PROFESSIONAL AUTONOMY AND RESISTANCE: 
MEDICAL POLITICS IN BRITISH COLUMBIA, 1964-1993

by

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The issues surrounding health care and health care policy are of great concern to politicians and the public alike. Government efforts in restructuring medicare, the "jewel" of Canada's social safety net, also affects the medical profession. It has been argued that this once powerful and dominant profession is experiencing a decline in its powers and authority. Is this decline inevitable or can the medical profession adapt to government reforms in such way as to maintain and even strengthen its power base?

This dissertation examines the themes of professional autonomy and professional resistance. The changing composition, and possibly the decline, of the medical profession's clinical, economic, and political autonomy, is analyzed through an historical case study of the British Columbia Medical Association (BCMA). Minutes from the BCMA's Board of Directors and Executive, along with interviews with doctors active in BCMA politics, and a media review, are used to generate a portrait of the social forces influencing medical politics in British Columbia from 1964 to 1993 and of the BCMA's relations with the various provincial governments of that period.

The negotiating strategies of the BCMA and the decisions behind these strategies are the focal point for an examination of professional resistance, an area neglected in sociology. The dissertation looks at the external and internal conflicts that impact on the resistance tactics of the BCMA and at the various successes and defeats the medical profession experiences in its bid to maintain professional autonomy.

During the time period under study, government intervention becomes more frequent and invasive. The BCMA has the least success in protecting the political dimension of professional autonomy and most success in controlling aspects of clinical autonomy. The vast variety of
resistance strategies at its disposal distinguishes it from labour groups and most other professions. Forced to accept measures it once fought against, the BCMA’s efforts become focused on ensuring that reform measures are under the control of doctors (rather than government) to the greatest extent possible. Although the BCMA has lost aspects of professional autonomy, it remains one of the few professional organizations today that can force compromise from the state.
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CHAPTER ONE

Introduction

I. Research Problem

The profession of medicine continues to fascinate social scientists. Much has been written on the rise of medicine as a profession (Berlant, 1975; Parry and Parry, 1976; Starr, 1982), the dominance of the profession once established (Freidson, 1970a, 1970b; Willis, 1983) and the decline of medical dominance (Coburn et al., 1983; McKinlay and Arches, 1985; Larkin, 1988).

Broader historical changes characterizing western industrial societies set an important context for understanding transformations within a profession such as medicine. The pendulum has swung from a period of almost unchallenged medical dominance to one where medical professional power is increasingly contested. In Canada, this transition is thought to have begun by the early 1960s with the introduction of government administered health insurance in Saskatchewan (Coburn et al., 1983) and to have intensified significantly in the 1980s— a time period associated with economic recession, the restructuring and erosion of welfare states, the new found strength of ideologies promoting the cost-effectiveness of private enterprise and the wasteful nature of government programs, and a growing public disenchantment with societal elites and experts. These and other social changes provide the deep background, the contextual backdrop, for fully understanding developments in the social organization of medicine.

A recurrent theme, especially in the American literature, is that during recent decades, the medical profession experienced and is continuing to experience, a loss of professional authority over its patients, its knowledge base, and its workplace. The theory of deprofessionalization (Haug, 1973) claims that doctors are losing some of their traditional authority through a
combination of forces, including: more educated and wary consumers, the growing strength of
paramedical occupations and consumer self-help groups, and the increased automation and
specialization of clinical practice. Theories of corporatization (Starr, 1982; Ginzberg, 1990) and
proletarianization (McKinlay and Arches, 1985; McKinlay and Stoeckle, 1990) argue that declines
in medical power can be best understood in relation to the changing work conditions of
physicians. The growth of for-profit, bureaucratized work settings in the United States has
resulted in a transfer of power from physicians to managers (corporatization) and perhaps, the
loss of key professional prerogatives (proletarianization). The last two theories also claim that
doctors, like other bureaucratized professionals, are experiencing deskilling as a result of
 technological advances and specialization trends.

The British literature has focused much more on the nature of state intervention, showing
how the British state has shaped medical authority, at times consolidating its powers while at
others, constraining its influence (Klein, 1983, 1993; Larkin, 1983, 1988). Although doctors in
the National Health Service (NHS) have endured enormous challenges, including Thatcherite
reforms such as the Griffiths Management Program (private sector management styles), it is far
from clear that there has been a significant loss of autonomy. British social scientists are hesitant
to claim medical decline. Most agree with Elston (1991) that "time will tell whether the
challenges...will bring about a major shift in the relationship between the state and the medical
profession and the replacement of managerial control for professionalism" (71). It is still
conceivable that doctors in the NHS may manage to adapt to government reforms in such a way
as to maintain and even strengthen their power base (Larkin, 1993; Hunter, 1994).

Coburn et. al. (1983) note that in Canada, medical dominance was severely shaken by the
establishment of national health insurance and the form of state intervention that necessarily
accompanied it. State support and patronage of the medical profession dwindled as the state
became accustomed to its new role as the employer of doctors and the sole paymaster of the
country’s health care expenses. "Tuxedo warfare" (Iglehart, 1990) ensued as doctors gradually
but progressively lost control over the setting of their fees to provincial governments. Coincident
with this, much of their traditional influence within health care bureaucracies and hospitals was
lost to planners and administrators (Coburn, 1993a). Coburn argues that Canadian medicine is
still powerful, especially in the health care division of labour where it remains the central and
dominant occupation, but notes its isolation. Medicine has no natural allies. It cannot expect
support from the other health care occupations over which it has been dominant for so long, or
from the labour movement from which it has successfully distanced itself (Coburn, 1993a).

It is this last transitional period when medicine is presumed to have lost dominance, which
is the focus for my research. I use literature and research from the areas of health care policy,
political economy and sociology of the professions to analyze the relationship of the British
Columbia Medical Association (BCMA) to the provincial state during the period 1964 to 1993.
A detailed historical case study of the BCMA allows me to reflect on my first research question:

How have changes in the political economy of British Columbia health care, in
particular the move from a laissez-faire arrangement to an increasingly regulated
market system, altered relationships between the medical profession and the
government of British Columbia?

II. Health Care and Public Policy

My interest in medical politics or "tuxedo warfare" (as one official of the Ontario Medical
Association colourfully described the Canadian experience) was sparked by public policy debates
surrounding the Canadian and the American health care systems, both of which were very much
in the media during the period in which I started thinking about a dissertation topic (around
1990). While American social analysts pondered the ability of the Clinton government to deliver
on its promise of universal health insurance, Canadians were grappling with how to restructure the most expensive and fastest growing item on provincial budgets. Ironically, some Canadians were advocating elements of the American system (such as privatization and user fees) as solutions to high cost and inefficiency, while Americans were debating the merits of "Canadianizing" their health care system in order to cut costs and provide better health care. Canadian newspaper headlines warned repeatedly that medicare, the jewel of our social safety net and a symbol of national identity, was ailing and not likely to remain intact for future generations.

This dissertation analyses medical politics in British Columbia, Canada using archival data from the British Columbia Medical Association (BCMA) as a principal, but not exclusive, source of data. It is not a comparative study in that it does not provide a detailed profile of the activities of medical professions and profession-state relationships in other Canadian provinces or in other countries. However, I depend heavily on research which has come out of academic and political engagement with health care policy and the medical profession elsewhere in Canada as well as in the United States and Britain. My research questions have been formulated with this material in mind. Many of the problems facing the Canadian health care system are similar to those in all Western countries and many of the solutions suggested by the experts have been attempted in other Western countries.

III. Controlling Doctors

A major similarity, and one which forms the crux of this dissertation, is the preoccupation with managing and controlling the medical profession. In Canada, health economists and bureaucrats insist that there is enough money already in the system to provide Canadians with
good health care (Province of British Columbia, 1991; Barer and Stoddart, 1991; Evans, 1992, 1993). One huge problem, they claim, is poor management of the health care system. Much of this poor management is allegedly due to an inability to control the gatekeeping activities of doctors and the number of doctors -- there are too many of them and they have too much "power".

Canadian provincial governments seem to accept this diagnosis. Every province in the country has a new health care reform plan and the medical profession is clearly identified as a major source of the cost problem.\(^1\) The solutions suggested within these blueprints are a clear sign that governments intend to clamp down further on the medical profession by limiting doctors' spending and taking measures to restructure and more effectively police the profession.\(^2\) For their part, medical associations complain that health care reformers ignore the unabated demands and expectations of patients which drive up the cost of the health care system. They argue that further restrictions on their profession will result in doctors losing their ability to perform effectively and therefore in a lower quality of health care for the public. In addition, medical associations claim that their members receive less protection from their government employer than do unionized workers.

I found two broad points of interest in these public policy debates around health care. First of all, I wondered what had happened to the notion of doctor as the undisputed expert on

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\(^1\) See for example: The British Columbia Royal Commission on Health Care and Costs, Vision for Health (Saskatchewan), Quality Health for Manitobans, Task Force on Primary Health Care (Nova Scotia), A Vision for Change (Prince Edward Island) and Strength at Two Levels (North-West Territories).

\(^2\) For example, government plans in British Columbia, Saskatchewan, Manitoba, Nova Scotia and Prince Edward Island, recommend that alternate physician payment methods be considered (Canadian Medical Association, in BCMA News, Feb/Mar., 1993).
all health care matters including health policy? This question required an examination of what was meant by reference to the "power" of the medical profession -- what did the term encompass and could it be shown historically that the medical profession had experienced a decline in its powers? Secondly, it seemed possible that the medical profession was not so much losing power but rather, adapting to its new circumstances. As Moran and Wood in a comparative study of Germany, Britain and the United States argue: "everywhere doctors are under pressure, but everywhere they have power" (1993:136). If this was the case, what form was this transformation taking and what consequences did it have for the various health care reformers whose solutions largely depended on controlling and restructuring the medical profession?

IV. Definitions: Dominance, Autonomy and Authority

In examining the first question, I found that in the health care policy literature the terms "power" and "authority", especially in reference to medicine, were used as descriptive terms rather than analytical tools helpful in exploring processes of social change. Within the area of specialization known as the sociology of the professions, debate on the maintenance or decline of medical "power" revolves around the concepts "professional autonomy" and "professional dominance".

As formulated by the American sociologist Eliot Freidson, professional autonomy in its original conceptualization (1970a, 1970b), refers to the ability of professionals to control the content, terms and conditions of their work. This is a privilege granted and legally sanctioned by those possessing political and economic power and is the key or defining characteristic distinguishing professionals from other workers. Professional autonomy is part of a framework of professional dominance, which, along with the key element of professional autonomy, also
includes a profession's control over the work of other occupations within its particular division of labour, control over clients, and control over definitions and relations concerning all matters pertaining to health and illness within the greater society (Freidson, ibid).

There has been considerable ambiguity in the way in which the concepts of professional autonomy and professional dominance have been used in the literature. Evan Willis, for example, uses the term "autonomy" in discussing medicine's control and self-regulation of its own work, while "authority" denotes issues involved in medicine's right to regulate and supervise the work of other health occupations, and "medical sovereignty" indicates the role of doctors as "institutionalized experts" within society (1983:3). Mary Ann Elston (1991) also retains Freidson's original use of autonomy to refer to the legitimized control that a profession exercises over the content and organization of its work but suggests refining the term into clinical, economic and political dimensions which encompass control over different aspects of work. She uses the term dominance to refer to authority over others. Following Paul Starr (1982), she distinguishes between "social authority" and "cultural authority". The former refers to a legitimised authority (Weber's Herrschaft) while the latter alludes to "the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true" (Starr, 1982:13).

My dissertation focuses primarily on the professional autonomy aspect of professional dominance. I have chosen to look at various dimensions of professional autonomy through Elston's categories of clinical, economic and political autonomy and have found her definitions to be a particularly useful guideline. They are as follows:

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3 Coburn (1992) notes that this ambiguity also exists within Freidson's work.
1. Clinical or technical autonomy. This refers to the "right of the medical profession to set its standards and control clinical performance, exercised, for example, through clinical freedom at the bedside, professional control over recruitment and training or collegial control over discipline and malpractice" (Elston, 1991:61).

2. Economic autonomy or "the right of doctors to determine their remuneration" (Ibid.).

3. Political autonomy involves "the right of the medical profession to make policy decisions as the legitimate experts on health matters" (Ibid.).

V. Theorizing the Decline of Medicine

Academic literature on the medical profession reflects the political evolution of organized medicine. During the period in which Western medicine enjoyed its "golden age", social scientists spoke of a medical dominance which was almost irrevocable regardless of whether it was viewed in positive or negative terms. By the mid to late 1970s, a period marked by limited constraints on health care spending, alternatives to Freidson's medical dominance framework began to emerge (most notably the work of Americans Marie Haug [1973] on deprofessionalization and John McKinlay [1977] on proletarianization). By the 1980s, academics responded to aggressive challenges to medicine's privileged position in the marketplace and today, theories explaining the decline of the medical profession predominate.

Haug (1973) argued that all professions were experiencing a backlash from the general public as well as an erosion of their knowledge monopolies. More educated consumers were changing the balance of power between themselves and professionals. Better able to comprehend
medical issues, consumers were aided in their efforts by computerization which made knowledge more accessible. At the same time, automation and specialization trends meant the growth of new occupations controlling knowledge and skills which were necessary to the traditional professions.4

Following the work of Oppenheimer (1973), McKinlay (1977) proposed that like other professionals, doctors were experiencing deskilling -- a transfer of skills was occurring as cheaper and more narrowly trained physicians' assistants and nurse practitioners, for example, were hired for work that doctors used to perform. Doctors were also being forced to leave their independent practices (where they had control over key professional prerogatives) to work as employees in bureaucracies (where they are progressively losing control over these prerogatives). The American medical profession was undergoing the proletarianization inevitable to all workers in capitalist societies and its members could no longer be considered professionally dominant.

The most recent American theories focus on corporate control of medicine in a country where health care has become an extremely lucrative product. Starr (1982), Ginzberg (1990) and Salmon (1995) argue that doctors are losing significant professional autonomy to the medical industrial complex of multihospital systems, Health Maintenance Organizations, Preferred Provider Organizations and insurance companies. The daily routines and performance standards of physicians are being monitored and regulated in accordance with corporate goals. The medical industrial complex was given free reign by the republican governments of Ronald Reagan and George Bush, both of which endorsed ideologies glorifying the efficiencies of the "competitive market".

4 In the case of medicine, we could include the technicians who perform ultrasounds, CT scans and Magnetic Resonance Imaging (MRI). None of these people have medical degrees but their work is now a necessary component of modern medicine.
VI. The Nature of State Intervention

The British literature has not produced theories of medical decline. MacDonald and Ritzer (1988) note that while the dominant tendency for American sociologists was to focus on the study of specific professions with the main objective of defining traits and characteristics, British sociologists have been more interested in analyzing historical and nationally specific events involving relations between the professions and the greater society. Much of this work, especially in the area of medicine, concerns the symbiotic nature of state and medical profession relations. Unlike the American situation where the early medical profession could not rely on state protection, the British medical profession was founded by the state with the granting of a royal charter followed by a privileged relationship of mutual benefit (Berlant, 1975). The British literature is a useful counter to the argument, advocated by North American doctors for years, that state intervention is the greatest threat to professional autonomy and that bureaucratized and nationalized health care systems necessarily allow the medical profession less autonomy than their market-driven free enterprise counterparts. Indeed, it can be argued that British and Canadian doctors currently have more clinical autonomy than American doctors (Bjorkman, 1989; Dohler, 1989; Evans et al., 1989; Harrison and Schultz, 1989).

With the election of the Conservative government in the United Kingdom in 1979, the British medical profession has met with financial and managerial constraints similar to those in other Western countries. The policies of the Conservative government have been heavily influenced by an ideology "emphasizing managerial effectiveness, cost containment through competition, and 'value for money' in health care" (Larkin, 1993:81). However at this point it is far from clear who is winning the battle.
How valid are the models and explanations proposed in the American and British literature for understanding the Canadian situation? My dissertation addresses the question of whether medical autonomy is declining in Canada (with a focus on the province of British Columbia), the possible causes of that decline, and the nature of state intervention into clinical, economic, and political matters concerning the medical profession. At least at first blush, the British approach is a better fit because, as in Canada, the challenge to the medical profession comes from the state rather than the corporate world as is the case in the United States.5

However, the Canadian situation must be understood within the particular political economy of this country. Any analysis of the Canadian situation cannot ignore the importance of the transition from a market driven system of private insurance plans to a nationalized and bureaucratic system of national health insurance. Relations between doctors and the state changed substantially with the advent of medicare, and these relations continue to change as medicare matures. Neither can the federal-provincial nature of this insurance system be ignored. Canadian doctors work within a system that is shaped by the two levels of the state and by the politics that exists between them.

VII. Professional Resistance

This dissertation deals with questions of professional resistance as well as professional autonomy. This is a relatively neglected area of study within sociology as most sociological literature is concerned with resistance employed by nonprofessional labour or by groups

5 The state has become more invasive in American health care policy (Estes, 1991; Ruggie, 1992) but one of the weaknesses of the theories of deprofessionalization, corporatization and proletarianization, is that the role of the state is ignored.
oppressed in terms of class, gender, sexual orientation, race, etc., and more recently, with the resistance generated from "new social movements". Marxist analyses of professions tend to be more interested in fitting professionals into a class schema than in resistance. In contrast, Weberian studies of exclusionary tactics are primarily interested in competition between professions (and sometimes nonprofessions) for privilege and are less useful in examining professional resistance against forces such as the state.

The literature on the medical profession has a definite tendency to either neglect resistance entirely or to portray it as inherent in the structure of a profession. In other words, resistance becomes a set of professional characteristics rather than a process requiring agency and actual strategies. For example, arguments made to the effect that medicine is able to retain power due to its ability to maintain control over self-regulation, entry into the profession and clinical work (Moran and Wood, 1993) are rarely accompanied by accounts of how the profession managed to retain this control. The state and/or corporations, on the other hand, are portrayed as more active and there is a sense of what the strategies were, how they were employed, and why they worked. But the profession, with few exceptions in the literature (see Eckstein, 1960; Klein, 1983; Starr, 1982; Saks, 1995), is not treated in the same fashion. This is especially true in literature analyzing the decline of the medical profession. Indeed, in much of this literature, things just happen and there is no agency involved, no actual actors who do things to make things happen. By focusing upon resistance in the profession, I hope to bring this sense of agency to light.

The resistance strategies of the Canadian medical profession are affected by state action (or anticipated state action) but also by professional ideology. Professionals have an "elevated and codified self-image" which they often use to associate their work with central social values
Doctors, for example, can argue that the cause at stake is not money but rather the quality of medical care which is an essential public service.

Much of the professional ideology of the medical profession is linked to doctrines of scientific orthodoxy. The success of medicine as a profession had much to do with its ability to distinguish its craft as 'scientific' and the practices of its competitors as 'quackery'. The medically qualified in Britain, for example, successfully minimized the practice of outsiders such as acupuncturists by equating the latter with "superstition, magic and the supernatural" (Saks, 1995:232).

Doctors have also been able to use the scientific and technical components of their profession in their battle with the state. Medical associations seek to define health care as a technical matter of a very specialized nature, best dealt with by those with the proper expertise. When state policies challenge the medical profession, the profession plays on the power of its professional ideology, telling the public that the government is interfering in areas where it has no knowledge or skill.

However, elements of a professional ideology can also place limits on resistance strategies. For example, Eckstein's (1960) study of the British Medical Association found that the internal norms of the association prevented consideration of overt political associations, public propaganda, and "trade union" tactics such as boycotts and strikes (29,70). Certain strategies that have, at least historically, been seen as illegitimate for a profession, are now, at a time when the profession is challenged, deemed acceptable. In British Columbia, for example, doctors staged a series of walk-outs during a 1992 battle with the provincial NDP government. The next year, the BCMA voted on unionization.

A question left unanswered in the literature is whether the professional ideology of medicine will be forced to change permanently in order to help medicine deal with current
challenges to its autonomy and authority. The proletarianization theory would indicate that the professional power of doctors has declined to such an extent that they will be left with no option but to use trade-labour protections. Even if this is true, however, the professional element of the ideology is likely to remain intact, and with it, important distinctions between professionals and labourers.

Historically, the medical profession has never needed to concern itself with the question of allies, other than corporate and state elites and occasionally, the public. Now that it is under attack from its natural allies, where will it decide to gravitate? Can it form alliances with other health care workers (which the profession believes, quite rightly, that it subordinates) or trade unionists (from which medicine has deliberately distanced itself)?

In analyzing the history of resistance strategies used by the BCMA over the last thirty years, my concern is to understand the following: how have the resistance strategies changed, why have they changed, how effective are these strategies, do they mark a departure from professional ideology, and if so, have they become indistinguishable from labour tactics? Do resistance strategies pursued by the medical profession continue to differ (in terms of their nature and effectiveness) from those of other professions and non-professions? Has professional ideology changed to accommodate new resistance tactics? Lastly, what kinds of alliances with other occupations or movements will the profession choose to form?

The overarching theme of the dissertation, then, concerns the dynamic between the external and internal forces that challenge medical power; the changing composition, and

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6 Many social changes occurred between 1964 and 1993 which can be said to have had an impact on the medical profession. My focus on professional autonomy (rather than the broader professional dominance) and the nature of my research questions and data sources necessarily limit the kinds of changes mentioned in the thesis. I am primarily interested in those changes which preoccupied the BCMA and/or the B.C. government to the extent that they had some
possibly the decline of the medical profession's clinical, economic and/or political autonomy; and
the strategies of resistance used by the profession to maintain its position and to influence health
care policy.

My intention is to chart the dynamics of "conflict and accommodation" (Tuohy, 1992)
within British Columbia health care politics from 1964 (when Social Credit and BCMA
collaborations on a provincial medical plan began) to 1993 -- a year marked by the settling of
a lengthy dispute between the BCMA and the NDP provincial government.

VIII. Research Questions

This time period will allow me to answer my central research question:

1. How have changes in the political economy of British Columbia health care, in
particular the move from a laissez-faire arrangement to an increasingly regulated
market system, altered relationships between the medical profession and the
government of British Columbia?

This very broad question leads to more specific questions within the areas of professional
autonomy and professional resistance. The more specific questions addressed in my thesis
include:

PROFESSIONAL AUTONOMY

2. How has the professional autonomy of the medical profession in British Columbia
been altered in the move from a laissez-faire arrangement to an increasingly
regulated market system?

3. How useful is it to break down professional autonomy into clinical, economic and
political types? Have there been changes in some aspects of professional autonomy
and not in others?

impact on their decision-making.
4. Are there forces internal to the profession which contribute to a loss of professional autonomy?

PROFESSIONAL RESISTANCE

5. What kinds of resistance strategies does the British Columbia Medical Association use? Have these strategies changed in the last 30 years? If so, why have they changed?

6. How effective are these strategies? Do they mark a departure from professional ideology, and if so, have they become indistinguishable from labour tactics? Has professional ideology changed to accommodate new resistance tactics? Are there groups or occupations with which the BCMA attempts to form alliances?

IX. Research Procedures

No single methodological strategy can be used to approach this array of questions. Given this, the following research strategies have been used in this study: 1) analysis of archival material of the British Columbia Medical Association, in particular, Minutes from the meetings of the Board of Directors and the Executive, as well as the Proceedings from the Annual General Assemblies; 2) analysis of selected secondary medical journals and newspapers such as the BCMA NEWS, The British Columbia Medical Journal, and the Medical Post; 3) a media review of relevant articles in the major provincial newspaper, the Vancouver Sun; as well as in the Province, the Victoria Daily Times, The Daily Colonist, and Canada’s self-proclaimed national newspaper, the Globe and Mail; 7 and 4) interviews with doctors who had been active in BCMA politics and service during the time frame of my dissertation.

7 The following abbreviations will be used: BCMJ (British Columbia Medical Journal), MP (Medical Post), VS (Vancouver Sun), Times (Victoria Daily Times), Colonist (The Daily Colonist), and G&M (Globe and Mail).
X. Organization of Thesis

In chapter two, I look at the dynamic between the external and internal forces that challenge medical power with an examination of the literature on professional dominance and the clinical, economic, and political autonomy of the medical profession. I then proceed with a review of the theories of medical decline and an assessment of some forms of intervention employed by the state in medical politics. This chapter concludes with an analysis of professional resistance and the connections between strategy and professional ideology.

Chapter three examines my data sources and research strategies as well as some of the methodological issues involved in studying an elite group.

Chapter four presents an analysis of the changes and challenges confronting the British Columbia medical profession from 1964 to 1970. This chapter looks at the evolution of the clinical, economic, and political dimensions of professional autonomy as public health insurance takes hold in the province. It also outlines strategies of resistance employed by the BCMA as the profession attempts to cope with the increased state intervention into its affairs.

Chapter five examines the health care vision of a new government (1971-1975) and the BCMA’s reaction to the proposed reform plans. This chapter also evaluates the internal conflicts within the BCMA and how these divisions may affect relations with government.

In chapter six, I profile the legal battles during the 1980s over extra-billing (won by the government) and billing numbers (won by the BCMA). Both of these issues threatened aspects of professional autonomy considered crucial by the BCMA.

The last time period (1991-1993) is examined in chapter seven. The BCMA argues that it has lost its professional bargaining rights as a result of a global cap unilaterally set by
government. The doctors consider the ultimate strategy of labour; unionization, in their struggle to protect their professional autonomy and strengthen their bargaining power with government.

Finally, chapter eight summarizes the major debates and conclusions of the research.
CHAPTER TWO

Literature Review

I. Introduction

This chapter draws upon a diverse body of theoretical argument and empirical research. I begin with a discussion of the sociology of the professions and formulations of professional power, focusing on Eliot Freidson’s concept of professional autonomy. I then examine research useful to my categorization of professional autonomy into clinical, economic and political dimensions. Following this is an examination of theories analyzing the decline of professional power (deprofessionalization, corporatization and proletarianization). The next major section of the chapter deals with political economy and the various kinds of state relations and state intervention influencing the medical profession. Finally, I deal with the subject of professional resistance.

Throughout this chapter I focus on the medical profession, bringing in other themes such as health care delivery or the history of medicine only as they bear directly on changes within the medical profession. I begin with theoretical arguments (I am using theory in the broadest sense here as sometimes the literature comprises little more than a series of speculations rather than a tight theoretical framework) and then evaluate them in terms of their applicability to the Canadian situation. The data chapters which follow will further analyse the arguments in relation to the medical profession and state in British Columbia.
Prior to the publication of Freidson’s *Professional Dominance* in 1970, the sociology of the professions regarded professional power from a rather benevolent standpoint. Theory evolved from work characterizing professions as highly moral institutions capable of saving society from the negative aspects of industrial capitalism (Carr-Saunders and Wilson, 1933; Durkheim, 1957), to a preoccupation with identifying traits and stages of professionalization common to the most successful professions (Caplow, 1954; Greenwood, 1957), to structural functional explanations based on the notion that the most successful professions were given protection, substantial remuneration and high social status in exchange for their knowledge, competence and altruism (Goode, 1960; Barber, 1963).

Trait and structural-functional models flourished during a time of economic prosperity and public trust in professionals, conforming with popular or folk understandings of the professional role. Freidson’s theory of professional dominance (1970a, 1970b), along with Terence Johnson’s work connecting professional power with state patronage (1972) and Magali Larson’s portrayal of professions as market monopolies (1977), marked the emergence of what came to be known as the power school of the professions -- critical analyses which considered the social and economic power relationships inherent in professional privilege. Freidson, Johnson and Larson demonstrated the link between formal knowledge and market power. These writers argued that knowledge and expertise were constructed from historical economic and social processes which valued some forms of knowledge and expertise over others and that professional organizations were first and foremost designed for acquiring and maintaining an advantageous position within the division of labour.

Occupations might aspire to obtaining professional traits (formal education for members,
a code of ethics, etc.) but this is not what made a profession. A profession "won" its status during an historical process in which its leaders were able to successfully convince the state to grant and legitimize a professional "autonomy" or control over the content, terms and conditions of work (Freidson, 1970b:23). The most successful professions were then able to use their credentialism in various strategies of social closure (Parkin, 1979) and occupational control to enhance market value and social mobility and to thwart outside competition and external regulation.

Marxist writers used this perspective of professional power to argue that professionals played a unique role in capitalist economies (that of managing and policing the working class) and therefore contributed to the production of subservient and disciplined workers (Carchedi, 1977). Feminist writers (Witz, 1992; Riska and Wegar, 1993) later added to the critique of professional privilege by highlighting the patriarchal nature of medicine as a field of research and practice as well as the power relations inherent in the doctor/female patient relationship.

The portrayal of professions as powerful and privileged (and generally void of altruistic tendencies) is not exclusively of the left, however. In England under Margaret Thatcher, proponents of the right-wing argued that the empire building of professions involved in the public service had resulted in services contrary to the needs of citizens (Harrison and Pollitt, 1994). The solutions offered by the political right in England (private sector style competition and management) were different from those of left-wing critics of professionalism. The latter tended to espouse increased consumer participation, but the conceptualization of professional power was similar.

1 Other Marxists, most notably Vincente Navarro (1986), argued that the notion of professional power was a false one because professionals such as doctors were only handmaidens of the capitalist state.
What is central to my argument is the conception of professions as collectivities using power to further their interests and goals. This power has, as I show later, been challenged in recent decades. However, before turning to work on the decline of medical power, I spend the next three sections specifying various aspects of professional power.

III. Professional Dominance and Professional Autonomy

Freidson argued that successful professions were dominant professions and he cited (1970a, 1970b) four different measures of professional dominance: 1) control over the content, terms and conditions of work; 2) control over other occupations within a particular division of labour; 3) control over clients; and 4) control over definitions and relations concerning all matters pertaining to a profession's self-proclaimed sphere of influence.

The first measure, control over work or "autonomy" is the defining or key characteristic of any profession. While members of most occupations may seek to be self-directing in their work, only professionals have gained organized autonomy and may assert that such freedom is a necessary condition for proper performance.

The core feature of professional autonomy concerns control over the technical content of work. As long as a profession is able to retain full control over the technical side of its work (for doctors this means the ability to control decision-making around clinical procedures), certain

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2 Freidson's use of autonomy is confusing. Sometimes the term is used in a narrow sense referring to control over the technical content of work, while at other times the term is used very broadly and includes control over other occupations. My use of the three categories clinical or technical, economic and political autonomy, not only clarifies the subject matter but also includes some aspects of professional dominance without negating the importance of the technical component of autonomy.
levels of market and state control can be tolerated and will not adversely affect the essential character of the profession. Freidson notes that professionals everywhere are free to control the content of their work and what varies is control over the terms and conditions of work. In some countries such as the United States, the professional autonomy of the medical profession is comprehensive in scope and professionals have a great deal of control over the economic and social organization of work as well as the technical content. In other countries (for example, the former Soviet Union) medical autonomy is less comprehensive and is restricted mainly to the technical content of work. However, Freidson argues that when the core autonomy is gained (control over technical content) segments of autonomy in other areas will usually follow (1970a:83-84, 1970b:44-45).

Freidson has mixed feelings about professional autonomy. On the one hand, professional autonomy facilitates the progression of certain types of knowledge and makes it easier for professionals to carry out their duties. On the other, there is a "critical flaw" in professional autonomy. The isolation and protected insularity of professions encourages members to overestimate their abilities and knowledge and underestimate the knowledge and skills of those in other professions and occupations. It also encourages patronizing attitudes towards the public. It is not surprising therefore, that professionals often have great difficulty in first perceiving the need for, and then in practicing, the self-regulation that society expects from them (1970b:368-70).

My focus is mainly on these aspects of autonomy as outlined immediately above. Freidson's other three dimensions are important but less directly relevant in my work. Nevertheless, to fully appreciate his contribution, I quickly review his other three dimensions. The second important aspect of professional dominance, for Freidson, is the ability to control other occupations within the profession's particular division of labour. In the case of Western
medicine, the profession won the right to the exclusive practice of certain healing tasks and skills as well as the right to regulate the work of other healers. Competitors were either driven out of the market or they were forced to limit their activities to those which would supplement or assist rather than compete with medical practice. The paramedical occupations (as Freidson refers to them) work within an hierarchical division of labour organized around the state supported authority of the medical profession. Their relative lack of autonomy (along with its accompanying attributes of authority, responsibility and prestige) make them sociologically distinct from the medical profession (Ibid: 49).

The two other dimensions Freidson emphasizes, control over patients and control over definitions and ideology, are slightly more central to my work. A truly dominant profession is not only able to control its own work and that of other occupations in its division of labour, but is also able to produce ideology around its area of competence, it is able to define and construct a particular sphere of reality for the public. The way that we think about health and illness has been defined and shaped by the medical profession and other groups (for example pharmaceutical companies) which promote the ideology of biomedicine. Starr (1982) and Elston (1991) label this aspect of professional dominance "cultural authority": "the probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true" (Starr, 1982: 13). It is because of the medical profession's cultural authority that most of us will be persuaded to take our doctor's advice. While doctors cannot force individual patients to accept their judgements, Starr points out that society's overall acceptance of the medical profession's cultural authority means that members of the general public are sometimes forced to undergo medical examinations for purposes of certification, or to obtain disability insurance, or to convince professors they have been ill and not lazy, or even to prove that they are sane enough to run their own personal affairs (Ibid: 13).
The cultural authority of Western medicine stems partially from the privileged status of science in the belief systems of Western societies, but it is more than that. Doctors have a higher level of cultural authority than other scientists. Kosta (in Horobin, 1983) argues that medicine evokes the charismatic authority of two ancient texts. The first is the Biblical "power to heal sickness and cast out devils" (Mark, 3:15). The second is the Hippocratic Oath "which refers to that ability of healing and that mastery over death which no profession save medicine can claim. It does not matter whether or not that ability or mastery are real; at times of distress the public perceives and invokes them" (Horobin, 1983:92). The modern doctor has been cast as a "secular priest" in modern societies. He or she does more than treat our aches and pains, the role of the doctor now includes moral prescription on lifestyle choices and on what constitutes good or bad behaviour (Zola, in Kelleher et. al., 1994:xii). Therefore, when doctors invoke a claim of "medical need", lay people are reluctant to contradict them (Starr and Immergut, 1987).

However cultural authority, like all other aspects of professional dominance, is not absolute. Freidson is very clear that all professional powers and privileges depend on the conviction of the dominant elites of the value of the work performed and on state protection and patronage. Therefore, the degree of professional dominance varies from time to time and from place to place (Freidson, 1970b:24).

IV. Professional Dominance and The Canadian Medical Profession

Coburn (1988, 1993a) argues that Freidson’s theory of medical dominance is applicable to the Canadian situation until the point of the introduction of provincial medical insurance (first carried out in Saskatchewan in 1962). At this point, Coburn claims that there is a decline in medical dominance which Freidson’s theory is incapable of explaining. Coburn, Torrance, and
Kaufert (1983) describe the history of Canadian medicine in three stages: the evolution of medical dominance (to the end of World War I); the peak years of that dominance (World War I to the 1960s); and beginning in the early 1960s, a decline in dominance (Coburn, 1988:94).

The Canadian medical profession did not occupy an advantageous position within the division of labour until the late nineteenth century. As Canada changed from a predominantly rural country of independent farmers to an industrial nation of wage earners, medicine was transformed from a "cottage" industry of solo practitioners to a complex, technological, bureaucratic industry with a rigid hierarchical division of labour dominated by physicians. Before the mid 1800s, a physician's social status had little to do with occupation. Upper class doctors came from upper class families and had wealthy patients. The poor were administered to by doctors further down the social scale with less education and training (Starr, 1982:81).

Between the mid 1800s and early 1900s, doctors became organized as a profession, concerned with raising status and income through exclusionary strategies such as licensing and limiting the channels of entry into the profession, and by controlling and subordinating other health practitioners and patent medicine makers.

The Canadian medical profession developed close connections with government and bureaucratic elites: "Canadian Doctors were well represented in elective political office, and career doctors became dominant in local, provincial and federal departments of health where they acted as liaisons between governments and the organized profession" (Torrance, 1987:19). From approximately 1900-1930, Canadian doctors used their powers to upgrade medical education, create an advanced system of hospitals and practitioners, participate in developing public health

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measures and provide wartime medical services within the armed forces (Ibid.:19). State intervention at this point was unthinkable.

However, the Depression and subsequent war years ushered in a different reality for doctors. When patients were unable to pay bills, doctors were forced to rely on medical relief plans. During this period the medical profession "displayed a co-operative if highly qualified attitude towards government health insurance" (Torrance, 1987:24). However after WWII, the Canadian Medical Association strongly opposed the idea of government medical insurance. The incomes of both doctors and their patients had risen in the postwar prosperity and the medical profession preferred to support its own hospital and profession-sponsored voluntary health insurance plans, where medical control and dominance could be assured.

Throughout this period, doctors consolidated their professional power. The government insurance plan in Saskatchewan which conceived of a system of salaried doctors under government control, engendered a bitter doctor's strike. This was an early step in state challenges to medical dominance. The government backed down, giving doctors full control of the administration of the new hospital insurance and medical insurance for pensioners (Swartz, 1977:323).

The medical profession also fought the implementation of federal medical insurance, but of course, lost the battle. State challenges to medical dominance continued with much more success as medicare matured. However, before looking at the nature of these challenges and their impact on the Canadian medical profession, I want to look more closely at the professional autonomy aspect of professional dominance and examine research useful to my categorization of professional autonomy into clinical, economic and political dimensions.
V. Dimensions of Professional Autonomy: Clinical, Economic and Political

My research deals with the period covering what Coburn calls the beginnings of the decline of medical dominance to present day. It is events occurring in this era that he suggests challenges Freidson’s theory of medical dominance. Since my focus is on relations between the British Columbia Medical Association and the provincial government, I will not evaluate all of Freidson’s theory of medical dominance. I do not, for example, look at the changing relationship between the medical profession and the paramedicals.

In undertaking an assessment of Freidson’s claims, I need to work with concepts which would not assume either professional dominance or powerlessness on the part of the medical profession. However, I did not want to take a narrow view of professional autonomy and view it only in the clinical/technical sense.

I chose to analyze professional autonomy along three dimensions: clinical, economic and political. No clear divisions separate these three dimensions, they tend to overlap and influence each other. Below I focus on each dimension in turn:

1. Clinical: the “right of the medical profession to set its standards and control clinical performance, exercised, for example, through clinical freedom at the bedside, professional control over recruitment and training or collegial control over discipline and malpractice” (Elston, 1991:61).

i) Clinical Freedom at the Bedside

This is the aspect which most of us would equate with the notion of clinical autonomy.
Clinical freedom at the bedside means that physicians are able to control all levels of patient care—diagnosis, orders for tests and procedures, admission to hospital and discharge from hospital—with little direct interference.

Rachlis and Kushner argue that in Canada, doctors have "virtually complete clinical autonomy" (1994:53-4). They contrast the Canadian situation with that in the United States where American physicians often are forced to "phone and get clearance from a nurse (or sometimes a clerk) employed by an insurance company in order to arrange hospital admissions, specialist referrals, and increasingly, diagnostic testing" (1994:54).

However, the ability of physicians to control patient care is affected by the availability of resources such as hospital beds and technology. This is an area where clinical and political dimensions of professional autonomy overlap. In Canada, state bureaucrats now dominate policy decisions concerning the allocation and supply of resources for health care and physicians must contend with waiting lists for hospital beds and technology. On the other hand, decisions on methods of clinical intervention directly impact on state resources but bureaucrats do not as yet make these decisions, doctors do. Having said this, there are certain procedures not covered by Canadian Medical Service Plans (for example, cosmetic plastic surgery) and there are other services which are not covered every year (for example, eye examinations in B.C.). So far this is a very small list of services and it varies by province. But if provincial governments become able to significantly enlarge this list, clinical freedom at the bedside could be significantly reduced for Canadian doctors.

Governments may find, however, that the doctrine of clinical autonomy provides them with some advantages. In particular, they may not want to be held accountable when difficult decisions are made with limited resources. In his analysis of the British National Health Service, Klein (1983) argues that the NHS was able to get away with very stringent criteria for renal
dialysis (and the subsequent deaths of citizens who would have been treated in some other countries) because the actual decisions on who would get treated were made by doctors within their jurisdiction of clinical autonomy (86).

ii) Professional Control Over Recruitment and Training

A second aspect of clinical autonomy concerns professional control over recruitment and training. In Canada, the medical profession has retained control over recruitment and training. However, in this area the provincial medical schools have authority, not the provincial medical associations. Sometimes the two bodies have different agendas. The tendency for medical schools is to continually want to expand while some provincial medical associations (such as the BCMA) have learned that it is not in their best interest to have what might be perceived as an oversupply of doctors.

Government has been preoccupied with the possibility of physician over-supply since the early 1970s. At that time it became the creed of health policy makers that every doctor added to the system caused a great increase in other costs primarily because of the services each one used in earning his/her income (Van Loon, 1978:457). The rate of medical training had been set, however, by the Hall Commission of 1964 which recommended the building of new medical schools and the expansion of existing schools. Demographers forecasting the Canadian population for the royal commission projected a population of 30 million by 1986 which turned out to be an overestimate of approximately 5 million (Rachlis and Kushner, 1994:174-5). The end of the post-war baby boom combined with increased numbers of doctors immigrating to Canada and fewer than anticipated doctors leaving the country following medicare, resulted in a growth of physician supply three times faster than the growth in population (Rachlis and
Evans (1992) argues that the "formulation and execution of manpower (sic) policy" has been the "least successful area in health care policy in Canada" (755). Physician supply continues to rise and medical schools continue to claim that their numbers need to increase. The latest arguments revolve around Canada’s aging population and the increasing numbers of women graduating from medical school. Concerning the latter, it is anticipated that women will work shorter hours than their male counterparts due to family responsibilities.

Control of recruitment and training is ultimately of concern to provincial medical associations mainly because of supply and demand factors. Too great a supply of physicians has the potential to depress physicians’ earnings, either directly through competition or indirectly through government decisions to restrict earnings (through caps on medical insurance payments) or physicians (through billing numbers). How this control over recruitment and training has changed is therefore an important reflector of medical dominance.

iii) Collegial Control Over Discipline and Malpractice

In Canada, the provincial Colleges of Physicians and Surgeons are responsible for setting qualifications, licensing and penalizing those who "violate the standards" or practice medicine

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4 In 1960, the physician to population ratio for Canada was 1:879. Today that ratio is estimated to be 1:450 (Taylor, 1978; Evans, 1992).

5 Evans disagrees with these claims for the following reasons: he calculates that the ratio of physicians per capita is rising about 2% a year while the aging of the population would mean an increase of approximately one third of one percent a year. He also argues that the increasing physician supply is resulting in overservicing of the elderly. As for the argument concerning female physicians, he asks why we have not witnessed a fall in gross fee billings per physician (1992:756).
without a license (Taylor, 1978:264). The Colleges are responsible for the protection of the public from unqualified or unethical doctors.

In contrast, provincial medical associations, under the umbrella of the national Canadian Medical Association, were established to protect and promote the interests of the profession. The medical associations negotiate with provincial governments over fees and any dispute that doctors may have with legislation. Members also provide public education and service but this is a secondary role. During the period after Medicare when governments started to analyse physician billings, it was not clear who should be in charge of investigating doctors with unusual billings -- the government, the provincial College or the provincial medical association?

The BCMA remains one of the few medical associations in Canada which continues to dominate the committee responsible for the economic discipline of doctors. The BCMA Patterns of Practice Committee analyses computer profiles of each practitioner’s billing habits generated by the province’s Medical Services Plan. The Committee can decide to handle aberrant physicians themselves or refer the matter to either the MSP, the College or the RCMP.

There is very little published on physician fraud and abuse in Canada and the economic discipline of doctors. Wilson et al. (1986a, 1986b) argue that the fee-for-service payment of doctors, typical in Canada, the United States and Australia is conducive to medical fraud and abuse. They have harsh words for the BCMA’s Patterns of Practice Committee, which they say allows criminal behaviour to be viewed as "mistakes" and "misunderstandings" and is ineffectual in doing its job (1986a:140).\footnote{They argue that in B.C. "no charges have ever been successfully laid by the RCMP against doctors for fraud or other abuse of the MSP. Only 20 doctors have repaid the Plan for claims 'incorrectly submitted' during the last 3 years and only one physician has been put on formula payment, where reimbursement from the Plan for scheduled fee items are at a reduced level. In the same time period, 7 physicians have been ordered to repay $200,000} They blame this on the fact that Patterns of Practice is dominated
by physicians and are more approving of the situation in Quebec where the Health Insurance Board deals directly with physician fraud and in Ontario where the provincial government is also in charge (1986a:141).

Control over discipline and malpractice is a third aspect of clinical autonomy and in British Columbia, some of this control (that of economic discipline), is exercised on behalf of the profession, by the BCMA. One of the themes running through my data chapters examines the strategies employed by the BCMA and the compromises they made in order to ward off government threats to remove Patterns of Practice from BCMA control.

2. Economic: Economics is a second dimension of professional autonomy. The economic dimension refers to "the right of doctors to determine their remuneration" (Elston, 1991:61). With the onset of socialized medicine in Canada, medical associations have negotiated with provincial governments over doctors' earnings. As health care budgets have increased and as deficit reducing programmes have become more central, pressure to limit doctors' earnings has increased.

3. Political: The third and final dimension of professional autonomy is political and it refers to "the right of the medical profession to make policy decisions as the legitimate experts on health matters" (Elston, 1991:61). Political scientist Malcolm Taylor (1960:108) wrote that:

...the medical profession as an interest group is a happy choice for examination, for not

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to the MSP due to servicing patients in excess of statistical norms and four physicians were ordered to return funds to patients who were extra billed. However, and importantly, no practitioner has been ordered out of the Plan in the past three years and the College, during this time, has neither removed or suspended any physicians from the Register as a result of MSP referrals" (1986a:141).
only does it provide insights into private government, and have a major influence on public policy, but it seems safe to state that in Canada, at least, no other private group is as deeply involved in public administration and this despite the fundamental antipathy between the healing arts and bureaucracy.

Taylor notes that it was "standard practice" in most provinces for governments to consult the medical profession before health legislation was introduced. Close personal relations with government as well as the presence of physicians in federal and provincial legislative bodies and health departments made the medical profession unique in terms of its influence over public policy (Taylor, 1960:115-17).

According to health economist Jane Fulton (1993), it is now very unusual for ministers of health to have medical training. It is also unusual for the chief executive officer of a hospital, regional planning board or long term care facility to be a trained physician. Only public health units continue to prefer a physician in that role (Ibid.:67-8). While medical associations routinely make submissions on most health policy issues, they do not necessarily dominate commissions or boards of enquiry and sometimes they are shut out of the decision making process entirely.

Sociologist Robert Alford (1975) developed a theoretical framework involving three groups of actors in the health care system. Since he was writing in the mid 1970s, he considered physicians to be "professional monopolists" whose structural interests were dominant. By this he meant that their interests were served by current political and economic structures and institutions, negating the need for them to continually organize to defend their interests. However, physicians were receiving some challenges from a second group of "corporate rationalizers" (i.e., hospital administrators, medical schools, government health planners, public health agencies and researchers) who had gained some power due to the increased complexity and specialization of medical technology and the health care division of labour. The third group within Alford's framework, consumers, had only negligible influence on health services (Ibid.:14-
Most commentators would now suggest that Alford's professional monopolists have lost some of their power. There is, it would seem, a growing need for physicians to organize and defend their interests. Corporate rationalizers, at least in the United States, have much greater power now than in the 1970s. In fact, Immergut (1990:454) argues that:

...in my view we should not completely discount the possibility that under certain conditions professional representatives can make positive contributions to health policy and can provide an important counterweight to the economic rationality that seems to be taking over the health field. Attacks on the medical profession have cleared the way for alternative modes of decision making, such as cost efficiency or greater popular participation, but the essays in this volume indicate that these alternatives are not necessarily attractive....

I return to this theme below, but first I provide some conceptual tools that are useful for examining this apparent challenge to professional monopoly.

VI. Theorizing the Decline of Medical Power

It seems obvious that there have been challenges to medical privilege. The question is whether these challenges have actually translated into a loss of professional autonomy for doctors? If so, how helpful are some of the theoretical perspectives in explaining the nature and extent of the decline in medical power? What are the implications for Canada and British Columbia? In the next three subsections, I review three prominent theoretical perspectives which have been used by social scientists to explore changing levels of medical power: deprofessionalization, corporatization, and proletarianization.
i) Deprofessionalization

Marie Haug posed one of the earliest challenges to the notion of professional dominance with her theory of deprofessionalization (1973). Her theory was based on what she believed were crucial changes in the way in which professionals and consumers were relating to one another. In the case of the medical profession, Haug argued that the profession was showing signs of losing its "monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over the client" due to increased automation and specialization of clinical practice, rising levels of education among patients, the emergence of a more diverse group of health care workers and the growth of consumer self-help groups (1973:197).

There are two important components to Haug’s argument. First, she argued that the knowledge gap between physicians and consumers was decreasing. Second, she claimed that the medical profession was facing serious challenges from consumers and consumer groups as well as from paramedical occupations. The end result of these processes was that the profession was losing both monopoly over medical knowledge and public support and esteem. What is the evidence for these claims?

One could certainly argue, as Freidson (1985) does, that the rapid accumulation of complex knowledge in the medical field means that a knowledge gap between physicians and patients will remain despite the fact that segments of the public may be more educated and aware of health matters. However many of the most common ailments, for example colds and back pain, can be easily explained in the numerous medical digests available for consumers in the marketplace. Consumers are certainly better equipped to study medical issues than in the past. Haug was also correct to suggest that computerization would make knowledge more accessible. Today, consumers can cruise the internet for their medical information.
Haug's second argument raises some interesting speculations. There have been very serious challenges from consumer groups (the women's health movement and the holistic health movement being obvious ones) and some very blatant medical errors have received great publicity -- the thalidomide catastrophe of the 1960s, IUDs which caused infertility, faulty and dangerous breast implants and so on. Along with the questioning of management and supply of doctors and appropriate remuneration, there currently seems to be a great deal of cynicism around the idea of professional altruism and the notion that doctors will protect the public. For example, in the first half of 1993, several cases alleging sexual misconduct on the part of doctors had been discussed prominently by the Canadian media and doubts were raised as to whether the profession can or will protect the public (HCH Feb. 10, 1993:A9; WFP Mar. 31, 1993:B1; TS May 18, 1993:A3). These allegations were followed by a case in which a man who was HIV positive was not informed of his disease by his doctor and subsequently infected his wife (VS Mar. 12, 1993:A7; G&M Mar. 12, 1993:A6). These cases, widely published in the local media, reinforce public disillusionment with the medical profession.

But how effective is scepticism at the cultural level in promoting change within the health care system and does it translate into a lack of support by patients for their doctors? For both Freidson and Alford, consumers are the weakest players in health care politics and challenges from consumer-based movements do not radically affect the power of the medical profession. On the other hand, politicians and bureaucrats consider health care reform the "issue from hell" (Evans, 1993) -- partly because of the perceived power of the medical profession but also due

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7 Halifax Chronicle Herald (HCH), Winnipeg Free Press (WFP), Toronto Star (TS).

8 In 1993, there were 77 entries listed under the heading: Physicians -- Discipline, in the Canadian Index (newspapers and periodicals). There were fewer entries in 1994 (46) and 1995 (36).
to public support for doctors and public response to proposed changes to the health care system.

British and Canadian data based on opinion polls show that there is still a high level of satisfaction with primary care and a high level of support for the medical profession as a whole (Blendon, 1989; Jefferys and Sachs in Calnan and Gabe, 1991). For example, a Canadian Gallup poll conducted in 1992 found that when asked to rate the honesty and ethical standards of various professionals, respondents placed physicians at the top of the list. A survey of Americans, Canadians and the British conducted in 1988, found that Canadians were the most satisfied with their health care and that the level of satisfaction on all indicators was fairly high. During the most recent feud between the medical association and the provincial government in British Columbia (1991-93), a Decima poll found that 89% of respondents regarded the doctors as "believable" while only 64% attributed the same characteristic to the minister of health. Respondents also supported the BCMA over the government -- 59% to 32% -- in the dispute over the health care budget (VS Nov 30/93:A14).

One British study did find that younger women were more critical of physicians than older women (Blaxter and Paterson in Calnan and Gabe, 1991). It is unclear, however, whether the results reflect a change in expectation or are simply a result of the fact that older women

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9 Doctors were followed by police officers, university teachers, engineers, accountants, psychiatrists, journalists, business executives, lawyers, labour union leaders, advertising executives and members of parliament. Respondents were asked: "How would you rate the honesty and ethical standards of the people in these different fields -- very high, high, average, low or very low." Doctors were rated very high or high by 64%, average by 28%, low by 6%, while 2% had no opinion.

10 Respondents were asked to express their level of satisfaction with: their overall health care system, health care services used in the last year, hospital stay within the last year, and the most recent doctor visit within the last year. Respondents were also asked to state a preference for either the Canadian, British or American health care system (Blendon, 1989).
have more health problems and are therefore more dependent on their doctors. Calnan and Gabe conclude from the British data that "there is little to suggest that patients have in general become less satisfied with the care and service of their GP in recent years nor do they seem to have become more willing to take individual or collective action if they are dissatisfied" (1991:156).

On the other hand, patients are becoming increasingly willing to challenge their doctors in the courts. While this is especially true in the United States, legal action against doctors has risen in Canada. Only ten writs were issued against doctors in 1956 but in 1991 there were 984 legal actions. Damages awarded to patients have increased from over $5 million in 1979, to just under $18 million in 1986, and to $45.6 million in 1991 (Canadian Medical Protective Association, various years, in Coburn, 1993a:99 and Dickens, 1993:1).  

Perhaps the more serious challenges have come from paramedical professions. Alford did not include paramedical occupations within his framework while Freidson argues that the increased popularity of an occupation like midwifery or chiropractic does not constitute a serious challenge if it can be "contained at the fringes" (1985:112). Deprofessionalization will not occur as long as the medical profession can retain monopoly over their designated tasks and skills. Coburn (1993a,b), commenting on the changing relationships between paramedical occupations and medicine in Canada, sees some evidence that medicine has lost some of its dominance within the medical hierarchy. He cites the recent legal recognition of midwifery in Ontario (British Columbia has followed suit) as well as legislation in Quebec and Ontario which grants self-regulation powers to a range of health occupations (1993a:98, 1993b:132). The latter is significant as the ability to control your own work and regulate the work of others is a significant component of professional dominance. However Coburn then notes that in Quebec the

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11 The authors do not indicate whether these figures are in current or constant (adjusted for inflation) dollars.
designated powers were much less than what medicine had previously been granted while in Ontario (where occupations were given exclusive rights to perform designated licensed acts), medicine can still perform more licensed acts than any other profession (1993a:98-99). I think that the state is responding less to the activism of the paramedicals and to what Coburn calls social movements, than to the appeal of cheap labour. The state, urged on by health economists, is considering allowing paramedicals to perform duties previously monopolized by doctors and this is reflected in the various blueprints for health care reform.12

ii) Corporatization

A decade after Haug put forth her deprofessionalization theory, theoretical perspectives known as corporatization and proletarianization, argued that transformations in medical power could be best understood in relation to the changing work conditions of professionals. Corporatization refers to the development in the United States of multihospital systems with established links with Health Maintenance Organizations13, Preferred Provider Organizations14.

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12 For example, the Seaton Report in British Columbia recommended that "the arbitrary limits that have been placed upon (allied health-care workers) must be removed in order to provide the best care possible to the greatest number of people possible" (1991, vol. 1:37) and that "people should not be barred from performing a task because they lack the education which is not necessary to performing that task and does not demonstrably improve health outcomes. The 'credentialization' of positions within the health care system must be stopped" (1991, vol. 1:7).

13 The classic model of the HMO was a group practice with physicians paid on a per capita basis and subject to peer review with health-care provided for by a fixed, predetermined payment. Today most HMOs are in fact controlled by big commercial insurers and physicians and procedures are monitored by the companies (Bodenheimer, 1990:215). In any case, HMOs have not really caught on. In 1987, only 12 percent of the population was enrolled in an HMO (Ginsberg, 1990:279).
and insurance companies. It also refers to the increased use of aggressive for-profit management strategies in not-for-profit or voluntary hospitals. Starr (1982) and Ginzberg (1990) argue that the consequences of the changing structure of health care with its emphasis on "health care marketing" include elements which will significantly reduce professional autonomy: increased regulation of the pace and routines of work, performance standards measured by revenue, close scrutiny of mistakes because of corporate liability for malpractice, and a restratification of the profession -- an internal differentiation between an administrative elite whose loyalty is to the organization and the bottom line, versus ordinary practitioners.

Examples of restrictions on clinical autonomy in the United States include: state or insurance company measures requiring doctors to request advance permission to hospitalize or perform certain operations, state laws forcing doctors to take certain groups of patients, the implementation of Professional Standards Review Organizations, and the implementation and reclassification of clinical diagnostic systems (DRGs) by the state.

White (1990) compares these developments in medicine to similar trends in U.S. manufacturing during the late 19th and 20th centuries: "Just as local cottage industries rapidly became dominated by large national firms ('big business') in products ranging from shoes to iron and steel, so locally controlled and financed hospitals are being replaced by huge horizontally integrated, multihospital regional, national, and multinational systems" (85). In this process he identifies three major characteristics of corporatization.

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14 Many major American corporations have tried to slow their company's medical spending by establishing incentives for employers to go to a specific network of doctors and hospitals which would accept limits on charges. These sorts of networks are known as Preferred Provider Organizations (PPOs). The employees have to receive prior approval for expensive procedures from the insurer's experts. The insurers are required to guarantee that overall spending stays within agreed limits (New York Times, Feb. 27, 1990).
The first is the centralization and rationalization of production through standardized mass production techniques. This has not been realized in the United States. Although there have been attempts to achieve this through the DRG (diagnosis related groups) system, medical services remain extremely heterogeneous. There is considerable cost variation in treating patients from the same DRG. There has been considerably more success in reaching the second characteristic: the creation of managerial hierarchies. Medical decision-making has become standardized and centralized. In hospital chains, decisions are made at corporate headquarters and applied at the local level. The final characteristic involves reorganization and standardization of work and training, the "deskilling" of traditional craft jobs and the creation of a new "professional/managerial" elite trained outside the workplace (87). Certainly, there has been a reorganization of medical work in that an increasing number of physicians are accepting salaried positions. Standardization has existed since the creation of the first medical schools and medical associations. However, the consistent monitoring of physician performance in HMOs and PPOs can only increase standardization.

One component of the last characteristic mentioned by White, deskilling, does not fit very easily. Ginsberg argues that physicians are not becoming deskilled because "removing a patient's appendix is inherently different from manufacturing an automobile or franchising Kentucky fried chicken" (1990:16). The bottom line for business may be profitability but to be profitable they are forced to rely on medical skill and knowledge. However, more and more of that skill rests in technology, either via imaging techniques or drug therapy, for example. This means that cheaper and more narrowly trained paramedicals can be hired for work that doctors used to perform. On the other hand, for-profit hospitals must attract established and prestigious members of the medical profession in order to be competitive, and this implies that physicians still claim an important monopoly on certain skills.
Although health care marketing is most pronounced in the United States, other countries are not immune to corporatization trends. Canada has experimented with certain elements of corporatization, including American for-profit management. In Ontario, Hawkesbury General Hospital (and later four other hospitals) contracted out management functions to a subsidiary of American Medical International (AMI) which has a management record in at least 13 countries. The Toronto-Queensway hospital contracted the American firm Extendicare to operate as well as build a chronic care unit, and Ontario was also the first province to adopt the "Business Oriented New Development" program or BOND. The scientific management techniques of BOND include strict personnel monitoring, hiring freezes, and greater use of volunteers (Tsalkis, 1988:111-114). There seems to be a fair degree of Canadian scepticism regarding this type of management. In the three studies which followed Hawkesbury -- two commissioned by the federal government, and one by The Ontario Federation of Labour -- all concluded that private management was not an improvement over public management and that management American-style had negative consequences for the Canadian system (Ibid.: 112). Still, there is interest in this type of management and with reduced federal-provincial transfer payments, Canadians may see more corporatization and privatization in the future.

The two trends of corporatization and privatization should not be confused however, nor are they necessarily linked. In Canada (unlike the United States) de-privatization efforts have coexisted along with corporatization approaches. The for-profit sector in Canada currently accounts for only 15% of health care expenditures (Evans in Fried et al, 1990:172). Our government funded and regulated system not only presents a formidable barrier to privatization efforts but also has continued to broaden its mandate to services previously offered by the private sector. 

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15 These include nursing homes, laboratories, pharmaceuticals, medical equipment, eye glasses and prostheses.
sector. Nursing homes, for example, are now becoming increasingly subsidized and regulated by the government. There are definitely strong challenges by special purpose clinics (for example, MRI) which are supported by some provincial governments and not by others.\(^{16}\)

The medical profession is also a strong supporter of private sector growth in health care. The passage of the Canada Health Act which banned the use of user fees and extra billing (and subsequently further deprivatized medical practice) has intensified organized medicine's support for privatization as a way of restricting government regulation and interference. However, Fried et al (1990) predict that while there will be "growth in the number and types of multi-institutional arrangements" in Canadian health care sectors as well as in "management technologies such as automated management information systems", reprivatization "is unlikely to accompany these efficiency moves" (182).

The question of whether managers have replaced doctors as the dominant interest in health care or in Alford's terms -- whether there has been a power shift from the medical profession to the corporate rationalizers -- is a question under review in Great Britain and Canada as well as the United States. British health care analysts are concerned with how the Griffiths management program (a legacy of the Thatcher government; it introduced private sector management styles into the NHS) will alter power relations and challenge medical autonomy in the 1990s (Cox, 1991; Calnan and Gabe, 1991; Hunter, 1991; Mohan, 1991). Coburn argues that "the new tide" of corporate rationalizers in Canada has meant the loss of "intimate association" between medical association leaders and health ministry bureaucrats (1988:105). In the United States, for-profit chains are managed by businessmen with backgrounds in real estate, construction and financing

\(^{16}\) In British Columbia the NDP government recently announced plans to regulate the province's two MRI clinics while Alberta's Conservative government seems to be encouraging the operation of private health care facilities (VS Nov. 18, 1994:B5).
(Ginsberg, 1990:16). Yet, there is also a tendency for hospitals, PPOs and HMOs, "to incorporate respected clinical leaders into top administrative or policy posts, promoting a new class of physician MBA 'product line' managers" (Feinglass and Salmon, 1990:245).

Any discussion of new corporate rationalizers must also mention the rise of the importance of the health economist in Canada, the United States and Britain. It can be argued that the health economist has become the new technical expert on health care as far as politicians and bureaucrats are concerned. While it is definitely convenient to rely on and promote the advice of those who promise to save you money on your most expensive and fastest growing budget item, rather than on those who insist on the need for more money, health economists also have an appealing moral justification for their approach. Klein notes that:

Contrary to the ethical individualism of the medical profession, the economists tend to take a utilitarian approach to policy issues...instead of seeking to maximize the health of individual patients, they argue for maximizing the health of a given population. They thus join hands with the public health movement...in challenging the medical profession to justify the efficiency and effectiveness of its activities. In short, managers seeking to control the expenditure-generating activities of clinicians now have an intellectual justification for what they are doing. They are not just trying to save money by preventing heroic doctors from doing their best. They are actually working to the benefit of the community as a whole (1993:206).

In Canada, most health economists (unlike organized medicine) support the Canada Health Act and reject demands for reprivatization, extra-billing and user fees. Robert Evans reflects the views of many of his colleagues when he cautions that privatization schemes are "quack remedies" which will raise overall costs and lead to greater inequality as well as inefficiency in the health care system (1993:41).

iii) **Proletarianization**

Proletarianization theorists (McKinlay and Arches, 1985; McKinlay and Stoeckle, 1990)
expand on the corporatization thesis and place it within a Marxist discourse. They argue that the trend in medical practice from self-employment in an individual 'free' practice to employment in large bureaucracies has resulted not only in corporatization but in proletarianization. Proletarianization is the more appropriate concept, they argue, because doctors are gradually losing control over key professional prerogatives\textsuperscript{17} such as technical tasks and procedures as well as overall goals and policy directions. This process subordinates the medical profession "to the broader requirements of production under advanced capitalism" (this is the Marxist version of the medical-industrial complex wherein some elements of physician autonomy are found to be no longer profitable). Doctors are unaware of this, however, due to their "false consciousness" and "elitist conception of their role" (1990:144). Medical associations may be very vocal (at least in some jurisdictions) about any loss of power, taking concrete measures to ward off any challenges to their power base, but members of the rank and file may be less vigilant.

There are two debates at the heart of the corporatization and proletarianization theories. The first concerns bureaucracy and poses the question of whether increased bureaucratization necessarily means a decrease in professional autonomy. Advocates of the corporatization and proletarianization approaches clearly believe that bureaucracy inevitably dominates professions. However, they characterize bureaucracy in the traditional Weberian sense which ignores the possibility that there may be more than one kind of bureaucracy and that bureaucratic institutions may not always operate in the same fashion. In an early study of professions in a hospital setting, Gross (1961) observed that two lines of authority were established within the hospital -- one administrative and one medical, and both were able to coexist quite amicably.

\textsuperscript{17} McKinlay and Stoeckle list seven traditional professional prerogatives: the criteria for entrance, the content of training, autonomy regarding the terms and content of work, the objects of labour, the tools of labour, the means of labour, and the amount and rate of remuneration for labour (1990:144).
Administrative decisions were not made in areas where doctors insisted on the necessity of professional judgment (in Freidson, 1970a:24-25). Although this separation of authority lines may have blurred to some extent since Gross's study, many hospitals continue to have strong medical directors overseeing a semi-autonomous medicine hierarchy.

Another side to this critique concerns bureaucratized health care systems rather than the narrower bureaucratized institutions (I will elaborate on this in my section on the nature of state intervention). The reasoning behind the corporatization and proletarianization theories would suggest that doctors who work within bureaucratized health care systems enjoy less professional autonomy than doctors who do not (i.e., than doctors in 'private' practice). There is no evidence for this position. In fact, there is strong evidence that a more bureaucratized health care system actually promotes certain aspects of professional autonomy and that the distinction lies in whether or not the bureaucracy is funded by the state or the market (Dohler, 1989; Klein, 1993; Larkin, 1988; Coburn et al., 1983).

The second debate has to do with the issue of deskilling and whether the parallel drawn between the increased specialization of modern professionals and the deskilling and routinization of craftsmen in the nineteenth and twentieth centuries has any validity. This is an argument that McKinlay and Stoeckle make with regard to physicians. Their critics argue that specialization "implies a deepening of technical knowledge and expertise" (Derber, 1982:173) and that overtraining is actually "a specific attribute of privileged work" (Larson, 1977:231). Light and Levine (1988) note that physicians have aggressively pursued specialization to achieve higher income and greater prestige. They also ask how the proletarianization perspective explains abuses of medical power -- the many documented unnecessary procedures, prescriptions, operations, and hospitalizations which play a role in the regulatory solutions prescribed by the state and corporations (Ibid.:16,17).
Larson (1977, 1980) argues that although bureaucratized professionals have become more dependent on an advanced division of labour, this does not necessarily result in technical proletarianization. The new division of labour typically narrows and restricts the range of responsibilities and tasks but leaves the professional with the most demanding duties in terms of knowledge and skill. Professionals are then left with "a continued 'craft-like' autonomy within a specialized and skilled technical arena" (in Derber, 1982:173).

These theories are problematic in explaining the American situation and do not work in the Canadian context where the private sector plays a minimal role in health care. Besides the problems with the way the theories conceptualize bureaucracy and deskilling, neither corporatization nor proletarianization theories address the professional autonomy of fee-for-service doctors in either country. They also do not distinguish between various forms of autonomy. Klein, for example, points to the situation in the former Soviet Union where doctors had low economic autonomy (they were not paid well) but they had a significant amount of clinical autonomy over their work (1993). Further, none of these theories address the impact of the state, an oversight that could be attributed to their American nature, except for the fact that the American state has become much more invasive in health care policy. The work of Estes (1991) and Ruggie (1992) illustrates that the market-driven American health care system, with its ideology of privatization, has proven so costly and difficult to administer that it has ironically produced a very intrusive state.

iv) "Feminization" and Medical Autonomy

None of the theories attempting to access changes in medicine's dominance and autonomy consider the question of gender and whether the growing number of women in the medical
profession has any implications for the future status of the profession. The literature concerning the changing medical profession is written in isolation from another on-going debate -- sex segregation within the profession (Riska and Wegar, 1993).

Freidson’s response to the deprofessionalization, corporatization and proletarianization theorists, was to agree that important changes had occurred since the early 1970s but that changes such as increased bureaucratic regulation would lead to an increase in professional stratification (for example, an increased influence of administrative and academic elites at the expense of the general practitioner). While individual practitioners might lose some autonomy, the profession as a whole would still maintain its dominance within the medical division of labour (1985). However, internal divisions and conflicts have always existed in medicine. One frequently ignored longstanding division is that of gender (Elston, 1993:29).

Studies of female doctors have found that women tend to concentrate in certain specialties (ones characterized by low professional status, such as general and family medicine) and are more likely than men to be part-time, salaried and working in bureaucratic settings. Women are underrepresented as medical academics, researchers and administrators -- the very areas predicted to become the new power base of the profession (Elston, 1993; Lorber, 1993; Riska and Wegar, 1993). This holds even in the Nordic countries where the participation of female doctors is highest.¹⁸ Riska’s study of female physicians in the Nordic countries suggests that there are certain sectors (primary care) and organizational settings (municipal health centres) that are particularly subject to bureaucratization and managerial control, and that women are disproportionately represented within them (1988). Women are also severely underrepresented

¹⁸ In Finland, 43% of physicians were women compared to 18% in Canada and the United States (Riska and Wegar, 1993; CMAJ, 1991; JAMA, 1990) [Statistics for 1992 (Finland), 1991 (Canada) and 1990 (United States)].
on the professional bodies where decisions are made regarding priorities and strategies for current and future medical practice and remuneration.

Reskin and Roos (1990) refer to the situation above as "ghettoization" and argue that all feminizing occupations show some form of ghettoization:

women and men worked in different subspecialties...for different clients within firms, in different industrial sectors, and at different ranks. Men retained most of the more desirable jobs; women were disproportionately relegated to lower-status specialties, less desirable work settings, lower-paying industries, and part-time rather than full-time work (72).

Ghettoization does not in itself, bring about diminished technical autonomy, status and remuneration to the entire occupation. In the case of medicine, ghettoization is a form of professional stratification based on gender. It means that we can predict which individual practitioners are more likely to experience a loss of professional autonomy. However, the feminization of the medical profession does not automatically mean that the entire profession will lose its dominance or aspects of its autonomy. If the medical profession should experience "resegregation" (women become the predominant gender in an occupation formerly dominated by males), on the other hand, the historical record shows that in all likelihood, the profession would be affected adversely.20

VII. The Nature of State Intervention

As Johnson (1982:186) notes, sociologists from Durkheim on have assumed that state

19 Occupations that women are entering in increasing numbers.

20 Bank tellers, teachers, clerical workers and telephone operators are examples of occupations which experienced resegregation and a considerable drop in status, remuneration, and in some cases, technical autonomy, as a result (Reskin and Roos, 1990).
intervention and professional autonomy have an inverse relationship — the more state intervention, the less professional autonomy. The assumption behind this argument is that professions began historically with a laissez-faire existence, one in which the state has gradually and increasingly sought control for various political and economic reasons. Johnson claims that this argument does not hold when looking at the history of the state and the professions in England. Rather, "the transition to capitalism in England was not marked by a separation of economic and political institutions but an historically unique articulation that involved the interrelated processes of state formation and professionalization" (1982:188).

The state played a critical role in the formation of the British medical profession by granting a royal charter to the Royal College of Physicians (RCP) in 1518 and by passing legislation which, for the first time, placed medical licensure in the hands of the medical profession rather than the church, state or universities (Berlant, 1975:130). The RCP was unlike the regulative bodies of the urban or craft guilds. Its special relationship to the Crown meant that it secured benefits by means of petition to the Crown rather than guild bargaining (Berlant, 1975: 136-137). With the Medical Registration Act of 1858 (which gave the profession control of medical education, training and qualifications as well as a monopoly over state employment), the transformation from royal to legislative privilege was secured. From this point until the National Health Service, the medical profession and the British state engaged in cooperative negotiations for mutual benefit. While the British state assumed certain authority in medical affairs, the medical profession was able to use the state to further its collective interests. Johnson argues that the imperialist nature of the British state also affected the dominance and autonomy of the British medical profession. For purposes of colonial management, doctors were incorporated into imperial state agencies and their autonomy and authority was legally extended with the implementation of various statutes. A pattern of dependence and autonomy emerged which,
Johnson argues, affected both the nature of professional and state operations (1982:197).

The idea of a laissez-faire professional existence does not hold even in the American situation. In Polanyi's words: "The road to the free market was opened and kept open by an enormous increase in continuous, centrally organized, and controlled interventionism....There was nothing natural about laissez-faire...laissez-faire itself was enforced by the state" (in Larson, 1977:53). However, the nature of the early American medical profession was formed and influenced by market forces and ideologies of laissez-faire and individualism, and the profession had great difficulty in relying on state protectionism. A good example is the fact that the profession had no control over licensure until after the American revolution and even at that point, the licenses granted were largely ineffective (Berlant, 1975:250). By the 1840s, American medicine was basically unregulated — the number and types of medical schools were booming and most could grant degrees which were then recognized as licenses, irregular sects were powerful and respected, and professional rivalries were rife (Kett, 1967:194).

The Canadian medical profession was not as strongly connected with the state as in Britain, nor as reliant on the market as in the United States. The Canadian medical profession was able to develop a close relationship with the state as early as the late 1700s when licensing boards filled by physicians formed in both upper and lower Canada (Kett, 1967:194). These structures survived despite power struggles with other healers and divisions produced by professional rivalries. And, they survived without competition from numerous other licensing agencies as was the case in the United States. Further, since Canadian proprietary schools were generally not allowed to grant degrees, the profession was better able than the Americans to keep the number of schools down and maintain control. Medical licensing procedures were standardized across the country by 1912, a decade ahead of the United States (Coburn, 1983:415).

My intent here is not to provide a complete history of the medical professions in Britain,
the United States and Canada. Rather, I am providing these brief examples to argue that state/profession relationships must be considered in historical, economic, and political contexts and that the common assumption that state intervention itself equals an assault on professional autonomy is incorrect. What is relevant is not whether the state intervenes, but rather, the nature of that state intervention. State intervention can be very beneficial for professional autonomy and market intervention can have negative consequences.

Shifting from the past to the present, the current literature suggests that the clinical autonomy of doctors is under more attack in the largely market-driven American system while economic autonomy is more restricted in nationalized and bureaucratized systems such as those in Britain and Canada (Bjorkman, 1989; Dohler, 1989; Evans et al., 1989; Harrison and Schultz, 1989; Mechanic, 1986; and Radovsky, 1990). In her comparative analysis of the United States, Germany, the United Kingdom, France and Sweden, Dohler (1989:196) concludes that clinical autonomy "is preserved best where doctor’s financial freedom is restricted most" because state attempts to regulate the income of physicians seem to provide a measure of protection to clinical autonomy even if the regulations have only a marginal impact on cost containment. Further, the institutionalization of state/doctor relationships has given medical associations various avenues for bargaining and self-government which are lacking in a market-driven system (Ibid.:197).

In the United States, business in partnership with state officials at the non-federal level, controls health care and promotes the changes which affect medical autonomy. Bergthold’s (1990) analysis of California and Massachusetts provides a good example. She explains that state officials found it expedient and necessary to organize business interests and shows how they stimulated business involvement by direct and indirect means. Almost every state in America, frustrated by federal inaction, is currently putting forth health care reform proposals. States have
much at stake in terms of outlays for Medicaid\textsuperscript{21} and electoral concerns. Their varied proposals have produced conflict with providers, insurers and certain sectors of industry (Lamm, 1991; Merritt and Demkovich, 1991). Many of the initiatives threatening the self-directing nature of medical work have been carried out by the state but at the non-federal level. At the federal level, the American state has had well-publicized difficulties in dealing with organized interest groups such as the medical profession.

Klein (1993) characterizes the British situation as one where the predominant pattern in relations between the medical profession and the state was one of mutual accommodation or the "politics of the double bed" within a corporatist\textsuperscript{22} style arrangement, disturbed every few decades by a major confrontation in which doctors lose ground and then are slowly able to rectify the situation (1993:204-5). Although Klein does not categorize Canada, one might imagine that the British scenario would be a close fit. Under the parliamentary system, the current federal government (providing it is not a minority) is able to command a majority for its policies and the relationship between the state and the medical profession has been characterized by dominance in its early years (Coburn, 1983) and by "conflict and accommodation" since the implementation of medicare (Tuohy, 1992:122).

A key feature of the Canadian political economy, however, is federal/provincial relations.

\textsuperscript{21} Medicaid is a health insurance program for the poor. States must share the health costs of their Medicaid residents with the federal government. A New York Times report claimed that in the 1980s, state governments resorted to 800 measures to slow Medicaid costs (Ginsberg, 1990:25).

\textsuperscript{22} Corporatism refers to "a form of social organization, in which the key economic, political and social decisions are made by corporate groups, or these groups and the state jointly. Individuals have influence through their membership of corporate bodies. These include trade unions, professions, business corporations, political pressure groups and lobbies, and voluntary associations..." (MacDonald, 1996:123).
Any analysis of health care policy in general, or the regulation of doctors in particular, must address the interplay between the two levels of the state and its effect on the medical profession.

1) **State Intervention in Canada: Reviewing the Context of Recent Struggles**

The Canadian health care system was set up in such a way that conflict between provincial and federal governments was inevitable. Health care is under provincial jurisdiction and therefore its management is the responsibility of each province. However, the cost of health care is shared by the federal government. The federal government can (and occasionally does) cut transfer payments to provinces, when policies of the latter violate federal legislation concerning health care such as the Canada Health Act.

Neither the federal nor provincial state had much involvement in health care until the introduction of national health insurance in 1968. Although the Canadian Medical Association fought long and hard against national health insurance, physicians were major beneficiaries of the new system in that their incomes increased and private medical practice as well as fee-for-service were left in place (Swartz, 1977). However, national health insurance had an immediate impact on economic autonomy as it removed the unilateral power of provincial medical associations to decide the profession’s fee schedule. The medical profession now had to negotiate fees with the government. In addition, state-administered plans also permitted "unprecedented opportunity for surveillance of [local] work and [income] patterns of medical practice" (Coburn et al., 1983:419).

During the 1970s, bureaucrats and politicians were forced to deal with the very costly medical infrastructure constructed during the postwar era. Now that the economy was stagnating, the system was deemed inefficient and blame was placed on doctors -- there were too many of
them, they cost too much, their procedures were too expensive and they had too much power in determining the "conditions and prices of supply" (Van Loon, 1978:459-460). The federal government began to erode its share of health care costs in 1977 with the passing of the Established Programs Financing Act (EPF)\textsuperscript{23}. The numbers and types of physicians was regulated during this period by provincial government initiatives controlling medical schools and curbing immigration of foreign doctors (the latter with the blessing of the Canadian Medical Association, Swartz, 1977:334). A few provinces also tried to control where doctors practiced by either offering financial incentives to doctors willing to locate in underserviced areas or penalizing doctors wanting to practice in overserviced areas by refusing to pay the full fee or by refusing to issue new billing numbers (Coburn, 1988:104).

During the 1980s, most provinces placed an annual global cap on total billings by physicians. Global budgets for hospitals were already in effect. Hospitals have traditionally served as the site of medical dominance but they are also the most expensive structures in which to treat the sick. The capping of hospital budgets has meant reduced services for doctors. Access to technological equipment is controlled by the state and administered by hospital planners.

Doctors' incomes began a gradual decline as provincial governments held back on increases in their fee schedules in the early 1970s and then from 1975 to 1978, doctors were subject to the wage and price controls administered by the Trudeau government. After the wage and price controls were lifted, doctors began to attempt to catch up economically and extra-billing

\textsuperscript{23} EPF made the switch from shared cost programs to a modified block funding system. This meant that federal contributions were now tied to the growth of the national economy rather than to the growth in provincial health spending. The Act also gave provincial governments greater flexibility in running their health care programmes but made them solely responsible for costs that exceeded the GNP.
became a problem. Extra-billing co-existed with user fees in some provinces where the provincial government decided to take advantage of the greater flexibility afforded to them by the EPF. The federal government’s solution was to use its legislative powers to ban both extra-billing and user fees and levy financial penalties against any province allowing the practice. The result, the Canada Health Act of 1984, was met (not surprisingly) with a passionate response from the Canadian Medical Association who argued that extra-billing was a necessary "safety valve" for doctors and that the legislation was unconstitutional. The president of the CMA declared: "the ultimate goal of this legislation is to radically change Canada’s ten diversified provincial health insurance programs into state medicine -- into a medical service that is completely controlled by government" (Coburn, 1987:657). In Ontario, the banning of extra-billing led to a legal challenge from the Ontario Medical Association and the longest doctor’s strike in Canadian history (Evans et al., 1989:575; Coburn, 1987:657; Tuohy, 1992:131).

The state was divided in its response to the Canada Health Act. The provincial health ministers were unhappy because they would lose revenue and were given the burden of passing the appropriate legislation and facing the wrath of the medical associations. Some, such as Alberta’s Dave Russell, were banking on the Conservative Party winning the upcoming federal election. This optimism was muted, however, as the Conservatives had supported the legislation.

The federal parties, provincial Liberal and NDP opposition parties (where they existed),

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24 The federal government would deduct one dollar in federal medicare transfer payments for each dollar that the provinces collected in user fees and extra-billing (Canadian Annual Review, 1984:63).

25 By 1984, six provinces -- British Columbia, Alberta, Ontario, Quebec, New Brunswick, and Newfoundland -- were in a position to be penalized financially as a result of hospital user fees.

26 The federal NDP had supported the legislation as soon as it had been proposed.
consumer associations and national and provincial health coalitions supported the legislation while most of the provincial Ministers of Health (in particular, British Columbia, Alberta and Ontario) and the national and provincial medical associations were virulently opposed (Taylor, 1987:97). As Tuohy argues, the federal/provincial nature of the country allows "political elites to legislate and enforce common standards across provinces, even in the face of considerable cross-provincial variation in the relationship between the state and organized interests" (1992:132).

Since the Canada Health Act, more federal legislation has been passed to ensure that the burden of health care costs continues to shift from the federal government to provincial governments. Bill C-69 (the Government Expenditures Restraint Act), passed in February 1991 under the Mulroney Conservatives, provided a formula under which transfer payments to the provinces were expected to hit zero after the year 2004 (VS, Feb. 7, 1991:B1,2). The current Liberal government has changed this picture somewhat. Transfer payments to the provinces for health and post-secondary education under EPF were merged with the Canada Assistance Plan (money for social assistance) in the federal budget of 1995. The resulting Canada Health and Social Transfer (CHST) is to be reduced by seven billion dollars in the next two years (VS Mar. 1, 1995). This year (1996) Finance Minister Paul Martin has promised to provide "a cash floor for social transfers that will allow Ottawa to hold a club over provinces failing to conform to its interpretation of the Canada Health Act" (G&M Mar. 7, 1996). This will not happen however, until the seven billion has been cut.

Martin's announcement was in response to arguments by social critics that without the federal threat of withholding money, there will be little to deter provinces from imposing user fees, allowing doctors to extra-bill, or creating two-tiered health-care systems -- one for the rich, one for the poor. The practice of withholding user fees has been very effective in the past. The
federal government withheld fifty million a year during Ontario's period of extra-billing until the practice stopped. Smaller amounts were withheld when Alberta allowed extra-billing and British Columbia had hospital user fees.

The trend of the federal legislation points to conflicting interests within the state as the wealthier provinces support less federal involvement in health and social programs in general and the poorer provinces worry that they will not be able to retain standards if left to their own resources. With the reduction in transfer payments, Ottawa has increased the provincial share of tax points (the percentage of personal and corporate dollars collected by the two levels of government)(VS Feb. 7, 1991:B1,2). Tax point transfers benefit provinces with above average incomes -- British Columbia, Alberta and Ontario -- because their tax points generate the most revenue. This legislation has interesting implications for medical dominance as it may mean twelve different health-care systems with varying degrees of regulations for doctors.

Tuohy (1992) notes that the balance of conflict and accommodation between the states and the medical profession varies across the provinces. She characterizes the relationship between the provincial government and the medical profession in British Columbia as the most adversarial in the country\(^\text{27}\) and locates the reasons for this in the "populist and polarized" nature of British Columbia politics in general and in the large numbers of doctors within the BCMA who originally had worked in the British National Health Service (1992:125). Tuohy argues that the adversarial nature of the BCMA has paid off in one of the highest fee schedules in the country, in warding off serious challenges to its professional autonomy (such as the government

\(^{27}\) In contrast, Quebec is labelled the "most statist", Alberta's laissez-faire approach is the least statist, while the Ontario state-profession relationship is viewed as a "tenuous accommodation" held together by mediation between health officials and an elite of physicians based in the medical schools and the College of Physicians and Surgeons of Ontario (1992:123-128).
attempt in 1985 to refuse billing numbers to physicians who located in certain areas) and its ability to self-regulate (the utilization review committee is in BCMA hands and Tuohy argues that it penalizes fewer doctors than the government regulated utilization review committees in Quebec and Ontario, 1992:125-6). I will examine Tuohy’s claims in the data chapters which follow.

VIII. Professional Resistance

During the nineteenth and first half of the twentieth century, the medical profession pursued the strategies of professionalization discussed earlier in this chapter. Doctors gained control over entry to the profession and the educational curriculum, and they devised ways to exclude, subordinate or limit, competitor occupations. They were also active and well-represented in politics and in health departments. Between 1900 and 1930, Canadian doctors used their powers to upgrade medical education, create the hospital infrastructure, participate in developing public health measures and provide wartime medical services within the armed forces (Torrance, 1987:19).

The Depression and war years ushered in a different reality for doctors. When patients were unable to pay bills, doctors were forced to rely on medical relief plans. During this period the medical profession "displayed a co-operative if highly qualified attitude towards government health insurance" (Torrance, 1987:24). However after the war, the Canadian Medical Association strongly opposed the idea of government medical insurance. The incomes of both doctors and their patients had risen in the postwar prosperity and the medical profession preferred to support its own hospital and profession sponsored voluntary health insurance plans where medical control and dominance could be assured. The 1930s and 1940s marked the early years of Canada’s
welfare state and pressure for health reform and government health insurance was intense. Canadian doctors responded with the creation of doctor-sponsored voluntary plans across the country, targeting provinces with sympathetic conservative governments (Alberta, Ontario and British Columbia). This strategy was quite successful and was continued during the 1960s in an effort to stop the spread of government-sponsored health insurance outside of Saskatchewan (Coburn, 1988:100).

The government insurance plan in Saskatchewan, which originally conceived of a system of salaried doctors under government control, engendered a bitter doctors’ strike (the first in Canadian history). There now have been three doctors’ strikes in Canada: Saskatchewan in 1962, Quebec in 1970, and Ontario in 1986. The first two strikes were partially successful in that doctors were granted some significant concessions. The same cannot be said of the Ontario strike, during which the vast majority of physicians continued to treat their patients (Iglehart, 1990:565). The use of the strike as a resistance strategy is risky for medical associations. The Hippocratic tradition dictates that doctors never withhold services from patients and professional ideology views strike action as a labour tactic rather than a professional strategy. Data from a national survey of Canadian physicians conducted between 1986 and 1987 found that only 25% of physicians approved of using strike action as a means of reinforcing the profession’s position (Stevenson et al., 1988).28

Something should be said about professional ideology at this point. One characteristic distinguishing professional resistance from labour resistance is the use of professional ideology. Professionals have an "elevated and codified self-image" which they often use to associate their

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28 Sixty percent disapproved and the remainder were neutral. Saskatchewan doctors expressed the highest rate of approval at 42.3%, doctors in Nova Scotia and New Brunswick the lowest at 13.1% and 13.2% respectively.
work with central social values (Burrage et al., 1990:209). For example they can argue that the cause at stake is not money but rather an essential public service such as the quality of medical care. However, elements of a professional ideology can also place limits on resistance strategies. In his study of the British Medical Association, Eckstein (1960:29,70) found that the internal norms of the association prevented consideration of overt political associations, public propaganda, or "trade union" tactics such as boycotts and strikes.

According to Larson, early professional ideology consisted of three important characteristics. The first stresses the intrinsic value of professional work. The goal of professional work is not to make money but to be true to a vocation or calling. The second concerns the ideal of community service, one that is connected to the belief that professional work can offset some of the negative aspects of industrial capitalism. The third captures beliefs related to the first two ideals -- that those of high rank and status should be above anything obviously commercial and that a privileged status grants rights but also imposes a sense of duty (1977:220).

Contemporary professional ideology is fundamentally concerned with status. Larson argues that "in the newer professions, the creation, expression, and protection of special status tend to be the most central dimension of the professionalization project" (1977:236). This preoccupation with status and the constant comparisons that it generates, means that professionals have great difficulty in forming alliances with other workers. Individualism is the second archetypical feature of contemporary professional ideology. The importance placed on technical skills and competence as well as the dominance of the "expert" over the layperson fosters a belief in and reliance on oneself and one's abilities. Finally, the professional world has become one of narrow specialization. Professionals try to solve problems within the framework of their specialized skills and knowledge and their solutions often are (as Freidson argued) ignorant of
and contemptuous of the knowledge and views of others (Larson, 1977:236-237).

During the last thirty years, Canadian doctors have tried a number of new resistance strategies. I have identified the following: strikes, legal action, opting out, extra-billing, setting up self-regulatory committees, hiring professional negotiators, threatening unionization, binding arbitration and the use of advertising to gain public support. Many of these strategies, such as strike action, violate features of both the old and contemporary professional ideologies. Of course, changes in resistance strategies are reflective of the external challenges to the medical profession discussed earlier in this chapter. At the same time, we have to be careful not to assume that these changes reflect a loss of distinction between professions and non-professions. Parkin notes that even when professionals strike, they do not picket. This is significant because picketing "represents an appeal for active support and a show of solidarity from organized labour in general. It is thus one of the most important symbols of contemporary class action, expressing as it does an appeal to workers in all occupations to give direct assistance by refusing to cross the invisible moral boundary staked out" (Parkin, 1979:111).

Unionization is another example of a traditional labour resistance strategy which may take on a different meaning if used by professionals. In the Stevenson study, only 28.9% of Canadian doctors approved of a "reconstitution of medical associations as labour unions under provincial labour laws" (1988:86). Professionals still consider unionization to be a mark of low social status. It is also seen as incompatible with professional goals of autonomy and self-regulation (Stevenson et. al. note comments to this effect attached to study questionnaires). Therefore, when medical associations ask their members to consider unionization (as the British Columbia Medical

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29 At 42% the level of support for unionization was highest in Quebec and Saskatchewan. This was double the approval rate in the other provinces.
Association did in 1993), they are careful to present unionization as something that is now necessary to protect professionalism and maintain the distinction between professions and non-professions.

In any case, strike action and threats to unionize are not common resistance strategies for medical associations. Medical associations certainly find activities such as opting out and extra-billing far more palatable and despite legislative prohibitions, these strategies never completely die.

IX. Summary

The sociological literature on the medical profession has focused heavily on Freidson’s theory of medical dominance (1970a, 1970b). I have attempted to draw some useful connections between some of Freidson’s insights concerning the narrower realm of professional autonomy (control over the content, terms, and conditions of work) and Elston’s (1991) dimensions of medical autonomy (clinical, economic, and political). Within Elston’s framework, I have incorporated much of the Canadian health policy research on, for example: physician supply, economic discipline, the remuneration of doctors, and the challenge of corporate rationalizers (for example, health economists) to the medical profession’s abilities to influence governments on health care policy.

I felt it was important to review the American theories of medical decline as they are mentioned so often in the literature on the medical profession. However in Canada, the decline in (or the contestation of) the various dimensions of doctors’ professional autonomy has not been caused by either a lack of consumer confidence (deprofessionalization) or by the deskilling of
doctors in for-profit businesses (proletarianization and corporatization). What is most important in the Canadian context, is the changing relationship of the medical profession to the state. Canadian doctors, unlike their American counterparts, are still overwhelmingly fee-for-service practitioners who negotiate the content, terms, and conditions of work with their employer, the provincial government. This sets up a different kind of dynamic in terms of their professional autonomy.

The British literature, which is historically focused on the changing tactics of both the British Medical Association (BMA) and the state in their interactions with one another, is more helpful in terms of my research questions. The chameleon-like nature of the state -- it can be the medical profession’s most powerful ally or its worst enemy is of interest. The British approach, unlike the American, also provides profiles of the BMA’s resistance to government challenges. It is never assumed that because the British medical profession looses some important battles that the profession becomes powerless. Instead, attention is paid to how the profession adapts to state interference in its affairs. One result may be that the profession experiences a decline within its professional autonomy, another may be that the BMA transforms its power base and becomes more effective in fielding off government challenges.

In the next chapter, I will review the data sources and methodology used to investigate my research questions on professional autonomy and professional resistance.

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30 Although all of these processes are occurring to some extent in Canada.
CHAPTER THREE
Research Methods

I. Research Questions

The central questions asked within this dissertation centre on the clinical, economic and political autonomy of the medical profession and on the possibility, that within those dimensions of professional power, some facets may be changing in ways that will affect the power and influence of the profession. To the extent that members of the profession are aware of these changes, it stands to reason that resistance strategies will be employed. Therefore I also ask questions about the nature of this professional resistance and how it differs from the resistance strategies usually studied by sociologists, that of labour movements.

My central research question asked:

1. How have changes in the political economy of British Columbia health care, in particular the move from a laissez-faire arrangement to an increasingly regulated market system, altered relationships between the medical profession and the government of British Columbia?

This was followed by questions more specific to professional autonomy and professional resistance:

2. How has the professional autonomy of the medical profession in British Columbia been altered in the move from a laissez-faire arrangement to an increasingly regulated market system?

3. How useful is it to break down professional autonomy into clinical, economic and political types? Have there been changes in some aspects of professional autonomy and not in others?

4. Are there forces internal to the profession which contribute to a loss of professional autonomy?
5. What kinds of resistance strategies does the British Columbia Medical Association use? Have these strategies changed in the last 30 years? If so, why have they changed?

6. How effective are these strategies? Do they mark a departure from professional ideology, and if so, have they become indistinguishable from labour tactics? Has professional ideology changed to accommodate new resistance tactics? Are there groups or occupations with which the BCMA attempts to form alliances?

II. Research Strategies

Historical methods and content analysis are the principle research methods used in the dissertation. Focused interviews were used as a supplementary method. In considering research strategies, I felt that my research questions did not lend themselves well to either survey research or participant observation. The issues were too complex and historically focused for either of the two techniques. Furthermore, my level of analysis was the medical profession and more specifically, the organization responsible for its economic and political affairs (the BCMA), not the individual practitioner. My interest with key actors was therefore limited to the activities of a relative small number or elite group of doctors -- those who had been actively involved in administrative and committee work within the BCMA -- past presidents, Board or Executive members, members who had served on negotiating teams, or held administrative positions such as the Executive Director. Outside the inner circle, few doctors really understand why this or that decision was made by the BCMA. As in most organizations, there is information deemed too confidential for the rank and file, information that is too detailed and complex, and even in cases where information is accessible to all (such as at the Annual General Meetings), most members do not attend. Therefore, it was much more important to do some focused interviews with doctors actively involved in the politics of the BCMA than to do a random survey of B.C. doctors. Participant observation would have made a good supplementary method in one sense -
- I am sure I could have learned something by observing, for example, ongoing negotiations. However, that was impossible due to the confidential and secretive nature of negotiations.

Although I did engage in focused interviews, this was not a major research strategy. Relying too heavily on someone's memory of past events is never a good idea, especially where, as in my research, detail and nuance relating to many events over a long period of time, was needed. In addition, some of my key actors had died or moved elsewhere. This method would also not allow me to see the process of negotiation and the development of strategy and tactics - elements absolutely essential to my research. Therefore, I found the interviews very useful as a supplementary method but one not as crucial to my research as my two major techniques: historical methods and content analysis.

i) Historical Methods

Some form of historical method was obviously necessary since there was an historical story that needed to be told -- a chronology of negotiation and conflict between the BCMA and the British Columbia governments over the time frame of my dissertation (1964-1993). Luckily, the BCMA was in the process of archiving its vast amount of material and the association's executive director, Dr. Norman Finlayson, agreed to allow me access to the private records as well as availing to me the services of the archivist Wendy Hunt and her assistants. I had originally planned a comparative study with the Washington State Medical Association but could not manage a similar arrangement with that organization where records were "down in the basement" and it was no one's job to help a potential researcher.
The Minutes of the Board of Directors and the Executive were immediately accessible and since they were also the "meat and potatoes" of the holdings, I began with them\(^1\). I had chosen 1964 as the first year for my data chapters because this was the year that the BCMA and the provincial government collaborated on a provincial medical plan. My final year would be 1993, a year marked by the settling of a lengthy dispute between the BCMA and the NDP provincial government. The Executive Director had no difficulty in allowing me to look at the earlier Minutes but I was not permitted to look at the Minutes past June, 1991. Negotiations for a new contract were in process and that material was considered very confidential.

My goal was to ignore the proceedings of the medical committees and any discussion which was medical in nature. From the Minutes, I summarized all events and discussions that had anything to do with state/profession relations and recorded what I felt (subjectively) were the more informative quotations. I was also careful to make note of any differences of opinion that doctors may have had on a given subject. This was important not only for the accurateness of the historical record, but also because I had a research question addressing the impact of internal conflict on the profession. I had to deal with the majority of the Minutes since most of the material was devoted to medical-political concerns. Eckstein (1960:40-41), in his study of the British Medical Association, notes the transformation of an organization preoccupied with scientific and collegial matters to an organization focused first and foremost on medical-political matters, trade unionism and public relations. This latter preoccupation was directly linked to the increasing involvement of government in medical affairs. The same could be said of the BCMA.

My data notes had been typed on a lap top commuter and were organized chronologically. After finishing my data collection, I made the decision as to what would be considered within

\(^1\) I also analyzed the Proceedings from the Annual General Assemblies and the President's Letters
the categories of clinical, economic and political autonomy. **Clinical** or technical autonomy, the "right of the medical profession to set its standards and control clinical performance," would include "clinical freedom at the bedside, professional control over recruitment and training [and] collegial control over, discipline and malpractice" (Elston, 1991:61). **Economic** autonomy would refer to anything that may affect the profession's control over remuneration (Ibid.). **Political** autonomy, "the right of the medical profession to make policy decisions as the legitimate experts on health matters" (Ibid.) would involve any influence or lack of influence the profession may have over government health legislation or policy direction.

I then reorganized my notes so that everything that fit under the category economic autonomy, for example, was in one place and in chronological order. I also had a category for internal conflict and arranged these disputes in chronological order. At this point, I composed Appendix A, "Significant Events at the Provincial and Federal Levels 1964-1993", so that I could use this as an historical guide when writing the chapters.

The strength of this archival method was that the Minutes were incredibly detailed. In the early years (I will use 1964 as an example), the formal record for an average meeting consisted of approximately seven to ten single-spaced pages in a very small type. In 1964, eighteen Board and Executive meetings were held. There was also a "special meeting," so called because it was held in conjunction with other groups to explore various issues. A special meeting may be held with the College for example. The constitution also allows for "extraordinary meetings" in which all members may attend. The purpose of these meetings is to inform the membership and receive direction on decision-making.² Finally, the BCMA holds

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² Conversation with Archivist/Record Analyst/Recording Secretary, Wendy Hunt, June 18, 1986.
an Annual Meeting. I found the proceedings from the annual meetings very informative because they include reports from the heads of all the committees, the outgoing speech of the president who reflects on the past year, guest speakers -- it was customary to invite the Minister of Health to speak, as well as discussion around the many resolutions rejected or passed and the elections. Comments from the past president and the Minister of Health were always a good barometer of the relations between the profession and the government.

By 1970, the Board and Executive Minutes had doubled in length to between sixteen and twenty single-spaced pages and nineteen meetings were held. Currently (June 1996) Minutes average between 25 and 30 single-spaced pages and meetings are held five times a year for two days at a time. There are teleconferences in between so the recording secretary estimates that meetings are really held once a month.³

From 1964 to 1981, my sense was that the Minutes were basically a verbatim transcript of everything said in the meeting. Verbal sparing matches were recorded so it was very easy to tell who the reformers were, for example, and which doctors were most opposed to their actions. Even the unethical behaviours of Board and Executive members were recorded. This changed in 1981, when on the advice of the new professional negotiator, all conversations regarding negotiations went in camera. Today, much more than just the negotiations is in camera. This has as much to do with the sheer volume of information as it has to do with more stringent concerns about confidentiality.⁴ So my sense is that the Minutes make a more valuable contribution in the early years and that the Minutes of the last five years or so were the least helpful in terms of my research. Another strength with my archival material was that there are

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³ Conversation with Wendy Hunt, June 18, 1996.
⁴ Ibid.
no gaps in the material. All of the Minutes for each meeting were available. There were also tape recordings of the meetings but due to time constraints I did not listen to them.

Probably the main limitation of using the BCMA Minutes was that they were obviously one-sided. I had access to the issues as they were discussed and understood by physician Board and Executive members. Occasionally (but very rarely), a politician would be invited to a meeting and their side of the story would also be presented in the Minutes. However, in general, the Minutes revealed one side of the story.

Another difficulty in using the Minutes of an organization for research is that they are designed for those in the know and they assume prior knowledge. Often, for example, there was discussion over an upcoming piece of legislation or over an event which had happened the week before and neither was identified. It was obvious that I needed other research strategies to supplement the archival research.

ii) Content Analysis

I used content analysis methods in order to look at the broader context in which physician strategies and tactics were developed. I was able to do a very detailed analysis of public newspapers. I used the British Columbia Library Newspaper Index and the Canadian News Index to access specific articles from 1964 to 1993. The number of articles read and summarized per year varied from a high of 66 (1981) to 12 (1976). I focused on the Vancouver Sun as it is the major newspaper in British Columbia. However, I looked at the headlines of the other provincial papers (the Province, the Victoria Daily Times, The Daily Colonist) as well as the Globe and Mail. If there seemed to be something that the Sun was not covering, or, if I had some
unanswered questions about the Sun's coverage of an issue, I supplemented the Sun material with the other newspapers.

The newspapers provided an historical account of the province's medical politics under three funding regimes: the private plans, the British Columbia Medical Plan and federal medicare. They reported on government offers of fee increases and the profession's response, speculation on pieces of legislation pertaining to the medical profession, and internal conflict within the profession. The BCMA felt its relationship to the media to be of profound importance and they used the media as a resistance strategy against various government tactics and to gain public support. Their public relations department was quoted by the Medical Post as being the best in the country\(^5\) and they trained their medical politicians in media literacy.\(^6\) The press always attended the BCMA's annual meetings. It would have been a big mistake on my part to have ignored the media coverage of BCMA/state relations.

At the BCMA, I also had access to the British Columbia Medical Journal (BCMJ) and BCMA NEWS. The former is published monthly by the BCMA "as a vehicle for continuing medical education and a forum for association news and members' opinions." It is predominately concerned with medical science but I found editorials, the odd column on BCMA affairs and the "Victoria File" (a regular column on attention given to health care issues in the legislative sessions) to be useful.

\(^5\) See for example, "BC Medical Association Leads the Way by Design in Public Relations" (Jan. 7, 1975:28).

\(^6\) Commenting on his early years (mid-1970's) as BCMA Executive Director, Dr. Norman Rigby recalled: "We were frontrunners [as compared to other Canadian medical associations] certainly in training all our Board of Directors, and presidents and elected officers coming up...we used to take a weekend and have media people come in and train us..." (Interview, July 7, 1995).
While the BCMJ was highly establishment, the BCMA NEWS was run by BCMA reformers, doctors who were unhappy with the status quo and advocated major reforms for the structure of the organization and in its dealings with the provincial government. The existence of these different news sources was also a bonus in showing some of the conflict within the profession -- forces internal to the profession which may contribute to a decline in professional autonomy. The first issue of BCMA NEWS came out in February of 1972 and by May of that year, the newspaper received a 60 day suspension by the BCMA Board who declared its content to be "extremely politically slanted" (VS May 29, 1972). This was possible because the BCMA paid for this paper and saw itself as responsible for its content. The BCMA Board and Executive tried on a number of other occasions to either censor, control, or shut down the newspaper. In 1978, the editor Dr. John O’Brien-Bell was replaced. He subsequently began legal action against the new editor and started a new medico-political newspaper by the name of Western Medical News (this paper had a short life and I did not have access to it).

Finally, I looked at a select number of articles in the Medical Post. This is a Canadian newspaper which along with providing articles concerned with medical education, addresses the affairs of medical associations across the country. I found these useful for comparative purposes. From the Minutes it was clear that the BCMA considered itself to be the frontrunner among Canadian medical associations in terms of innovative solutions and strategies to perceived government interference. I wanted to know how outsiders viewed the association and how well the BCMA was doing in terms of fees etc., in comparison to the other medical associations. I did not have access to the Medical Post at the BCMA. I was able to access the newspaper through the University of British Columbia library system but unfortunately it did not become
available to me until after the research stage of my dissertation had been completed. Therefore, I was not able to make full use of this resource.\(^7\)

I also used some government publications including: *Closer to Home: Report of the British Columbia Royal Commission on Health Care and Costs*, (vols. 1 and 2., 1990) and *New Directions for a Health British Columbia* (1993). The former was commissioned by the Social Credit government and during its mandate conducted an extensive 20 month examination of health services in British Columbia. In *New Directions*, the NDP (elected in 1991) announced its health care reforms based on the recommendations of the Royal Commission on Health Care and Costs.

All of the content analysis was arranged in chronological order and referred to, in conjunction with the BCMA primary material, in the process of writing the data chapters. I did not undertake a formal, quantitative content analysis wherein one might track the frequency of use, and the context within which, a term like "extra billing" might be used. My research questions did not lend themselves to this detailed search strategy. I was interested in large questions related to themes relevant to my research questions.

**iii) Focused Interviews**

Interviewing was my last research technique. I chose to save the interviews until I had written drafts of my data chapters so that I could ask specific questions in areas where my material was confused or where there were gaps. I also wanted to use the interviews to help in verifying my understandings and interpretations. An additional benefit to this strategy was, I looked at the following years: 1971-1976 and 1981.
think, that my knowledge of the issues meant that the doctors took me more seriously. The fact that I was able to say, "remember when such and such happened," gave me a legitimacy that I would not have had otherwise and as a consequence the interviews were richer and more detailed.

I came up with the names and addresses of potential interviewees in a discussion meeting with Dr. Finlayson and archivist Wendy Hunt. From my research, I was familiar with the names of the doctors most active in BCMA politics and service during the time frame of my dissertation. Many potentially valuable respondents were deceased but I was able to generate a list of thirteen. The only stipulation placed upon me by the Executive Director was that I not ask politically sensitive questions about the most current period 1991-93.

Letters were sent to the thirteen doctors (the actual letter was approved by Dr. Finlayson). I contacted seven doctors by telephone and conducted five interviews. I was fortunate that I was able to get feedback on the earliest time period of my dissertation as well as the later years. Of the doctors that I interviewed, two had been active in the BCMA since the 1960s, two since the 1970s and one since the 1980s. They had a range of experiences both inside and outside the BCMA. For example, one doctor had also worked for the Medical Services Commission, one had been an executive director of a hospital, one had been involved in the Professional Association of Residents and Interns (PARI) at the beginning of his career, and another had served as president of the Canadian Medical Profession. The interviews were tape recorded and ranged from one to two hours. The doctors were offered anonymity, but other than the occasional off-the-record comment, none of the doctors felt it necessary to be anonymous. The interviews were unstructured, open-ended, and in depth. I began by asking each respondent to

8 I did not have the means to interview the four doctors outside of Vancouver. Of the four Vancouver-based doctors that I did not interview, one had to leave just before the interview to deliver a baby, one said he would not be available for another month (when I would be out-of-town) and two were on holiday.
comment on his (they were all men) involvement with the BCMA. I then proceeded to ask specific questions about events, legislation, controversies and so on during the time period that particular person was active and then concluded by asking the doctors to comment on changes within the clinical, economic and political dimensions of professional autonomy as well as changes pertaining to the internal politics of the BCMA, the professional ideology of its members and chosen strategies of resistance. I partially transcribed these interviews, recording the topic with the counter number on the tape recorder. Then as I was writing about an issue, I went back to listen to what the doctors had to say about it. This would have been difficult if I had done many interviews, but with just five, it worked out well.

III. Limitations to the Research

Each method has limitations and therefore it was important to use multiple methods. My biggest methodological problem was not having access to the BCMA Minutes for the last data chapter (1991-1993) and not being able to ask any politically sensitive questions of the interviewees for that period. I do not have an internal record of what went on in those years and have had to rely solely on the media and the BCMA journals and newspapers.

I was also only able to look at certain aspects of professional autonomy through the BCMA. In terms of clinical autonomy, for example, I was not able to look at the issue of clinical freedom at the bedside (the ability of the physician to control all levels of patient care - diagnosis, orders for tests and procedures, admission to hospital and discharge from hospital - with little direct interference). I did ask the doctors that I interviewed about the issue and occasionally the topic did come up in the Minutes, usually in cases where an order-in-council was proposed or passed that would affect clinical decision-making (see for example, the order-in-
council on laboratories in Chapter Five). However, the issue of clinical freedom does not receive much attention in the BCMA Minutes or the media. Perhaps this is because, as Rachlis and Kushner (1994) maintain, Canadian doctors simply have not had to deal with the restrictions of their clinical freedom that doctors in some other countries, the United States for example, have had to deal with. There is however, nothing in my thesis to verify or dispute this argument. Most of what I have to say about clinical autonomy in the thesis has to do with professional control over recruitment, training and economic discipline. I also have nothing to say about professional control over unqualified or unethical doctors since the College, not the BCMA, deals with those matters.

I was in a much better position to answer questions about economic and political autonomy. These were the two dimensions of professional autonomy most discussed in the BCMA primary material and the media, and the BCMA has total responsibility for protection of these aspects of medical autonomy. In terms of economic autonomy, I was able to find massive amounts of detail on battles over the fee schedules, including discussions on strategies for the BCMA and what the doctors thought the government strategies would be, and the internal conflicts produced by disagreement over strategy. With respect to political autonomy, there was constant discussion in the primary material as to whether or not the government had consulted the profession on policy initiatives. I was able to chart the decline in government consultation with the medical profession quite easily. I was also able to find information on whether the profession was able to reverse or modify the government’s initial policy direction and on the strategies used by the BCMA to pressure the government.
IV. Studying Elites

One of the points that I make in my thesis is that doctors have traditionally been considered part of an elite profession. What difference does this make in terms of methodological considerations? Susan Ostrander remarks that "Social scientists too rarely 'study up'" (1995:133). I certainly found this to be true. There seems to be very little in social science methods books about studying elites. It is typically assumed that the researcher is more privileged and powerful than the research subject and that this power imbalance needs to be of great concern in terms of research ethics and the potential negative consequences to the respondent.

Ostrander argues that there are some methodological issues similar to studying elites and non-elites but that there are also important differences. One of the first issues she deals with is that of gaining access to elites and establishing rapport. The researcher of elites, writes Ostrander (1995:135), must be especially careful that the right contacts are made in the right order, must be aware that gaining access is not the same as establishing trust: "there will likely be an ongoing process of being 'checked out'", and must balance the need to be appreciative without ever becoming deferential.

I had first contacted the BCMA archivist to talk about what material was available and whether it would be possible to have access. She had told me over the telephone to bring a research proposal with me. After my meeting with her, she gave my proposal to the Executive Director and then set up a meeting for me with the Executive Director. I was instructed to bring a letter from my advisor to the meeting. This was the "right order" although I did not realize it at the time. I chose the order for research reasons but as it turned out, this was also the necessary order to gain access. The archivist was able to convey my research needs to the
Executive Director and satisfy him that her staff could handle my project. Permission was needed by the Executive Director in order for me to see any of the material.

This was also the beginning of the process of being checked out and it was an on-going one. Any unusual request on my part (for example, a request to photocopy a document) went to the archival assistant to the archivist and on to the Executive Director. I was also checked out by the doctors that I interviewed. This surprised me somewhat as I had already been at the BCMA off and on for a few years, had completed my data collection, received permission to do the interviews, and had sent my letter for the interviews out on official BCMA letterhead with the Executive Director's signature on it. However, I was not known to my potential interviewees of course. Several of the doctors indicated that they had talked to Dr. Finlayson prior to agreeing to do the interview. When I arrived at the home of one of the doctors, he queried me about my dissertation, asked some questions about the BCMA and about the current situation with the government and then said: "Okay, I'll do the interview. I hadn't decided for sure that I would do it, you know." This of course was completely his right. My point here was that I was cocky enough to believe that if I got an appointment to go to his home, I was automatically going to get an interview. I didn't foresee that he would interview me first -- check me out -- and then decide for himself. In addition, this was a good example of a situation where the researcher is not the more powerful person.

This also relates to another point Ostrander makes: "elites may check you out by asking hard questions. They will also check you out by seeing if you know people they think you should know and by asking what you expect to gain from the research as well as what you intend to give back to them" (1995:149). I was initially asked these kinds of questions by the Executive Director. I remember at one meeting he had asked whether or not I had read Malcolm Taylor's book (1978) on the emergence of public health insurance in Canada. He also asked how I
intended to talk about resistance strategies and was it possible to do that without giving away information that the BCMA would not want the current government to know about. All of the doctors that I interviewed asked some questions about my research although I was only extensively interviewed in the one case. For my part, I promised the BCMA a copy of my dissertation and also the tapes of the interviews (after being granted permission by the interviewees) for the BCMA archives.

Ostrander's last point, be appreciative but not deferential, I think I dealt with by just trying to be as prepared and knowledgable as possible. As I have already indicated, I believe that having very specific knowledge about BCMA events and disputes gave me legitimacy in the interview process and also helped me control the interview. Ostrander notes the tendency for elites to "converse easily, freely, and at great length but not necessarily with the kind of substantive context the researcher requires" (1995:142). This is a generalization and I noticed very different styles of interaction with all the doctors. However, the generalization holds to the extent that these were articulate men who rarely gave yes or no answers. I did not expect the doctors to follow a fixed progression of questions but I made sure that I fit in what I wanted to know with what they wanted to talk about.

V. Summary

I chose to organize my data collection around three methods: historical methods, content analysis and focused interviews. The strength of the historical method was that it allowed me to chart and interpret negotiations between the BCMA and the British Columbia governments from 1964 to 1993. I was able to look at the processes involved in these negotiations and gain insight into why certain forms of resistance developed while others did not. I was able, with the
aid of my content analysis, to look at the relationship between the structural constraints that the BCMA was forced to operate within and the agency of the organization in dealing with or resisting those constraints.

The kinds of documents that I relied so heavily upon -- Board and Executive Minutes and Proceedings from the Annual Meetings -- were made available to me without the kind of difficulties often faced by those doing archival research, i.e., just trying to locate and identify the material in the first place (Mariampolski and Hughes, 1978). I also did not face another common difficulty, gaps in the data (Ibid.). There were no years unaccounted for in the BCMA archives.

However, like any historical researcher, I had to account for biases in the data. Two issues were crucial here: the selectivity of the data -- what was included and what was left out, and the obvious ideological orientation of the data source. The BCMA material was selectively recorded, although as I point out, this was less so in the early years of my research. Nonetheless, the archival data left out much of the social context necessary to understand the overall picture as well as much of the "backroom" negotiations and gossip. That which was selected for inclusion in the Minutes was probably highly accurate for four reasons: the recorder was 1) geographically and 2) chronologically near to the event, 3) egocentrism⁹ would not have been a factor for the recording secretary and, 4) these were not public documents so matters of propriety probably did not play a large role (Mariampolski and Hughes, 1978).

However, there is also an obvious ideological orientation to this data which meant that while the Minutes may have given me an accurate picture of what was said in the BCMA meetings, it was also a one-sided picture. The actors were all doctors working for a particular

⁹ The individual sees his or her actions as "the most important things that were said or done" (Mariampolski and Hughes, 1978:109).
organization. This does not mean that they all had the same opinions, they did not, but they would share some self interests that for example, government bureaucrats would not. Therefore, it was also necessary for me to use other methods in order to get a more complete picture of BCMA/government relations. My content analysis provided me with a larger picture and viewpoints from the government side while my interviews gave me some access to the backroom thinking and informal negotiations that had occurred.
CHAPTER FOUR


I. Introduction

In this chapter I examine how the economic, clinical and political autonomy of the British Columbia medical profession has been altered by changes in the political economy of British Columbia health care in the 1964 to 1970 period. Prior to 1964, private voluntary medical plans were the central mechanism through which physicians were paid. This changed with the introduction of the British Columbia Medical Plan in 1965, and for a short period of time, health care was funded and administered through both public and private plans. Finally, under federal medicare in 1968, the cost of health care was shared by the federal and provincial governments and administered by the provincial government with no role for private carriers. My intention here is to show in detail how the government came, in the eyes of the medical profession, to increasingly intervene in affairs that physicians regarded as their domain. These unwelcome intrusions were met by organized resistance on behalf of physicians, co-ordinated almost exclusively through the BCMA. By examining what the professional organization did to counteract what they perceived as external threats, I show how, and with what success, the BCMA was able to cope with challenges to professional autonomy.

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1 The first of these plans was established in 1940 (Shillington, 1972; BCMA News, Dec., 1983:9).
II. Economic and Political Autonomy

i) Private Voluntary Doctor-Sponsored Health Insurance

In order to assess changes in the economic autonomy of the medical profession from 1964 to 1970, it is first necessary to know where the BCMA stood in its ability to determine the remuneration of doctors prior to this period. In the section that follows, I briefly outline the BCMA's relationship to private voluntary health insurance. This section also deals with political autonomy because private health insurance plans were designed and controlled by the medical profession.

British Columbia was the first province in Canada to propose a health insurance scheme involving government and this precipitated the emergence of the private doctor-sponsored insurance system. Organized medicine played a major role in the 1937 indefinite postponement of a health insurance plan passed by the Pattulo (Liberal) government. Among the profession's objections were aspects of the bill believed to threaten the professional autonomy of doctors. The health insurance commission administering the insurance was given the right to determine the scope and standards of the insured medical services (Shillington, 1972). These were powers that the doctors felt they should have -- the health insurance commission would be encroaching on their political autonomy. Of even greater concern, was the degree of control over doctors'

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2 The term health insurance is used in the literature first to refer to the coverage of doctors' services and later to plans encompassing both medical and hospital services. The term should not be confused with that of hospital insurance. Saskatchewan introduced the first universal hospital insurance plan in 1946. British Columbia followed in 1947. A national hospital insurance programme with costs shared between the federal and provincial governments was adopted in 1957.
incomes. The Minister of Labour, George Pearson, remarked: "the chief fear of the medical men seems to be that their earnings will be threatened" (Naylor, 1986:58). Doctors could be paid by fee-for-service, salary or capitation. Although the medical profession was promised that the final choice of payment would rest with them, they were clearly uneasy about the wording of the legislation (Naylor, 1986). In addition, government had decided on a fixed rate for total physician services. In the judgment of the BCMA and the College, this would eventually lead to a downward prorating of doctors' fees (Shillington, 1972). However, the BCMA was aware that public opinion and some segments of the business community favoured health insurance and if the medical profession did not act quickly, the government would soon put forth another proposal. In addition, doctors' incomes had suffered during the Depression and had not recovered to pre-Depression levels (Naylor, 1986). Therefore in 1940, the BCMA responded to societal and professional concerns with the establishment of The British Columbia Medical Services Associated (BCMSA), an organization which targeted employee groups and sold service contracts to their employers (the latter were to pay at least 50 per cent of the premium). The medical profession financed the initial expenses but were repaid by 1944 (Shillington, 1972).

Taylor (1990) characterizes the BCMA initiative as the "most aggressive" and in some ways the most successful, of the Canadian profession-sponsored prepayment plans. Fees paid to doctors could be quite high because of the premiums. The plan provided unions with a clear

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The Royal Commission on State Health Insurance and Maternity Benefits surveyed "96 companies with 58,272 employees, including the Canadian Pacific and Canadian National Railways, Consolidated Mining and Smelting and various coalmining companies" in 1929. The Commission reported in 1932, that all of these companies contributed in some way to the cost of medical services for their employees and "were unanimously in favour of the introduction of a state-wide scheme in the province" (Shillington, 1972:41). The Commission also found "an overwhelming desire on the part of the public for the introduction of state health insurance and maternity cash benefits" (Taylor, 1990:40).
incentive to bargain for health care coverage and thus pushed up the number of employee groups registered. In addition, in what Taylor calls a "brilliant stroke of public relations", the BCMA decided that the board of directors would not be dominated by doctors. Instead, the board consisted of four union representatives, two employers and two doctors. This made it unique among the country's sponsored prepayment plans and led to relations that were "invariably more harmonious" and a "fee schedule, in comparison with other provinces, among the highest" (1990:62,63).

The idea that the doctor-sponsored plans were primarily resistance strategies that attempted to stop the spread of government-sponsored health insurance outside of Saskatchewan (Coburn, 1988) is substantiated by an interview with one of the doctors involved in the setting up of the MSA:

They [the doctors] feel that private health schemes plus a helping hand from the provincial government when it is needed will lessen the threat of a compulsory government health scheme which could precipitate a 'Saskatchewan Crisis' in British Columbia. For such a compulsory scheme...will cost more to operate than private schemes, will ruin doctor-patient relationships, will take the initiative away from doctors in general practice, will lead to abuse by the patients, will overwork doctors and will lead to a general deterioration of medical standards.... In addition, the doctors...fear that once legislation is passed removing control of their profession from professional hands into political hands it's only a matter of time before more and more controls and restrictions will be brought into effect (VS, July 7, 1962, in BCMA News Dec., 1983:9).

The weakness of the prepaid plan system was that it did not cover everyone, and with comprehensive insurance in Saskatchewan and the Hall Commission investigating the possibility of national insurance, this became a political problem for the BCMA.

The doctors decided to come out as frontrunners and advocate that the BCMA, along with the plans and the provincial government, work together to provide insurance to the 5% of British

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4 Other plans entered the B.C. marketplace such as the Credit Union and Cooperative Health Services Society (CU&C). MSA was the largest private plan.
Columbians who were medically uninsurable and the 20% that could not afford to belong to the existing plans. In this way the public could be satisfied, the voluntary prepayment principle preserved, and government involvement in health insurance limited to taking care of the needy. The proposal was framed in altruistic terms: "Only those of our citizens who need financial help remain outside the prepayment family. Now is the time for our association to knock loudly on the door of the provincial government and say, 'we need your help to finish the job'. We have accepted with many difficulties a large share of the cost of rendering care to underprivileged members of our society....The government must also share" (VS Sept. 28, 1962:55).

In 1963, a new Medical Services Inc. (MSI) open plan was set up at the request of the BCMA. The profession had given up on government assistance for the needy and decided to establish a plan within the doctor-controlled MSI.

The BCMA was also careful to keep its fees down so that health plan rates would not get too high. In 1962, doctors followed a BCMA policy against "overservicing" and premiums for the plans (for the first time since their formation) decreased slightly. However one year later, the BCMA decided on a 6% increase to the fee schedule. It was a risky decision politically and it took the two largest carriers (MSA and CU&C) six months to agree to the fee hike. In order to get the fee increase, the BCMA was forced to agree to stricter surveillance of doctors' accounts. The BCMA and MSA set up a joint committee whose mandate was to deal with "over-utilization of benefits by members and with over-servicing of patients by doctors" (VS Dec. 24, 1963:2). The latter was deemed easier to control. All billings were to be entered into the MSA computer and each month the doctors' new accounts were to be compared with the previous year's average for those of other physicians with similar practices.

The stricter surveillance of physician incomes and the lengthier negotiations with the insurance carriers shows that the BCMA was beginning to make some of the compromises that
it would later make on a grander scale with the government. It is not the case that the BCMA went from the "golden age of medicine" with complete economic, clinical and political autonomy, to a situation of state control and a loss of professional autonomy. There were incremental changes along the way. During the early 1960s, the profession had a reasonably good relationship with the MSA and the other plans but some of the BCMA executive felt that their counterparts within the MSA fancied themselves as representing and speaking for all British Columbians (in other words, exaggerating their authority and importance) and that the organization was too controlled by labour -- the end result being that introducing changes to the schedule of fees was becoming more and more difficult for the BCMA (Minutes, Dec. 18, 1963; Feb. 26, 1965). At the association’s annual convention in 1964, BCMA president N.J. Blair commented that:

...Going back to the events at the beginning of 1964, I feel that some of our members came out of the fee schedule discussions with a feeling that we should never 'negotiate' our fees again. I suggest to you that negotiation is a modern way of life, although it needn't ever become a synonym for surrender. We negotiate ourselves among ourselves, one group with another, we negotiate with our patients, hospital boards, and third parties whoever they may be. In our profession if we do not negotiate these matters then we must end up dictating them, and this is not possible. I live to recall the quotation of President Kennedy, 'never negotiate through fear - but never fear to negotiate' (Proceedings of the General Assembly, Oct., 1964).

Whatever its difficulties with the private plans, the spectre of government involvement in health insurance was far more troubling for the BCMA. The profession stood behind voluntary insurance as the best way to cover health care costs. Voluntary insurance was a means of restricting government involvement to subsidies for those who could not afford the private plans and a means of ensuring a measure of patient responsibility (the doctors were always concerned about possible patient abuse). The public needed to be constantly convinced of the above and therefore, regardless of their private battles with the plans, doctors needed to publicly support them and keep them competitive.
In the 1963 provincial election, the Social Credit government was easily returned to power and this gave the doctors a false sense of security. The provincial NDP stood for comprehensive government-sponsored health insurance and were, therefore, a definite threat. However, the doctors allowed themselves to believe that Social Credit was so philosophically against this idea that the government would be more than willing to fight for retainment of the voluntary prepaid plans even if it decided to set up some form of government health insurance.

The BCMA officers knew that some form of state-supported health insurance was probable if not inevitable. It was "a vote-catching political plum" to those "pied pipers of politics" (VS, Sept. 26, 1962:33). In his 1963 speech to the general assembly, the chair of the economics committee, Dr. Hart Scarrow said:

"...In our studies one basic idea dominated all the deliberations; that sound economic and social principles should govern, and our traditional right to set our own fees with due regard to those who pay and those who receive the fee, should not be jeopardized. We considered it proper that we adhere to this principle ourselves, and that we again demonstrate it to the people of B.C. and to the government of the day, that it may prevail in any form of state supported health insurance that may be contemplated or introduced..."


Dr. Scarrow went on to say that his committee had studied the details of the introduction of government-sponsored insurance in Alberta and Ontario and found it gratifying that the basic principles accepted in both provinces are compatible with those we have enunciated for B.C. Of much greater importance is the trust and good faith exhibited by the governments of these provinces in their discussion with properly elected representatives of medicine. This deeply contrasts with the action of the government of Saskatchewan in 1962 where the hatreds and perfidy then engendered live on today (Proceedings of the General Assembly, October 1, 1963).

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5 Both provinces had established subsidized programmes solely for low income individuals and families (Canadian Annual Review, 1965; Badgley and Wolfe, 1967). The BCMA characterized the Alberta plan as a "very modest government arrangement" (Proceedings of the General Assembly, Oct. 5, 6, 1965).
ii) **Public and Private Medical Insurance: A Period of Transition**

a) The Hall Commission

Government involvement in health care insurance in British Columbia came at the heels of the Royal Commission on Health Services Report released in 1964. The Diefenbaker government had initiated the Commission in 1961 at the request of the Canadian Medical Association (CMA). The CMA had hoped that Commission members would conclude that the government of Saskatchewan had gone too far and that wide-scale government intervention in health care was not desirable. The Commission could then be used as a tool to forestall further developments in Saskatchewan and to discourage any other provincial government from implementing a Saskatchewan-style insurance programme (Gray, 1991:42). However, the medical profession was to be unpleasantly surprised by the Commission's findings. In its final report, the Commission found that "after more than 25 years of endeavour on the part of voluntary and commercial insurance companies, only slightly more than one-half of the population of Canada has any degree of voluntary insurance protection and this for medical services alone. Of these, the coverage held by nearly 3 million is wholly inadequate" (Hall Report, vol. 1 [1964]:744 as quoted in Gray, 1991:42). The Commission argued against the views of the medical profession and insurance companies that government interference should be limited to providing private insurers with subsidies to care for the poor: "the number of individuals who would require subsidy to meet total health services costs is so large that no government could impose the means

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6 Known as the Hall Commission after its Chair, Chief Justice Emmett Hall, the Commission included two doctors (one had been a former president of the Canadian Medical Association), a dentist, a nursing educator, an economics professor and a financier (the latter resigned after being appointed to the Senate) (Canadian Annual Review, 1964: 391).
test procedure on so many citizens or would be justified in establishing a system requiring so much unnecessary administration" (Hall Report, vol. 1 [1964]:743 as quoted in Gray, 1991:43).

Instead, the Commission concluded that:

the best solution for Canada is the establishment of a comprehensive, universal Health Services Programme...Canada requires the establishment of health insurance funds, provincially administered, contributed to by the Federal Government from general revenue and by provincial governments as they may determine, structured along similar lines to the Hospital Insurance Programme (Hall Report, vol. 1 [1964]:743 as quoted in Gray, 1991:43).

The Commission recommended that the country put together a set of principles for all provinces to follow and that the federal government provide set up grants to each province. The range of benefits outlined by the Commission was even more comprehensive than what was available in Saskatchewan (Canadian Annual Review, 1964:391). The medical profession and insurance companies attacked the Hall Commission report of course. The BCMA response was that the Commission’s philosophy was not only at variance with most of the medical profession in Canada but was also "so far out of step with Canadian thinking that only a small segment of the population [would] go along with the report" (Proceedings of the General Assembly, Oct. 6, 1964). The BCMA, in agreement with its umbrella organization the Canadian Medical Association, was a strong advocate of voluntary health insurance plans and very much against "monopolistic" control of health care. The medical profession warned that "compulsory schemes" would eliminate the freedom of doctors and patients, raise the cost of health care, lead to irresponsible patient demands and overworked doctors and ultimately, to the deterioration of medical standards and the quality of medical care (Canadian Annual Review, 1964:394; VS, July 7, 1962, in BCMA News Dec., 1983:9).

Unlike some Royal Commissions, the recommendations of the Hall Commission had considerable impact on the press, the public and politicians. The Canadian Annual Review of
1964 (395) reported that changes in the financing and delivery of Canadian health care were inevitable, it was just a matter of how and when those changes would occur.

At a federal-provincial conference in 1965, Prime Minister Pearson announced the conditions by which the federal government would provide financial and technical assistance to the provinces for medical insurance. Provinces could implement their own programmes but to qualify for federal funds they had to satisfy four requirements: 1) comprehensive physician services, 2) universal coverage, 3) government administration, and 4) portable benefits. At the BCMA annual meeting it was noted that the Prime Minster had not consulted the CMA on the four requirements and that "it appears to be politically untenable for any government to consult with an interested organization such as ours prior to making a policy decision" (Oct. 5,6, 1965).

The federal government promised to pay half the national per capita cost. Concerns of many of the provinces were alleviated once it became clear that this commitment was firm regardless of what the per capita cost turned out to be. An additional perk -- money for medical research, training and construction of health facilities -- would also be available (Canadian Annual Review, 1965:434-435). This kind of federal assistance would not only give provincial governments the necessary resources to implement their medical insurance programmes, they would also have the power and resources needed to catch up to and to pass those of the medical profession.

b) The British Columbia Medical Plan

In early 1965, fee schedule discussions within the BCMA were more protracted than usual due to the knowledge that a medical plan to be sponsored by the provincial government was likely on its way. Board and executive members debated how to provide the profession with
maximum economic protection. Some members felt that it was necessary to be more innovative than Alberta and Saskatchewan, neither of which had a mechanism in place for fee schedule increases. It was suggested that the schedule should be fixed to a statistical index, such as the consumer price and/or wage and salary indexes. Those who argued for an index felt that increases would be automatic and the profession would not be forced into messy negotiations. The majority seemed to feel that this idea had merit. However, there were others who disagreed because either they felt that doctors would greatly resent their profession transformed into a "service-type industry" or that the profession would fare better with negotiations. Both sides agreed that doctors must have the right to opt out and to extra-bill. Doctors worried that they were both inexperienced negotiators and "amateurs in economics". There was talk of hiring a professional negotiator -- something the association would do sixteen years later (Minutes, Feb. 26, 1965).

In the British Columbia legislature, the second reading of the Medical Grants Bill (which would introduce government-sponsored health insurance in the province) engendered a long and angry debate. The opposition charged the government with "plotting with doctors to prevent full medicare and with insurance companies to keep their political backing" (VS Mar. 13, 1965:16). NDP leader Robert Strachan said there were two reasons for the bill: "to bail out the doctor-controlled MSI which [was] in financial trouble, and to ensure the political support of insurance companies" (VS Mar. 13, 1965:16).

The Social Credit government did legitimate the medical profession's political autonomy, the idea that doctors should be the recognized experts on health policy, by asking the BCMA for help in designing and establishing the British Columbia Medical Plan (BCMP). Some doctors were against such overt cooperation with the government, but their president, Dr. Peter Banks, cautioned that: "...The many aspects of this situation, and the fact that the profession was invited
to assist the government in finding ways and means of carrying out the intent of the legislation meant that it was most important to maintain our internal lines of communication..." (Proceedings of the General Assembly, Oct. 5,6, 1965). A special meeting was held April 1, 1965 with representatives of the government to set up an advisory committee for the BCMP. The plan would be voluntary and it would cover individuals and families who were not able to obtain coverage through the profession's prepayment plans. Members of the profession and the government believed that attempting to subsidize individuals through insuring agencies would be "cumbersome, and potentially dangerous to the independence of the plans" (Dr. Peter Banks quoted in Taylor, 1978:341). The doctors were urged to "assist in setting up this plan so that it will function in the best interests of all..." (Minutes, April 6, 1965).

Some key considerations were agreed upon: subscribers should be able to go to any doctor and individual premiums within the BCMP must be higher than group premiums in the private plans in order to prevent a breakdown of those plans (Minutes, April 23, 1995). Doctors were to have equal representation on the Board of Directors of the BCMP: the profession would appoint two doctors and a layperson while the government would appoint one doctor and two laypersons. However, the government had the privilege of appointing the Chair, who would have a casting vote (Minutes, May 15, 1965).

The BCMA was also adamant that chiropractors and "other unqualified practitioners" should not be in the BCMP. However despite numerous objections from the BCMA, the government insisted that chiropractors and naturopaths be included in the same manner as in the
British Columbia Government Employees’ Medical Service (BCGEMS) contract (Minutes, May 24; June 5, 6, 1965). The BCGEMS was taken as a standard in the preparation of the BCMP.\(^7\)

The BCMP was scheduled to begin in September. By June, the government abandoned its original intention of limiting the plan to low-income earners (which was what the BCMA had asked for) and announced that all British Columbians were entitled to join. The plan was only open to individuals, not groups. However, Premier Bennett announced that the BCMP would accept applications for individuals whose employers were prepared to share their premium costs. Bennett said he doubted there would be many applications of this kind because employers would lose certain tax advantages. At this point, 84% of British Columbians were already covered by medical insurance, most of them in group plans (VS June 9, 1965:1,2).

The BCMP covered all services provided by the medical profession and paid up to $100.00 a year for chiropractic and naturopathic treatments. The plan did not cover ambulance service, drugs, dental treatment, or eye exams to determine need for glasses (VS June 9, 1965:1,2). The government announced that it would pay half the premiums of subscribers with no taxable income and one quarter of the premiums of those with taxable income under $1,000.00 (VS June 9, 1965:1,2). The table below compares the monthly premium rates of the BCMP with other private and government plans:

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\(^7\) Dr. Banks remarked at the annual meeting: "...If you could have been with us in the many sessions we had during the formative stages of the plan, you would know how empty is the accusation 'the doctors wrote the plan'. If nothing else, the inclusion of benefits for services performed by chiropractors, etc. is a good indication of this..." (Oct. 5, 6, 1965).
The rates of the BCMP were lower than what the doctors and the other BC plans had hoped. Dr. Joseph Corsbie, manager of CU&C, told the press that he expected to lose between five and six thousand members to the government plan (VS June 16, 1965:12). This was an early sign that the government was prepared to go against the wishes of the medical profession -- that it may not be willing to protect the principle of maintaining multiple insurance carriers (a promise made to the BCMA, Minutes, Sept., 1965) but instead, would allow its own programme to overtake the private plans.

An reiteration of this concern could be seen in a comment by the president of the BCMA, Dr. Peter Banks, that the "plan is rather broader than we expected." But, he added optimistically: "This is an excellent plan for all the people of the province and an excellent example of the government on one hand and the profession on the other both working in the interests of the
public" (VS June 9, 1965:1,2). NDP leader Robert Strachan held the opposite view. He said the plan was not comprehensive enough as it did not take care of those people who neither earned enough money to pay taxes or qualify for social assistance. Said Strachan: "The Social Credit scheme has the highest premiums in the country for the most limited coverage. I wouldn’t even call it minicare, let alone medicare" (VS June 9, 1965:1,2).

If doctors lost some ground on the actual design of the BCMP (their political autonomy), they were determined to make up for it in their own agreement with the government. During the negotiations for the first fee schedule, the government put forward five different proposals for consideration:

1. That the consumers’ price index for Canada be used, and no ceiling would be imposed.
2. That a combination of Canada consumers’ price index and the B.C. Industrial Composite Index of weekly wages and salaries be used, with a ceiling of 2.75% per year.
3. That a combined index be used for 1967 without a ceiling, and then the whole matter be renegotiated for 1969.
4. That no index be used and that negotiation and arbitration be carried out at each change of schedule.
5. That there be no ceiling but that the combined index be used and the doctors reimbursed at 85% of the Minimum Fee Schedule (Minutes, May, 15, 1965).

The government’s last proposal was that the combined indices be used -- i.e., the Canadian consumers’ price index and B.C. Industrial Composite Index of weekly wages and salaries, each weighted 50% and that any increase above 5 1/2% over two years must be agreed to by both sides. If the combined index rose between 5 1/2 and 8% there would be negotiation. If it rose above 8%, the matter would go to arbitration with the decision binding on both parties (Minutes, May 15, 1965).
In the discussion which ensued, some representatives were in agreement that "in the long run this is not going to work to the advantage of the profession but maybe it is all we can get" (Minutes, May 15, 1965). Concerns about professional freedom and the fee-for-service principle were expressed. As in the last discussion over the fee schedule, those who were pro-index argued that an index would result in automatic increases and "there would be no bad publicity as there is every time we try to negotiate with the Plans" (Minutes, May 15, 1965). The BCMA's lawyer agreed with an index, saying that even in negotiation, requests have to be backed up with reasons and these reasons usually have something to do with a change of index. However, their insurance officer was opposed to locking the fee schedule to an index without some provision to negotiate above the index. He stressed the importance of a clear understanding that there will be escalation: "The changing index is not the only economic event that will affect doctors' incomes or their relative income within society" (Minutes, May 15, 1965). The preferred strategy seemed to be: accept the index but try to get the government to agree to eliminate a ceiling.

In the end, the BCMA signed a five year "Master Agreement" with the Bennett government which contained an escalator clause providing for automatic increases in payments based on the consumer price and industrial wage indexes as well as the freedom for doctors to extra-bill and opt out of the BCMP (VS July 5, 1965:1,13). This was a unique agreement of

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8 Under the formula, doctors would initially receive their current rate of pay. In 1967, payments would undergo the first of two yearly adjustments based on the industrial wage and consumer price indexes weighted equally. With 1962 as the base year, increases in the composite index between 1963 and 1965 of up to 8.5% (an average increase of 2.75% a year) would result in identical fee increases. If the increase in the index was between 8.5 and 12%, the BCMA would be able to negotiate with the BCMP or submit the matter to an advisory committee. If the increase was greater than 12% the doctors would have the right to obtain arbitration (VS July 5, 1965:1,13; Province July 7, 1965:2).
its kind. No other medical association in Canada had such an agreement and although it was innovative and looked to the future protection of the profession, it also went against traditional professional ideology. One of the doctors that I interviewed said: "...We were known as Pinkos all across Canada because we had actually signed an agreement with government...We were getting into bed with government which was a terrible thing to do."  

Ironically, the BCMA was in bed with the government during the earliest years of this time period. No other profession had relationships with the government that were as close as those of the BCMA. The Executive Director of the BCMA, Dr. Tim McCoy, was a personal friend of Premier Bennett and Bennett (not the Minister of Health) dealt with the BCMA: "in the early days the fee increases were very offhand and usually only...decided between the Executive Director...Tim McCoy and the Premier of the province. They would go off and have a handshake deal and come back and tell everybody else what it was. Formal negotiations...began about 1970, 1971."  

The above may be the reason why the Minutes from Board and Executive meetings gave no indication of problems with these particular negotiations or revealed how they were eventually settled. However, BCMA president for 1965, Dr. Hart Scarrow, recalled: "weeks of unproductive wrangling by large groups of experts [which] led no-where. Finally, the then minister and the president found themselves standing downzipped in adjourning stalls of the 'Gents.' There, in desperation and relief, agreement on outstanding points was reached in minutes. It was probably the proper beginning" (quoted in McDonnell, 1984:674). BCMA president for 1967, Dr. Michael Turko, remembered his tenure as: "the year that the fee schedules were settled with a handshake

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9 Interview with Dr. David Bolton, July 26, 1995.
10 Interview with Dr. David Bolton, July 26, 1995.
in the premier’s office. An extra one per cent on top of an already settled increase was obtained to the utter dismay of the minister of finance, the minister of health, etc." (quoted in McDonnell, 1984:675). In any case, fee schedule negotiations were "gentlemen’s agreements" but by the end of the time period discussed in this chapter, they would become more formal, technical, adversarial, and democratic (in the sense that many more people would become involved and BCMA negotiators would be held accountable to the BCMA Board).

The collegiality of the early agreements was based in part on economic satisfaction. BCMA was pleased with their early fee increases under the BCMP. For their first fee increase they had originally requested a 9.91% increase and eventually received 9.2% (Minutes, April 29, 1966). However, there was conflict within the ranks even at this early stage. During 1966, the section of general surgery asked permission to bill to their own schedule. The Board’s response was that although individual doctors could opt out or extra-bill, it was another matter for a group to make this decision. The surgeons were told "that it would be in bad faith for the surgeons as a group to go against the fee schedule" (Minutes, May 28, 1966).

Traditionally, when doctors’ fees were raised, health care premiums also rose. However, in the case of the BCMP, Premier Bennett’s determination to subsidize medicare rates "as much as necessary" meant that BCMP subscribers were unaffected by the doctors’ fee increase (VS June 3, 1966:6). The fee increase did however, affect the premium rates of the other plans since the new fee schedule applied across the board to all the plans, not just to the BCMP. The BCMA was very vocal about its objections to further government subsidization of the BCMP. In February, the Premier had announced substantial cuts in premiums for low income BCMP
The BCMP had already taken away one third of CU&C's individual subscribers and was threatening certain high-rate group plans (VS June 3, 1966:6).

The BC Medical Plan turned out to be very successful. Between March 1966 and March 1967, the Plan doubled in size, covering 400,000 people or 20% of the population (Proceedings of General Assembly, Oct 12, 13, 1967). By 1968, it became clear that large groups were entering the Plan on an individual basis and that Premier Bennett and his government had no plans to sanction this behaviour. The doctors now realized that it would be next to impossible to maintain multiple carriers (Minutes, March 29, 1968).

The first plan to die was MSI which had operated since 1955. By 1967, the plan was in trouble because it could not compete with the government subsidized BCMP. A joint meeting of MSI and BCMA officials decided that MSI should be disbanded as MSA could do a better job of underwriting groups and the BCMP could do a better job underwriting individuals (Minutes, March 31, 1967).

During this period of transition (the government had entered the field of medical insurance but the old funding regime of private plans still existed), the federal government was believed to pose the greatest threat to the doctors' professional autonomy. The Hall Commission recommendation that Canadians should have access to universal and comprehensive health insurance had been accepted by "key segments" of the federal Liberals (with support from the federal NDP) as "a vital piece of social legislation" (Gray, 1991:44). The Social Credit government, on the other hand, had reassured the doctors that if federal medicare should come along, the Bennett government would "retain most of the status quo" (The President's Letter, "Those with no taxable income and those with taxable incomes up to $1,000. would now pay one half of what they paid originally (VS Feb. 12, 1966:1)."

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11 Those with no taxable income and those with taxable incomes up to $1,000. would now pay one half of what they paid originally (VS Feb. 12, 1966:1).
Dec. 28, 1967). Yet at the same time, the Social Credit government was bent on destroying the private voluntary plans which the doctors felt were so important to their professional autonomy. In addition, the government continued to redesign the BCMP without any input from the BCMA, a sure sign that their political autonomy was diminishing.

iii) Federal Medicare Comes to B.C.

I give credit to the socialist government in Saskatchewan for establishing the first medicare plan, but it was opened up with great controversy with the doctors there -- an awful mess. We were the second province, and we started medicare in a small way for those in need. The NDP called it 'tin-cup medicare' -- they held it up to ridicule. The federal government passed an act in parliament permitting them [the federal government] to come in on a combined basis with the provinces on medicare. What province was pushing stronger than all other provinces combined? British Columbia. Saskatchewan wasn’t pushing it, because they had theirs; all they wanted was the federal government to pay a share. British Columbia wanted it not only for British Columbia, we wanted medicare for all Canadians. And we fought it out in the conference in Ottawa (W.A.C. Bennett as quoted in Mitchell, [1983]1995:358).

Unlike most of his counterparts, Premier Bennett decided early on that British Columbia would join federal medicare. It wasn’t the case that he was completely happy with Ottawa. In 1965 Bennett returned from a provincial/federal conference, disgusted with the "electioneering" tactics of the federal Liberal government of whom he said was "preaching co-operative federalism but practise destructive federalism" (VS July 24, 1965:1). Bennett claimed that the federal government didn’t really have a well-thought-out plan of their own at this stage but nevertheless, seemed intent in wiping out all of the existing government and private plans in each province. He also felt that the cost of national medicare would be prohibitive and much higher than Pearson’s estimate (VS July 20, 1965:1; July 24, 1965:1).

Nevertheless, Bennett was not about to pass up an opportunity to share the cost of health care 50-50 with the federal government and there was evidence that he really needed the money. In 1967, Bennett had put a freeze on education and health expenditures. The opposition claimed
"that the education and health departments and the municipalities were being starved to finance Hydro borrowing from provincial pension and investment funds. An estimated $620 million were to be borrowed by BC Hydro from funds usually used to loan to other government agencies" (Canadian Annual Review, 1967:159).

Doctors in B.C. were told that medicare would be introduced regardless of how they felt about it (McDonnell, 1984:675) but that the province would try to maintain the status quo as much as possible. Although the federal plan was not well-defined at this point, Prime Minister Pearson had outlined four principles of eligibility at the federal-provincial conference: comprehensiveness, universality, public administration and portability. In order to qualify for federal medicare and about $20 million in annual assistance, British Columbia had to provide a health programme which would be comprehensive in terms of covering the services of medical practitioners and specialists (with limited exceptions such as plastic surgery), universal as defined by coverage of at least 90% of the population, be administered fully by a government department or government agency, and allow for benefits to be transferable or portable from province to province (Canadian Annual Review, 1965, 1966).

The existing government-sponsored BCMP already met the comprehensiveness requirement but it was run as a private society jointly set up by the medical profession and the government and it did not cover 90% of the population. In 1967, Social Credit passed a proclamation bill (a bill which does not come into effect until ordered by Cabinet) to enable its existing health plan system to qualify for federal medicare. The Medical Services Act gave Cabinet the powers to set up a three member medical services commission (MSC) which would have the authority to set standards of care, fix uniform premiums, and handle financial arrangements between government and private operators (VS Mar. 14, 1967:9). One of the members of the MSC was to be a doctor. The existing prepaid plans could continue but only as
licensed carriers under the commission and at its discretion (they could not sell health insurance
privately) and doctors would be able to opt out of the plan.

By 1968, 93% of British Columbians were covered by one plan or another. Therefore, once the plans became licensed carriers, the province would be able to achieve the required percentage. One month before British Columbia was to join Medicare, seven plans (BCMP, MSA, CU&C, Fraser Valley Medical Services, Provincial Teachers’ Medical Services, Canadian Pacific Employees and Automotive Retailers’ Medical Services) became licensed carriers under the MSC (VS June, 29, 1968:29). As licensed carriers, they would handle the actual enrolment of individual and group subscribers, the collection of premiums and the processing of claims. The private organizations were also permitted to sell their own supplemental insurance policies, including disability insurance and coverage for dental treatment, nursing care and drugs (Fisher, 1972:53,54)

British Columbia entered federal medicare on July 1, 1968. It was one of two provinces to do so -- Saskatchewan was the only other province to qualify. In the board room of the BCMA, doctors consoled themselves with the logic that "the medical profession [was] in a strong position as the Provincial Government [would] have to get along with the profession in order to obtain federal money" (Minutes, May 31, June 1, 1968). The doctors felt that there were some protections for them in the Medical Services Act: the premium structure and the privileges of opting out and extra-billing remained intact. They were also hopeful that the "good faith" on both sides could be maintained (Minutes, May 21, June 1, 1968). However, there was also the realization that the government seemed be going it alone on legislative decisions. Since consulting with the profession on the BCMP, Social Credit had passed legislation amending the Medical Grant Act (1966) as well as the Medical Services Act, without discussions with the BCMA. The medical profession’s advice seemed to be no longer necessary or welcome.
III. Clinical Autonomy

In the previous sections, I have outlined transformations in the political economy of
British Columbia health care and the consequences of those changes for the economic and
political autonomy of the medical profession. What about clinical autonomy? The three
dimensions of clinical autonomy were: clinical freedom at the bedside, professional control over
recruitment and training and collegial control over discipline and malpractice (Elston, 1991:61).
My thesis considers the last two dimensions (control over recruitment and training is a major
issue for the BCMA in chapter six) but in this chapter, I will concentrate on control over
economic discipline (the only kind of control that the BCMA has in terms of discipline and
malpractice). Before setting aside the issue of recruitment and training, however, I should say
that the BCMA did not spend much energy on these issues because the government was
convinced that there were not enough doctors for the population.12 At the annual meeting in
1967, it was noted that due to a doctor shortage, the BCMA had advertised in the British Medical
Journal for general practitioners and received 250 letters (Oct. 12,13).13 However at a Board
meeting in 1969, Dr. E.A. Horniman argued that there would be a major confrontation with
government down the road and that the BCMA should work to reduce the numbers of doctors
in the province. In his mind, this would enable the BCMA to more effectively negotiate with

12 Demographers forecasting the Canadian population for the
Hall Commission projected a population of 30 million by 1986 which
turned out to be an overestimate of approximately 5 million. The
experts and the government also overestimated the number of doctors
who (opposed to medicare) would leave the country, and
underestimated the numbers of doctors immigrating to Canada.

13 The main reasons that doctors gave for wanting to leave
Britain were: "over-work, lack of hospital privileges, and the lack
of texture of general practice" (Proceedings of the General
the government (Minutes, Oct. 9, 1969). It appeared that the other Board members did not agree with or support Dr. Horniman in this regard but his concerns would turn out to be prophetic.

The advent of medicare also meant changes to the economic self-regulation of doctors. Although many doctors were unhappy with the establishment of the BCMA/MSA joint committee on professional relations (under the private plans system), the BCMA had been in the driver’s seat in that committee and problems were dealt with in a quiet and confidential manner: "When a doctor’s statistics appeared to be out of line with that of other doctors in his district he would be asked to come in and discuss them quietly with the Joint Committee..." (Minutes, June 5, 6, 1965). Now, under medicare, the profession had to deal with the Medical Services Commission’s Claims Adjudication Committee and under it, a sub-committee on doctors’ profiles. The sub-committee was made up of the Medical Directors of the licensed carriers, and as Dr F.S. Hobbs, head of BCMA’s Patterns of Practice Committee pointed out: the carriers now had common fees and benefits, and a united purpose in scrutinizing doctors’ accounts with the help of a computer set up by the MSC (Proceedings of General Assembly, Oct. 7, 8, 1969). Further, under the Medical Services Act and Regulations, "the assessment and approval of all individual accounts for insured services under the Plan and the determination of the amount paid shall be carried out by the Commission" (Proceedings of General Assembly, Oct. 7, 8, 1969). In practice however, the Sub-Committee on Doctors’ Profiles would refer cases to the BCMA Patterns of Practice Committee, which would make a recommendation to the BCMA Board of Directors, which would then make a recommendation to the Medical Services Commission. The MSC was somewhat reluctant to take on its new role. Said Dr. Hobbs: "So far the only recommendation that has gone to the Commission, to our knowledge, has not been acted upon. The commission seems very loath to accept their responsibility, and keeps throwing the ball back to the profession to do their own economic discipline" (Proceedings of General Assembly, Oct. 7, 8, 1969). If this aspect of
clinical autonomy was to be left in the hands of the medical profession for the moment, there was not complete agreement within the BCMA as to which doctor organization should handle economic discipline. Some BCMA board members felt that all professional discipline, including that which was economic in nature, should be handled by the College of Physicians and Surgeons and not the BCMA (Proceedings of General Assembly, Oct. 7,8, 1969).

IV. Making Public Doctors’ Incomes

The Master Agreement had worked well for the BCMA and the Association was pleased with its early payments. By 1967 British Columbia had one of the highest fee schedules in Canada (Minutes, May 5, 1967). The province also had the greatest number of practising doctors per capita and the highest cost per capita for doctors’ services (Minutes, May 5, 1967). However, 1967 was also the year that the federal government and the provinces began to be concerned about the rate of inflation in the economy (Canadian Annual Review, 1967). The next year, concern about rising health care costs dominated the conference of federal/provincial health ministers and a series of task forces was set up to look at health care costs and delivery (Canadian Annual Review, 1968,1969). The preoccupation with health care costs and the knowledge that the BCMA was doing well economically in comparison with the other provinces would greatly influence future Socred dealings with the doctors.

During the 1969 fee negotiations, it became obvious that the formula within the master agreement was open to different interpretations. In the BCMA’s opinion, the composite index formula dictated a 9.9% increase. Premier Bennett, on the other hand, felt that an increase of 8.75% was justified. This included a 2% SAMS (Social Assistance Medical Service) increase (Minutes, July 18, 1968). SAMS recipients were now to be covered under the BCMP.
Previously, SAMS had been run by the College. Because the BCMA did not feel that SAMS should be a part of the overall increase, they reported their fee increase to the press as 6.75% and announced that "the medical profession was showing itself to be responsible and willing to exercise restraint in an inflationary period" (VS July 23, 1968:19).

Not all of the executive agreed with a strategy of reasonableness and self-sacrifice. In a letter to the 2,600 BCMA members, Dr. E.A. Horniman charged:

> Once more we have fallen sadly behind the indices in our latest negotiations for a fee increase. Over the years, there has been a progressive loss on the part of the medical profession of its powers to set its own fees, and latterly to control its conditions of practices. This has been caused by the ever-increasing economic power of the prepaid schemes, and latterly by the unbounded powers of medicare legislation, and the orders in council, which are the 'rules of medicare' that give the government limitless power to rule our professional lives. How much stronger a position our president would have been in when facing that astute and ruthless politician if he had been able to say, 'Mr. Bennett, you make a very strong case but I am sure that the general membership will not vote to accept it and I cannot sign it without their ratification (VS Oct. 5, 1968:29).

Dr. Horniman submitted a resolution to the BCMA annual convention in Kelowna that year to the effect that all fee agreements must be ratified by the full membership in a majority vote. His resolution was defeated 83-25. However, a similar resolution passed the next year and the BCMA became the first medical association in Canada to have membership ratification on a fee agreement (VS Oct. 8, 1970:72).

Dr. Horniman's concerns were backed by Dr. R.G. Hepworth, an unsuccessful liberal candidate in the previous provincial election. He claimed that the BCMA was "in need of radical change" but that the present executive was "impotent" (VS May 15, 1969:29). Hepworth was of the opinion that the BCMA needed a professional negotiator: "How anyone can believe that a few inert, unexperienced doctors can sit down with experienced negotiators and hammer out a fee schedule suitable for the profession and fair to the public is beyond the belief of any thinking member of the profession" (VS May 15, 1969:29). Hepworth was also in favour of
ratification of all fee agreements by the membership and he was particularly angry with remarks by Health Minister Ralph Loffmark that "some BC doctors were abusing the BCMP" by charging too much (VS May 15, 1969:29).

Loffmark's remarks were followed with a cabinet order to force disclosure of doctors' incomes under the provisions of the Public Bodies Financial Information Act. Doctors objected strongly to the reasoning that they were now civil servants paid out of public funds and therefore the public had a right to know how much money they made. Said doctor and Social Credit MLA, Scott Wallace, "We are self-employed individuals who negotiated with the provincial government on a certain fee schedule" (Times Nov. 5, 1969:41). Doctors argued (as they do today) that publishing gross incomes gave no indication of hours worked, the quality of service, or the cost of staff and other overhead. Despite BCMA objections and its pleas that if the incomes must be made public, at least the government could publish the figures in a manner less damaging to the profession, the government proceeded to publish the incomes, in gross form, in what was called "the blue book" (Minutes, Jan. 16, 1970; Feb. 20, 1970).

V. Internal Conflict and a Moratorium on Fee Increases

This was a turning point in relations between Social Credit and the BCMA. Two camps were solidifying within the BCMA: the "moderates" who believed that the association must continue to stress diplomacy and quality of care and the "reformers" who argued that the BCMA should take a stand, make its terms stiff and not worry so much about getting an agreement with the government. One board member declared: "This is a hostile government whose object is not to keep costs down but to embarrass the profession" while another insisted that "We should somehow get it across to the government that our relationship is not a master-servant relationship.
and that they cannot expect to slap us whenever they feel like it. It is a partnership" (Minutes Dec. 6, 1969).

The doctors were envious of the situation in Alberta where doctors seemed still to be in charge, but they were also conscious of the situation in Manitoba. In that province, the favoured resistance strategy of the medical association was a mass opting out of doctors from medicare. Although a large percentage of doctors backed this strategy, only 25% actually opted out when asked to do so by their medical association. This reinforced BCMA members' belief that "opting out, as a weapon, is unreliable" (Minutes, Dec. 5, 1969).

The government strategy in dealing with the BCMA was clear at that point: tell the public that the government has grave concerns about the cost of medicare, speculate that some doctors may be abusing the medicare plan, publish a complete list of doctors' gross incomes and then suggest publicly that since doctors are "fine citizens" it was hoped "they wouldn't seek an increase in fees at this time" (Times Aug. 12, 1970:1). Said the Victoria Daily Times: "...the government was able to play the role of the stern guardian of public interests -- which is what it is supposed to be -- making it difficult for the doctors to play the same role, which they often claim as their fundamental principle" (Aug. 12, 1970:1).

The BCMA tried to fight back by showing Victoria that the association was taking the economic discipline of its doctors very seriously. Joint meetings were held with the College of Physicians and Surgeons to discuss the matter and the College agreed to help with those doctors showing abnormal patterns of practice. The following motion was passed at the March Board meeting: "that as of April 1, 1970 it be the official policy of the BCMA that all physicians whose net annual income derived from fees paid by the Medical Services Commission is in excess of $50,000 be scrutinized as to quality of care rendered. This study would be by a select committee appointed by the Executive of the Association" (Minutes, Mar. 20, 1970). The Committee was
named the Cost Quality Study Committee and the government was impressed enough to fund its operation (Minutes, May 29, 1970).

However, it did seem as though the doctors were thoroughly outwitted. In their next round of negotiations, the premier told the Association that 1) there were certain doctors, in one or two specialties, earning incomes that could not be justified and 2) Medicare was costing the province about $120 million a year and that the province could not afford to pay more. Therefore, the BCMA needed to rearrange its fee schedule and there was to be no increase in fees. Those doctors entitled to an increase should get it at the expense of the high earners. The Premier made it clear that he personally did not agree with the formula by which increases were given to the Association (Minutes, July 24, 1970). The original Master Agreement had expired and the new one would not contain the automatic escalator clause.\textsuperscript{14}

The BCMA was told that these were "bad times" and a moratorium on fee increases was proposed. The Board decided to go along with Bennett's request under the following conditions: 1) that there be no unilateral changes during the course of the moratorium, 2) the moratorium was to be only for one year, 3) it must be approved by referendum, 3) disparities in the fee schedule were to be corrected, 4) the formula for fee increases was to be left in the contract even if it was not implemented, and 5) the right to balance bill was to be stated and guaranteed (Minutes, Oct. 30, 1970).

Publicly, Dr. Corbett, the new BCMA president, said: "We now recognize the exceedingly difficult situation in which our economy is faced with the dual problems of inflation and

\textsuperscript{14} According to Dr. Peter Banks, the BCMA was approached by Social Credit before the 1969 election to re-sign the original Master Agreement for another five years. However, due to pressure from the reform element of the association, the BCMA refused to sign, Social Credit won the election and promptly withdrew the offer (BCMJ, Vol. 24, 3, 1982).
recession, side by side, and some responsible segment of society, sometime, somewhere, is going to have to say 'get off this wicked treadmill, we will not ask for an increase even though other groups have done so’” (VS Oct. 9, 1970:17). Privately, the BCMA had been told by the Deputy Premier, Wesley Black, that they needed to be the leaders and others would follow. However, "that was not the case at all. We were left high and dry. We vowed that would never happen again."  

In the BCMA’s first referendum, the doctors were asked: "Are you in favour of an (increase) moratorium for not more than one year?" 77.8% of the doctors who responded (1,454 to 389) voted in favour of the moratorium (VS Dec. 23, 1970:1).

VI. Summary

After a very promising beginning, the partnership between the BCMA and the Social Credit government fell apart. It seemed that mutual accommodation and "the politics of the double bed" (Klein, 1993:205) had outlived its usefulness as far as the provincial government was concerned. The British Columbia Medical Plan became broader, cheaper and more successful than the BCMA had envisioned. Their cherished voluntary plan system could not survive public desire and political expediency. In British Columbia, as in the rest of the country, not only had the public "accepted the belief that access to health care had become a right of all citizens" but there was also "general acceptance of the concept that costs should be shared by all" (Canadian Annual Review, 1970:458).

15 Interview with Dr. David Bolton, July 26, 1995.
The BCMA had signed an amazing Master Agreement with the provincial government. No other medical association had such an agreement, complete with an automatic escalator clause for fee increases. However, they could not hold onto the special privileges contained in that agreement and by the end of the 1960s, the BCMA lost the escalator clause and were faced with a moratorium on fee increases. Certainly, by 1970, the rising costs of health care were an issue for every provincial government. The Canadian Medical Association actually requested that provincial associations delay increases to their fee schedules and in the year that the BCMA accepted their moratorium, doctors in six provinces received no fee increase (Canadian Annual Review, 1970:459; BCMJ 26,10, 1984:679).

However, no other provincial government published their doctors’ incomes during this time period, an act of betrayal as far as the BCMA was concerned, and one which would help facilitate greater militancy among British Columbian doctors. Even today, provinces such as Manitoba, do not make doctors’ incomes public (VS Jan. 24, 1995:A9).16

The BCMA also lost much of its political autonomy: "the right of the medical profession to make policy decisions as the legitimate experts on health matters" (Elston, 1991:61). They had been planning partners with Social Credit on the BCMP and now the provincial government was passing legislation without consultations with the BCMA.

The one aspect of professional autonomy that the BCMA managed with relative success within this period was that of self-regulation. Despite government preoccupation with individual

16 One year later doctors’ incomes were made public in Alberta. However according to the Medical Post, the media cooperated with the Alberta Medical Association "and presented a much more accurate view of the payments" (Mar. 9, 1971). When Toronto newspapers published the names of high earners in 1976, editorial comments were highly critical of the Ontario government for allowing this to happen (VS, Dec. 17, 1976:1; Minutes, Feb. 26, 1977).
high earners and high earning specialties, the BCMA was able to maintain control of economic discipline, mostly due to the reluctance of the government to interfere in this area.

Professional resistance, during this time period, took the form of adaptation to government imposed change. The BCMA took to heart former president Blair’s comment that negotiation had become necessary -- there was no way out of that for the profession -- but that negotiation need not mean surrender. Examples of resistance strategies included the careful preparations for the BCMP and federal medicare, making sure that the BCMA had proper (and if possible dominant) representation on government/profession committees, and insisting on retaining the right to opt out and extra-bill. These were strategies very much in keeping with the professional ideology of the time. More radical strategies such as hiring a professional negotiator and collective opting out were considered, though not seriously, while walk outs and legal actions were not considered at all.
CHAPTER FIVE

Internal Wars and a Change in Government: 1971-1975

I. Introduction

In the previous chapter, I outlined some of the changes and challenges confronting the medical profession as health insurance in British Columbia evolved from that of private doctor-sponsored medical plans to government-sponsored insurance co-existing with private plans, to finally a system where government was the sole payer and administrator of health insurance.

During the time period of this chapter, the early 1970s, the federal and provincial governments and the medical profession came to grips with the positive and negative consequences of Medicare. On the positive side, Medicare was enormously popular with the Canadian public and it provided immediate financial gains for the medical profession (Swartz, 1977; Naylor, 1986). On the negative side, health care costs continued to rise and at a pace deemed out-of-control at the federal and provincial levels. Doctors' incomes began a gradual decline as provincial governments held back on increases in their fee schedules (Canadian Annual Review, 1971; Naylor, 1986).

A flurry of task force reports on health care delivery and costs were produced during this time period and they "shaped the debate on the health-delivery system throughout the 1970s" (Gray, 1991:107). In British Columbia, the Foulkes' Report was typical of its counterparts in stressing the need for a radically reorganized health delivery system with community human resources and health centres at its core. This model would allow for increased public participation in health care, localized decision-making and a decreased reliance on physicians. It would also threaten the fee-for-service payment of Canadian doctors (economic autonomy),
give government and laypersons more control over hospital budgets and governing boards (all aspects of professional autonomy), and allow the paramedical professions to encroach on the professional dominance of the medical profession.

There was, most definitely, a relationship between the findings of the task forces and an emerging ideology which combined the merits of holistic or "healthy environment" health care with a critique of the value of clinical or "curative" medicine (Gray, 1991). The 1974 federal report: "A New Perspective on the Health of Canadians" (the Lalonde Report) was the standard bearer for this way of thinking in Canada. The report concluded "that increased expenditures on curative health services would yield fewer returns than expenditure in three other areas that influence health: human biology, environment, and life-style" (in Gray, 1991:108).

As Gray (1991:108,109) points out, the Lalonde Report was cleverly put to use as a justification for reduced government spending on health care:

If expansion of the health care system could not have much impact on mortality and morbidity, then neither could curtailing its growth. The politically explosive arguments that failure to fund the system at levels professionals declared 'needed' would lead to suffering and death could thus be rebuffed. The epidemiologist was recruited to stand beside the accountant in defending the public purse against the clinician (Evans in Gray, 1991:109).

This quote also points to the fact that government strategy toward the medical profession may use attacks on one form of autonomy (for example, clinical) as a lever to deal with another (for example, economic).

In this chapter, I will look at how this more aggressive stance toward the medical profession by the state is played out in British Columbia. How does it further change the clinical, economic, and political autonomy of the medical profession? How does the BCMA react? What kinds of strategies and tactics does it engage with? A more hostile federal and/or provincial government also has the potential to create tension and conflict within the medical
profession as its organizations grapple with ways to deal with the tough controls over various aspects of their professional autonomy. Therefore, I will also examine a research question only alluded to in the last chapter: "Are there forces internal to the profession which weaken or strengthen the BCMA vis-a-vis the government?"

II. Clinical, Economic, and Political Autonomy

i) Restrictions on Laboratories

In 1971, Social Credit was still in power and its relations with the medical profession were at an all-time low. The government had proposed two orders-in-council which infuriated the BCMA. The first would force licensing and restrictions on private doctor-run laboratories and other diagnostic facilities. Government reasons for this legislation seemed fairly straightforward. Between 1970 and 1971, medicare costs in British Columbia had increased $14 million and the province was still the leader in per capita costs for medical services (Minutes, May 28, 1971). One of the problem areas was thought to be the rising costs and utilization of private laboratory services which were more costly than services in public labs. According to the government, some hospital laboratories were operating at one-third capacity while new private facilities were being developed near by (Minutes, May 28, 1971).

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1 The Health Minister at that time, Ralph Loffmark, was considered to be very "anti-physician" (Interviews: Dr. David Bolton, July 26, 1995; Dr. J. William Ibbott, July 27, 1995).

2 There were three kinds of laboratories operating in British Columbia: private labs operated by independent physicians, public hospital labs and the B.C. government lab which primarily tested for sexually transmitted diseases.
As far as the BCMA was concerned, the order-in-council was a definite restriction on the profession's clinical as well as economic autonomy. The proposed legislation would affect doctors' decisions around diagnostic tests and where they could be performed and would give the Health Minister the final decision on whether to institute or revoke a laboratory license (Minutes, July 8, 1971). In addition, the BCMA argued that the legislation would halt research on laboratory medicine which was primarily conducted in private labs (VS July 23, 1971:27). It was also a violation of the profession's political autonomy because the BCMA had not been consulted in the drafting of the legislation. The Minutes indicate that the association had met with the government over the concerns of rising costs and utilization of laboratory services, and the BCMA had hoped that the government would accept a doctor-designed solution involving the BCMA Laboratory Accreditation Committee (Minutes, July 8, 1971).

The BCMA set in motion their resistance strategies. These included public relations -- they received a great deal of public and media support for their position in spite of government arguments that a method was needed to force doctors to use the cheaper hospital labs (Province August 21, 1971:1) and a series of negotiations with the government. In the end, the intent of the legislation remained -- to be covered by the medical insurance plan, a lab had to be licensed -- however the BCMA was able to modify the legislation so that they would have a great deal of control over licensing decisions and approval of laboratory payments. The BCMA gained the right to set up an appeal mechanism, run its own laboratory accreditation program and to have members on an advisory committee to the Minister of Health (Minutes, Aug. 17; Sept. 18, 1971).
ii) Physician Appointments to Hospitals

The second order-in-council concerned amendments to the Hospital Act which would allow the Minister of Health the right to veto the decisions of hospital boards as to whether or not a doctor may be granted privileges in their hospitals. The order also appeared "to authorize Loffmark to attach conditions to the doctors' hospital privileges" (VS July 28, 1971:26A). Government had three reasons for this legislation. They didn't like the power hospital boards had with respect to: 1) the distribution of doctors, 2) treatment of immigrant and transferring doctors, and 3) decisions as to where specialized medical services such as open heart surgery would be performed (Canadian Annual Review, 1971:186). This was the Social Credit government's first attempt to deal with the problem of doctor distribution in the province. Vancouver, Victoria and Kelowna were over-serviced while other areas (especially small, remote communities) experienced a severe shortage of doctors. Loffmark also claimed to be concerned that some hospital boards were treating new, immigrant and transferring doctors unfairly and that only a privileged few doctors were given permission to perform certain specialized medical services (Ibid).

Not surprisingly, there was an immediate and powerful reaction from the medical profession. Control over physician supply is an important aspect of clinical autonomy as I have defined it. The Canadian Medical Profession declared the order to be a "fascist-like document" attempting complete control of the profession, while BCMA executive director Dr. E.C. McCoy claimed that the legislation "opened the door to political appointments of doctors to hospitals" made by a minister who knew nothing about doctors’ qualifications (VS July 28, 1971:26A). The
press threw their support behind the doctors -- the *Province* even called for Health Minister Loffmark's resignation (July 28, 1971).³

However, there may have been a more important underlying reason for this legislation. Premier Bennett said publicly that the government would not enforce the order and would "give doctors 'full freedom of action'...if they would pledge co-operation in holding down costs" (Province, Aug. 21, 1972:1). Perhaps this was the real reason for this piece of legislation which was unique in Canada (VS July 28, 1971:26A). 1971 was a negotiation year. Premier Bennett had suggested to the BCMA that the doctors take a 10% cut in their fee schedule. Bennett pointed to the rise in health care costs but even more damaging as far as the BCMA was concerned, he was able to show that physicians' net incomes were now ahead of the composite index of average weekly wages and salaries and the cost of living (the index used in the original master agreement; Minutes, Aug. 6, 1971). Still, the BCMA made it clear that it was determined to fight for a fee increase. Perhaps both controversial orders-in-council were part of a strategy to bring the profession in line with government demands. This would then be a good example of a government strategy to attack one type of autonomy (clinical) in order to deal with another (economic).

Once again, the BCMA was able to substantially modify the legislation. Health Minister Loffmark agreed to an extensive rewrite of the hospital order. According to the BCMA Minutes, "The minister was finally convinced that the distribution of doctors was not really a matter that

³ Social Credit MLA and doctor Scott Wallace resigned from his party and became an Independent. The only doctor on the opposition side, Liberal leader Pat McGreer said: "This recalls the early days of Social Credit when they thought they could practise their own kinds of medicine. It's Social Credit quackery." He referred to speeches in the early 1950s, where a Social Credit MLA "opposed fluoridation, smoking, liquor, candy and comics and proposed a diet of potassium-rich foods as a cure for cancer" (VS July 28, 1971:26A).
came under the Hospitals Act" (Sept. 18, 1971). The two parties agreed to set up three committees: 1) a Medical Manpower Committee to discuss medical manpower needs and doctor distribution, 2) a Medical Review Board to recommend policy and review hospital board decisions concerning expensive special referral services and facilities, and 3) a Medical Appeal Board for doctors denied hospital privileges. Since doctors were to dominate each of these committees and any right of the Health Minister to impose his will on hospital boards was eliminated from the order-in-council, it is difficult to understand how or why The Canadian Annual Review for 1971 came to the conclusion that "Overall these new changes clearly represented a considerable modification in the traditional operating relationship between hospitals, the medical profession, and the government" (188). The one operational change that was made was to allow medical staffs to elect their Chief and President as well as members of Credentials and Utilization committees by secret ballot, and while this may have provided for better accountability within the profession, it did not result in any transfer of power from the profession to the government (VS, Sept. 14, 1971:35; Proceedings of the Annual Meeting and Assembly, Oct. 5, 1971; CAR, 1971:186-188).4

III. Internal Conflict

i) The Reform Platform

These aggressive moves by Social Credit did, however, have an impact on the internal politics of the BCMA. One of the most significant developments of this time period concerned

4 The VGH, as a teaching hospital, was exempt from this requirement.
the rise of the reform movement within the BCMA. As indicated in the previous chapter, the
continued belief that the BCMA schedule had not kept pace with inflation, combined with
government strategies perceived as unnecessary and hostile to the profession (such as the
publication of doctors' incomes), gave strength and legitimacy to those who wanted to take a
more militant stance with the government. The reformers were mostly doctors who had
immigrated from England and saw themselves as refugees from the socialized medicine of the
National Health System (NHS)(BCMJ 36,1, 1994). Communications director Jim Gilmore
described the challenges of this period as "internal rather than external. The profession was at
war, with the reformers on one side and the establishment on the other, and it was a bloody, no-
holds-barred battle" (BCMJ 36,1, 1994). One of the doctors that I interviewed felt that "the
divisions within the profession were at least as important as any of the confrontational
experiences with the government of the day...."

The reformers were committed to "taking a stand" with the government and keeping the
BCMA's terms "stiff". They believed that the BCMA should have principles that were non-
negotiable. These included fee-for-service as the only acceptable method of payment for doctors,
and full physician control over medical work, appointments to hospitals and the licensing of
doctors and laboratories (Province, Oct. 5, 1971:1). They felt that the BCMA establishment was
so concerned with coming to an agreement with the government that it compromised the welfare
of the profession. According to reformer Dr. John O'Brien-Bell, aspiring to notions of a
"professional image" put doctors in a "straight jacket" when it came to negotiations with the
government (BCMA News, 1,2, 1972). More radical strategies for dealing with the government

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were urged: "our greatest weakness is of course our profound reluctance to use the strike weapon" (BCMA News, 1,1, 1972).

Reformers also sought internal changes within the BCMA to make it more "democratic". They argued that the association was being run by an elite group that did not represent the rank and file. Therefore, they "took the stand that no important decision should be made by the Board alone. Anything to do with fees etc., should all go to a referendum to the entire profession so that one small group, even if they were elected people, could not run the show". Reformers were certain that the rank and file of the profession was more amenable to reform ideas.

During the 1971 annual meeting, reformers put forth a number of motions aimed at constitutional changes within the BCMA: that ratification of all fee agreements and other financial matters be part of the constitution, decisions made at the AGM should have "official force", and the negotiating committee should be elected by members at the annual meeting (Province, Oct. 5, 1971:1). The latter was deemed necessary because "the president is picked from gentle men, kind men, good men, and these types of men cannot deal effectively with ruthless government negotiators" (VS Oct. 6, 1971:15).

The reformers won their motion requiring ratification of membership for all financial agreements and a motion was passed to study the possibility of an elected negotiating team. They lost the other motions as well as a bid to have one of their members elected from the floor. On the surface, it looked as if the medical mainstream had retained control. The Medical Post reported that the executive and the board were in favour of the referendum motion (Oct. 19,

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6 Interview with Dr. David Bolton, July 26, 1995.

7 Although the BCMA held its first referendum in 1970, it was not a constitutional requirement that it do so.
1971:1), an observation not entirely true: the Minutes revealed that many officials felt that the
general membership was not educated enough to make decisions on important BCMA matters.

At the same meeting, the government was chided for its ineptness and its lack of
consideration towards the medical profession. The following motion was passed unanimously:

That this General Assembly strongly suggests to the Provincial Government that it is in
the interests of the people of this Province that the Medical Services Commission work
closely with the proper professional authorities to solve the problems arising from the
delivery of medical care by prior discussion of this problem before enacting legislation
which is ill-conceived, often unworkable and liable to lower the quality of care without
achieving the mutually desired end of reducing costs (Proceedings of the Annual Meeting

The very need to discuss this motion indicates the decline of medical power, at least as
perceived by physicians.

IV. Economic Autonomy

i) A New Fee Schedule

While the BCMA had been successful in modifying government legislation which they
felt would threaten aspects of their professional autonomy, they were finding the government to
be immovable as far as the new fee schedule was concerned. Both the reform and moderate
camps were united in their initial rejection of the government offer for the new fee schedule.
The association had asked for a 15% increase in fees or 5% per year over a three year contract
(Minutes, Nov. 27, 1971). The government offered a 10% increase in the overall budget for
medical services which was to cover increases in utilization, population growth and new
procedures, as well as doctors’ fees. The board and the executive felt that this offer would
amount to no actual fee increase and possibly a reduction in fees. It was also felt that Social
Credit owed the profession, since the BCMA had agreed to the 1970 moratorium of fee increases and no other sector of the economy had followed its example. The government offer was sent to referendum and was rejected by a large margin — 2,228 to 94 (VS Jan. 6, 1972:1).

The BCMA decided to increase their fee schedule by 8.2% and attempt to bill to it. However, the government refused to pay the new rates. And, despite the dominant feeling that a fee increase was justified and overdue, the negotiating team insisted that officials recognize the difficulty of their position. As pointed out in a March, 1972 Board meeting:

1. They were negotiating on behalf of a high income segment of society.

2. The strike weapon is, to all intents and purposes, unavailable, and the available alternatives have problems, i.e., balance billing — public relations, and opting out would only be effective if the vast majority of the profession opts out, which is highly unlikely.

3. B.C. has the highest ratio of doctors per capita in Canada. The number of doctors is the greatest single escalator of costs.

4. The frequency of physicians' services increases as the number of doctors per capita increases.

5. B.C.'s cost per capita for physicians' services is the highest in Canada.

6. With a constant Fee Schedule 876 G.P.'s had significantly higher gross payments in 1971 than in 1970.

7. Each time a Fee Schedule item is increased it becomes more popular.

8. Patient participation is not to be permitted by the Medical Services Commission.

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8 Interview with Dr. David Bolton, July 26, 1995.

9 Provincial Secretary Wesley Black, cabinet minister responsible for medicare, on his impressions of the referendum question: "I read that ballot. It's got to be the worst I ever saw. It's just like asking children if they want ice cream on July 1" (Colonist, Dec 24, 1971:14).

10 "Extra-billing" is the more common term.
9. Despite the absence of a fee schedule increase since 1969, doctors' average net incomes have advanced more than the economy generally.

10. The average overhead for doctors in B.C. in 1969 was $1,500, less than the average for Ontario, Manitoba, and Saskatchewan, and $3,000, less than the average for Alberta.

11. We have about 300 doctors who net twice the income of the Premier and Cabinet members (Minutes, Mar. 3, 1972).

After this realistic appraisal of the negotiating situation, the BCMA cut 2% from the fee schedule to bring it in line with the 6.5% ceiling the provincial government imposed on teachers, public officials and civil servants (Times, April 15, 1972:15; VS, April 18, 1972:27). Some reformers opposed this move and argued that the BCMA should stop negotiating with the government and balance bill (Minutes, Apr. 8, 1972). The government did not directly accept the 6.5% increase but rather, promised that if the overall increase in government medicare payments within the next year fell below 6.5%, a bonus would be awarded to make up the difference. The BCMA board recommended this offer to the membership and it was ratified with 65% in favour (Province, May 6, 1972:1).

V. Internal Conflict II

i) Attempting to Correct Income Disparities

The compromises over the fee schedule led to more internal problems. Reform was strong in Kamloops and doctors there passed a motion of non-confidence in the BCMA board and executive and were determined to extra bill. However, a more immediate and potentially serious challenge came from some of the specialist sections who threatened to resign from the association. The BCMA had decided, after years of complaints from general practitioners and
other "low-earning" sections, to attempt to correct some of the income disparities within the profession in the new fee schedule. This was in line with the Canadian Medical Association's recent commitment to "give top priority to a study of physicians' earning disparities..." (CMAJ, March, 1971). It was also another way of placating government demands that the BCMA do something about its high earners -- even though the association claimed that one half of the high earners were in low earning sections (Minutes, Aug. 6, 1971). It had been decided that low earning sections such as general practitioners, dermatologists, internists, anaesthetists, psychiatrists and pediatricians would receive a fee increase while fees for other sections would remain the same. During the course of negotiations, however, re-adjustments to the fee schedule resulted in a decrease for some of the high-earning sections.\(^{11}\) In the uproar that followed, specialists plotted to oust members of the BCMA executive, demanded changes to the board to allow more direct representation by specialists and threatened to opt out of the MSC and possibly leave the association (Province, May 4, 1972:21). To make peace, the BCMA promised those specialists "whose fees stand to be trimmed" that they would get first priority in any adjustment of fees (Province, May 9, 1972:8; Minutes May 5, 1972).

\(^{11}\) Urologists, radiologists, and neurosurgeons stood to lose the most (VS May 20, 1972:13).

ii) Advancing the Reform Agenda

These internal disputes in conjunction with doctors' unhappiness with the Social Credit government had a spill-over effect at the 1972 annual meeting. Prior to the meeting, the BCMA board suspended its newspaper BCMA News for 60 days after deciding that the newspaper's
content was "extremely politically slanted" (VS May 29, 1972:6). A record number of 700 doctors turned up for the annual meeting, many of them outraged high earners who found natural allies in the reform group. This meeting was pivotal to the future of the BCMA. Would the reform group be able to implement the rest of its constitutional changes? Would they be successful in steering the BCMA toward more radical strategies in dealing with the government?

Doctors at the annual meeting considered some of the reform motions to be too extreme -- they defeated motions to impeach president-elect Dr. David Bachop and not permit him to take office and to censure and fire the board of directors. However, a nomination of a reform candidate from the floor was successful in defeating the president-elect nominee and doctors voted in favour of a motion suggesting that the negotiating committee "employ a proven expert negotiator to deal with the B.C. government because recent past negotiations with government appear to have been inexpert and outmanoeuvred [sic]" (VS May 26, 1972:13). A motion was also passed to change the composition of the negotiating committee -- from the president and selected board and executive members to a committee of three physicians, one of whom would be elected annually by the general assembly and two would be appointed by the board -- and to make it responsible to the general assembly (MP June 13, 1972:2). So reformers were able to implement changes to make the BCMA more democratic and to move the association closer to hiring a professional negotiator to deal with the government. Time would tell as to whether these changes would strengthen or weaken the BCMA both in terms of its cohesiveness as an organization and its effectiveness in dealing with government threats to its professional autonomy.

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12 This was a new publication (it debuted in February of 1972) amidst the BCMA’s battles with the Social Credit government. The newspaper was funded by the BCMA and its purpose was to devote space to medical politics. The first editor, Dr. John O’Brien-Bell was a member of the reform group and the other camp within the BCMA, the "moderates", felt that the paper was unfairly biased toward reform points of view.
In the immediate fallout from the meeting, the conservative nature of the medical profession was exposed. Neither the College nor the CMA were pleased with the way many of the doctors had conducted themselves or with the bad publicity. Dr. H.B. Graves, president of the College, called the in-fighting over fees a "degrading, disgusting exhibition that has smeared the profession for years" (Colonist May 27, 1972:26). Dr. Harry Roberts, president of the CMA, told the BCMA: "When we fight among ourselves, especially over matters of income and fee schedules, we can expect little sympathy from a public that makes considerably less than we do" (MP June 13, 1972:2). He argued that, in comparison with the other provinces, the BCMA had managed to obtain a very good deal with the government. These attitudes are also reflective of the old style professional ideology. Professionals should be seen as altruistic and committed to public service. Negotiations over remuneration are ideally done privately, not in the public eye. In promoting the hire of a professional negotiator, the doctors were committing yet another violation -- outsiders should not hold positions of power. Therefore, the *Medical Post* urged that the BCMA use a professional negotiator solely in an advisory capacity because "only a physician should be talking for physicians" (June 13, 1972:12).

VI. Facing the NDP

i) A Different Philosophical Approach to Health Care

Three months after the 1972 AGM, the NDP won the provincial election and the BCMA prepared to deal with a new provincial government whose ideas and plans for health care reform were quite different from that of Social Credit. While the NDP were in opposition, their philosophical leanings in regards to health care reform were well-known. The NDP were
advocates of the community health centre model -- a model which was supposed to provide for community participation and localized decision-making; integrated, comprehensive and flexible services which were efficient and cost-effective; and health promotion (Clague et al., 1984:129). This model was proclaimed, in major federal and provincial studies, as the solution to the "fragmented and haphazard co-ordination" of health care services in Canadian provinces (Ibid.: 118). In their condemnation of the just released Hastings Report, B.C. doctors argued that "there is little support in the report for the sweeping statements that community health centres would increase productivity, control quality and prevent duplication of services" (Colonist Oct. 18, 1972:23). The doctors had a point. The model had only been put into actual practice in a few communities and in Quebec. Based on the recommendations of Castonguay, Quebec was the first province to launch an experiment with the community health model, but in 1972, it was still in its infancy (Taylor, 1990).

Of course, any model proposing that doctors work in community-run, state-owned clinics, on salary, and as part of a leaderless health care team posed a difficult reorientation from the profession's cherished (if not entirely accurate) notions of the independent fee-for-service practitioner who is "captain of the ship". In terms of professional autonomy, doctors were not interested in a model which threatened to subject them to greater lay, collegial and government control. And they were not at all convinced that this push for change came from the public. Although politicians and researchers insisted that consumers wanted more say in the health care system, doctors felt that consumers were generally quite happy with the current system and talk of its overhaul was the result of "political movement" underfoot (Minutes, Sept. 30, 1972).

Health Minister Dennis Cocke hired Dr. Richard Foulkes, a member of the NDP and the executive director of Royal Columbian Hospital, to carry out a study on health care in the province. Foulkes carried out a very comprehensive review which "touched base with all aspects
of the health care system" (Clague et al., 1984:122). However, he either underestimated the power of the BCMA or lacked the political skills to deal with the organization. In his first meeting with the BCMA, Foulkes told the doctors that although he believed strongly in a pluralistic system of community health centre group practices and was not in favour of fee-for-service, he also felt that doctors could preserve professional autonomy by continuing to maintain peer review and internal control (clinical autonomy) and by paying themselves by setting up contracts with clinics in order to avoid bureaucratic interference in their remuneration (economic autonomy). Foulkes argued that the new proposed system would eventually show itself to be in the profession’s best interest (Minutes, Nov 25, 1972). However, Foulkes later made a series of public statements suggesting that doctors chose their patients on the basis of financial reward and were therefore more likely to treat patients requiring expensive surgical procedures over those needing only a routine examination. Placing doctors on salary and in community clinics would rectify this problem (VS May 1, 1973:1). The BCMA said that Foulkes did not know what he was talking about and demanded he back up his statements. Foulkes replied that he did not have the information readily available (VS May 1, 1973:1).

The BCMA went on the offensive, claiming that "setting up clinics would raise costs phenomenally and increase fragmentation by introducing more people into the health care delivery system" and that Foulkes' "outrageous" statements had the potential to "destroy...doctor patient confidence" (VS May 1, 1973:1; VS May 4, 1973:1). The reform oriented BCMA News nicknamed Foulkes "Tricky Dicky" and the BCMA warned Health Minister Cocke that he would have to choose between Dr. Foulkes "and the continuing confidence and co-operation of the profession" (VS. May 8, 1973:21).
The BCMA had a very favourable working relationship with Dennis Cocke and they liked him personally. They preferred to believe that Cocke represented that side within government and the Department of Health which would protect their interests while Foulkes' represented the side which would turn their world upside down if allowed. There were a few reformers who took exception to this. Dr. Horniman argued that "the reform movement of the British Columbia Medical Association believe that when Dr. Foulkes talks they hear the health minister’s voice...Dr. Foulkes is doing a 'Spiro Agnew' to Mr. Cocke’s 'Nixon', a 'Loffmark' to Mr. Cocke’s 'Bennett'" (VS May 17, 1973:5). However, this was not the view of the majority and Cocke did his best to reassure the BCMA that "doctors in British Columbia [would] not be asked to participate in any health delivery system not of their own choice" (BCMJ 15,6 July, 1973). He reminded doctors that he was in charge (not Foulkes) and he would have the final say on any health care developments within the province.

Clague’s (1984) interviews with bureaucrats working within the health department during this time period revealed that Cocke became progressively more conservative as he became enmeshed in the political realities of cost pressures and pressures from various interest groups. Foulkes, on the other hand, refused to budge from his original principles and quickly became a political liability (125). Upon release of the Foulkes Report, Cocke did what he could to appease the medical profession and play down the more overtly political aspects of the report. He called

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13 When the NDP was defeated in 1975, the British Columbia Medical Journal declared that Dennis Cocke was the best health minister that B.C. had ever had (18,1 Jan., 1976). William Ibbott, BCMA president in 1975, told me: "One of the saving graces between 1972 and 1975, during the NDP era, was that we had a very strong, candid, truly I think as close to an honest relationship and a trusting relationship between the medical profession and the NDP Ministry of Health and that was primarily because of the essential integrity of Dennis Cocke" (Interview, July 27, 1995).
Foulkes specified the following themes as integral to his report:

- the need for a system that is rational and efficient, possessing clarity with regard to functions and responsibilities, and harmony and consistency among the components of policy-making, management and administration, finances, and programmes;
- an emphasis on decentralization and a 'net lowering of authority': 'The PUBLIC must really be in control.' (Richard Foulkes, Health Security for British Columbians, quoted in Clague et al., 1984:130).

Foulkes told the media that his report was sensitive to the 'spirit of the times' in that: "We refer to the increased desire for participation, the rise of consumerism, the increased knowledge of the public concerning health and social affairs, the revulsion against 'rip-off' and an increasing awareness of social injustice and deterioration of the environment" (VS Jan. 17, 1974:1).

Privately, many within the BCMA agreed with the statement of one of its officers that "the idea of making the consumer an effective participant in the community health centre program has to be a philosophical fairy tale" (Minutes, Feb. 1, 1974).

The report stated that health care in British Columbia, dominated by physicians and civil servants, was an expensive, rapidly-expanding, fragmented, and unco-ordinated field, distinguished by its 'lack of good business management' (VS Jan. 17, 1974:1). Foulkes advocated the creation of a whole new health care system rather than incremental reform of the status quo. The new system would be decentralized into seven health regions which would revolve around a network of community clinics and health centres. The key to the success of creating a new system "will lie in the management of power. It is this which dictates priorities" (VS Jan. 17, 1974:1). In the 264 recommendations, there was nothing prohibiting private medical practice. There was however, a recommendation to create a health disciplines regulatory board - - "the majority to be publicly-appointed, knowledgeable laymen" (VS Jan. 17, 1974:1).
board should have the "power to revoke, if necessary, regulations made by the professional colleges...and that professional statutes be amended to impose an obligation on individual colleges...to accept and obey rulings of the board" (Prov. Feb. 7, 1974:50). It is this recommendation which the BCMA first attacked publicly as "perhaps one of the Foulkes report's most dangerous recommendations" (Prov. Feb. 7, 1974:50).

However, the BCMA's main objections to the Foulkes Report remained centred on its "funding premise" and the Community Health and Human Resources Centres (Minutes, Feb. 1, 1974). A speech given by Dr. Peter Banks, a former BCMA president and then current president of the CMA, at the 1974 annual meeting, sums up the attitudes of most BCMA officers. I quote him at length because of the importance of his remarks:

What I find much more nonsensical is the central theme of all these reports - that medicine is too important to be left in the hands of the medical profession who are running what is called a crisis orientated service that ignores the social and preventative needs of the people. This so-called non-system is to be replaced in the golden age by a chain of health clinics in which leaderless egalitarian teams of doctors, nurses, social workers, nutritionists, educationalists, social scientists, social researchers, social adjusters and managers, and anybody else who wants a hand in the public's pocket will somehow work in glorious harmony at, the miracle of miracles, lesser costs....We already work in teams. We get along very well with our colleagues in other professions. We are going to remain the captain of the team because we have to take the decisions, and we know more. We are the best people to be captains of the teams. Obviously there is a social component to medicine. We use social workers all the time and we are interested in working with anybody that can help us. But we don't want to set up a huge, costly monument to false idealism at the expense of our very excellent medical system....I am delighted to see that the Federal Minister of Health has produced a book on lifestyle....However, I am very distrustful of those who, after a short university course in social science, anthropology and psychology, are prepared to tell people how they should live their lives whether they like it or not; and to make us, the medical profession the instruments of their will. I am very sceptical about this current idea that medicine is too important to be left in the hands of the doctors, but must be controlled by the people. Superficially this is a truism. There has never been any argument about the necessity for ultimate lay control over any branch of society, whether it be law, the military, medicine or the executive themselves. But professions were set up to govern themselves because the complexities of their field were such that they were best understood by those with expertise and experience in the field (BCMJ 16, July, 1974).
Health Minister Cocke also attended the annual meeting and in his reply he said that he hoped to be able to alleviate concerns about salaried physicians and a superministry: The Foulkes report "was right on when it said 'Let's coordinate the system,'....But I certainly said at the outset that I thought that recommendation was somewhat bureaucratic and somewhat big and didn't agree with it" (BCMJ 16,6 June, 1974:174C).

Were there really significant philosophical differences between Dennis Cocke and Richard Foulkes? Cocke did support the concept of community health centres and told the doctors that "action on community health centres wasn't happening fast enough and that he would like to see some development in this area" (Ibid.:174c). However, the political realities of his position as Health Minister meant that he was far more cautious and pragmatic in his dealings with the medical profession than his researcher, Richard Foulkes. A comment from one of the doctors that I interviewed suggests yet another angle:

...there was not a philosophical difference of opinion [between Cocke and Foulkes], but a practical difference of opinion...How to accomplish what they both wanted to accomplish. Foulkes' idea was that you tell people what to do and they'll do it...Cocke's idea, on the other hand, was that okay this is what we want to accomplish and we'll give you incentives and we'll arrange to accomplish it. And that was quite effective. One of the accomplishments was enough funds. You can't do something unless somebody's going to pay for it...14

If economic negotiations under Cocke were far sweeter than the raging battles the BCMA had become accustomed to with Social Credit, then perhaps other disagreements between the Health Minister and the BCMA could be forgiven.

14 Interview with Dr. Murray Kliman, July 14, 1995.
ii) Economic Autonomy: Negotiating with the NDP

Besides the concern given to the Foulkes Report and labour relations, the everyday business of the association still needed massive amounts of attention. The BCMA had, since the days of the BCMP, desired frequent meetings with the provincial government. It had become progressively more difficult to arrange meetings with the Social Credit government during their years in power, but one indication of the favourable relationship between the BCMA and the NDP was that regular meetings were held every six weeks between the Minister of Health and BCMA officers. These meetings were described by the association as "an exceptional example of valuable ongoing communications between doctors and politicians" (BCMA News Dec., 1974).

In their first set of negotiations with the NDP in 1973, the BCMA negotiating committee reported that "the negotiating committee started at $23.3 million and the government started at $2.5 million -- they came up and the negotiating committee came down and this seesaw type of negotiations continued until about $10.5 million" (Minutes, Mar. 2, 1973). Of a total budget of $152 million, the profession was offered approximately 6.7% which the Board accepted for recommendation to the members. The membership voted 83.6% in favour of the proposed agreement (Minutes, Mar. 16, 1973).

The agreement also included two fringe benefits: a disability insurance program which was to be formulated jointly between the government and the BCMA and a personal education bank, also to be a joint venture between the two parties. Dr. Cody, chair of the negotiating committee, called the programs "innovative and practical" and claimed that they could reduce a doctor's personal expenses by approximately 5% (MP April 3, 1973:1). Reform was well represented on the negotiating committee and it claimed that fringe benefits on a fee-for-service basis, while a brand new concept for Canadian medical associations, was one of the few ways
to get around government restraint guidelines (MP April 17, 1973:11). The traditional Medical Post was not so sure and cautioned that such fringe benefits may lessen the independence of the profession by tying it even closer to the government (April 3, 1973:12).\textsuperscript{15}

During the next set of negotiations the following year, the BCMA lowered its initial demands slightly (they asked for 19 million) and the government's initial offer was quite a bit higher (at 9.5 million) than in the previous set of negotiations. Government concern focused on the 'utilization' factor -- the percentage increase in medical service costs which could not be attributed to such anticipated costs as fee schedule increases, new programs, and population increase (Minutes, April 16, 1974). The negotiating committee agreed that doctors should take some responsibility for the utilization factor. In the offer finally accepted by the Board, doctors were to be given a 8.6% fee increase in the first year and in the second year, a formula would be used that would take into account the consumer price index and the average weekly salary settlement in the Vancouver area and would subtract from that, half of the utilization factor (VS May 6, 1974:14). The reformers felt that the offer was too low (since the cost of living had risen 9.3% in 1973) and argued that doctors should not be penalized for utilization increases because there were many factors that raise utilization that doctors have no control over and it may impose

\textsuperscript{15} This sentiment was echoed by the BCMA's executive director, Dr. Norman Rigby: "I personally felt then as I do now, that if the profession wished to have professional personal and fiscal autonomy, you must not allow the government to pay anything for you. I do not agree with the education fund, disability fund, overhead fund etc., etc.,. All these little gimmes that the profession negotiated and [were] popular...I think that every year you go back to negotiate, the first things that the opposite side say to you is well you know things are very tough and we don't think we can continue this education fund and it becomes part of your annual negotiation to try to retain them. I felt so strongly that I felt that the medical profession should set up something akin to a credit union...which would then be responsible for things like overhead insurance, personal insurance, education fund, retirement fund RSP...through M.D. management..." (interview, July 7, 1995).
a financial consideration on whether a particular service is ordered for a patient. However, the offer survived the referendum with 1133 of members in favour and 949 against (Minutes, May 22, 1974).

The last set of negotiations with the NDP were derailed by federal government policy—the Trudeau government’s anti-inflation guidelines implemented in the fall of 1975. The BCMA president in that year remembers:

At the time that that was imposed...we were, at the BCMA, on the verge of what was appearing to be a very successful fee schedule negotiation. And I might say, very carefully negotiated, and then the anti-inflation board guideline came in with a national policy of restriction of no more than 6% increases. That was far short of the mark that we were already approaching...that was the last set of negotiations with the NDP.16

Overall, the BCMA’s negotiations with the NDP lacked the animosity that had characterized relations between the former Social Credit government and the BCMA:

Dennis was an excellent Health Minister...Actually the NDP were very good to the medical profession in negotiations. We never had any serious problems. I think they dealt with our negotiations the same ways they did labour negotiations. They heard what both sides had to say and came up with a reasonable response.17

iii) The Right to Represent Public Service Doctors: Contemplating Unionization

I have included this dispute between the public service doctors and the NDP because it asks the question: "what is more salient?"—the nature of doctoring or the relationship to the employer, and is particularly interesting in light of the proletarianization theories which argue that doctors can lose professional privileges and autonomy when they cease to be independent fee-for-service practitioners and become salaried employees in corporate or government settings. Within

17 Interview with Dr. David Bolton, July 26, 1995.
the BCMA, this case also facilitated further discussion as to whether the association should become a union.

During their first year in office, the NDP set up the Higgins commission of inquiry into bargaining rights for civil servants. The approximately 200 B.C. doctors working for the provincial government submitted a brief to the inquiry in which they "took the position that we were physicians first and that we wished to be represented by our section and our association in any negotiation with government regarding terms of service of our members" (VS, May 18, 1973:19). However, the Commission's final recommendation was for the establishment of a labour union for all civil servants, including professional groups. Government doctors then met with the health minister and received his assurances that despite the recommendation they could remain within the BCMA's section of salaried physicians and that the BCMA could continue to negotiate for them (VS, May 18, 1973:19).

However the following year a new labour law, the Public Service Labor Relations Act, enforced the Commission's recommendation. A new union was set up -- the Professional Employees Association (PEA) -- and government doctors were required by law to join (VS, May 24, 1974:2,20).¹⁸ Dr. G.D. Kettys, chair of the BCMA section for salaried doctors, stated: "Our message to our colleagues and to government is that we are first and foremost doctors. The fact that we are paid salary as opposed to fee-for-service does not change either the nature of our work or our approach to it" (VS May 24, 1974:2,20). The BCMA told the doctors that they were behind them one hundred percent.

¹⁸ Among the professional groups to be included in PEA were doctors, dentists, engineers and foresters. For some reason, lawyers were excluded.
The Minister of Health, Dennis Cocke, did agree with the legislation. However, he responded to pressure from the BCMA. The law was ignored and the BCMA continued to represent the government doctors in negotiations over the 1975 fee schedule. The government was planning to introduce amendments to the Public Service Labor Relations Act to solve the problem. However, before they could do so, PEA charged the provincial government with unfair labour practises, arguing that the Health Minister and his staff "were conducting negotiations and concluding a tentative agreement...with representatives...who were not part of a certified bargaining agent for the doctors" (VS Feb. 24, 1975:8). PEA was further incensed when the Public Service Commission decided to cease negotiations with the union pending the proposed legislation (Minutes, Feb. 14, 1975).

Certainly the BCMA was not a union and was not covered by the Labour Relations Board. This led to discussions within the association as to whether it should become a union. Not only was the section of salaried doctors a problem for the association but there were now constant problems with the Workers' Compensation Board. The Health Minister had admitted that "It's very difficult for the WCB to recognize any group not covered under the labour relations board" (VS May 12, 1975:15). In addition, medical residents and interns (who had been affiliated with the B.C. Health Association) recently had won the right to form their own

19 Interview with Dr. Norman Rigby, July 7, 1995.

20 According to the WCB, the BCMA did not have legal status as a negotiating body. Under the WCB Act, WCB had complete autonomy and they did not have to deal with the BCMA. The BCMA exacerbated the situation by attempting to negotiate higher fees for some services than what the Medical Services Commission was paying. The WCB was threatening to negotiate with doctors individually. The BCMA knew that they would not have a legal leg to stand on if WCB decided to take this course of action (Minutes, July 17 and Sept. 12, 1975).
trade union, the Professional Association of Residents and Interns (PARI). There had been talk of the BCMA representing residents and interns (VS Mar. 22, 1975:45; MP Jul. 20, 1976:1).

An edition of the BCMA News in February of 1975 dealt with the pros and cons of unions for doctors. Some of the advantages to having a "doctors' union," independent in terms of organization and funding from the BCMA, were thought to be: 1) that the BCMA would not have to be so preoccupied with economic issues and could spend more time on medical concerns; 2) a unionized organization would force all B.C. doctors to join and pay membership dues (the BCMA is always concerned with "free riders" -- those doctors who do not belong to the association but benefit from the BCMA's work); 3) the current "hardnosed negotiations" with the government were better suited to union-style bargaining rather than professional negotiations which used to be conducted as "gentlemen's discussions" and 4) the BCMA would no longer have to deal with the major expenses of bargaining. The only disadvantage mentioned was that a doctors' union would "deprofessionalize" the profession in the eyes of the public and government negotiators. Both parties would be more likely to perceive the medical profession as preoccupied with economic matters rather than with clinical work and the health of average British Columbians.21

In June of 1975, amendments to the Public Service Labor Relations Act placed doctors and justices of the peace in the same class as lawyers so they would not have to bargain through PEA (VS, June 13, 1975:13). PEA then filed a Supreme Court action against the Health Minister, the BCMA and others, stating that the defendants frustrated its right to act as exclusive

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21 There were other concerns not mentioned by the BCMA News. Executive Director Dr. Norman Rigby said that he felt at the time that the BCMA "had the best of both worlds...I felt that I had more flexibility as a CEO without being bound to a union. Once you get into a union there is all sorts of legislation that you have to adhere to and be subject to" (Interview, July 7, 1995).

BCMA discussion on whether it should become a union was squashed when their unionization committee found that "since the majority of members of the BCMA are not employees within the meaning of the Act, the BCMA cannot form a trade union and be certified as an appropriate bargaining unit" (Minutes, Mar 6, 1976). In any case, very few on the Board and Executive supported the notion of unionization. However, efforts to unionize the profession resurface in later years (see chapters six and seven).

VII. Summary

Although the NDP's philosophical approach to health care was not shared by the BCMA, in the end it really did not matter since the more ambitious restructuring of health care was not adopted. BCMA resistance to the more radical ideas of community health centres, salaried doctors and more public participation, certainly contributed to the downfall of the Foulkes' agenda, although the association was in no way entirely responsible.

The NDP shared the same economic concerns about the medical profession as did Social Credit -- concerns about utilization and high earners. During the 1970s, the federal government was placing considerable pressure on the provinces because the cost of medicare was running well ahead of the growth of national income. As early as 1973, the federal government proposed
to amend and possibly end cost-sharing agreements with the provinces (Canadian Annual Review, 1975:57).\textsuperscript{22}

However, the NDP was able to facilitate a much more congenial atmosphere at the bargaining table than the previous government. The NDP’s relationship to the BCMA did not take the form of “gentlemen’s agreements” as in the early days of W.A.C. Bennett. Far too many issues and people were now involved in the negotiating process for that to have been the case. Yet the relationship with the NDP also lacked the animosity that the Loffmark team and the BCMA had felt for each other. Dennis Cocke and his bureaucrats were perceived by most of the BCMA to be fair and pro-doctor in their attitudes. They also delivered on the economic front: the BCMA was doing well with its fee schedule in comparison to the other provinces.\textsuperscript{23} This had an effect on the internal politics of the BCMA -- the reform camp lost some of its momentum.

Therefore it is not surprising that the more radical (and innovative) resistance tactics adopted by the BCMA -- tactics such as membership referendums, the establishment of a negotiating committee more responsible to the rank and file, a particular style of public

\textsuperscript{22} By 1977, the federal government was able to erode its share of health care costs with the passing of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF). The EPF made the switch from shared cost programmes to a modified block funding system. As a result, federal contributions were now tied to the growth of the national economy rather than to the growth in provincial health spending.

\textsuperscript{23} By 1977, B.C. doctors were first in earnings in Canada (Minutes, Mar. 26, 1977). Evans (1990:116) notes that during the early 1970s Canadian physicians’ fees dropped sharply, running well behind inflation until the mid-1970s, at which point they rose on average to the same level as prices generally.
relations, and movement towards hiring a professional negotiator -- were adopted in the two years before the NDP came to power. During this time the reform camp’s ideas were taken very seriously because of the profession’s adversarial relationship with the Social Credit government. These tactics brought the profession closer to labour strategies even though unionization itself was not adopted.

Did the internal conflict between reform and establishment weaken or strengthen the BCMA in terms of its relations with government? In a sense this question is a bit premature since this theme is continued in Chapter Six. However, comments from the doctors I interviewed indicate that most (but not all) felt that the reform influence was beneficial for the profession, especially in the sense that it strengthened relations with the government:

Yes it did. Absolutely...they certainly put under the microscope everything the BCMA was doing and where necessary...criticized it very heavily and that was a great help when you’re going to government saying...the troops out there are certainly not very happy with what’s going on and unless we do something...it’s going to have a major adverse effect on our relationship in the future.25

It caused a great deal of dissention at the time in the association and led to some very difficult situations. I do believe however, it was a good thing for the association. Yes, I think the introduction of the referendum has proved to be absolutely an excellent thing for the association.26

That also is the time when we began more formal bargaining because the negotiators for the BCMA had to satisfy the entire profession because it was going out to referendum and there had to be true logic behind it and nobody could make any deals...this is not something we can sell to our people. Before it was a matter of selling to the Board...the government definitely did [respond to that]. I believe it changed the nature of

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24 The Medical Post commented that "the BCMA really is the leader in Canadian medical public relations...it is doing what associations in other provinces are so far only talking about doing..." (Jan. 7, 1975:28).


26 Interview with Dr. David Bolton, July 26, 1995.
negotiations considerably. It gave the negotiators for the BCMA a great deal more
strength.\textsuperscript{27}

...It is fair to say that in those years from 1972 through 1980...the profession expended
excessive energies on internal disputes...It was a waste of energy, time, expense, it
compromised the strategic sessions...\textsuperscript{28}

It is interesting that despite the favourable relationship the BCMA had with the NDP,
traditional beliefs about free enterprise vs socialist governments were still present. The BCMA
president in 1975 (the year the NDP were defeated) told me:

...When I left office, I can recall saying on a CBC interview when I was asked: ’what do
you think will happen now that the NDP are no longer in power’? And I made a
statement that infuriated Dennis Cocke and David Stupich and a number of other people,
when I said to the interviewer that I thought that the majority of doctors in B.C. would
be pleased to see a private enterprise government return to power. I was never more
mistaken in my life other than that the doctors thought they would be pleased but as it
turned out the Socreds that followed from 1975 through 1981 were extremely difficult to
deal with. They were anything but fond of dealing with the medical profession. And
indeed that led to a great eruption in the 1980s and some of the outstanding reformers of
the day went to the wall and very nearly brought the profession to the wall with them on
a negotiation with Bill Bennett...\textsuperscript{29}

It is not only the medical profession which wants to believe that so-called conservative
governments are more sympathetic to the interests of doctors. In a recent paper on Canadian
medical politics, Burke and Stevenson write: "In the health care sector, conservative governments
and the medical profession form one alliance of mutual interest, and hospital workers, health
advocates and other professive social forces form another" (1993:72). This is far too simplistic
a statement. Conservative groups do not always have the same goals and philosophies and they
do not always support each other. During the 1980’s, the BCMA and the Social Credit
government would take their battles over extra-billing and physician supply into the law courts.

\textsuperscript{27} Interview with Dr. David Bolton, July 26, 1995.

\textsuperscript{28} Interview with Dr. J. William Ibbott, July 27, 1995.

\textsuperscript{29} Interview with Dr. J. William Ibbott, July 27, 1995.
CHAPTER SIX

Legal Battles: 1980-89

I. Introduction

As I noted in the previous chapter, during the early 1970s, the BCMA was able to modify several government challenges: they saved private laboratories, stymied the government effort to control doctor distribution in the province, played an important role in the downfall of Richard Foulkes and the NDP's health care restructuring plans, retained the right to represent public service doctors, and continued to win significant economic increases. The internal conflict between the reform and moderate groups did not seem to inhibit successful relations with the government. In fact, it could be argued that reform demands were used to the association's advantage in negotiations.

During the 1980s, Canada went through a major recession and health care costs continued to soar. Provincial governments were left to deal with the lion's share of the financial burden as the federal government, subsequent to the Established Programs Financing Act, moved unilaterally three times to reduce its cash contributions under the EPF formula (Evans and Law, 1991:13). The medical profession argued that neither the federal nor provincial governments was providing adequate funds for health care (Gray, 1991:115).¹

Doctors were convinced that their incomes had not kept pace with inflation. After a spectacular rise in income from 1950 to 1971 (Evans in Begin, 1984), physicians' wages were

¹ The Canadian Medical Association conducted its own national inquiry into health care spending. However, the task force did not conclude that inadequate funding existed. Instead it declared that evidence did not exist either for the view that the Canadian health care system was underfunded or overfunded (in Taylor, 1990).
kept below inflation by the national wage and price controls operating from 1975 to 1978.\textsuperscript{2} Once the controls were removed, doctors began to try to catch-up economically, and strategies such as opting out and extra-billing became more popular. At the same time, some of the provinces decided to take advantage of the greater flexibility afforded to them under the EPF. British Columbia and Alberta increased their user fees for hospital services and Newfoundland introduced user fees (Gray, 1991:116).

Two very different visions of the health care system and its problems emerged. The first argued that the problem of "underfunding" was really one of too many doctors (physician supply) and too many high-earners (physician income). The Hall Report of 1980 and the 1981 Task Force on Fiscal Federalism, concluded that provincial governments should focus on reducing physician supply and physician’s incomes while the federal government should clarify and protect the five national standards of medicare (Gray, 1991:121,122). Medicare should be strengthened and privatization measures such as extra-billing, user fees and insurance premiums should not be allowed (Ibid.:118,121). This was the position of the federal health minister, Monique Begin, and its principles would be enshrined in the Canada Health Act of 1984. Begin had the support of the Canadian public. A national opinion poll conducted in 1983 showed that the majority of Canadians supported Medicare and were opposed to extra-billing and hospital user fees (Gray, 1991:124).

\textsuperscript{2} Medical fee schedules "were held below the rate of inflation between 1971 and 1976, falling in real terms by 20 per cent. In the late 1970s increases were held in line with inflation but the rate rose in the early 1980s" (Barer and Evans in Gray, 1991:114). However, provincial variation is important. Doctors in Quebec were hit the hardest, while fee increases in British Columbia had been consistently well above average (Barer, Evans and Labelle, 1988:22,32).
At the same time, there was growing support for neo-Conservative economic ideas. Advocates of this stance, which included the Canadian Medical Association, argued that government needed to withdraw from health care administration. The system required either full or at least partial reprivatization. During the early 1980s, the Canadian Medical Association actively promoted "the privatization and 'demonopolization' of medicare" (Naylor, 1986:249). Similarly, the Vancouver-based Fraser Institute called "for government withdrawal and a return to private insurance and market forces" (Gray, 1991:119).

This should have been good news for the British Columbia Medical Association as the Fraser Institute and its director Michael Walker played a major role in Social Credit economic policy after the 1983 provincial election (Garr, 1985). However, the Social Credit government considered doctors, in the same vein as trade unionists, teachers and lawyers. The medical profession was a special-interest group. According to Michael Walker:

If governments [were] serious about cutting costs and getting free enterprise back up to speed, they [had] to break the grip of the special-interest groups that prey[ed] upon their budgets, sap[ed] the vital fluids of the marketplace, and create[ed] political turmoil with their lobbies and protests (Ibid.:94).

British Columbia medical politics during the 1980s was marked by public confrontations and aggressive tactics on the part of both the BCMA and the Social Credit government which culminated in legal actions. Despite the Social Credit's neo-Conservative policies, the government was very much involved in health care. Legislation prohibiting the practice of extra-billing was passed in 1981, three years before the federal government, under the Canada Health Act, would financially penalize provinces allowing the practice.

The Social Credit government also attempted to restrict doctors' billing numbers as a solution to medical manpower problems of supply and distribution. In 1983, Social Credit tried to deal with the surplus of doctors in Vancouver, Victoria and Kelówna and the lack of doctors
elsewhere by ordering hospitals to refuse billing numbers to doctors applying in those centres.

This chapter profiles the battle over extra-billing (won by the government) and the billing numbers dispute (won by the BCMA). I will use the narrative of events to highlight attacks on economic, clinical and political autonomy, state strategies and BCMA resistance tactics.

II. Economic Autonomy: The Right to Extra-bill

i) A Resistance Strategy and a Government Response

In the spring of 1980, BCMA president-elect Alex Mandeville (a reformer) notified the press that doctors were going to "play hardball" during their upcoming negotiations with government. Doctors were going after a whopping 30% fee hike and if the government didn't deliver, doctors would balance-bill (the association's term for extra-billing) 40 percent (VS Mar. 3, 1980; June 2, 1980:D10).

Extra-billing was, at this point, legal in all provinces with the exception of Quebec. Only governments in Quebec and Saskatchewan had tackled this issue and both in the early stages of their medicare programs. While doctors in Quebec lost the right to extra-bill, in Saskatchewan, public health insurance was obtained with a compromise to the medical profession that doctors

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3 For obvious political reasons, the medical profession preferred the term 'balance-billing' to describe the practice where doctors billed the medical services plan for the amount allowed by the negotiated fee schedule with the government but also billed the patient for additional money. The patient was to supply the balance of what the medical association had determined was a fair price for a service rendered. Governments, on the other hand, referred to this practice as 'extra-billing', reasoning that doctors were making extra money unfairly at the expense of patients. I use the term 'extra-billing' since that is how the practice is commonly referred to by most Canadians (for example, in the media and by other health workers).
be allowed to extra-bill. The highest levels of extra-billing occurred in Alberta and Ontario
(Taylor, 1990).

Doctors in British Columbia did not have the right to extra-bill under the private doctor-
sponsored plans (MSI and MSA) but they were able to gain this option from the provincial
government during the first agreement (Master Agreement) under the British Columbia Medical
Plan in 1965. The BCMA Minutes in 1970 mention that there had been many complaints from
patients about extra-billing and that perhaps the association should control this behaviour as it
was supposed to be used only rarely in cases where doctors were providing a "luxury type" of
care (Minutes, Apr. 17, 1970). In 1974, the NDP government passed an order to restrict extra-
billing to those patients requesting "unusual, time-consuming service" (Minutes, May 22, 1974).
The BCMA tried to change the wording of the order but to no avail and they had no better luck
with the succeeding Social Credit government whose Health Minister, Bob McClelland, was
adamant in his opposition to extra-billing (VS Nov. 23, 1977:D1). However, it was not until the
1980s that the issue became explosive, and legislation, first at the provincial level in British
Columbia and then at the federal level, was introduced to outlaw extra-billing. The BCMA
argued that a provision placed in their Master Agreement in 1968 under medicare and renewed
in 1974,\(^4\) meant that doctors could extra-bill en masse if no suitable agreement was forthcoming
from the government (VS Apr. 1, 1981:A1).\(^5\)

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\(^4\) That doctors may bill their patients for the unpaid balance of medical costs if the province was unwilling to pay 90% or more of the doctors' fee schedule.

\(^5\) According to former Health Minister Ralph Loffmark, the provision allowing doctors to extra-bill in the event that the government and the BCMA could not agree on a fee schedule was written in as a commitment 'never to introduce compulsory medical service by doctors' (VS Apr. 1, 1981:A15).
The right to extra-bill was considered absolutely crucial to the profession's economic autonomy. Doctors did not want to be completely dependent on government funding. If the government was unable or unwilling to pay doctors at levels they felt they deserved, they wanted the right to ask the patient to pay the difference: "If the government doesn't recognize the value of doctors' services, the consumer must assume at least partial responsibility" (BCMJ 23,2:45).

The extra-billing threat was the key BCMA strategy in its 1980-81 negotiations. The BCMA (after years of urging by reformers) hired Ben Trevino, a labour lawyer, as their professional negotiator in September of 1980. Trevino was the first professional negotiator hired by a medical association in Canada. A tour across the province to access doctors' attitudes about possible strategies in dealing with the government had convinced Trevino that the BCMA's most promising lever or weapon was extra-billing. The right to extra-bill, along with the right to opt out, had been viewed as a crucial safeguard by BCMA officers during the early years of public health insurance. Extra-billing was still regarded as a privilege of professional life (despite NDP legislation to the contrary) and so it was a safe strategy and one which did not require that doctors break with tradition or violate their sense of professionalism. Trevino told the Board that he had a strong impression that their members would take action as long as patient care was not affected and paper work did not increase (Minutes, Nov. 22, 1980).

In February of 1981, the government offered the BCMA an increase of 13.02% (10.5% plus disparity). Although this was the second highest government offer in the last ten years, Trevino felt that the association could get an even better offer and he suggested that the Board not put the offer to referendum if they wished to encourage "the membership into a balance billing situation" (Minutes, Feb. 7, 1981). He also wanted to avoid an early referendum which might allow the government too much time to manoeuvre before the April 1st deadline. A
majority on the Board agreed and the government offer was rejected (Minutes, Feb. 7, 1981).  

BCMA president Alex Mandeville was also doing his best to encourage the membership to favour extra-billing rather than a settlement. He framed the negotiations in a very negative light to the press, stating that he was certain the negotiations would fail (VS Feb. 10, 1981:A1). He was more than willing to give detailed accounts of what would happen once doctors resorted to extra-billing. The public should be reassured that the patient’s ability to pay would be taken into consideration, and payments would be convenient and pain free -- the BCMA had already arranged a deal with Visa and was currently negotiating with Mastercard so that doctors could accept credit cards from patients (VS Feb. 13, 1981:A3; VS Feb. 25, 1981:A14). The BCMA had also upped its demands from 30 to 41 percent. These demands consisted of a 'catch-up' increase of 26.4% plus another 14.6% to match 1981 wage and salary increases (VS Feb. 10, 1981:A1; VS Feb. 13, 1981:A3).

Soon after, the government made another offer of 15.19 percent. The Board rejected the offer but this time the offer was sent to referendum with the recommendation of rejection. Further preparations were made for what was thought to be a done deal. A motion was carried to set up a complaint mediation committee (similar to one operating in Alberta) to deal with potential conflicts between doctors and patients regarding extra-billing (Minutes Feb. 28, 1981).

For the first time, B.C. health minister Jim Nielsen and federal health minister Monique Begin found themselves on the same side of an issue. Nielsen, claiming that British Columbia’s medicare fee schedule was already the highest in Canada and that doctors’ earnings from 1950

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6 At this meeting, Trevino asked that nothing be reported in the minutes about future strategy.

7 This was true. By 1982 health care spending and physician fees in B.C. were the highest in the country at 35 and 34 percent above the national average (Barer, 1988:3).
to 1978 had risen faster than the consumer price index in Vancouver,\(^8\) threatened legislation to outlaw extra-billing if doctors rejected the government's offer (VS Mar. 6, 1981:A2; VS Mar. 17, 1981:A2). Begin advised that extra-billing cost Canadians an additional $56-million a year ($43-million in Ontario alone) and vowed that if the provinces could not be persuaded to end extra-billing voluntarily, she would recommend to the federal cabinet that extra-billing be banned (G&M Mar. 20, 1981:6).

It is important to note here that while Monique Begin was philosophically opposed to extra-billing, Jim Nielsen was not. There was nothing in Social Credit ideology which would suggest an aversion to extra-billing. This was a Party committed to privatization -- the Party which introduced health care premiums and user fees into British Columbia's health care system. The threat of outlawing extra-billing was used as a negotiation tactic. Nielsen hoped his threat would bring about an agreement to the latest government offer on fees. Instead, the BCMA warned that it would take court action to fight any legislation passed to ban extra-billing. They argued that their master agreement had a provision allowing for extra-billing: "We have a legal binding contract with the provincial government stating that in case of a failed agreement, doctors will balance bill" (VS Mar. 17, 1981:A2).

At the end of March, the BCMA released the referendum results to the press. 93.71% of the membership had voted to reject the government offer and 86.48% were in favour of extra-billing (Minutes, Mar. 30, 1981). The same day, the provincial government introduced a bill to prohibit extra-billing within the Medical Services Plan. Bill 16, the Medical Services Plan Act, allowed doctors the option of opting out but did not allow doctors to remain within the plan and

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\(^8\) This was also true if one considered the entire 28 years. Over the last six years, fee levels in B.C. "followed the general price level quite closely" (Barer, Evans and Labelle, 1988:32).
extra-bill. The bill also made it impossible for future agreements between the government and the BCMA to include a provision for extra-billing and allowed the cabinet to appoint an arbitrator or arbitrators\(^9\) in the case of a dispute (VS Mar. 31, 1981:A1).

The press supported the proposed legislation. The Vancouver Sun said that the government was left with little choice and that the doctors had violated the original intent of the right to extra-bill (Apr. 1, 1981:A4). The Socreds had argued that the total package demanded by the BCMA would mean an increase of 70% or $295 million to the health care budget (G&M Apr. 1, 1981:2). The opposition NDP decided to support the ban on extra-billing (although Cocke made a point of saying he wished it had not been necessary) but they did challenge two provisions, one which gave the cabinet powers to appoint an arbitrator or arbitration board and another which would allow cabinet to alter arbitration proceedings as well as change any medicare agreement coming from arbitration (VS Apr. 3, 1981:A13).\(^{10}\) The Sun supported the NDP challenge, saying that the government should not have the sole discretion in choosing an arbitrator (Apr. 4, 1981:A3).

At their April 4th meeting, the Board passed a motion that legal proceedings proceed against Bill 16 and issued the following statement:

...the BCMA expresses its outrage that the Government of British Columbia has unilaterally destroyed a legal agreement with a group in British Columbia society, in this case the physicians of British Columbia. The BCMA is appalled at the implications of this action on other groups including labour, unions and business in British Columbia (Minutes, Apr. 4, 1981).

\(^9\) BCMA executive director Dr. Norman Rigby remarked: "That is the cunning part. The arbitration is binding on us and the medical services commission, but not on the government which means that they are immune to the arbitrator’s decision if they don’t like it (MP Apr. 7, 1981:1).

\(^{10}\) The NDP amendment called for a three member arbitration board composed of one person appointed by each of the three sides and a third member agreed upon by both sides (VS Apr. 3, 1981:A13).
They also passed a motion condemning the arbitration process as outlined by Bill 16. The doctors received support from labour groups on the proposed arbitration clauses but not on the issue of extra-billing. Labour worried that Social Credit was not taking collective bargaining seriously and did not want to establish a precedent whereby government would avoid negotiation through the use of legislation. The director of the British Columbia Federation of Labour commented that "legislation has no place in negotiations" (VS Apr. 6, 1981:A3).

The BCMA decided to fight the court battle on two legal fronts: 1) the right of physicians to bill patients directly as outlined in the BCMA master agreement and 2) the legality of Bill 16 itself (VS Apr. 6, 1981:A3). After the legal challenge was announced, Health Minister Jim Nielsen hinted that the bill could be delayed if doctors agreed to resume negotiations (VS Apr. 7, 1981:A1). Again, this brought home the point that the government’s concern lay with the fee schedule, not with extra-billing. The government decided to increase its offer by 1.1% -- a proposal the doctors labelled "derisory" (VS Apr. 16, 1981:A1).

At the May 1st board meeting, the decision was made to proceed with immediate job action. Doctors would be asked to vacate their offices during the annual general meeting as well as to send opting out documents to the BCMA (Minutes, May 1, 1981). In Prince George, Penticton, Kelowna and the Fraser Valley (all reform territory), doctors took additional job actions including suspending free over-the-phone services to patients and refusing to sit on hospital committees (VS May 5, 1981:A1).

By May 7th there was a new offer on the table. Doctors would receive a 40% increase over the next two years and would be eligible for further funding if the cost of living in Vancouver rose 15.5% or more at any time during the next 18 months. This time, reformers and moderates could not agree. BCMA president Alex Mandeville told reporters that the new offer was not "adequate to satisfy what doctors are seeking" (VS May 9, 1981:A2) and before the
Board even met to discuss the offer, doctors in the more militant districts voted to either reject the current offer (Surrey and West Kootenay), opt out (Kelowna, Kamloops and Vernon) or extra-bill (Burnaby, Nanaimo and North Vancouver) (VS May 8, 1981:A5; VS May 9, 1981:A2).

Despite the opposition, the Board approved the offer (both the president and the president-elect voted against it) and sent it to referendum. The Board’s job was made all the more difficult by an announcement by doctors in Kamloops two days before a critical by-election that they would extra-bill as a group and a subsequent announcement by Premier Bennett that extra-billing would be banned regardless of the referendum vote. At the BCMA’s Annual General Meeting, reformers (including president-elect Raymond March) moved that the pact be rejected and the Board forced to reconsider its earlier recommendation. It was defeated. Moderate Dr. William Ibbott called the agreement "the most exceptional settlement in the history of Canadian medicine" and said that those doctors opposing it were "right-wing Genghis Khan militants" (Province May 17, 1981 in BCMA News June, 1981).

In his banquet address at the Annual General Meeting, health minister Jim Nielsen announced that plans were still in the works to pass legislation to end extra-billing and added defiantly that the government might also find it necessary to ration billing numbers in order to limit the number of physicians practising in over-doctored centres. An observer at the AGM,

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11 According to Dr. Peter Banks, the Kamloops announcement angered the government to the extent that extra-billing became a lost cause for the BCMA: "Mr. Bennett, not unsympathetic to the doctors, was given absolutely no room for political manoeuvre" (BCMJ 24,3, 1982:102).

12 According to Dr. Ibbott: "The president of the day...Dr. Alex Mandeville...was...personally convinced that it was not yet time to accept that very large negotiated increase. He thought there was more there....He wanted to go back to the table to increase the basic amount. There was great concern that that could have been a destructive process to follow because it was already the largest agreement in the history of any medical association anywhere in Canada..." (Interview, July 27, 1995).
political scientist Malcolm Taylor, noted: "The audience broke out in a cacophony of catcalls, hisses, shouts and footstomping that would have alarmed the stewards at a meeting of stevedores" (Taylor, 1990:173).  

Doctors voted 71% in favour of accepting the government offer -- an offer which Health Minister Nielsen was obviously unhappy with as he continued to warn that the doctors’ new fee increase would cause a deficit in the provincial government’s budget (VS June 16, 1981:A3; June 17, 1981:A1). Nielsen also predicted that medicare premiums would rise 35 to 40% (VS June 20, 1981:A3).

The BCMA had won a spectacular fee increase but it came with a price. They were to lose their right to extra-bill. Either the fee increase was considered adequate as compensation to BCMA demands and/or the militancy of the reformers had angered the government into taking their own aggressive stance. Bill 16 passed June 26 after the government deleted the unpopular arbitration clauses. Said the new BCMA president Dr. Raymond March:

Bill 16 means that the physicians of British Columbia have been stripped naked at the negotiating table, completely subservient to the government’s position. Bill 16 and its passage is against all the basic concepts of professionalism, of a free, open and just society unparalleled in Canadian medicine. The results can only lead to continuing bitterness, frustration, confrontation with government and withdrawal of services. It leaves you as a civil servant without any of their privileges and benefits (BCMJ 23,8 Aug, 1981).

In August, the BCMA initiated their legal challenge to Bill 16, asking the court to declare that the bill was beyond the power of the legislature to enact. If that part of the suit succeeded, the BCMA planned to ask the court to pay doctors an estimated $50 million for losses incurred while the legislation was active (VS Aug. 28, 1981:A3).

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13 The members voted overwhelmingly for a motion recommending that the Board request members to opt out en masse if the Premier carried out his threat to end extra-billing rights (MP June 2, 1981).
The largest fee agreement by a medical association in Canada just happened to coincide with "the onset of the worst recession since the 1930s in Canada and the western industrial world" (Schofield, 1984:43). The recession of 1982 meant reduced revenue for the Social Credit government as demand for natural resource products fell and lower levels of economic activity decreased revenues from sales and income taxes. Unemployment rose to the highest level recorded since the Depression and therefore the need for welfare payments increased substantially (Ibid.).

The Social Credit government chose a neo-conservative plan of action. The priority of their economic policy continued to be the promotion of "private sector resource investment" (Malcolmson, 1984:77). They had been moving in this direction since 1975. However, they would now, as part of their new restraint programme, stringently control government spending by streamlining the public sector (Ibid.). The Compensation Stabilization Programme (CSP) was the focal point of the restraint programme. It "was initially designed to cap public sector wage increases at 8% to 14%; later, toward the end of 1983, it was tightened to bring settlements within a minus-5% to plus-5% range" (Ibid.:79).

In the summer of 1982, BCMA representatives were called to meet with Premier Bennett. They were joined by representatives of other groups who had a fee-for-service relationship with the government. Citing the seriousness of the federal and provincial deficits, the Premier asked the representatives to consider rolling back increases received from their negotiations. Health minister Jim Nielsen said "that professionals were symbolic and asked them to show leadership and participate" in doing their share to fight the recession (Minutes Jul. 23, 1982). Reference
was made to the fact that "there was one group of health professionals that got a much larger settlement than anybody else" (Minutes Jul. 23, 1982).

BCMA executive members came up with the following strategies: 1) emphasize cooperation rather than confrontation, 2) divert focus from that of professional self-interest to that concerning the requirements of the health care system, 3) point out that the BCMA has a task force looking at the problem of health care costs, 4) suggest that the essential components of the health care system need to be protected in tough economic times, 5) don’t mention the need for patient participation in paying for health care as it may be used against the profession, and 6) make the government do its dirty work so the BCMA can publicize the fact that this is the second time government has torn up an agreement with the medical profession in two years (Minutes, July 23, 1982).

At the next BCMA meeting with the health minister, Nielsen announced that he was ending the 20 month old Denticare plan and was planning to institute some form of user fee in the health system. The BCMA told him that they were not prepared to collect this money for the government and that it would be impossible to ask their members to take a rollback (the proposed rollback was 6% to 8%). Upon hearing the health minister’s response which was that if the profession would not agree on a voluntary basis, it would be made compulsory, the BCMA went back to the strategy table (Minutes Aug. 28, 1982).

BCMA Board members passed the following resolution:

whereas the Minister of Health has indicated he cannot provide funds for essential health services, and
Whereas the BCMA is concerned with the maintenance of the highest quality of health services,
Therefore the BCMA will give consideration to asking its members to donate 'free days' of care during the remaining seven months of its contract with the government to reduce this apparent shortfall.
The BCMA will assist the Health Ministry in assessing priorities for health care funds and in efforts to control costs (Minutes, Aug. 28, 1982).
However, president Bill Jory and executive director Norman Rigby devised a more radical plan — to present the provincial government with a tax deductible "gift". After gaining assurance from the federal Deputy Minister of Finance that this action would be possible, Drs. Jory and Rigby offered the Social Credit government $30 million on the condition that the base of the BCMA contract remain untouched.\textsuperscript{14} Dr. Jory told the press: "Even though doctors would still lose money under the BCMA proposal, it has the advantage of maintaining baseline fees for future negotiations and avoids the necessity of breaking any contracts..." (VS Aug. 31, 1982:A1,2).

The offer was equivalent to a mere three quarters of one percent.\textsuperscript{15} The government was well aware of this but could not reject an offer so lavishly praised by the press. Publicly, Nielsen could only express concern over the doctors' maintaining their big salary base and what that might mean for further negotiations. The Vancouver Sun said that the doctors had offered "a beautiful gift" and set a good example for others (such as the teachers who were now considering a similar offer) and that the government should accept and stop contemplating the worst scenario (VS Sept. 1, 1982:A4). The government accepted the BCMA offer on Sept 2 and it was sent to referendum (Minutes, Sept. 3, 11, 1982). A special general assembly was called by doctors critical of the offer\textsuperscript{16} but only 400 of the 4,000 members turned up (VS Oct. 19, 1982:A4). The 30 million payback was approved by a narrow vote: 1,490 in favour (52%) and 1,336 against. Only 60% of the membership responded to the referendum (VS Oct. 25, 1982:A7).

\textsuperscript{14} Interview with Dr. Norman Rigby, July 7, 1995.

\textsuperscript{15} Interview with Dr. Norman Rigby, July 7, 1995.

\textsuperscript{16} Drs. Rigby and Jory had not consulted the profession prior to making the offer which angered many Board members (Minutes, Sept. 3, 1982; interview with Dr. Rigby, July 7, 1995).
By June 1983 the court decision was in on Bill 16 and the doctors had lost. The BCMA had changed its strategy to argue that doctors had been deprived of a property right and were therefore entitled compensation.\textsuperscript{17} Justice W.J. Wallace stated that there had not been "a taking or acquisition by the Crown of any property or right of the doctors and they were not entitled to compensation for the loss of the balance-billing privilege" (VS Jun. 3, 1983:A16). He added that the 1974 agreement permitting balance-billing under certain conditions did "not entitle the doctors to claim any remedy, monetary or otherwise. 'It merely provides that, when the preconditions are satisfied, they may legally bill patients who agree, for medical services provided them at rates in excess of the existing schedule. Until such a doctor-patient relationship prevails and services are rendered for which the patient agrees to pay, the doctors have no claim enforceable in a court of law'" (VS Jun. 3, 1983:A16). The BCMA appealed the decision but lost in November of 1984, seven months after the Canada Health Act (which penalized financially those provinces allowing extra-billing) was proclaimed law.\textsuperscript{18}

\textbf{III. Clinical Autonomy: The Billing Numbers Dispute}

The BCMA and the provincial government began serious discussions around issues pertaining to physician supply in the late 1970s. This was an area considered crucial to the BCMA in terms of one dimension of its clinical autonomy -- its ability to control the recruitment and training of the profession. The Social Credit government felt "that there was a surplus of

\textsuperscript{17} Originally they had argued that Bill 16 was beyond the powers of legal authority.

\textsuperscript{18} the BCMA lost leave to appeal the lower court decisions in May of 1985.
physicians in B.C., particularly general practitioners".\textsuperscript{19} Government interest in physician supply had to do with economics. Governments could try to control their health care budgets by controlling fee increases but they had a much more difficult time dealing with doctors' billings. Since the vast majority of doctors were paid fee-for-service, it was possible for doctors to respond to fee controls by increasing their billings.\textsuperscript{20} Rapid growth in physician supply only compounded the problem. By the end of the 1970s, it was obvious to provincial ministries of health "that more physicians did not translate into lighter workloads for each" (Barer, 1988:3).

The provincial government asked The Black Commission in 1978 to report on physician supply in the province. The BCMA had representation on that commission and also established its own medical manpower committee to assist the Black Commission and to analyse and provide feedback on its findings and recommendations. The Black Commission found the two most pressing concerns to be that of doctor distribution within the province and the likelihood that British Columbia would be facing an oversupply of doctors in the future (Rayson, 1984:270). Its most controversial recommendation and one that the BCMA adamantly opposed, was the restriction of billing numbers.

No such action was taken by the government and the recommendations on physician supply "just literally sat there."\textsuperscript{21} The BCMA representative on the Black Committee, Dr. Norman Rigby, claimed that "at that stage of the game" government was not "really too serious

\textsuperscript{19} Interview with Dr. David Bolton, July 26, 1995.
\textsuperscript{20} During the 1970s, both physician supply and utilization per physician rose. Utilization refers to the percentage increase in medical claim costs from one year over the next which cannot be accounted for by either increases in population or fee schedules (Minutes, Apr. 16, 1974).
\textsuperscript{21} Interview with Dr. David Bolton, July 26, 1995.
about it (rationing billing numbers)." However, a government representative on the Committee, Dr. David Bolton, said that no action was taken by the government because "the BCMA had too much clout [and] because the government didn't have the appropriate legislative authority in place." The issue of doctor distribution was dealt with by devising a northern allowance incentive for physicians who were willing to go to the isolated northern area of the province.

During the 1981 fee-for-service negotiations, the issue of rationing billing numbers resurfaced. A joint committee was formed which evaluated various options but no method of control was adopted (Rayson, 1984:270). Some of the options were not difficult for the BCMA to support, for example, reliance on the market to balance physician supply and demand, placing the onus on the BCMA and the College to educate and attempt "moral suasion" on their members, encouraging the use of local medical manpower committees and more careful consideration of immigrant physicians. Other less desirable (and potentially unacceptable) controls included: controlling medical school enrolment, more stringent licensure requirements for physicians from other provinces desiring to practice in British Columbia, the linking of licensure to hospital privileges, differential fee schedules which would provide financial disincentive to doctors wanting to practice in over-serviced areas, and billing number restrictions (Rayson, 1984:270).

Then in July of 1983 the Social Credit government tabled Bill 24. This was a unilateral decision by the government to limit the numbers of physicians permitted to bill the Medical Services Plan. The previous month, the Health Minister, Jim Nielson, had told the president of

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22 Interview July 7, 1995

23 Interview with Dr. David Bolton, July 26, 1995.
the BCMA that the "two things which worried him about doctors were that there were too many of them and they made too much money" (Minutes, June 18, 1983). Nielson reminded the BCMA that British Columbia had the highest ratio of doctors to citizens of all the provinces. The Social Credit restraint programme seemed to require aggressive action on physician supply as well as fees.

Ironically, despite government concern (in the departments of finance and health) over the surplus of doctors in certain areas of British Columbia and the surplus of doctors in the province in general, and despite a report from the BCMA medical manpower committee which agreed that the province should take steps to limit the numbers of doctors, the Universities Minister Pat McGeer, was implementing plans to have the UBC medical school more than double its graduating class. McGeer argued that the surplus of doctors in British Columbia was due to immigrants from other countries and graduates from other Canadian universities and it was unfair to limit opportunities for young British Columbians who wanted to become doctors (VS Sept. 1, 1983:A3).

Although the main agenda of Bill 24 was to restrict physician supply, other elements of this Medical Services Act reflected the neo-Conservative bent of the Social Credit government. The Vancouver Sun editorial called it "the most serious and potentially the most dangerous product of the 'new right'" (July 12, 1983:A4). The Bill included significant increases for hospital user fees and gave the Medical Services Commission "the authority to contemplate a system of public medical insurance in which a number of practitioners could, in fact, opt out and

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24 This was true. The supply of doctors per capita was 5% higher than the national average (Barer, 1988:3).

25 Eighty percent of the province's doctors had been trained outside of British Columbia (Barer, 1988:3).
set themselves up...as private physicians and surgeons" (Canadian Annual Review, 1983). Most ironically, Bill 24 would once again allow doctors to extra-bill!

The BCMA was able to obtain what it thought were major changes to Bill 24 four months after its proposal. The Sun reported that:

While the doctors have publicly attacked some provisions of Bill 24, they have concentrated their campaign for change on private jawboning sessions with the minister and his officials rather than taking to the streets in protest. Their efforts...seem to have been spectacularly successful as far as the medical profession is concerned. In fact, the doctors may have gained more than they stood to lose from the bill in its original form....The provisions that would have allowed the government to dictate where doctors can practise are also reported to have been withdrawn: the doctors themselves are to police 'overdoctoring' of popular areas. They are also to have a say in drafting regulations under the Act. Physicians are to be allowed not only to opt out of medicare, but to jump back in any time they decide they don’t like being out in the cold. In return, it seems those who stay in will not be allowed to engage in extra-billing...it has been a very strange exercise in the preparation of legislation. If the government is ready to make wholesale changes that alter the thrust of the bill before it has even been debated in the legislature, it can’t have been very sure of what it was doing in the first place... (VS Oct. 29, 1983:A4).

The BCMA agreed to appoint representatives to 28 regional manpower committees (LMMCs) as well as to a provincial committee which would oversee the policing of billing numbers. The LMMCs were, however, restricted to making recommendations to the Ministry of Health, the government retained the ultimate authority to grant or deny billing numbers (Barer, 1988:7). By January of 1984, the government was still holding the threat of rationing billing numbers over the BCMA’s collective heads. Then the government made the decision to tie billing number restrictions to hospital privileges. Hospitals in Vancouver, Victoria and the
Okanagan were asked to refuse billing numbers to doctors applying in those centres (BCMJ 26,3, 1984).26

The association vacillated as to what stance it should take. At the BCMA annual general meeting, delegates discussed the proposal of the Professional Association of Residents and Interns (PARI) and the Canadian Association of Interns and Residents (CAIR) to take the government to court over Bill 24. However, it was decided that too much “effort and cooperation” had gone into the revisions of Bill 24 and the establishment of the local medical manpower committees to warrant "any outright opposition" to the government (BCMJ 26,6, 1984). Indeed, PARI and CAIR initially viewed the BCMA as part of the problem and believed that either the BCMA had stuck a deal with government behind closed doors or had at least agreed to back the legislation.27

However by July, the BCMA decided to join PARI and CAIR in exploring the possibilities of a court case against the government and passed a motion that the association would no longer participate in joint committees whose mandate was to limit billing numbers (Minutes, July 20, 1984).

By September, the BCMA along with PARI and CAIR, was preparing a legal challenge to government restrictions on billing numbers.28 Behind the scenes, a government official admitted that the government would probably lose the case "but did not care because the

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26 Hospitals did cooperate and set up medical manpower committees (Interview with Dr. David Bolton, July 26, 1995).

27 Interview with Dr. Derryck Smith, July 31, 1995.

28 It was revealed that the number of new billing numbers granted since September 1983 was less than one third of those given out in the previous year (G&M Sept. 19, 1984:4).
rationing of billing numbers was solving the problem and they would legislate it" (Minutes, Nov. 23, 1984).^29

The medical profession won the billing numbers case. They had used as their test case, that of Dr. Raziya Mia, a general practitioner who had practised in Alberta for five years and had been denied a billing number upon moving to Kamloops, British Columbia. Dr. Mia had been invited on staff at a local clinic in Kamloops and had also obtained hospital admitting privileges. However, MSC would not grant her a billing number, stating that there was no need for another general practitioner in Kamloops. Mia v. Medical Services Commission of B.C. was heard in the B.C. Supreme Court on March 21, 1985. Counsel for Dr. Mia argued that government through the Medical Services Act and the Medical Service Plan Act, did not have the authority to restrict the issuance of billing numbers and further, this practice was most certainly a violation of the Canadian Charter of Rights and Freedoms (Barer, 1988:8).^30

In a strongly worded decision, Chief Justice Alan McEachern said that the Medical Services Commission had "decided upon a drastic procedure which (was) far beyond their authority" and one which was "Orwellian," "patently unfair and unjust" (quoted in BCMJ 27,5:311). The practice worked "against youth and talent and could not be justified under the federal Charter of Rights" (VS Mar. 22, 1985:A1,2).

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^29 Dr. David Bolton said, "It [was] most unfortunate. I had made a recommendation at the time to government that if they wished to pass legislation which would exclude everyone who was currently in medical school or had been accepted to medical school, this would probably be something that the BCMA might be able to live with. However, the government...was determined to have immediate action and the only way to have immediate action [was] to stop everybody." (Interview, July 26, 1995).

^30 Counsel argued that the practice violated Section 6 (Mobility) and 7 (Liberty) of the Charter.
The British Columbia Medical Journal noted that Judge McEachern "not only struck down the limitation of billing numbers program but enshrined, in judicial precedent, doctors’ rights to practise in Medicare and to freely move within the province to set up practice" (BCMJ 27,5:311). Commenting on the principles of liberty and mobility, the Chief Justice pronounced that "the right of free movement for the purpose of work, which we take for granted," had been a fundamental part of Canadian heritage for hundreds of years (BCMA News, June/July, 1985).

The judgment did not deter the government in its quest to restrict medical manpower. Immediately after the court ruling, Health Minister Jim Nielsen introduced another piece of legislation giving government the power to control and limit billing numbers. Bill 50, the Medical Service Amendment Act, authorized the Medical Services Commission to issue or withhold doctors’ billing numbers and to attach conditions to those numbers, such as the areas in which doctors could practise. Bill 50 was designed to provide government with the proper legislative authority which had become legally necessary to carry out their policy. Nielsen told reporters the bill was introduced because the Chief Justice indicated in his ruling that there was a weakness in the existing law. Said Nielsen: "The court has to interpret law the way it exists. This will change the law. It’s non-discriminatory... anyone who applies for a billing number is treated exactly the same as everyone else. I think (if the law is challenged in court) it will be upheld". Dennis Cocke (NDP medical critic) disagreed: "We spend a lot of money educating doctors, then they finish their education, they get out and they can’t practise. I believe there should be losts of room for everybody in our society to work" (VS April 19, 1985:A1,2).

A Vancouver Sun editorial called Bill 50 "a shockingly underhanded attack on the doctors of British Columbia and an insult to the B.C. Supreme Court" (Apr. 20, 1985:A8). The editorial

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31 Bill 24 died on the order paper. The policy of limiting billing numbers was implemented without legislative authorization.
went on to say that the legislation was "unwarranted" and "unacceptable" as doctors had already agreed to take a cut in fees if necessary and therefore, the honourable thing for the government to do was to negotiate with the profession on the problem of doctor distribution (Apr. 20, 1985:A8). Additional concern was expressed over the fact that the bill allowed government to overrule all court decisions on the matter, past or future (VS May 15, 1985:A4).

On the federal level, Prime Minister Brian Mulroney announced that he agreed with Liberal leader John Turner "that provincial restrictions on the mobility of doctors in British Columbia" constituted an "attack on medicare and the Charter of Rights" (VS May 9, 1985:A1,2). And Chief Justice McEachern said: "The orders in this case have not been obeyed. I wish the government would obey the law. I can't put it any stronger than that." The judge granted a three week period "for everyone to do the right thing" (VS May 4, 1985:A1,2). Soon after, the MSC began to issue unrestricted billing numbers to doctors.

Like its predecessor, Bill 50 was never enacted. Calling himself "Mr. Nice Guy," the health minister terminated Bill 50 but introduced in its place, Bill 41, the Medical Service Amendment Act. The new act still allowed the MSC to restrict or attach conditions to billing numbers, but as a concession to the BCMA, eliminated the retroactivity clause contained in Bill 50 (VS May 16, 1985:A3). This meant that "any practitioner who had applied for a billing number during the period since commencement of the policy and now reapplied would be granted a geographically unrestricted billing number" (Barer, 1988:10). The new bill also provided for

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32 BCMA president Gerry Stewart told reporters that "as late as half-an-hour or possibly an hour before this Bill 50 was introduced I was on the phone with Mr. Nielsen confirming cooperative efforts" to do with controlling doctor distribution. Mr. Nielsen did not even hint that something like Bill 50 was in the works (VS Apr. 20, 1985:A8). For his part, Jim Nielsen argued that he had been forced to introduce Bill 50 because "the BCMA refused to work cooperatively with the government to solve the problem of an oversupply of doctors" (VS May 8, 1985:A2).
the appointment of a medical manpower advisory committee, made up of representatives from the government, the medical profession and the public, to study alternative solutions to the manpower problem in the province. The bill did not require all doctors to have hospital admitting privileges before they received a billing number (VS May 16, 1985:A3).

Both PARI and the BCMA continued to reject any measure which would restrict billing numbers and threatened to take the government to court if it passed Bill 41. The medical profession insisted that the answer to medical manpower problems lay in decreasing medical school enrolments and the number of foreign doctors entering Canada and in providing "well-thought-out, realistic incentive programs" to encourage doctors to work in rural and remote areas (VS May 21, 1985:A1,8).

Bill 41 passed on May 24. Although Jim Nielsen was confident that the Bill would stand up in court and be "used as a model in other provinces with the same problems," the Socred government referred the legislation directly to the British Columbia Court of Appeal asking the court to comment on the constitutionality of the new law (VS June 5, 1985:A4).

The NDP vigorously opposed the legislation and urged the government to return to negotiations with the BCMA. They agreed that physician supply and distribution was a problem but argued that the Socreds had imposed the "simplistic heavy-hand of a centralized government" rather than considering other options such as the differential fee scheduling system used in Quebec\(^\text{33}\) or the expansion of alternative care systems composed of salaried doctors and paramedicals (BCMJ 27,9, 1985:540; VS May 23, 1985:A16; VS June 5, 1985:A4).

\(^{33}\) Doctors who agree to practice in rural areas at the early stage of their careers are paid more than doctors beginning their practice in urban areas.
By the fall of 1985, suits were filed against the Medical Services Commission by a number of physicians who had been refused unrestricted billing numbers, one group was sponsored by PARI, the other by the BCMA. Lawyers for the doctors argued the Medical Services Amendment Act contravened sections 6, 7 and 15 of the Charter of Rights and Freedoms. As in the Mia case, it was argued that restrictions on billing numbers violated mobility rights as doctors from outside British Columbia were not able to move to the province and pursue a livelihood as well as rights to liberty because doctors could not practice in their chosen location. However this time around, the petitioners also argued the case for the violation of equality rights (section 15), stating that the legislation discriminated by age by not letting new doctors into the system and by sex because the percentage of women among new graduates was considerably higher than the percentage of female doctors already in the system (Barer, 1988:13; VS June 11, 1986:A10).

On Jan 5, 1987, the Honourable Mr. Justice Lysyk of the Supreme Court of B.C. ruled that Bill 41 did not violate sections 6, 7, or 15 of the Charter. Pronouncing the petitioner’s situation as "neither unique nor very exceptional" (VS Jan. 6, 1987:A1,2), Judge Lysyk found that the sections pertaining to mobility and liberty in the Charter did not guarantee rights to either intraprovincial mobility or the engagement of employment and commercial activity, professional

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34 Section 6. (2) Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right (a) to move to and take up residence in any province; and (b) to pursue the gaining of a livelihood in any province. Section 7., Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. Section 15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability (Selected Sections, Canadian Charter of Rights and Freedoms, 1982,' in Barer, 1988:23).
or otherwise. Furthermore, the judge concluded that the grandfathering clause of the legislation which allowed issuance of unrestricted billing numbers to physicians already billing the Medical Services Plan did not constitute discrimination under section 15(1) (Barer, 1988:15).

Lysyck opined: "In the private sector, the current reality is that many highly (and expensively) trained professionals -- engineers, architects, lawyers -- are unable to find work in a location of choice, or at all, in B.C. and the same is, of course, true of non-professional workers. In the public sector, no one suggests that any level of government is obligated to hire civil servants or contractually retain the services of others (e.g., teachers) beyond its perceived needs. Nor is it suggested that government is under an obligation to accord an unrestricted choice of location" (VS Jan. 6, 1987:A1,2).

It took only two weeks for CAIR and PARI to announce that they were appealing and slightly longer for the BCMA decision to follow suit. However, during that time an interesting debate ensued within the BCMA. Their lawyers cautioned them to consider both the issues with which they had in common with PARI and those where the two organizations may have different interests and therefore different strategies (Minutes, Jan. 30, 1987). The majority of BCMA members were, as the editorial of the BCMA News put it, "comfortably ensconced in our practices" (Mar./Apr., 1987) and were not affected in such an immediate way by the bill as were interns, residents and medical students. Furthermore some of PARI's suggestions as to what solutions the government should consider in lieu of billing number restrictions such as capping the health budget was very much against BCMA policy. Therefore in addition to the concern that young doctors were critical of and disappointed with the BCMA, feeling "sacrificed" by the organization in order to "protect the geographic freedom of those established in practice prior to May 1985." (BCMJ 29,4, 1987) doctors were asked to consider the impact of the bill on professional freedom and autonomy. At the January Board meeting, Dr. O'Brien-Bell read an
excerpt from Mr. Justice Emmet Hall’s original Commission Report in which Hall states that the philosophy of Canadian Medicare must be based on freedom of choice for the patient and on a free and self-governing medical profession. The latter included "free choice on location and type of practice" as well as "professional self-government" (Minutes, Jan 30, 1987). At that Board meeting, the motion was carried to appeal Bill 41.

On August 5, 1988, the B.C. Court of Appeal decided in favour of the medical profession. The Court ruled that the legislation restricting billing numbers was "so procedurally flawed and manifestly unfair in substance" that they violated doctors’ constitutional rights (BCMJ 30.9, 1988). B.C. Health Minister Peter Dueck announced that the government would appeal the decision to the Supreme Court of Canada. In the meantime, the government’s request to continue with the policy until the appeal had been decided was denied (BCMJ 30.9, 1988).

Finally on November 3, 1988 the Supreme Court of Canada denied British Columbia’s leave to appeal. The one sentence judgement read simply: "The application for leave to appeal and stay of execution are dismissed with costs" (BCMA News Nov/Dec., 1988). After six years of court battles, the medical profession had won. British Columbia, and other provinces who were awaiting the outcome before launching similar programmes, would have to find alternative ways of dealing with the oversupply of and uneven distribution of doctors.

IV. Internal Conflict: Income Disparities

As in the 1970s, disappointments and frustrations with negotiations had an impact on the internal cohesion of the BCMA. However, with the exception of the early 1980s, the central division during the rest of the decade was not between reform and establishment. Instead the major divide was between specialists and general practitioners. In Chapter 5, I mentioned that
the BCMA tried to tackle the issue of income disparities in the fee schedule during the early 1970s. A BCMA committee report on income disparities in 1976 (The Coady Report) recommended that general practitioners be paid 77 to 80 percent of that of specialists. This differential was viewed appropriate in light of the extra training of specialists and their shorter working life. At that time, many specialists were of the opinion that general practitioners earned less because they worked fewer hours (Summary of the Findings of the Disparity Group presented to the BCMA Board meeting of Jan. 31, 1987).

However, the gap between specialists and general practitioners increased steadily since the mid-1970s. A Price Waterhouse Study commissioned by the BCMA revealed that by 1987, the 80:100 relationship in respect to net incomes had dropped to 60:100 (President’s Letter, Feb., 1987). The section of general practitioners threatened to leave the BCMA and negotiate on its own.

For their part, specialists were insistent that the net incomes of general practitioners were reflective of the amount of work GPs were doing in relation to specialists (Minutes, July 16, 1987). They were opposed to higher percentages of fee increases going to general practitioners in an attempt to narrow the disparity between the two groups. Specialists argued that the section of general practice had strong lobbying power and that nothing comparable existed for the specialists (Minutes, Sept. 30, 1987). They also threatened to negotiate on their own. The First Association of Specialists of British Columbia became a registered society in late 1987 but it was far from clear what role it would play in medical politics.

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35 At this point, GPs and specialists comprised approximately 55% and 45% respectively of BCMA membership. The elected governing body of the BCMA favoured GPs (64%) over specialists (36%) (BCMJ 30,3, 1988).
By the late 1980s, the BCMA was forced to admit that efforts in dealing with income disparities between general practitioners and specialists and within specialist groups\textsuperscript{36} had only produced more divisiveness. However, a survey of the membership revealed that 78% of the membership was in favour of continuing the practice of unified negotiations (Minutes, Oct. 6, 1989). During the Annual General Meeting in 1989, the executive director of the BCMA, Dr. Norman Finlayson, presented a report to the association in which he argued that separate negotiations in the province of Quebec had a dismal effect on the incomes of doctors. Separate negotiations would be a dream come true for the B.C. government, said Finlayson, "they will deliberately and wilfully play one group against the other" until the group receiving the worst treatment decides to leave the BCMA. At that point, neither group would be left with any "negotiation levers" (Minutes, Oct. 7, 1989). He predicted that general practitioners would be given preferential treatment in the early years for two main reasons: to reassure members of the public that their own personal family physicians were receiving fee increases, and to successfully encourage general practitioners to look after patients without referring them out.\textsuperscript{37} He added that ultimately specialists would be placed on salary or sessional contracts while general practitioners may find themselves on capitation contracts (Minutes, Oct. 7, 1989).

It was necessary for the BCMA to convince specialists that they would receive the bum deal by going down the path of separate negotiations since only 66% of them were in favour of maintaining unified negotiations compared to 91% of general practitioners (Minutes, Oct. 6, 1989). By the close of 1989, the BCMA constitution was amended so that a council for general practitioners would

\textsuperscript{36} Psychiatrists, pediatricians and internists also complained on a regular basis about disparities.

\textsuperscript{37} Government could greatly reduce their total expenditure with this tactic since most utilization increases occur in referred services (Minutes, Oct. 7, 1989).
practitioners and a council for specialists could have elected input into the negotiating process by having members on both the negotiating and negotiating advisory committees (Minutes, Oct. 7, 1989). The BCMA would face government negotiators in the 1990s as a unified team of general practitioners and specialists.

V. Summary

I began this chapter with a discussion of the politics around extra-billing. For the BCMA, extra-billing was a traditional professional right, a symbol of economic autonomy, that could be conviently used as a negotiation strategy. The medical profession was also willing to spend time and money fighting the government in the courts to keep this right. For federal health minister Monique Begin and her supporters, extra-billing (along with user fees) was a sign that the integrity of medicare was in danger. For Begin, the role of the federal government was to fight against the greed of the medical profession and provincial finance ministers who "tend to look just at ways to get money, instead of the consequences" (CAR, 1983:50). From the perspective of her provincial counterparts, however, the Canada Health Act was a sly way of passing the buck. The provinces would have to deal with the problems of decreased revenues and angry doctors. For the Social Credit government, extra-billing was not philosophically right or wrong. It could be used as an effective tactic against the wilful medical profession. Social Credit outlawed extra-billing when it suited them, proposed it two years later and then in the next year, protested against the Canada Health Act which would penalize provinces where extra-billing took place.

The second major battle between the medical profession and the government during the 1980s was over the issue of physician supply. At the beginning of the 1980s, British Columbia
ranked first among Canadian provinces in terms of health care costs, physician fees, and the number of practising physicians (Barer, 1988:3). These were not separate issues. Social Credit visualized the capacity of each unneeded doctor to raise utilization rates and hence, health care costs. There were also those within the BCMA who felt that doctors should become a scarcer commodity so that the profession would have stronger bargaining power.38 Medical manpower was high in British Columbia despite the fact that the province had and still has the lowest ratio of medical school positions to population of any province in Canada.39 This was a reflection of the fact that physicians found Vancouver and Victoria to be very desirable places to live. W.A.C. Bennett is reported to have said that it was not necessary in British Columbia to add to the existing medical school or to build a bigger medical school because "every physician in Canada would like to come to B.C.".40

This perhaps explains why British Columbia was the province to initiate restrictions on billing numbers. In any case, the BCMA was perhaps the medical association in the country best able to respond to such a challenge. During the 1980s the BCMA continued to be the most innovative of medical associations in terms of its public relations, use of referendum, negotiating advisory committee, and negotiating teams. After the highly successful settlement in 1981, BCMA professional negotiator Ben Trevino was hired by medical associations in Alberta, Saskatchewan and Ontario to advise them on fee negotiations (VS Feb. 10, 1982:H12; BCMA News Feb., Apr., 1982).

However, that successful negotiation turned out to be a flash in the pan. The next year the recession hit, and the BCMA found themselves the target (along with the rest of the public

38 Interview with Dr. Norman Rigby, July 7, 1995.
39 Interview with Dr. David Bolton, July 26, 1995.
40 Interview with Dr. David Bolton, July 26, 1995.
sector) of the Social Credit restraint programme. By 1984 the BCMA News announced that the medical profession was "standing under the shadow of both Bill 24 and the threat of a legislated global budget..." (Feb.). There would be no fee increase until 1986 and during those negotiations the BCMA was forced to accept a clause in the contract which allowed for contract talks to be reopened if total expenditures in the Medical Services Plan ran 2% over the budgeted amount (VS Aug. 12, 1987:A1,2).

The nature of negotiations continued to evolve in the 1980s. While the 1970s marked the change from personal one on one talks between Premier W.A.C. Bennett and BCMA executive director Dr. Tim McCoy (characteristic of the late 1960s) to BCMA negotiating teams which held talks with high ranking ministers and the chair of the Medical Services Commission, during the late 1980s it was announced that negotiations would now be handled by government personnel services (BCMJ 30,11, 1988:747). At the BCMA's Annual General Meeting in 1988, Health Minister Stan Dubas told the doctors that he felt "he should not be involved in negotiations because his duty [was] 'promotion of health care in a positive and pragmatic way'. He [wanted] his ministry to be seen as 'facilitators and deliverers of health care,' not opponents in the negotiating struggle" (BCMJ 30,11, 1988:747). Government Personnel Services was the body which negotiated with the B.C. Government Employees' Union. A clear message was being sent to the BCMA. They would negotiate with government in the same manner as every other union composed of government employees.

The BCMA felt that clause 3 in the 1986 agreement provided protection "from utilization that was either beyond our control or justifiable" (Letter to the Premier from BCMA president John O'Brien-Bell, Aug. 20, 1987). Since government interpretation was to the contrary, the BCMA was forced to make up $11.86 million of a $15.36 million overrun to MSP (VS Aug. 12, 1987:A1,2; VS Sept. 15, 1987:D12).
Finally, the BCMA found itself dealing with an internal problem. General practitioners and specialists could not agree on how much their services were worth. This internal conflict was much less public than the old battles between reformers and moderates. The press did not pick up on the disputes (or was not interested). The issue of income disparities did not affect the BCMA’s relationship with the government during the 1980s. However, it clearly had the potential to cause problems at a later date. The BCMA would continue to work on this internal conflict into the 1990s.
CHAPTER SEVEN


I. Introduction

As I noted in the previous chapter, the 1980s was a period of lengthy legal battles between the BCMA and the provincial government over the issues of extra-billing and billing numbers. The success of the BCMA in winning the billing numbers dispute gave the profession an important boost in its control over issues of physician supply (an aspect of clinical autonomy) and economic autonomy. Unlike most other professions, every new graduate of medical school would continue to be virtually guaranteed a job. The same held for any doctor wishing to move from one province to another.

During the early 1990s, the BCMA’s main concerns focused around the determination of the newly elected NDP government to legislate a global cap on total billings as well as caps on individual doctor’s earnings. The BCMA argued that the global cap (set unilaterally by the government) meant that the medical profession had lost its bargaining rights. The resistance strategies outlined in this chapter frame the struggle between the BCMA and the NDP as one of workers who have lost their right to negotiate with their employer (a hypocritical government whose philosophical leanings promised the protection of these rights). Along with staging walkouts, the opting-out of the MSP by doctors in smaller communities, a $3-million advertising campaign, and a petition signed by over 300,000 British Columbians, the BCMA seriously considered unionization as a resistance strategy.

There is a line of thinking which would view the unionization strategy as proof that the professional power of doctors had declined to such an extent that they had no option but to use
trade-labour protections (McKinlay and Stoeckle, 1990). However, it will become clear in this chapter, that while the BCMA was appealing to labour sensitivities in its framing of the issues between itself and the NDP, the impetus to unionize came from the desire to protect professionalism. It was hoped that unionization would increase doctors' incomes and maintain the distinction between professions and non-professions.

In terms of government strategy, the majority of provincial health departments were busy analyzing recommendations produced by the numerous task forces commissioned during the early 1990s (see chapter 1:5). In British Columbia, the NDP's blueprint for health care reform was the Seaton Report from the Royal Commission on Health Care and Costs. Similar to all of the other inquiries, the Seaton report called for increased economic controls on doctors and restrictions on physician supply. It also advocated a more decentralized and community-based health care system. It is striking in how well these recommendations fit with traditional NDP ideology on health care and the Party's attempted reforms of the early 1970s. When Social Credit defeated the NDP in 1975, the new government promptly dismantled, much to the relief of the medical profession, the community human resources and health centres (CHRHCS) which were to provide for community participation and localized decision-making. Now the NDP is back in power and its health minister, Elizabeth Cull is impressed by the report and promises to take steps to ensure that it does not "just sit on the shelf and collect dust" (VS Nov. 13, 1991).

II. The Seaton Report

The Social Credit government commissioned the Royal Commission on Health Care and Costs but its findings (the Seaton Report) were released shortly after the 1991 British Columbia election which saw the Social Credit government fall to the NDP. The report adhered to one of
the visions of health care outlined in chapter 6 -- the principles of medicare should be protected, privatization measures should not be allowed,¹ the system needed to be re-designed and managed more effectively, and further economic controls placed on doctors and hospitals.

The set of recommendations dealing with the economic autonomy of the medical profession focused on the need for annual global caps on total billings by physicians and caps on hospital funding. The commissioners argued that a "hard" cap should be imposed, rather than a "very loose cap" such as the one negotiated in the previous agreement between the BCMA and the former Social Credit government. Under the Social Credit arrangement, when physician billings exceeded the allowed cap, the government almost always paid for the extra services. A hard cap meant that increases in service use (with the exception of those resulting from population change) would not result in increased payments to doctors (1991, vol. 2:B-89). Said the commissioners: "We recognize that physicians in British Columbia may be distressed by this recommendation...but if this major cost component [physician billings] continues to grow more rapidly than the economic base which supports it, we do not believe that the health care system will survive in its present form" (Ibid.:B-90).

The BCMA certainly was distressed by this recommendation. In its official response, the association called the cap "totally unacceptable" (Bolton, 1992:726). The doctors wanted a loose cap which would consider increases in utilization. They were not prepared to take full

¹ The Report recommended abolishing insurance premiums which existed only in British Columbia and Alberta and supported the Canada Health Act's banning of user fees and extra-billing. Private funding was regarded as "a popular 'quack' remedy with dangerous ingredients which would defeat, not support, the objective of controlling costs. The harm it could bring was one of the strongest pressures forcing Canadians to find better ways to manage the present system and, therefore, preserve it" (1991, vol. 2:B-83). The Commission further noted that private health insurance in the United States cost considerably more than the Canadian public insurance plan (Ibid.).
responsibility for utilization, arguing that technological changes and other "essentially unquantifiable" factors were also involved (Ibid.). The medical profession has always argued that health care economists and government neglect the demand side of the equation, i.e., excessive or improper public use of health care. The Seaton report did recommend a public education campaign but the BCMA laments that overall, "the regrettable lack of importance assigned to this most significant factor...must be underlined" (Ibid.:721).

Another set of recommendations concerned physician supply and thus an element of the BCMA's clinical autonomy. These recommendations included a further reduction in the numbers allowed into medical schools, disallowing immigrant physicians to practice in British Columbia, and requiring those on training visas to agree not to stay in Canada as a condition of their educational license (1991, vol. 2:D-5,6). It should be clear from the discussion on physician supply in chapter 6 that these were not the sort of recommendations that the BCMA had problems with. They would much rather see restrictions on new and immigrant doctors than on doctors already in the system. The continued input of the BCMA in decision-making (political autonomy) around physician supply to ensure that government stayed on the "right track" was what was important: "It should be noted that the BCMA has repeatedly volunteered to enter into discussions with the ministry to determine the appropriate number of physicians and their geographic distribution within the province, and we readily accept the need to coordinate postgraduate training programs with other provinces" (Bolton, 1992:726).

Recommendations advocating the re-design of the health care system called for a shift from the traditional hospital-based system dependent on the fee-for-service practitioner, to a community-based health care system where physicians would work primarily on salary and where other health workers would be given more responsibility and status (1991, vol. 2:B-50). To accomplish this, the commission recommended a stiff reduction in hospital beds with the resulting
savings used to finance long-term care facilities, home care and free standing clinics. As if once again anticipating the disapproval of physicians, the commissioners claimed "evidence that the traditional opposition of physicians to alternative health service delivery organizations is fading" (1991, vol. 1:16). In any case, the commissioners were intent on attacking medical dominance: the "credentialization' of positions within the health care system must be stopped" (Ibid.:7) and "the arbitrary limits that have been placed upon ...[allied health-care workers] must be removed in order to provide the best care possible to the greatest number of people possible" (Ibid.:37). People "should not be barred from performing a task because they lack education which is not necessary to performing that task and does not demonstrably improve health outcomes" (Ibid.:7).

Two important issues for professional autonomy are involved here. The first is economic -- the BCMA has never objected to a minority of doctors working in salaried positions. However, fee-for-service payment raises doctors’ incomes and if most doctors are on salary, the remuneration for the entire profession will drop. The BCMA’s response to this was totally in character: "The BCMA is fully aware that under certain circumstances, fee-for-service is not the most satisfactory method of remuneration for physician services, and there are already community-based clinics that employ salaried general practitioners in this province" (Bolton, 1992:726). Further, "This recommendation is not out of keeping with the previously expressed willingness of the BCMA to develop pilot programs with the Ministry of Health to evaluate alternative methods of delivery of care and physician remuneration, provided patients and providers participate on a voluntary basis" (Ibid.).

Secondly, the acute care sector comprises the power base of the profession. Within the acute care sector, doctors are dominant over all other players. Due to its own self-interest, the BCMA would not want to see any significant decrease to that sector. The BCMA’s response to such suggestions was that the government could not expect to finance "the many extremely costly
proposals in the report" by simply redirecting funds from the acute care sector and that the recommendation of 2.75 acute care beds per 1000 population was not in the public interest (Ibid.:719,721). As in the case of physician supply, political autonomy is of utmost importance: the Association supports the recommendations regarding the appropriate use of hospitals, but believes that it must be involved directly in the development, introduction, and application of any utilization standards and "...although it is contrary to the recommendations of the Commission, we believe it essential for the best operation of a hospital that at least one, and preferably two, physicians be voting members on each board (Ibid.:721).

The Seaton report called for the decentralization of health-care decision-making. Both decisions and services should be "closer to home." In order to achieve the closer to home ideal, the report recommended the creation of regional health authorities (1991, Vol. 1:15). The BCMA argued that the creation of regional health managers would only result in increased bureaucracy and administrative costs. Further, decentralization or regionalization was a popular idea with politicians because it meant government could pass the buck and refuse to be accountable for "local shortages, cutbacks, and other gaps in the system" (Bolton, 1992:719). Most seriously, regionalization would "result in unequal levels of care, with higher levels being provided in wealthier areas..." (Ibid.).

In addition to responding to every recommendation in the Seaton report that involved the interests of doctors, the BCMA had some overall comments. They felt that the greatest weakness of the report (and that most capable of embarrassing its supporters) lay in the fact that "there was a total absence of any costing of the recommendations" (Bolton, 1992:719). "How could this be?" asked the BCMA, especially "considering the composition of the Royal Commission?" (Ibid.). The last comment was a dig at Robert Evans, the health economist on the commission, of whom Dr. Gur Singh, current president of the BCMA, said: "hasn’t had one new idea in the last ten years" (VS Nov. 14, 1991:A3).
III. Towards Medicare II

However, health economists were in vogue and at a meeting of provincial health ministers in early 1992, the politicians relied heavily on the advice of health economists, authors of the Barer-Stoddart report\(^2\). Agreement was reached (Quebec was not at the table) for a "drastic administrative restructuring of the medical profession" (VS Jan. 29, 1992:A1). The politicians referred to statistics showing increases in the number of doctors and in their national cost to the health care system.\(^3\) They proposed major changes which included: a nationwide 10% reduction in medical school admissions in the 1993 academic year; movement away from unaudited fee-for-service payments for physicians and toward either salaried compensation, community clinic grants, or bulk fees for long-term treatment; changes to existing regulations which give doctors a monopoly on medical practice in order to permit increased use of para-medicals such as midwives and nurse practitioners; and a commitment to "establish predictable medical care expenditures through a combination of global, regional and individual practitioner budgets" (Ibid.).

Politicians expressed concern and pessimism about the future of universal medicare. The three NDP governments were united in their defence of medicare but were also well aware that the options of poorer provinces were more limited than those of their wealthier counterparts. British Columbia finance minister Glen Clark accused the federal government of having

\(^2\) Morris Barer and Greg Stoddart. *Toward Integrating Medical Resource Policies for Canada*. This report was initially prepared for a conference of deputy ministers of health in June, 1991.

\(^3\) The national cost of doctors had increased by approximately 70% in the last ten years. From 1975 to 1987, the percentage of doctors increased by 46% while the percentage of the population grew by about 13% (VS Jan. 29, 1992:A1).
deliberately squeezed the poorer provinces (by reducing transfer payments) until they were forced to consider user fees. His comment came after the premiers of New Brunswick and Newfoundland questioned the principle of universality and advocated user fees in restructuring their health care systems (G&M Feb 15, 1992:A3).

IV. Economic Autonomy: Bills 13 and 14

Armed with the recommendations of the Seaton Report and the proposals of the provincial health and finance ministers, the NDP announced its legislative intentions. In his budget address (Mar. 26, 1992), finance minister Glen Clark claimed that physicians were responsible for over 20 percent of health care expenditures and that further economic controls on doctors would permit funding for other "priority areas" (BCMJ 34,6, 1992:357). To this end, he introduced Bills 13 and 14. Bill 13, the Medical Practitioner Fee for Service Apportionment Act, would legislate a global cap of 1.27 billion on all funds going into the medical services plan as well as a cap on the earnings of individual physicians. Billings for general practitioners would be limited to $300,000 and billings for specialists to 360,000 (VS Apr. 10, 1992:E1). The cap on individual earnings went beyond that recommended in the Seaton report but was in keeping with the Barer-Stoddart recommendations.

Just months before the defeat of Social Credit, the doctors negotiated a three-year agreement which included a $25 million annual contribution to doctors' pensions. The NDP said that the pension plan was not affordable. Bill 14, the Professional Retirement Savings Plan

4 It was estimated that 250 out of the 6,000 physicians practising in B.C. would be affected by the cap on individual incomes (VS Apr. 8, 1992). The average G.P. billed $151,000 in 1990-91 while the average specialist billed $202,000 (VS Apr. 10, 1992:E1).
Agreement Extinguishment Act, would extinguish it. The media reacted with delight to the prospect of an NDP government about to break a "workers'" contract. "Sledgehammer Law Smashes MDs' Pensions" read a headline (VS Mar. 31, 1992:B1). Labour leader Ken Georgetti called the action "bargaining in bad faith" and said: "If this was happening to one of our affiliates, we would be jumping up and down" (G&M Mar. 30, 1992:A15).

The BCMA reacted furiously to both Bills. In their comments concerning Bill 14, they followed the lead of the media and organized labour, appealing to labour sensibilities and centring the problem around the NDP's refusal to bargain in good faith. BCMA president Gur Singh said that:

the NDP's stated commitment to fairness and consultation has evaporated...[the] real issue is the fundamental rights of a profession, the tearing up of a legal contract. Once the public understands, hopefully they will put enough pressure on the government and say 'look, you can't do that in a free society. These are draconian measures. You have to sit down and at least talk to [the doctors], give them back the right to negotiate and live up to a legal contract' (VS Apr. 4, 1992:A6; Apr. 6, 1992:B2).

In fighting Bill 13, the BCMA pointed to what they saw as a more favourable situation in Ontario where the OMA had recently negotiated "soft" global and individual caps as well as the right to take part in the setting of future health policy. In contrast the BCMA were given "hard" global and individual caps, had no say on the ceilings, and were bluntly told by Health Minister Elizabeth Cull that doctors needed to be put "on the same footing as the other professionals in the health care system" (VS Apr. 4, 1992:A6). The BCMA argued that they were actually at a disadvantage compared to other professionals because the government had "abandoned the traditional routes of consultation" and had put nothing in its place (BCMJ 34,6, 1992:357). Finance minister Glen Clark contributed to the effectiveness of the BCMA's

5 The OMA negotiated an individual cap of $400,000 with a number of exemptions (G&M Mar. 30, 1992:A15).
argument by stating in the legislature that "he did not think the medical profession had any rights
to negotiate, since they were not union members with a collective agreement" (Ibid.). The
opposition Liberal party and the media immediately portrayed the dispute as one where the
doctors were not given the same considerations as groups such as the B.C. Nurses’ Union and
the Hospital Employee’s Union.

V. Professional Resistance: The Advertising Campaign

Less than three weeks after the Bills were introduced, the BCMA initiated a $3-million
advertising campaign. The campaign began with a television show, radio and television ads, and
several full-length newspaper ads. All of these ads contained essentially two messages. The first
was a self-interest statement on behalf of the BCMA. But it had nothing to do with economics.
It said nothing about doctors desiring higher fees or a pension plan. The message was one
of basic human rights (worker’s rights): the "right to negotiate", to "fairness" and "honest and
open discussion" in the workplace, and to have "duly negotiated and legally binding contracts"
respected. The ads pointed to the hypocrisy of the NDP in violating bargaining rights, something
that the Party was supposed to regard as sacred.

One ad was especially effective in this regard. It bared the heading: "If Power Doesn’t
Corrupt, It Can Affect One’s Memory" (VS Apr. 15, 1992:B7; VS Apr. 21, 1992:A7). The ad
consisted of a letter written in 1990 by Health Minister Elizabeth Cull who was then a member
of the opposition. Cull wrote that the BCMA had every reason to be angry at the Social Credit
government for cancelling negotiations pending the completion of the Royal Commission on

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6 The exception was the ad discussed below and note that it was a politician not a doctor who raised the issue.
Health Care and Costs. According to Cull, the timing of the Royal Commission "[was] a cynical attempt to avoid the immediate problems facing our health care system, not the least of which is the question of adequate and fair remuneration for physicians." She stated that doctors and other health care workers had borne the brunt of Socred mismanagement and promised NDP commitment in redressing this situation, which "can only be done through honest negotiations with physicians directed towards a settlement which both the physicians and the government, on behalf of the public, recognize as fair."

The second message of the campaign had to do with the public interest. The NDP made decisions "behind closed doors" -- poor decisions -- that would lower the standards of health care in British Columbia. Services would be rationed: "Need a hip replacement? Better get in line now in case the money runs out by December" (VS Apr. 14, 1992:A11). Two ads involved the NDP taking a scalpel to health care. One pictured two doctors anxiously watching a man in a suit (a politician) raising a scalpel in a menacing manner. The heading reads: "The NDP's approach to health care is definitely on the cutting edge." The ad then goes on to talk about cuts to services, doctors, and new technology (VS June 20, 1992:A11; VS June 25, 1992:A8).

The ads promised that doctors would do everything they could to protect the public and to "fight the NDP's crude and thoughtless interference in our health care system and our relationships with patients" (Ibid.). The message was clear: not only were doctors on the side of the public good, and politicians against, but there was also a clear division of professional and political boundaries. The government was mucking around in something that it did not know anything about and it had no right to do so. Health care was a private matter between doctor (as medical expert and altruistic professional) and patient. Stated one ad: "Politicians shouldn't stand between you and your doctor" (VS May 23, 1992:A6; VS May 28, 1992:A21).
VI. The Government Compromises: Bill 71

The BCMA's advertising campaign was effective enough to force the government to compromise. The NDP announced that it would eliminate Bill 13 and replace it with amendments to the existing Medical Services Act (Bill 71). The BCMA was given concessions to its economic and political autonomy -- the cap on individual doctors' fees was to be eliminated and the BCMA would have a voice on the new medical services commission which would oversee the health care budget (VS June 4, 1992:A6). The government also softened Bill 14 by agreeing to negotiate a new pension plan (VS June 8, 1992:B4). However, one new task for the medical services commission involved tighter controls on doctors and other health professionals, they would be audited to see whether the services billed to MSP had in fact been rendered (VS June 19, 1992).

Membership on the new medical services commission would be evenly split among the BCMA, government and the public. The commission strategy no doubt served a dual purpose of reassuring the public that the NDP would not dictate health care policy formulated "behind closed doors" but rather, decisions would be conducted in a democratic context which acknowledged both the expert advice of the BCMA and the needs of the public. Public participation was also recommended by the Seaton Report and was a part of the NDP's new health care agenda. Said health minister Cull: "This is the first time that the public will be directly involved in managing the delivery of medical and health services in Canada" (VS June 17, 1992:B1).

The BCMA was not placated by these concessions. The ceiling on the global cap was regarded as far more of an economic threat than the cap on individual doctors which only affected a small minority. The government had stood firm and refused to compromise on its
powers to "claw back any fee increases and utilization overruns" (BCMA Annual Report 1993-94). The BCMA was not impressed with the new medical services commission because from their point of view, it simply added another party to the negotiating table. The BCMA would now have to consider the wishes of three public representatives in addition to those of the government. The three public representatives were to be chosen by the government and therefore likely supportive of government initiatives. Dr. David Forrest of the Professional Association of Residents and Interns (PARI) said that the act "authorizes an unelected body mainly accountable to government and with limited input from doctors to accommodate an imposed budget" (VS June 8, 1992:B4) while BCMA president Gur Singh argued that the commission should not have the power to arbitrate doctors' fees (VS June 4, 1992:A6).

With a new president on board, the BCMA continued a line of attack on Bill 71 similar to that on Bills 13 and 14, i.e., that it would ration services, limit access to treatment and circumvent negotiations between doctors and government. President Steve Hardwicke said that Bill 71 was the "equivalent of a declaration of legislative war on the medical profession" and prepared a list of BCMA demands which highlighted a fee agreement and pension plan as well as a process for negotiating fees and a mechanism for resolving disputes with the government (VS June 16, 1992:B1). The BCMA argued that the health care budget should be increased by at least $60 million (VS June 29, 1992:A1).

The NDP attempted to reassure the public with its own ads. The ads used the language of economic restraint, stating that the health budget had been increased to almost $6 billion dollars at one-third of the provincial budget. This was an enormous amount of money. Taxpayers could not afford more. The ads implied that the BCMA was behaving in a totally unreasonable manner. The government had offered the doctors a pension plan, "full participation in the management of the budget for doctors' services" and a "new, balanced and impartial body
to resolve disputes over doctors' fees and benefits." But doctors still wanted more. They were not content to negotiate with the government "on all issues within the medical services budget." They wanted to actually set the budget for health care throughout the province. They wanted to do the government’s job, a job doctors were not "entrusted" with. The NDP declared: "...we cannot abandon this responsibility to anyone else - including an arbitrator." Said the NDP: the government respects doctors as "health care providers" and wishes that the doctors would "respect government’s role as guardians of health care" (VS June 5, 1992:A8; VS June 6, 1992:A5).

VII. Professional Resistance

i) Walk-outs, Withdrawal of Services, Opting-Out, and a Petition

Bill 71 passed July 3, 1992. Doctors had staged a series of walk-outs and engaged the sympathies of provincial Liberals who read out letters in the legislature written by doctors who were rationing services (VS June 25, 1992:A1). These strategies, along with the high media profile of the BCMA, prompted the government to soften, once again, the proposed economic controls. The last government offer (prior to the passing of Bill 71) promised that regardless of how large the doctors’ overrun might be, the government would claw back no more than two percent of total fees (approximately $25 million) (VS July 3, 1992:A16). This was not accepted by the BCMA. The association reacted by releasing to the press the results of one of its polls which found that although 92% of British Columbians trusted their doctor, less than half felt the same way about health minister Elizabeth Cull (MP Jan. 26, 1993:1). The BCMA then withdrew all of its non-essential services to the government. The Patterns of Practice Committee, the
Professional Advisory Committee\(^7\) -- "any joint committees, any communication with government that was not essential was dropped." Former Social Credit health minister Jim Nielsen, who lost the battle with the BCMA over billing numbers during the 1980s, told the press that the government had placed itself in a "no-win" situation: "over-all, the government does not win this fight...It's pretty tough to beat the doctors. The problem is that individuals do not think their own doctor is overpaid or anything like that" (VS July 3, 1992:B3).

Physicians in the towns of Nanaimo, Prince Rupert and Prince George initiated a very militant resistance strategy -- they began to opt out of the Medical Services Plan.\(^9\) This was obviously a resistance strategy geared to doctors working in smaller centres or to specialists whose numbers were limited, rather than those practising in over-doctored and competitive cities such as Vancouver and Victoria. The government was concerned, especially when Nanaimo doctors said that they would "maintain solidarity" by refusing to accept patients who left an opted-out doctor (VS Oct. 3, 1992:B3).

\(^7\) Consists of representatives from the BCMA, the government and the College and is responsible for decisions of a clinical nature such as the provision of psychiatric, transplant and anaesthetic services (Interview with Dr. David Bolton, July 26, 1995).

\(^8\) Interview with Dr. David Bolton, July 26, 1995.

\(^9\) Doctors who opt out of the Medical Services Plan bill their patients directly and set their fees by either the MSP or BCMA fee schedule. The BCMA fee schedule has higher rates for most services. Opted-in physicians may use this fee schedule for foreign patients. Doctors opting out of the MSP forgo benefits such as disability insurance and continuing education. They are also not entitled to money paid by the MSP for malpractice (VS July 30, 1992:B5) and they must set up their own billing and computer systems which add about 10% to overhead costs (VS Feb. 4, 1993:A1).
By February of 1993, some of the opted-out doctors began to charge their patients extra fees in order to cover the additional over-head costs associated with opting-out. Health minister Elizabeth said that this constituted extra-billing and should be banned. However, the government was in a sticky situation since its legislation outlawing extra-billing only referred to doctors within the jurisdiction of the medical services plan. Cull would need to bring in new legislation to address the opted-out doctors. She threatened to do so (VS Feb. 5, 1993:B1).

The BCMA also initiated a petition campaign from doctors' offices and shopping malls. The petition called for an end to the lengthy dispute with the government through mediation and binding arbitration. This was a chance for the BCMA to once again use their most powerful allies, the public, to influence the government. By the time BCMA president Steven Harwicke and a delegation of doctors delivered the petitions to Victoria, they had 380,411 signatures (BCMA News May/June 1993).

10 By 1993, approximately 70 doctors had opted-out. In a letter to BCMA members, Steven Hardwicke claimed that the majority of opted-out doctors found it to be a very positive experience: "The Nanaimo doctors...have found that their patients are more compliant, that most patients have remained loyal and supportive of the step they have taken, that their cash flow has improved considerably believe it or not, that the hassles with MSP have vanished, and that practising medicine is once again a pleasure without the government involvement" (President’s Letter Apr. 14, 1993:2).

11 Ontario had a law on the books which forced opted-out doctors to defer their fees until their patients received their reimbursement from the government. This law decreased dramatically the number of doctors opting out of medicare.
VIII. **Economic Autonomy: Negotiations**

At the same time that the NDP was attempting to pass legislation which would give legal authority to their health care plans and the doctors were reacting with their own resistance strategies, the BCMA had been in negotiation with government bureaucrats over their fee schedule and master agreement. These negotiations stood in the shadow of the proposed legislation, the BCMA and individual doctors' reactions, and the media coverage. The government's last offer of 1992 consisted of a one percent fee increase for 1993-94 and another one percent increase for 1994-95 (VS Dec. 22, 1992:B6). BCMA president, Steve Harwicke's response was identical to his reaction to Bills 13 and 71: "I reiterate that this is not a money issue," said Hardwicke (VS Dec. 14, 1992:A3). The BCMA continued to argue that the two main issues were the lack of "meaningful" negotiation and a dispute resolution mechanism. In a document sent to the Medical Post, the BCMA insisted that doctors must have the right to negotiate the funding base upon which fee increases were applied as well as the utilization amounts (Jan. 26, 1993:1). Further, it was not acceptable that the MSP should have the right to impose settlement in the case of a stalemate between the BCMA and the government (Ibid.).

A fed-up Elizabeth Cull decided to bypass the BCMA and sent a package outlining the proposed agreement to every doctor in the province. The BCMA accused her of showing "disrespect for the BCMA and the negotiation process" (VS Dec. 23, 1992). The BCMA Board of directors later rejected the offer (VS Jan. 23, 1993).

Talks resumed in February and government inched up its fee increase offer to 1.5 percent in 1993-94 and 2 percent in 1994-95. However once the new health care budget was declared in March, the BCMA announced that it was withdrawing from negotiations. Most of the increase in the health care budget was to go to community health as part of the government's new reform
plans (VS Mar. 31, 1993:A18). According to the NDP, the budget for physician billings was increased by 4.2 percent (VS Apr. 3, 1993:A9). However, the economists at the BCMA insisted that the government had actually reduced that budget by $50-$55 million (VS Mar. 31, 1993:A18; VS Apr. 3, 1993:A9). The president of the BCMA, Dr. Steve Hardwicke demanded that the health minister Elizabeth Cull resign and said that the BCMA would be withdrawing from all "further negotiations with the government on the basis... we no longer have any faith in her" (VS Mar. 31, 1993:A18).

IX. New Directions for a Healthy British Columbia

By February of 1993, the NDP had implemented one-third of the 379 recommendations from the 1991 Seaton Report (VS Feb. 3, 1993:B4). Now work would start on regionalization and the move toward community-based health care. Community health councils,\textsuperscript{12} regional health boards,\textsuperscript{13} and community health centres would be established and as a result of the shift in priorities, there would be a reduction in acute care hospital beds. The nurses were as worried as the doctors as to what the changes would mean to their profession. B.C. Nurses' Union president, Debra McPherson, warned that "health care workers cannot wholeheartedly embrace the reforms unless they have job security" (VS Feb. 3, 1993:B4).

\textsuperscript{12} The NDP planned to establish approximately 100 community health councils (CHCs) throughout B.C. The CHCs would be responsible for the coordination, delivery, and integration of health services and facilities at the local level. They would include representatives elected by the public (Province of British Columbia, Feb. 2, 1993).

\textsuperscript{13} Regional health boards would work with community health councils in deciding what services its region needed and how to coordinate them within guidelines provided by Victoria (Province of British Columbia, Feb. 2, 1993).
Criticisms of the NDP reform plans mimicked those made of the Seaton report by the BCMA. BCMA president Steven Hardwicke argued that the government was off-loading its responsibilities and predicted that the funding provided to regional health boards would be inadequate (VS Feb. 4, 1993). Liberal MLA Linda Reid said that Cull was putting "all the eggs in one basket" and that people would be caught in the middle as hospitals were downsized and beds closed. She also argued that the government would not save money with the shift to community care (VS Feb. 3, 1993:A1). Most of the NDP's critics echoed this last point. Like the BCMA, they felt the NDP was dramatically increasing the layers of bureaucracy and as a result, cost.

Keeping with the Seaton report, the NDP decided that new acute care beds were needed in the rapidly growing suburbs rather than in the city of Vancouver. The government announced that Shaughnessy hospital, one of the Lower Mainland's oldest hospitals (and needing renovations to many of its buildings) would close by summer (VS Feb. 11, 1993). The NDP had to deal with an enormous amount of negative publicity from the Hospital Employees' Union (HEU) (1,300 of its members worked at the hospital), doctors, nurses, and the provincial liberal opposition. It was claimed that patients would suffer long waiting lists, the specialty clinics at Shaughnessy could not be easily moved, the NDP was moving much too quickly, and many health care workers stood to lose jobs (Feb. 12, 1993:A13; Feb. 19, 1993:B2). Neither the BCMA, the HEU, nor the health care staff at Shaughnessy was consulted by the NDP in their reform plans for Shaughnessy.
The BCMA was able to use a proposed deal with the province's three health care unions in its struggle with the NDP. After negotiations led by Finance minister Glen Clark, the BC Nurses' Union, the Health Sciences Association and the Health Employees' Union were all offered packages containing increases between 12 and 15 percent (VS Mar. 24, 1993). Commentators called the deal "too rich" and a sell-out to the unions (either because the unions were "friends" of the NDP or because their cooperation was crucial to the reorganization process of the health care system, Ibid.). The NDP responded that the deal was not as rich as it looked because 4,800 jobs would be eliminated over the life of the contract. However according to the proposal, jobs could only be eliminated through attrition or voluntary early retirement (Ibid.). Critics argued that the government would never be able to meet its target (Ibid.). BCMA president Steven Hardwicke commented that: "the government gave away too much of the store in order to buy labor peace in the health care system" (Ibid.). The Health Labour Relations Association (HLRA), the bargaining agent for the hospitals, would reject the deal but not before it was of use to the BCMA in their fight with the NDP. A Vancouver Sun editorial sympathized with the doctors saying that they had "spent the last year banging their heads against a brick wall in a vain attempt to get a compensation agreement with the provincial government, only to see their fellow workers in the health-care unions quickly extract a sweetheart deal from the government..." (Apr. 8, 1993).

14 At least one media commentator thought that it was significant that Clark, not Cull, was the "chief architect" of the deal (VS Mar. 29, 1993).

15 Four percent of the increase was due to a reduced work week of one hour which increased the hourly wage rate. Three percent was for pay equity (VS Mar. 24, 1993).
X. Professional Resistance: Unionization

The notion that the BCMA should become a union in order to strengthen its bargaining power with the government had been around since the 1970s as part of the reform platform (see chapter 5). This time around, the BCMA announced to the press that "our back is to the wall" (VS Apr. 3, 1993:B7). "We have exhausted all means with which to work with this government. There are no choices left" but to consider unionization (VS Apr. 7, 1993:A1). A new provision of the labour code was in the works and the doctors said that they would attempt to be defined as dependent contractors\(^{16}\) under the code (Ibid.:A13).

There was precedent for doctor trade unions. The British Medical Association became a trade union in 1971. In the United States, where it is illegal for fee-for-service doctors to unionize due to anti-trust laws, approximately 250,000 residents and interns and salaried doctors working in private corporate hospitals and HMOs belong to unions. In Canada, Quebec is the only province where fee-for-service doctors are unionized. In that province, specialists and general practitioners belong to separate unions. And, as noted in chapter 5, the Professional Association of Residents and Interns of B.C. (PARI-BC) was unionized in the mid-1970s (Smith, 1993:4-7).

\(^{16}\) The Labour Relations Code defines a dependent contractor as "a person, whether or not employed by a contract of employment or furnishing his or her own tools, vehicles, equipment, machinery, materials, or any other things, who performs work or services for another person for compensation or reward on such terms and conditions that he or she is in relation to that person in a position of economic dependence on, and under obligation to perform duties for that person more closely resembling the relationship of employee than that of an independent contractor" (in Smith, 1993:1).
In most respects the BCMA was already a union. According to Dr. Derryck Smith who chaired the BCMA committee on the union issue:

...when we looked at the structure of the BCMA under the new labour law, the BCMA was in every effect a union. We met the definition of a union. What we were not was a certified labour union and to become a certified union what you have to do is to apply to the Labour Board for certification but we felt it would be given very easily because we met all the criteria.

Reacting to the BCMA's press announcement, health minister Elizabeth Cull said that she would welcome the concept of doctors in a union because then doctors would have to "stick to issues like fees and benefits and working conditions" (VS Apr. 3, 1993:B7). Referring to the bone of contention in the current dispute, Cull said that she could only assume that the doctors realized that unions do not negotiate government budgets. Then, alluding to one of the medical profession's biggest privileges: "I don't see a lot of unemployed doctors in this province, but I can tell you there are a lot of unemployed union members" (Ibid.). Ken Georgetti of the B.C. Federation of Labour said that doctors would need a lesson in solidarity if they wished to form a union. Commenting on the BCMA's negative reaction to the latest agreement negotiated with the health care unions, Georgetti warned that the rest of the labour movement would not feel "sympathetic to the needs of doctors when they don't reciprocate" (Ibid.). Carmela Allevato of the Hospital Employees Union commented: "It's interesting that the group which is at the top of the hierarchy in an industry that's extremely hierarchal is looking to trade unionism to advance its collective rights" (VS Apr. 7, 1993:A13). A Vancouver Sun editorial declared that "Forming a union would not give doctors what seems to work best for those seeking favours from the government -- the right brand of politics. But it would enable them to enlist the help of the

17 Bill 84, the Labour Relations Code, passed in April of 1993.
18 Interview with Dr. Derryck Smith, July 31, 1995.
Labour Relations Board to force the government to negotiate with them on the same terms enjoyed by unions that are politically correct" (VS Apr. 8, 1993).

Cull's remarks reflected her understanding that the BCMA did not intend to negotiate on the same terms enjoyed by trade unions. The doctors did not intend to give up professional privileges for trade union rights. Rather, they wanted to add the force of labour legislation to their professional privileges. Furthermore, the doctors did not need to rely on solidarity to the extent of trade union members because they had other resources. However, Georgetti and Allevato's comments are interesting because they suggest that doctors may have to seriously consider strategies to attract allies other than the public which has always been the doctors' "natural ally." Could the doctors do this and maintain their dominance within the medical division of labour? The BCMA Annual Report for 1993-1994 refers to the need for allies:

Major effort was spent on enhancing our network in areas of mutual interest with health, business, labor, community, and political organizations. Our membership in the BC Business Council should give us an opportunity to participate in the promotion of our views of health-care policies through the business community. This opportunity to participate along with other associations is critical, especially in this era of change and restructuring....(13).

In the BCMA report on unionization, the author stated that although the doctors would still have to negotiate with government, with "the force of labour legislation on our side," the BCMA "may well be able to attract allies from other health care professionals in unions" (Smith, 1993:11). Other benefits of unionization cited in the report included: access to structured negotiation, mediation, and arbitration; the collection of dues under the Rand formula19 and the choice "to affiliate with other health care unions if this is to our advantage" (Ibid.:12). Most importantly, unionization would reinforce, not diminish the doctors professional status. The

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19 The BCMA is the only medical association (with the exception of the North West Territories) which does not have mandatory dues (Smith, 1993:4).
report warned doctors that they were in grave danger of losing many of their professional
characteristics. Their cherished independent practitioner status was clearly threatened by trends
toward placing doctors on salaries and service contracts which "clearly define them as employees,
not free-standing professionals" (Ibid.:10). Doctors were losing their dominance within the
medical division of labour: "In many hospital settings today, physicians are considered simply
another health care worker, much like lab technicians and nurses" (Ibid.). The NDP’s "closer to
home" agenda was diminishing the profession’s economic, clinical and political autonomy in
several ways. With regionalism, physician practice would be governed by regional or local
health boards comprised mainly, if not exclusively, of lay people (Ibid.). Fee-for-service
physicians may be required to provide more services for less money as the NDP continued to
transfer money out of the fee-for-service pool (Ibid.:11).

BCMA members were told that doctors in the United States, Britain and Quebec had
found that unionization protected their professionalism as well as their bargaining rights. The
report cited an article by the British Medical Association which argued that:

The association’s character as a professional body has not changed. The fears
mentioned...that its newly acquired trade union status could harm the profession by
impairing its reputation and credibility as doctors as a profession - have not been realized.
Indeed, the BMA has evolved for its own purposes, a style of trade unionism that meets
doctors needs, takes account of their professional and ethical standards and is quite
distinct from the 'industrial unionism’ that most doctors have firmly shunned (Ibid.:5).

American physicians provided the following reasons for joining trade unions: "to protect
professional autonomy, to increase income and benefits, to effectively shore up slipping controls
over their professional lives, and to ensure their patient’s well being" (Ibid.:6). There was plenty
of reinforcement of the structural functional notions of professionalism in this report. For
example, an address by the president of the American College of Rheumatology is cited where
the argument is made that a professional trade union will always be distinguished from traditional
trade unions in that there is a commitment beyond self-preservation to the public trust and in addressing issues that affect the public good (Ibid.:7).

The BCMA called the president of the largest American Union of Physicians down for a debate at the Annual General Meeting. However, when the members voted (turnout was high at 70% of all eligible voters) 64 percent rejected the unionization strategy. According to the Medical Post, many doctors were worried about public reaction. Would the public believe that doctors could be professional, altruistic, and union members? Surveys commissioned by the BCMA seemed to indicate that was a difficult picture for the public to buy and patients would be uncomfortable with the prospect of a unionized medical profession (MP Aug. 10, 1993:107). Dr. Derryck Smith believed that the members had other fears as well: "I think many doctors don’t understand how you can be a trade union without behaving like a HEU or the Teamsters or something like that." What they did not understand, he said, was that "as a professional union, you do not have to have...any of the clauses or any of the powers [seniority clauses, the right to strike] 20 that the membership would find unacceptable." 21

However, while all of the information given to BCMA members went to great lengths to show doctors that unionization was not at odds with their understanding of professionalism, there was little evidence that unionization had slowed the decline of the economic, clinical or political autonomy of doctors. Perhaps the majority of them simply couldn’t see the point in making such a change.

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20 For example, PARI-BC’s collective agreement does not prohibit it members from crossing picket lines (Smith, 1993:6).

21 Interview, July 31, 1995.
XI. Economic, Clinical, and Political Autonomy: The Agreement

In August of 1993, after 18 months of dissention, the NDP and the BCMA finally came to an agreement and it was a good agreement for the doctors. The key elements of the five year working agreement included: a total fee increase of 6.5 percent; a retirement saving plan, the cost shared equally between government and the BCMA; funds for continued medical education, physical disability insurance and Canadian Medical Protective Association rebates; a process for dispute resolution; co-management of the Medical Services Plan, a partnership plan for managing utilization, and a global budget. The government softened the global budget and at the same time provided incentive for the doctors to stay in budget by allowing a reserve fund. Any year that physician billings came under budget, that money would be set aside in a reserve fund not to exceed $40 million. The reserve fund would then be used in years that billings exceeded the global cap (VS Aug. 24, 1993:A1).

The Board of Directors strongly recommended approval by the membership and the agreement was ratified, 87.5 percent in favour (VS Sept. 22, 1993:B1). In their annual report, the BCMA declared that the "agreement has been labelled by some as a landmark agreement that will provide a blueprint for future involvement of physicians in public medicare" (1993-94:13). This is what pleased the doctors the most about the new agreement. Their relationship to the government would be closer to that of a partnership -- not the partnership of the old days certainly -- but a kind of partnership nonetheless and one which the BCMA hoped would result in more power and influence for the medical profession. The tripartite Medical Services Commission (one-third of its members elected from the BCMA, one-third from government, and
the remaining third elected jointly by both parties) was unique in Canada (Ibid.: 14). The doctors had retained their right to opt out of the MSP and they had regained their voice on contentious matters such as utilization and physician supply (economic and clinical autonomy). In addition, the protocol guidelines for what could and could not be billed under the MSP would be developed with their participation. And, in cases of extreme dissatisfaction with Victoria, the doctors now had their dispute-resolution mechanism (their labour protection). The Commercial Arbitration Act would now deal with disputes between the two parties (VS Aug. 25, 1993: A1). Premier Mike Harcourt echoed the doctors' sentiments: "What we have achieved is unique on the continent...our doctors will have a much greater say in the environment in which they practise and in how Medicare serves patient needs" (VS Aug. 31, 1993; A11).

**XII. Summary**

This chapter began with a discussion of the Seaton report, used by the newly elected NDP as the "blueprint" for its reform plans. The economic control issues of the 1980s -- physician utilization rates and physician supply -- were marked as crucial in this report. The NDP took an aggressive stance on utilization and implemented a "hard cap". If the doctors went over the budget (an amount the BCMA called "inadequate"), the doctors would have to pay for it, not the government. The BCMA responded and the variety of resistance strategies they were able to implement over this short period of time, surely attests to medicine’s distinctiveness as a profession and its still considerable professional autonomy. The fact that the doctors were able

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22 The MSC "has the statutory authority to administer the Medical Services Plan within the confines of the budgets established by legislature and the negotiated constraints of the master agreement with its various protections" (BCMA Annual Report 1993-1994: 14).
to dismiss their professional privileges and centre their resistance strategies around their right to be treated like trade union workers is neither ironic nor a sign of proletarianization. It speaks of a powerful cultural authority that other professions do not have. For the most part, the media and public responded positively to the BCMA’s assertion that the NDP had taken away its bargaining rights. The least attractive BCMA resistance tactic for the public was, not surprisingly, the opting out of doctors in the smaller centres.

The BCMA was also able to force the NDP government into giving the doctors what was considered a very good agreement for the early 1990s. The issues of utilization and physician supply were not going to disappear. The best the doctors could do was to have some control over decision-making. This was given to them in the 1993 agreement. However, becoming co-captains of the ship does not mean that they will have a lot of choice over direction. For example, although the BCMA felt that the tripartite Medical Services Commission was "functioning very well,...under the act [it] has clear responsibilities such as if expenditures go over budget and proration is required, the commission is obliged to do that provision." The doctors have agreed, as part of their deal with the government, that they will help the government limit the number of doctors and distribute them more evenly throughout the province. They will have to make some tough decisions on this and on other issues. One of the doctors that I interviewed (who is currently the president of the BCMA) said:

> We have a co-management model that I think is unique and we...must make it work. So I think it's in everyone's interest that we make it work....The trouble for the profession is going to be that we have to make some hard decisions. We just had a referendum on limiting the numbers of office visits that GPs can have, for example. That's another example of a very tough collective decision. 60 percent in favour, 40 percent opposed....There are going to be an increasing number of issues that come up that are

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23 Interview with Dr. David Bolton, July 26, 1992.
going to have to be decided in that way. That if we have the collective responsibility for looking after the health budget we have to make some tough decisions.\textsuperscript{24}

The other theme that runs through this chapter is that of the "closer to home" plans of the NDP. The BCMA knows that almost every element of community-based and regionalized health care reduces some dimension of the medical profession's professional autonomy. The BCMA wants a voice on the direction of these reform plans and has been frustrated in this regard by the government. For example, hospital beds have been closed without any input from the medical profession and at the end of 1993, doctors were not represented on any of the Regional Health Boards. The BCMA will continue to push for representation and at the same time, the doctors hope that many of the reforms will not see the light of day. What the BCMA has on its side is the enormous difficulty governments have in dealing with this kind of sweeping reform. Restructuring is an expensive, uncertain and unpopular process.

\textsuperscript{24} Dr. Derryck Smith, July 31, 1995.
CHAPTER EIGHT

Conclusion

I. Discussion of the Findings

i) The Social and Historical Context

I began this dissertation with a broad research question:

How have changes in the political economy of British Columbia health care, in particular the move from a laissez-faire arrangement to an increasingly regulated market system, altered relationships between the medical profession and the government of British Columbia?

From 1964 to 1993, British Columbia experienced many political and economic changes affecting the funding and administration of health care policy in the province. These included: public demand for public health insurance and the transition from the private doctor-sponsored plans to government-administered health insurance as outlined in chapter four, the rising costs of health care and the use of task forces to back competing views on health care management (chapter five), economic recession and the increased responsibility of provincial governments for the financing of federal medicare (chapter six), and a renewed commitment by many provinces (including British Columbia) to regionalize and decentralize health care (chapter seven).

1 There were other changes occurring simultaneously. I want to echo my remarks in Chapters One and Two that due to my focus on professional autonomy (rather than on all four measures of professional dominance) and on physician resistance to state initiatives, some interesting social changes: the growth of alternative medicine and the socio-cultural model of health, for example, are rarely mentioned in the thesis. I should also add that the above issues were rarely addressed in any of my data sources. These social trends may, of course, become issues for the BCMA to contend with in the future.
These political and economic changes impacted on government strategy in dealing with doctors and on the professional autonomy of the medical profession. In general terms, the government intervened more often in the affairs of the medical profession and its interventions became more invasive and therefore more offensive to the doctors. There is nothing new in this observation. Coburn et. al. (1983), Naylor (1986) and Taylor (1990) have come to similar conclusions. However to date, the literature on the Canadian medical profession has not included historical case studies of the medical profession and the nature of its responses to government intervention. One of the contributions of this thesis is to provide a detailed empirical account of how a particular medical association works to maintain professional autonomy. Both Elston (1991) and Saks (1995) argue that this kind of research is absolutely necessary before we can reach any conclusions about the decline of medical power.

I have found that, during the 29 year period of my study, the BCMA not only reacted to government actions but was also often able to anticipate these actions and therefore make immediate plans for the protection of its professional autonomy. A good example of this was the Master Agreement signed with the government of W.A.C. Bennett. This was the first agreement of its kind in Canada and it included an escalator clause providing for automatic fee increases as well as a guarantee that extra-billing and opting-out of the government plan would be permitted. Although doctors in British Columbia were "known as Pinkos all across Canada because [they] had actually signed an agreement with government," they had correctly anticipated that such an agreement would be necessary in the future.

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2 Interview with Dr. David Bolton, July 26, 1995.
ii) Changes in Political, Economic, and Clinical Autonomy

In fleshing out the answer to my primary research question, I found that answering two related questions was helpful:

How has the professional autonomy of the medical profession in British Columbia been altered in the move from a laissez-faire arrangement to an increasingly regulated market system?

How useful is it to break down professional autonomy into clinical, economic and political types? Have there been changes in some aspects of professional autonomy and not in others?

All three dimensions of professional autonomy experienced decline during the time frame of the dissertation. Political autonomy, or "the right of the medical profession to make policy decisions as the legitimate experts on health matters," (Elston, 1991:61) has perhaps declined the most. The Social Credit government did consult with the BCMA on the design of the British Columbia Medical Plan in 1965, however even in that case, many of the association's objections were overlooked. As time went on, it became increasingly obvious that the various provincial governments did not find it necessary (and in many cases, found it undesirable) to confer with the BCMA on pending health care legislation.

The "corporate rationalizers" of hospital administrators, Ministry of Health bureaucrats, and health economists, usurped the medical profession’s traditional position as advisor and decision-maker in this regard. This happened not only because governments obsessed with cost efficiency "take a business approach to everything" and think that "doctors will only act in their own self-interest," but also because much of the health legislation passed was designed to

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3 Interview with Dr. David Bolton, July 26, 1995.

4 Interview with Dr. Derryck Smith, July 31, 1995.
control doctors.

A weakness in political autonomy has ramifications for economic and clinical autonomy. Most health care policy affects doctors in some way. Legislation allowing the downsizing of the acute care sector, for example, is as important for the BCMA as legislation limiting physician supply or allowing the capping of individual doctors' incomes. However, although the BCMA was able to alter government plans on the latter, it has had much more difficulty dealing with the former. Therefore, as I outline in chapter seven for example, the BCMA had two strategies: first, alter the NDP's "closer to home" blueprint and second, place doctors in positions of decision-making to better control the route that change will take.

In terms of economic autonomy, "the right of doctors to determine their remuneration" (Elston, 1991:61), several factors have been important to the BCMA: the fee schedule, the privileges of extra-billing or opting-out of the medical services plan, the retention of fee-for-service payment for the majority of doctors, and a negotiable health care budget (which usually meant that when doctors went over budget, the government paid the difference).

The BCMA, like the other provincial medical associations, experienced a gradual decline in fee schedule increases during the mid-1970s. However, the BCMA managed to keep its fee schedule consistently above average and still has the "most generous fee schedule in Canada" (VS July 20, 1995:A17).\(^5\)

The freedom to opt-out and extra-bill were considered absolutely crucial to the profession's economic autonomy. Doctors did not want to be completely dependent on government funding. If the government was unable or unwilling to pay doctors at levels they felt they deserved, they wanted either the right to ask the patient to pay the difference or to take

\(^5\) However, the net incomes of B.C. doctors are not the highest in the country (VS July 20, 1995:A17).
their business out of the medical services plan. The BCMA has been able to preserve the right to opt-out. Extra-billing, however, has been another issue. As the legal battle over extra-billing in chapter six indicates, the Social Credit government and the federal Liberal government took turns in outlawing extra-billing. During the 1990s, the two levels of the state have taken issue with extra-billing by opted-out doctors.

The majority of doctors in British Columbia are still paid fee-for-service, i.e., they bill the government for each service rendered. This method of payment is crucial to the doctors' vision of themselves as business people or free-standing professionals, rather than government employees. Chronologically, government concern with fee-for-service, began with the issue of "high earners." The BCMA was told to deal with those individual doctors who were taking advantage of the system. However quite soon thereafter, government concern shifted from the individual doctor to the entire profession. Increased utilization rates became the issue and fee-for-service was under attack for driving up health care costs. Doctors were providing more services to increase their incomes and billings to the medical plan (utilization rates) increased.

During the early 1970s, the NDP had planned a more community-centred health care system with the majority of doctors on salary (chapter five), but their reform plans died after they lost the 1975 election. The issue resurfaced with the Seaton Report (chapter seven) but the current NDP government is not even close to changing the way in which most doctors are paid. Instead, the current government resorted to a global cap on total billings. As far as the BCMA was concerned, a capped budget meant that "there is no such thing as economic autonomy." As I noted in chapter seven, however, the NDP softened the global budget with a reserve fund that could be used in those years where the global cap was exceeded. The consequence of global

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6 Interview with Dr. David Bolton, July 26, 1995.
caps is likely to be that the BCMA will more carefully police its own members. Doctors who bill over the average number of services will be accused of taking more than their fair share. Individual economic autonomy will be sacrificed for the collective good.

Three elements of clinical autonomy were explored in the dissertation. The first was clinical freedom at the bedside or the ability of physicians to control all levels of patient care. Canadian doctors have little interference from the government in this regard but the reduced availability of hospital beds, places for psychiatric patients, and technology, does affect their decision-making. Furthermore, some would argue that we are entering the era of evidence-based medicine. If certain procedures cannot be proven to be effective, the government may refuse to pay for them. In the 1993 agreement between the BCMA and the NDP, the two parties agreed to save $80 million over a three year period by developing a set of clinical guidelines. The question here is whether medicine will continue to have the dominant voice in determining the guidelines.

The second element of clinical autonomy has to do with professional control over recruitment and training. My focus here was on physician supply. During the 1960s, a doctor shortage for Canada was incorrectly predicted by demographers working for the Hall Commission. By the next decade, the issues of physician supply and the uneven distribution of doctors had become of great concern to government. Concern about physician supply was linked to economics. More doctors meant more billings and increased pressure on the health care budget. This was true in all the provinces but was especially relevant in British Columbia, the "California of Canada." During the 1970s, the BCMA had committees working on the problem but as far as the government was concerned, they were not really doing anything. Therefore in 1983, the government tried to legislate and limit the number of doctors permitted to bill the Medical Services Plan (chapter six). The government lost the battle in the courts. However, the
BCMA has since agreed to certain interim measures allowing for restrictions on billing numbers. The doctors have finally accepted that the measures they fought against are inevitable (perhaps in a slightly altered form) so long as they control the process.

The last element of clinical autonomy has to do with collegial control over discipline and malpractice. The College of Physicians and Surgeons is responsible for protecting the public from unqualified or unethical doctors but the BCMA has control over economic discipline through its Patterns of Practice Committee. The BCMA remains one of the few medical associations in Canada which continues to dominate the committee responsible for the economic discipline of doctors. The BCMA does not have full control over the process (an Audit and Inspection Committee now reviews the actual patterns and sends recommendations to an audit panel) but the initial recommendation from the Patterns of Practice Committee is still necessary.

iii) Internal Conflict

While my first three research questions examined the external forces challenging medical autonomy, my fourth research question asked:

Are there forces internal to the profession which contribute to a loss of professional autonomy?

This question was central to chapter five where I examined the internal conflict created by the reform movement in the early 1970s, and arose again in chapter six with the issue of income disparities. In both cases, the internal divisions were exacerbated by government actions. The reformers were able to gain strength and legitimacy within the BCMA because doctors were angry with their fees and because the government was seen as provoking the profession by

7 Interview with Dr. David Bolton, July 26, 1995.
publishing doctors’ incomes. The battle between reformers and moderates took up a lot of the BCMA’s time and energy. However, the internal changes sparked by reformers—the membership referendums, the hiring of a professional negotiator, more representative negotiating committees, and aggressive public relations—were by most accounts, to the advantage of the BCMA and many of these innovations were copied by other provincial medical associations.

There has always been a division between specialists and general practitioners within medical associations. At its core, is the issue of income disparity between the two groups. However, this traditional divide has been aggravated by increasing disparities and by shrinking health care budgets, and in particular, global caps. Whereas in the past, the BCMA could ask the government for more money for disgruntled general practitioners, for example, now the association is placed in the role of developing some method to equitably divide up the available funds. In 1993, the BCMA’s Relative Value Guide project was cautiously inching its way towards some sort of resolution. If any internal conflict threatens the professional autonomy of the BCMA in the future, it is likely to be this one.

iv) Professional Resistance

My last two questions dealt with professional resistance:

What kinds of resistance strategies does the British Columbia Medical Association use? Have these strategies changed in the last 30 years? If so, why have they changed?

How effective are these strategies? Do they mark a departure from professional ideology, and if so, have they become indistinguishable from labour tactics? Are there groups or occupations with which the BCMA attempts to form alliances?

The BCMA has a variety of resistance strategies at its disposal and as I noted in chapter seven, this variety is one of the characteristics that distinguishes the medical profession from
labour groups and other professionals. In the early years, the BCMA used resistance strategies that were very much in keeping with the professional ideology of the time. The association tried to use its traditional personal relations with government members to its advantage. It made sure that the BCMA had proper (and if possible dominant) representation on government/profession committees and that the freedom to opt-out or extra-bill would be part of any agreement with government. However, as I have already noted, the BCMA also prepared itself for government intervention in ways that were not traditional, most notably with the Master Agreement.

During the 1970s, resistance strategies were highly influenced by the agenda of the reform movement. All of these were innovative and marked a departure from the traditional ways of doing things. No other medical association needed its membership to ratify its deals with the government. No other medical association was seriously considering hiring a professional negotiator. And, according to the Medical Post, the BCMA’s public relations department was also ahead of its time.

The professional negotiator was hired in 1980, and during that decade, the threat of extra-billing was used as a negotiation strategy, one which eventually backfired and sent the BCMA to court to protect this traditional right. This was a decade where "outsiders," i.e., non-doctors (the professional negotiator and lawyers), were also used to fight the association’s battles. This was against traditional ideology which argued that: "Only a physician should be talking for physicians" (Medical Post, June 13, 1972).

During the early 1990s, the BCMA used the following tactics: walk-outs, withdrawal of services, opting-out, petitions, and advertising campaigns, in its battle with the NDP over the global budget. However, its main strategy was to use the language of labour in arguing that the government had taken away the doctors’ bargaining rights, and as a result, the BCMA lacked the power of a union. Although many within the BCMA were serious about unionization, the very
public campaign arguing its need was just as effective in conveying the message of unfair
treatment to the public as it was in relaying information to the members.

As I indicated in chapter seven, the unionization strategy was not proof that the
professional autonomy of doctors had declined to such an extent that they had no option but to
use trade-union protections. Those who advocated unionization clearly intended to use it to boost
the power of the profession in ways that would maintain distinctions between themselves and
labour. Unionization was never intended to replace all of the other resistance strategies, some
of them, the mark of professional privilege. The rejection of unionization by BCMA members,
however, was perhaps an indication that elements of traditional professional ideology still existed
making some doctors uncomfortable with continually adding on any new resistance tactic to the
old arsenal. Resistance strategies had to be tailored to the professional image in certain ways in
order to be acceptable to the doctors and to what they thought the public, their major ally, would
find acceptable. Although the unionization campaign stressed the differences between a
professional union and a labour union to its members, there was evidence that the public was
uncomfortable with the notion.

Throughout the time frame of the dissertation, the most effective resistance strategies for
the BCMA remained access to politicians and bureaucrats, and the use of media to influence
public opinion. Through these two means, the BCMA tried to alter every aspect of government
legislation not to their liking. They were often successful. Many Bills died on the order paper
as a result of pressure from the BCMA. The legislation was reborn in a form which reflected
the input of the BCMA and the often long periods of struggle between the medical profession
and the government. Perhaps this will be less true in the 1990s. However, even the last
agreement between the BCMA and government in 1993 revealed the continued professional
autonomy of the BCMA. The government was not able, in the end, to act with the kind of
dominance that most employers take for granted in the 1990s. Compromises had to be made.

However, the BCMA has cut back on its demands. One of the lasting effects of government control over the medical profession is that the profession has been forced to police itself on issues of concern to the government. Not only will the profession react to government challenges with more of an attitude of collective responsibility, but ironically, it will also likely anticipate government action and monitor itself without government intervention.

II. Theoretical and Methodological Considerations

i) Professional Autonomy

This thesis does not support Freidson’s (1985) contention that medicine is not losing power but is simply being restructured. It is true, as I have noted, that on some issues individual economic autonomy will be sacrificed for the collective good. However, the thesis points to areas in all three dimensions of political autonomy where the collective power of the BCMA has declined.

In looking at the relationship between the three dimensions of professional autonomy in my study, the BCMA has had the least success in protecting the political dimension and the most success in controlling aspects of clinical autonomy. This follows Freidson’s assertion, as outlined in chapter two, that control over the technical or clinical (in the case of doctors) content of work is the core feature of professional autonomy. Control over the terms and conditions of work may vary, but technical autonomy must be maintained. If it is not, professional status will be lost.

Does the case of the BCMA represent a particular pattern of professional decline? Is political autonomy always the first dimension to go, followed by economic, and then possibly,
technical/clinical? The difficulty in asking this question and in generalizing about the BCMA's pattern of professional decline to other professions, is that the medical profession is somewhat unique in having won high levels of clinical, economic, and political autonomy. Very few professions have experienced economic autonomy and even fewer could lay claim to political autonomy.

The legal profession can be said to possess all three dimensions of professional autonomy. Law has often been considered, along with medicine, as an archetypical professional occupation. I have not been able to find a study looking at the various dimensions (as I have outlined them) and changes within legal autonomy. However, one very obvious difference between the two professions in Canada has to do with their relations with the state. The "size of the state’s bill for health care dwarfs the bill for legal aid" and in any case, most lawyers, unlike doctors, derive their income from the private sector (Brazier et. al., 1993:210). The Canadian legal profession would not have experienced the same challenges from the state that the medical profession has had to endure. However, it would be an interesting project for future research to compare challenges that law may experience from the private and public sectors with the current situation of the medical profession. Canadian teachers, on the other hand, have a similar (although a much less powerful) relationship to the state as that of the medical profession. However, the teaching profession has only managed historically to gain technical autonomy. Teachers are currently dealing with the issue of pre-packaged curriculum and are now concerned that they may lose their only dimension of professional autonomy.  

Another consideration in looking at the relationship between the three dimensions of professional autonomy is that the definitions or boundaries of the technical and the political are

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8 Conversation with David MacLennan, August 30, 1996.
constantly changing. Much of what had been considered the private domain of technical authority in the past, is now public and political (Starr and Immergut, 1987). The negotiation process between the BCMA and the various provincial governments also involved a negotiation of professional and political boundaries. The BCMA sought to convince the public that health care policy was a technical matter of a specialized nature, best dealt with by those with the proper expertise. In contrast, the provincial governments increasingly tried to portray health care as a political matter and therefore open to lay judgement and control by the politicians and public servants who represented the public, and perhaps with the direct participation of the public. The best protection for political autonomy in the past was that it was actually considered part of the profession's clinical or technical work or as Halliday describes it, "moral orientations" were "smuggled in...under the cloak of technical superiority" (1985:430).

One last reflection on professional autonomy. Although the BCMA pattern follows Freidson's argument that control over the content of work or technical autonomy should be the last area to show decline, this does not match the American experience (Radovsky, 1990; Bjorkman, 1989; Dohler, 1989; Evans et. al., 1989). If I had been able to proceed with my original project in comparing the BCMA with the Washington State Medical Association, I would have been better able to gage which aspects of clinical autonomy were in decline in the United States and to what extent. The literature points to private business interests as a more dangerous challenge to physicians' control over clinical decision-making than the state. If this is the case, the BCMA should be extremely wary of privatization measures. Ironically, both the BCMA and the CMA have promoted privatization measures in the past. Yet as Coburn points out, the interests of doctors are not "entirely coincident with those of a bourgeoisie intent on efficiency in the public sector and profit in the private sector" (1988:110).
ii) Internal Conflict

In terms of divisions within the profession, I have already mentioned conflict between specialists and general practitioners, but age and gender are two additional areas to watch. It will be much easier for the BCMA in the future to place restrictions on newcomers rather than established doctors. The BCMA's interim measures allowing for restrictions on billing numbers, for example, disproportionately affects new graduates. Young doctors may feel that they are being shut out of the system and as a result, they may not be as loyal to organized medicine as their predecessors. Women remain relatively unrepresented within the BCMA. During this past year (1995-96), there were four female doctors on the Board and twenty-five men. The president, past president, and president-elect were all men. A notation in the 1995-96 Annual Report, announcing that an Ad Hoc Committee on Female Physician Participation in the BCMA had been struck, indicates that there have been concerns about this gender imbalance within the BCMA. In chapter two, I noted that female doctors are disproportionately situated in the less lucrative areas of medicine. It is unclear as to how the rising numbers of female doctors will impact on the profession as a whole. Speculation exists that because of their childcare responsibilities, female doctors, like women in other occupations, will be more likely to choose to work fewer hours than their male counterparts. However, health economists argue that total gross billings have not decreased as a result of more female doctors (Evans, 1992:756). An interesting project for future research would be to compare billings of female and male doctors. The double-day syndrome will likely be modified by the training and socialization of female doctors, the high cost of their education, and the fact that they can more readily afford good quality child-care than most other female workers.
iii) **Professional Resistance**

One of the contributions of this thesis is that it looks at how professionals resist outside challenges to their autonomy and illuminates the decision-making behind their choices of resistance strategies. In chapter two, I outlined some of the characteristics of professions which heighten their ability to resist -- professionals have a market monopoly over their knowledge and skills, they have had special relationships to elites or the state and likely still have important connections, and they have developed highly sophisticated collective organizations. The medical profession has all of these qualities, but in addition, doctors have a very special relationship to their customers. All of us, regardless of our age, race, gender, or class, can fall ill and good health is a priority for most of us. As long as biomedicine is a "religion" in Western societies, doctors will be treated by the majority of the public as "secular priests." This is why doctors are such a difficult elite group for governments to deal with.

As the thesis shows, however, the BCMA does not rest on its privileged status, but very actively plans and promotes its interests. The research is one-sided in that it shows how the BCMA interprets and anticipates government actions but it does not show the decision-making behind government strategies. It was beyond the parameters of this study (and also not possible due to time and resource constraints) to have looked at the government players in the same manner as the BCMA. The actions of the government are presented as interpreted by the BCMA in their private and public documents, by the media in the newspaper analysis, and by the reviewers of the *Canadian Annual Review of Politics and Public Affairs* which I used extensively in the thesis. Future research examining primary sources on the government side and interviewing government negotiators would provide another angle on professional resistance and a more complete picture of BCMA/government relations.
A more intimate look at the government players would also, I think, have made the self-interests of the state more obvious. The focus on medical dominance in sociological analyses of health care, tends to obscure the other side of the coin -- what are some of the negative aspects of government or state dominance of health care? As the American literature reveals, there are certainly negative consequences to the public and to health care professionals when private interests dominate in a health care system. The Canadian literature to date, however, has not addressed the question of state dominance. The particular agendas of provincial governments remain unanalysed while concern is expressed at the minor role currently played by the federal government. I would agree with Saks (1995) and others, that while the medical profession does pursue its goals out of self-interest it does not necessarily follow that doctors' interests are always opposed to that of the public or that they cannot be valuable critics of state policy. This is an important consideration, especially in light of the current preoccupations of governments with economic rationality and little else.
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APPENDIX 1

Significant Events at the Provincial & Federal Levels 1964-1993

1964
Provincial: The Social Credit government asks the BCMA to collaborate on a provincial medical plan.


1965
Provincial: The B.C. Medical Plan comes into effect under the Medical Grants Bill. The first master agreement is signed between the government and the BCMA. It contains a unique formula for determining the doctors’ fee schedule.

1967
Provincial: A proclamation bill, the Medical Services Act, is introduced to enable the B.C. health plan system to qualify for federal medicare.

1968
Provincial: Federal medicare is introduced in British Columbia and Saskatchewan (the other provinces began their programmes between 1969 and 1972). Statistical data is now available for most aspects of fee-for-service practice.

Federal: The National Medical Insurance Plan

1969
Provincial: Order-in-council passed enabling the disclosure of doctors’ incomes under the Public Accounts Information Act.

1970
Provincial: Cost Quality Study Committee established. The B.C. government publishes individual doctor incomes in the "blue book". The BCMA agrees to a moratorium on any increase in the fee schedule. The BCMA carries out its first referendum.

1971
Provincial: The "reformers" gain power within the BCMA. Order-in-council issued to license private laboratories. Order-in-council issued to allow ministerial veto of physician appointments to hospitals.

1972
Provincial: The NDP is elected in British Columbia.
1973
Provincial: The BCMA vs. PEA for the right to represent public service doctors.

1974
Provincial: The Foulkes' Report is released.

Federal: The Lalonde Report is released.

1975
Provincial: The NDP is defeated and the Social Credit Party returns to power.

1977
Federal: The Established Programs Financing Act (Bill C-37); block funding replaces 50-50 cost sharing.

1978
Provincial: BCMA and Social Credit settle their dispute over Medicare Claim Cards out of court.
The Black Commission is established to examine medical manpower in B.C.

1980

1981
Provincial: Bill 16, the Medical Services Plan Act of 1981; designed to abolish extra billing.
Lawsuit launched by the BCMA against Bill 16.
The BCMA becomes the first medical association in Canada to hire a professional negotiator.
The BCMA bargains their highest fee increase ever (40% over two years).


1982
Provincial: The BCMA offers the government a "gift" of $30 million.

1983
Provincial: Introduction of Bill 24, the New Medical Services Act, restricts the numbers of physicians allowed to bill MSP. User fees also announced in the provincial budget.
The BCMA loses its legal challenge against Bill 16.

1984
Provincial: BCMA teams up with PARI to oppose government restriction of the issuance of billing numbers.
The BCMA loses its appeal over Bill 16.
Federal: The Canada Health Act.

1985

Provincial: Public relations at BCMA begins Project 2000 "designed to restore strength to the profession and return it to its traditional role of being the senior health care providing group."
PARI and CAIR win their legal challenge as the B.C. Supreme Court strikes down the limitation of billing numbers program.
Bill 24 is revised into Bill 50 which is revised into Bill 41. The BCMA begins legal action against Bill 41.

1987

Provincial: Bill 34, Health Statutes Amendment Act.
The First Association of Specialists of B.C. becomes a registered society.
Compulsory electronic billing is introduced.

1988

Provincial: The BCMA wins legal action on Bill 41. The B.C. government appeals to the Supreme Court of Canada.

1989

Provincial: Public Opinion Survey commissioned by the BCMA reported that 97% of British Columbians believed that doctors should have the leadership role in making health care decisions.

1991

Provincial: The NDP is elected.
The Royal Commission on Health Care and Costs (the Seaton Report) is released.

Federal: The Government Expenditures Act (Bill C-69). Allows the federal government to progressively diminish the amount of money it transfers to the provinces to fund health care and other social programs.

1992

Provincial: Bill 13, the Medical Practitioner Fee for Service Apportionment Act, legislates a global cap of 1.27 billion as well as a cap on the earnings of individual physicians.
Bill 14, the Professional Retirement Savings Plan Agreement Extinguishment Act, allows the NDP to break a BCMA/Social Credit contract which would have provided a $25 million annual contribution to doctors’ pensions.
Bill 71, a revision of Bill 13, passed July 3 with the cap on individual doctors’ fees eliminated and with provisions for BCMA membership on the new medical services commission.
1993
Provincial: Sex-misconduct bill will allow doctors and other health practitioners to take action against sexual misconduct within their ranks.
BCMA members vote against becoming a union.
Doctors okay deal with the NDP which includes a seven year master agreement and a five year working agreement along with a binding dispute resolution mechanism.