system. And the rationalist schemes of academics or bureaucrats often have little support outside these groups.

State involvement, itself a product of pressure from the organized working class, has produced a decline in sweeping medical powers regarding the health care system, health policy, and regulations governing medicine, but these are partial and limited, just as medical power has its limits. There has been an increasing control by others over the organization of health and health care, and medical work itself is being "rationalized." The work of physicians is open to monitoring and manipulation.

Can this be called proletarianization? Yes, there is a beginning of proletarianization. But it is a process which is far from advanced.

And, in terms of class structure and the class struggle, how has medicine been proletarianized? It could be argued that the nineteenth century saw the rise of medicine as a self-governing occupation, whereas the late nineteenth and early twentieth century saw an increasing de facto medical control over an emerging health division of labor. That control has been recently decreasing. Was medicine first petite bourgeoisie, then bourgeoisie, and now somewhere in between? Medicine is certainly less homogeneous by class than it once was, and now seems the epitome of an occupation in a contradictory class location. Its interests are not those of labor, nor are they entirely coincident with those of a bourgeoisie intent on efficiency in the public sector and profit in the private sector.

But politically and ideologically medicine has not changed much. Organized medicine has become increasingly conservative, although this conservatism does not necessarily accurately represent the divergent views of its membership. The recent revival of conservative free-enterprise movements in Canada have made more "legitimate" the free-enterprise minority within medicine. But medicine has always espoused petite bourgeoisie ideas. Organized medicine, if not all of its members, closely followed Cold War rhetoric in the postwar years. The medical leadership has always seemed more at home, and friendly, with Conservative rather than Liberal or NDP provincial and federal governments. The present medical push for partial privatization of health care, user fees, and "private funding" is congruent with the wishes of the more conservative governments in Canada. But those in contradictory class locations are influenced by external ideological and political forces. A decline in conservative forces generally could reinforce the more liberal reform groups within medicine itself. The situation is fluid.

The beginnings of proletarianization are evident as are some of the expected consequences. Government as sole paymaster has produced strikes and walkouts. But medicine is not part of the labor movement and has no allies within it, reflecting the continuing predominance of private practice within the profession. This situation contrasts sharply with that of teachers and nurses whose militant unions are now at the forefront of labor struggles.

But medicine has far from given up the fight to push back control by the state. The recent "free-trade" agreement between the United States and Canada, arranged by the Conservative government, if enacted

in 1989, would clearly have a long-term impact in strengthening conservative forces within the country and weakening those forces which helped initiate and preserve Medicare. Free-trade supporters openly speak of the agreement as ensuring that market forces will predominate in the Canadian political economy (Segal 1987). The fight over free trade has a definite class basis (Laxer 1986). A market emphasis would lead to a system of health care in Canada more like that of the United States. While a small group of ideologues within the profession would approve such a change, it is unlikely that the majority of Canadian doctors would do so. The practice of "corporate medicine" is not attractive. Doctors are faced by equally unpleasant alternatives—junior partners of the grande bourgeoisie, a bourgeoisie some physicians also view as a threat.

Certainly, medicine has lost some of its control over the provision of health care. It is still the central health occupation, however, and the outcome for medicine, and for other occupations, cannot be predicted from the idea of proletarianization as a slippery slope with no return once started. The fate of classes, and of occupations—like medicine—depends at least partially on the outcomes of struggles, which by definition are not predetermined. And in defending its privileges, and fighting against proletarianization, medicine, like other occupations, is also helping to reproduce proletarianization within the health division of labor.

A decline in dominance, yes. The beginnings of the proletarianization of medicine in Canada, a change in medicine's objective class position, if not its class relationships, yes. But medicine is still the dominant occupation in the health care system. It is struggling mightily against all encroachment on its privileges and prerogatives. A conservative medical elite is trying to turn neoconservatism to its own ends. The fate of medicine, however, is dependent on the outcome of broader class struggles in Canadian society.

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