

PERSISTENT POWER? THE WEAKENING OF THE MEDICAL PROFESSION'S
CONTROL OVER KNOWLEDGE IN CANADA

by

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Submitted in partial fulfilment of the requirements
for the degree of Master of Arts

at

Dalhousie University
Halifax, Nova Scotia
August 2013

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Abstract

Canadian doctors have historically been an extremely powerful interest group. While there are many variables that account for their political influence, it is widely accepted that much of their power is due to their control over specialized knowledge. To determine whether or not physicians' control over knowledge is changing, I examine doctors' position relative to the state, the public and other health professionals. This research finds that, in all three relationships, physicians' control over knowledge is weakening. Moreover, organized medicine's response to these developments has largely been a strategy of co-optation, demonstrating that doctors are aware that these changes often cannot be openly fought. This strategy signals that the medical profession recognizes that some changes in its control over knowledge are bound to occur. This study concludes that these changes could contribute to a 'critical juncture' signalling the potential for significant change in the physician-state relationship.

List of Abbreviations Used

ACP: Alberta College of Pharmacists

AIT: Agreement on Internal Trade

AMA: Alberta Medical Association

BCMA: British Columbia Medical Association

CAPA: Canadian Association of Physician Assistants

CBC: Canadian Broadcasting Corporation

CEC: Collaborative Emergency Centre

CFHCC: Commission on the Future of Health Care in Canada

CFHI: Canadian Foundation for Healthcare Improvement

CHI: Canada Health Infoway

CHSRF: Canadian Health Services Research Foundation

CIHI: Canadian Institute for Health Information

CIHR: Canadian Institutes for Health Research

CMA: Canadian Medical Association

CPSA: College of Physicians and Surgeons of Alberta

EHR: Electronic Health Record

EMR: Electronic Medical Record

FMM: First Ministers' Meeting

GDP: Gross Domestic Product

HCC: Health Council of Canada

HCIWG: Health Care Innovation Working Group

HIT: Health Information Technology

HMO: Health Maintenance Organization

IT: Information Technology

NS: Nova Scotia

OECD: Organization for Economic Cooperation and Development

PPO: Preferred Provider Organization

WHO: World Health Organization

Acknowledgements

This project has benefitted from a lot of support. I would like to first acknowledge the work of my supervisor, Dr. Katherine Fierlbeck, who went above and beyond the call of duty to ensure this project was done the way it should be.

I would like to also thank my family for providing much-needed encouragement, reassurance and hot meals throughout this long and busy year.

Finally, I would like to thank Rebecca McFadgen for keeping me sane, being a constant source of advice and putting up with me talking about doctors incessantly for the past year.

Chapter 1

Introduction

While the specific dynamics of the doctor-state relationship differ from province to province, the overall trend is the same: Canadian physicians are willing to fight to protect their interests. It is their extremely successful defence of these interests throughout Medicare's history that has become one of the most pressing issues in the Canadian health care debate. This prompts the central question of this project: is the political power of Canadian physicians changing? I propose that, if one assumes that physicians' power in Canada rests on control over medical knowledge – an assertion supported both empirically in the Canadian case and theoretically with respect to the medical profession in general (Tuohy 2003; Dingwall 1983) – the base of Canadian doctors' power is being eroded. This project tests this proposition by examining changes in doctors' control over knowledge vis-a-vis the general population, the state and other health professionals. It then explores the various ways in which doctors are reacting to any changes to the base of their power, focusing particularly on the strategy of "co-optation" on which organized medicine is relying (see Bonang 2012; CMA 2010c for examples).

Properly examining this question requires first a methodological argument about how physician power has traditionally been understood, as it is necessary to adopt a solid understanding of where this power stems from before asking if it is changing. Carolyn Tuohy has presented the best approach thus far to understanding the particularities of physician influence in Canada, as she accepts the idea that that power comes from knowledge, but emphasizes as well the factors that make doctors *uniquely* powerful in Canada through an historical institutionalist

framework, from Canadian organized medicine's characteristics as an interest group (Tuohy 1999, 42) to the impact of Canadian institutions such as federalism (207). However, as she focuses her attention mostly on the medical profession's relationship with the state (203), I argue that Tuohy underemphasizes the importance of doctors' relationship with two other sets of actors: the general public, as well as lower-paid health care providers. In neglecting physicians' relationship with the public, she underemphasizes the importance of informal institutions such as discourse. To overcome this gap, this study supplements her historical institutionalist approach with sociological institutionalism. Likewise, in order to take physicians' relationship with lower-paid health care professionals into account, this study focuses appropriate attention on the dynamics of health care provision itself. Finally, Tuohy also lacks a theoretical explanation for motivations. While that may not be critical to her particular discussion, which focuses on health care more generally, this study does require such an explanation as it focuses significant attention on how doctors are reacting to changes in their power. For this purpose, the third neo-institutionalism – rational-choice institutionalism – is employed in order to provide a theoretical base for explaining physicians' actions.

Background: Doctors and Canadian Medicare

The research question asked in this project is relevant and important for three main reasons. First, it is clear that Canadian physicians are extremely powerful; this is reflected both in doctors' material well-being and in the key role played by the medical profession in discussions of health policy. Materially, Canadian doctors are extremely well paid. The OECD reports that, as of approximately 2009, the average general practitioner earned 3.1 times the times the average

person's wage in Canada, while the average specialist earned 4.7 times the average (OECD 2011, 67). While the OECD does not provide data for all of its members, Canadian doctors are among the most generously paid of the countries that were surveyed for this question (ibid). This is despite the fact that Canadian health care is also among the most expensive in the world, with Canada being ranked 5th of all OECD countries, well above the average, on metrics of health expenditure per capita and as a percentage of GDP (149, 151). The expensiveness of Canadian health care is increasingly being seen as problematic considering the widely-accepted idea that the performance of the system is mediocre (Lewis 2007b, 103; Lewis 2008b; Simpson 2012, 172); the fact that doctors are still able to maintain a relatively high level of income therefore speaks to their notable influence within the health care system.

However, even more significant than doctors' paycheques is the extent to which the entirety of Canadian health care policymaking revolves around the medical profession. This dynamic is unique to Canada, with doctors being of significantly less importance to discussions of health policy elsewhere (Tuohy 1999, 30, 67; see also Katz et al 1997, 1414). In *Accidental Logics*, Tuohy argues that Canadian health care has historically been defined by an accommodation between doctors and the government (1999, 30). This dynamic has been in place since the original establishment of Canadian Medicare, which placed an enormous amount of decision-making power in the hands of physicians (56). Doctors and the organizations that represent them are then consistently central to high-level discussions of health care in Canada – this in addition to the aforementioned day-to-day role they play in lower-level policy making such as establishing drug formularies, licensing standards, etc. (Fierlbeck 2011, 145), as well as individual physicians' active role on provincial regional health boards, which have become

increasingly central to health care policymaking since the ‘regionalization’ trend of the 1990s (Lewis 2004; Capital Health n.d.).

Doctors are then clearly extremely powerful in Canada. While this in itself is not a problem, it is important to ask how that power affects the system as a whole. As such, the second reason why it is useful to examine whether Canadian physicians’ power is changing is the potential relationship of that power to the stagnation of health care in Canada. Canadian health care has not seen significant overarching reform since the inception of Medicare in 1966, despite numerous pressures faced by the system (Tuohy 1999, 102). Bégin et al describe Canada as a “country of pilot projects” – there is a lot of minor experimentation happening at the provincial level, but no large-scale reforms sufficient to tackle the problems Medicare faces (Bégin et al 2009). Instead, issues with system performance – the most infamous being long wait times (CIHI 2012, 1) – have been tackled using short-term solutions such as cash transfers (34; FMM 2004). At the same time, skyrocketing costs have been dealt with by imposing austerity rather than fundamentally restructuring the system itself (Tuohy 1999, 91; Payton 2011).

Significant academic attention has been paid to the question of why Canadian health care has remained relatively stagnant while other countries have succeeded in achieving meaningful reform (Tuohy 1999, 102). The institution of federalism is perhaps the most intuitive explanation for this phenomenon: as health care is recognized as constitutionally provincial policy, any pan-Canadian change necessitates discussion and compromise between the provinces, with the federal government having only the power to increase or reduce funding and provide leadership in negotiations (Tuohy 1999, 41; Stanbrook 2012). Indeed, it is only due to the common principles by which the various provincial systems must abide that one can even speak of

“Canadian” health care in the first place (Tuohy 1999, 91). Given the disparate regional interests that often define policy discussions in Canada, it is unsurprising that this dynamic would complicate any plans to fundamentally alter the structure of health care across Canada. Tuohy writes that on many occasions meaningful health care reform has been scuttled due to ideological differences between provinces, preserving the status quo as the “default option” (1999, 106)

The argument that the institution of federalism is what stifles health care reform in Canada is persuasive, as it is immediately obvious from a quick glance at Canada’s long history of failed federal-provincial negotiations. There is an element of irony here as well, as the decentralized nature of Canadian health care is what allowed Saskatchewan to experiment with Medicare in 1962, ultimately demonstrating to the wider Canadian public that such a universal scheme was feasible and paving the way for Canada-wide universal medical insurance (Tuohy 1999, 53). However, federalism alone is not a satisfactory explanation for the stagnation of Canadian health care. This is because of the high degree of autonomy individual provinces have in health policy; decisions of a given province are obviously not dependent on any negotiations with other governments¹. How, then, can one explain persistent health care inefficiencies within individual provinces? Despite widespread budget deficits and serious questions about Medicare’s long-term sustainability (Marchildon 2012, 148), fundamental changes such as reform of primary care and physician remuneration remain elusive (21, 105). It is then necessary to look beyond federalism to other possible explanations for why meaningful health care reform is so difficult to achieve in Canada.

¹ An argument could be made that smaller provinces lack the necessary capacity to institute major changes without a Canada-wide strategy. However, for larger provinces this is not the case.

Commentators have also explored in detail the role of culture in maintaining the status quo in Canadian health care. A 2008 Ipsos Reid poll reports that universal health care is widely considered a national symbol, ranking among the likes of the maple leaf and the beaver (1). There are numerous theories for how Medicare came to be so popular: Medicare represents a contrast with the United States (Maioni 2010, 225), all three major political parties had a hand in its creation (Simpson 2012, 129), it has been repeatedly reaffirmed by the discourse and actions of politicians in all parties, most notably via the unanimous support for the 1984 *Canada Health Act* in Parliament (Tuohy 1999, 90, 94), and it served as a symbol of national unity during the threat of Québec separatism in the last decades of the 20th century (Boychuk 2008, 141). Some argue that Medicare's popularity has significant implications for how health policy is approached, forbidding any fundamental changes to the system regardless of necessity. Jeffrey Simpson opens his 2012 book *Chronic Condition* with the dramatic assertion that, "Medicare is the third rail of Canadian politics. Touch it and you die" (i). Throughout his book, Simpson argues that policymakers' hesitance to risk alienating the public is what has allowed health care in Canada to remain stagnant for so long, as politicians prefer to promise increased funding rather than offer bold solutions that are sure to be controversial (366). Medicare has, according to this view, become too popular for its own good, preventing the very reforms that are needed to ensure its survival (ibid).

However, it is difficult to determine what exactly is so appealing about Medicare in the eyes of the public. Boychuk cites a study reporting that, by 1985, Medicare had become so entrenched in Canadian political culture that 95% of Canadians agreed that medical care, "should be guaranteed by the government" (2008, 141). That is hardly akin to agreeing that every

element of Canadian Medicare should remain the same, however. Marchildon, in his 2012 Health Systems in Transition report, writes, “Canadians have a relatively poor view of at least some dimensions of their system” (148); while they may view the guiding principles of Medicare as central to Canadian identity, they are critical of many aspects of the system’s performance. In 2010, two years after the Ipsos-Reid poll demonstrating Medicare’s iconic status, the Health Council of Canada (HCC) reported that only 38% of Canadians believe that, “On the whole, the system works pretty well and only minor changes are necessary to make it work better” – and that was actually a slight improvement from previous years (9). 52% of respondents supported “fundamental changes” to Medicare, while another 10% supported a complete rebuilding of the system (ibid). Contrary to Simpson’s allegations of widespread delusion about the quality of Medicare (Simpson 2012, 171), then, Canadians seem to be acutely aware of the challenges facing their health care. Just as it is not accurate to blame all of Canada’s health care troubles on federalism, it is also not appropriate to claim that public opinion alone has kept Medicare stagnant. Other factors must be taken into account when discussing the lack of meaningful reform in this area. The political power of doctors is one factor worth examining as an obstacle to reform, as doctors’ material interests are served by preserving the status quo (see Lewis 2008b) – exactly why this is the case will be discussed in detail in Chapter 2. Asking whether or not physician power is changing then has massive implications for broader discussions of Canadian health care.

Finally, the third reason why the research question asked in this project is important is the fact that physician power is badly undertheorized in discussions of Canadian health care. There used to be some discussion of the power of American doctors, some of which could be adapted to

the Canadian context; however, in the last twenty years, doctors in the United States have been overshadowed by large insurance companies (Tuohy 1999, 240; Wilsford 1991, 262), a trend which appears to have quieted discussions of the medical profession's power. In Canada, there is little discussion beyond the complaints of policy commentators about the status quo (see Lewis 2008b). General academic discussions of pressure politics can be applied to organized medicine, but there is little that specifically analyses the power of the Canadian Medical Association (CMA) and its provincial divisions, which are the official representative bodies for Canadian physicians (although they also play a direct role in governance which will be discussed later). There is international sociological literature that analyses the knowledge base of physician power – but, as previously mentioned, this is not specific to the Canadian context. While Carolyn Tuohy provides an impressively comprehensive approach to understanding Canadian physicians, she is asking a broader comparative question about health care in general – as such, her approach cannot be adopted without modification when asking whether changes are occurring in Canadian physicians' power.

Chapter Outline

For these reasons – the unique power of Canadian doctors, the stagnation of health care in Canada (which is not suitably explained by federalism and culture) and the undertheorization of Canadian physicians' power – it is worthwhile to ask whether Canadian doctors' power is changing. In the pages that follow, this will be examined in detail, drawing from a wide variety of sources. The following chapter begins this discussion by exploring what is known about doctors' power, both in terms of how it affects Canadian health care policymaking and how it can

be explained. It concludes that, while there are numerous factors unique to Canada that render Canadian doctors especially powerful, knowledge is clearly the ultimate base of physician power. Carolyn Tuohy's historical institutionalist approach, which assumes knowledge as the base of the medical profession's power (Tuohy 2003, 196), is singled out as most promising, but does not adequately explore physicians' relationship with every relevant set of actor, instead focusing almost exclusively on physicians' direct relationship with the state (see 203). The literature surveyed in this chapter suggests that a broader approach is needed, as doctors' political power is also influenced by their relationship with the general public as well as other lower-paid health professionals. As such, I argue that the theoretical framework utilized by Tuohy – historical institutionalism – must be supplemented sociological institutionalism and an appropriate emphasis on the dynamics of health care provision itself. As well, I argue that rational-choice institutionalism is a useful supplement to Tuohy's approach in order to suggest motivations in discussions of how organized medicine is reacting to changes in its power.

Chapter 3 then argues that physician control over knowledge is being eroded on three fronts, affecting doctors' relationship with all three different sets of actors. First, bodies such as the Canadian Institute for Health Information (CIHI) and the Canadian Institutes for Health Research (CIHR) allow governments to make informed policy decisions without consulting with physicians (Tuohy 2003, 206). Second, the internet has caused a diffusion of medical knowledge to the public, undermining physician authority and the high stature they enjoy as a profession (Nonato 2012; Kivits 2010, 279). Finally, scope of practice changes, prompted in large part by an increasing economic imperative to contain costs, continue to increase the decision-making power of lower-paid health professionals at doctors' expense (Chadi 2011, 44), suggesting a decline in

physicians' overall importance to health care provision. These developments demonstrate quite clearly that the base of physician power is indeed being weakened in Canada.

Chapter 4 explores how doctors are adapting to these changes, noting that not every contributing factor to the undermining of the base of physician power has prompted a direct repose from organized medicine. While occasionally the physician lobby has directly opposed threats to doctors' control over knowledge (CBC 2007), its general response has been to employ a strategy of co-optation, in which the profession endorses certain changes given conditions that would preserve as much physician control over knowledge as possible, mitigating the effects of those reforms on doctors' political power (see Bonang 2012; CMA 2010c). While this strategy could be seen as more promising than simple staunch opposition to reforms that are nearly certain to be implemented regardless, it nonetheless signals an acceptance that doctors' control over knowledge is bound to weaken at least somewhat.

Chapter 5 concludes the discussion first by exploring the counterargument to my findings, noting that doctors are still extremely well-paid (OECD 2011, 67) and that certain elements of the system favourable to physicians' interests have persisted (Tuohy 2012, 626-7). The objective of this section is to suggest that the fact that there have not yet been concrete changes does not negate the central argument of this project, which suggests only that the conditions underlying doctors' power are changing in such a way that weakens the original source of that power. It is then suggested that such concrete changes might soon be made following the Harper government's recent withdrawal from the health care negotiating table and the subsequent formation of the Health Care Innovation Working Group (HCIWG) (Kondro

2012b, E178), which represents a fundamental realignment in how pan-Canadian health policy is made – this has the potential to be a ‘critical juncture’ in the doctor-state relationship.

If meaningful health care reform is to be at all possible in Canada, the dynamics underlying the enormous power of organized medicine must first be understood. While commentators such as Lewis, Evans and others have reported on organized medicine’s extraordinary influence in the past (Lewis 2008b; Evans 1998; Vogel 2010), this project actually examines whether the factors underlying that dynamic are changing. This has major implications for the prospects for major change in Canadian health policy. Since the beginning of Medicare, organized medicine has all but dominated discussions of health care policy in Canada; in the pages that follow, an explanation is given for why that may change.

Chapter 2

What is Known About Physician Power?

There is very little written on whether or not the power of Canadian doctors is changing. However, before this question can be properly answered, it is important to establish where the enormous political influence of Canadian physicians comes from in the first place. There are numerous approaches to explaining the medical profession's influence in Canada – some based on sociology, others building off of interest group theory, and still others adopting institutionalist frameworks. In the following chapter, these approaches and others will be analyzed, the best features of each being adopted into a comprehensive approach for understanding physician influence. This will set the stage for an effective examination of whether or not Canadian doctors are seeing changes in their political power.

Complaints

A review of the relevant literature produces a clear consensus that Canadian Medicare is highly favourable towards doctors in numerous ways. This is not necessarily a problem; however, it is frequently suggested that the benefits doctors enjoy often come at the expense of taxpayers and patients. There is a wealth of literature complaining of physicians' ability to maintain the status quo in Canadian Medicare. Most of this literature does not actually explore where this power comes from – however, the ways in which doctors benefit from the status quo shed light on the nature of their power and thus its sources. In the section that follows, the complaints of Lewis,

Dupuis, Reid, Evans and others will be explored, backed up with empirical evidence when possible.

Most of the ways in which the aforementioned commentators argue that the current system favours physicians are related to the concept of ‘professional autonomy,’ which is at the core of the doctor-state accommodation in Canada. It is often said that physicians are partners with the state, rather than state employees; that is the relationship secured at the inception of Canadian Medicare (Tuohy 1999, 56), and that is the relationship organized medicine is determined to defend (see Reid et al 2003, 3). Professional autonomy in the Canadian context then means that physicians can freely and independently make their own clinical decisions and that organized medicine maintains direct control of many elements decision-making that are relevant to the medical profession (ibid, Greer 2008, 1). Reid et al note that the protection of professional autonomy, along with financial issues, has historically been a major driving force behind doctor-state clashes, as doctors see this autonomy as important enough to protect via job action if necessary when they feel it is threatened by proposed reforms (2003, 3). For the medical profession, this concept needs no justification; Dupuis writes that it is simply to be accepted as an inherently good thing that doctors have a significant amount of independence and control in Canadian health care (2000, 493). This is because, according to defenders of the concept, only doctors know enough about certain areas of health care to regulate them effectively (Collier 2012, 1559).

In theory, this argument might be quite convincing. However, a review of the literature on this topic uncovers many ways in which physician autonomy, while certainly beneficial to doctors, is perhaps not always in the best interest of Canadian health care. Steven Lewis, fierce

critic of both organized medicine and the general state of Canadian health care, writes that the amount of faith placed in physicians essentially gives them “autonomy without accountability” (Lewis 2008b, §13). He complains in particular of the lack of ability the state has to oblige doctors to adopt more efficient and effective practices, noting that Quality Improvement tools and techniques are not mandatory (§6), nor is the adoption of more efficient technologies that could save the system money; Lewis argues that this means the adoption of new technologies and techniques is incremental, putting an unnecessary financial strain on the system (2007b, 103). This not only hurts taxpayers, but patients as well. Lewis blames this autonomy for a situation in which, “medical practice harms 10% of patients in hospitals; there is routine prescribing of dangerous dosages and drug combinations to the elderly; there is widespread failure to diagnose and effectively manage the most common and straightforward chronic diseases [and] primary healthcare patients get all of the evidence-based care they need only about half the time” (2008b, §6).

However troubling Lewis’ assertion may be, perhaps the most prevalent critique of physician autonomy revolves around the stubborn persistence of the fee-for-service method of payment, which, as of 2012, accounted for 74% of physician payments across Canada (Marchildon 2012, 21). Fee-for-service is a method of remuneration by which physicians are paid a set fee for each service they provide. Despite having been widely discredited amongst academics and other commentators, fee-for-service remains popular amongst physicians and the organizations which represent them politically because it grants doctors control over how much money they make, incentivizing them to work as hard as possible (78; Vogel 2010; Picard 2012; Lewis 2004, 18; Tuohy 2012, 627). As well, alternative systems that still maintain some form of

professional autonomy come with their own problems (Blomqvist & Busby 2012, 6; Lewis 2009, 8), allowing fee-for-service to endure as the default option. Criticisms of fee-for-service typically centre on how it allegedly incentivizes physicians to provide as much care as possible regardless of cost (Marchildon 2012, 78); Picard writes that this is detrimental to patients, as incentives are not at all tied to outcomes, and that it harms the system financially because as there is no method of cost control; doctors could easily be spending state money on unnecessary procedures (2012). Evans and McGrail write that, according to doctors, there is no unnecessary health expenditure – if patients are demanding it and doctors are willing to provide it, then it is inherently necessary (2008, 27). However, this argument simply does not hold water in the Canadian context. Lewis explains that, given the incentives of fee-for-service, supply in health provision actually creates demand. This is because, as health services become more widely available, patients tend to seek them out in more and more situations – and doctors have little reason not to provide them (Lewis 2005, §9).

The idea that doctors paid via fee-for-service have an incentive to overprovide services is backed up empirically by numerous studies. Basky reports that a Newfoundland study found that doctors paid on a fee-for-service basis prescribe more antibiotics than those who are salaried (Basky 1999). The findings were said to be generalizable beyond the province (*ibid*). Similarly, it was reported in 2013 that Ontario doctors were found to be performing unnecessary diagnostic cardiac tests, with critics suggesting this is due to the “conflict of interest” posed by the fee-for-service system (Boyle 2013, §6). Finally, Chan et al find that “fee code creep,” a tendency of primary physicians to gradually perform more intermediate and fewer minor assessments, has contributed in large part to the growth of health spending in Ontario (1998, 749). Together, these

studies provide sufficient empirical evidence to support the idea that fee-for-service incentivizes doctors to provide as much and as expensive treatment as possible, even when such treatment may not be medically necessary.

This would be worrisome enough if fee-for-service only affected the amount of health spending dedicated to direct physician remuneration – about 20% of Canadian health expenditure (Blomqvist and Busby 2012, 1) – but physician decision-making affects health care budgets more deeply than is perhaps immediately obvious. In a report for the C.D. Howe Institute, Blomqvist and Busby write that decisions made by physicians actually account for the vast majority of health expenditure, citing facility use, prescriptions and referrals as examples of when physician decisions drive costs beyond what doctors are directly paid (*ibid*). Lewis deems these additional costs the “footprint” of a doctor’s patients (2011), arguing that they deserve to be considered as direct effects of how doctors are remunerated. Fee-for-service is then an even bigger cost-driver than is immediately apparent; while it benefits doctors by allowing them to make as much money as possible, it is highly detrimental to the long-term sustainability of Canadian Medicare.

Picard argues that at in the early days of Medicare, when doctors provided mostly, “episodic acute care” (2012), fee-for-service may have worked quite well; however, now that chronic care is responsible for the majority of health care spending, the incentives it provides are harmful (*ibid*). The Commission on the Future of Health Care in Canada’s 2002 report, commonly known as the Romanow Report, emphasizes the idea that fee-for-service shifts physician incentives away from primary care and towards the provision of more expensive procedures (CFHCC 2002, 124). This points to an additional problem with the dynamics of

physician remuneration in Canada, highlighted by Lewis, which is the power of physician groups to divvy up global budgets for fee schedules (2008b, §5). This dynamic dates back to the early days of Medicare, in which it was established that overall changes to fee schedules would be negotiated while organized medicine would determine what specific procedures were worth; this compromise was seen as necessary to protect as much professional autonomy as possible within the new system (Tuohy 1999, 205). Lewis writes that medical associations have used this advantageous position to create a situation in which, “the doctors who use their hands out-earn those who use their brains” (2008b, §5). In other words, while medical associations’ ability to shape physician fees has empowered doctors enormously within the fee-for-service system, it has produced incentives for doctors to abandon primary care in favour of more lucrative specialties (ibid). This is despite the fact that an emphasis on primary care is increasingly being recognized as key to improving Medicare’s performance (Lewis & Edwards 2005, 89); the empowerment of physician groups within fee-for-service reduces the state’s ability to adequately prioritize this aspect of health care provision.

Fee-for-service therefore comes with two major advantages for physicians: doctors are more or less able to determine for themselves how much money they will make, and medical associations have control over the details of fee schedules. The second of these relates to the ‘self-government’ aspect of professional autonomy, which is the ability of physician organizations to act as governing bodies in addition to their political role as physician representatives (Greer 2008, 1). This gives the profession the power to not only set specific prices, but also establish drug formularies and clinical guidelines (Fierlbeck 2011, 145) – once again, the justification for this is that only doctors have sufficient medical knowledge to regulate

these areas effectively (Collier 2012, 1559). Notably, colleges of physicians and surgeons² have the power to set licensing standards for Canadian doctors (Pross 1992, 137). This has led to occasional complaints of discrimination, as residency positions are only open to foreign physicians after those trained in Canada have been placed (Fierlbeck 2011 134-5). While the reluctance of physician organizations to support a high influx of foreign doctors dates back decades (Evans 1976, 147), the issue has become increasingly important given organized medicine's somewhat contradictory complaint of a physician shortage (Evans & McGrail 2008, 20). This raises questions as to why, exactly, provincial colleges have adopted this posture. Although colleges are separate entities from physician professional associations, it might be noted here that the Canadian Medical Association and its provincial divisions represent medical students as well as practicing physicians and residents (CMA n.d., 'Students'); allowing foreign doctors easy entry into the Canadian healthcare system is obviously not in the best interest of Canadian medical students. More importantly, suppressing the population of foreign doctors keeps policymakers focused on attracting physicians from other provinces, which can involve creating a more financially inviting environment for physicians (McDonald & Worswick 2012). The empowerment of physician colleges in licensing is then an enormous way in which physicians and physicians-in-training benefit from the status quo in Canadian health policy.

Complaints about the status quo of the physician-state relationship comprise the bulk of the literature on doctors' power; however, as previously mentioned, they do not typically actually explore the *causes* of physician power, which is necessary for determining whether that power is changing. Perhaps it is not fair to expect them to do so, as many of those cited in this section –

² These are not the same as medical associations; their licensing power means that membership in colleges is not voluntary, and their role is exclusively one of governance rather than political representation (CPSO 2013)

Lewis, Blomqvist and Busby, Picard, etc. – only aim to *comment* on hard policy issues rather than *explain* why that dynamic exists. However, this section has nevertheless revealed that much of physician power revolves around professional autonomy, which includes the empowerment of doctors' groups in decision-making. It is then necessary to ask why they have this kind of power in the first place. In the section that follows, the first of many possible approaches to exploring the causes physician power will be examined, assessing its methodological potential for the purposes of this study.

International Literature

There is relatively little written about the sources of physician power that is specific to the Canadian context. For this reason, it may seem useful to look at international literature on this question. The most obvious starting point would be literature from the United States and the United Kingdom; not only is there no language barrier to overcome, but Canadian Medicare is essentially a compromise between the state-run National Health Service of the UK and the free-market approach of the US (Tuohy 1999, 203-5). There is a reasonable amount of literature here, including Eckstein's *Pressure Group Politics: the Case of the British Medical Association* (1960) and Wilsford's *Doctors and the State* (1991), an analysis of the power of the medical profession in the United States compared to that of France. However, it is important not to expect too much of relevance when reviewing this sort of literature. In the United States, doctors have seen their role in policymaking overshadowed by major insurance companies in recent decades due to the rise of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) (Tuohy 1999, 240; Wilsford 1991, 262). In the United Kingdom, doctors have been state

employees since the establishment of the National Health Service, and had a negligible amount of influence leading up to the Thatcher government's internal market reforms (see Tuohy 1999, 67). As previously mentioned, doctors in Canada are uniquely powerful; this is especially apparent upon comparison with the US and UK (203). As such, not all American and British literature on this topic can be relevant in the context of the Canadian situation.

Methodologically speaking, it is then crucial to have realistic goals for what international literature can accomplish in the context of this study. There are three situations in which international literature can be useful for understanding physician power. First, as has just been demonstrated, comparisons with other countries establish Canada as unique, confirming that Canadian doctors are indeed exceedingly influential. Second, international sources can be useful for establishing general rules about what makes an interest group effective – for example, Wilsford focuses significant attention on the consequences of uniting doctors under a single cohesive professional group (1991, 84). This allows for conclusions to be drawn about what makes the Canadian case unique. Finally, international literature can be used to describe attributes that are common to doctors everywhere, keeping in mind that such attributes cannot be used to explain differences between jurisdictions.

The sections that follow will indeed incorporate a certain amount of international literature when appropriate. The following section, which deals with interest groups, will draw from general discussions of pressure politics and apply them to Canadian organized medicine. The section on sociology of the professions then deals exclusively with non-Canadian literature discussing attributes inherent to doctors themselves. In this way, international literature is surveyed in a way that is appropriate to the context of this study.

The Medical Profession as an Interest Group

To address how doctors have successfully maintained their political power, one potentially useful approach is to explore what is unique about the organization of the profession as an interest group. This section draws largely from Pross' *Group Politics and Public Policy* (a discussion of pressure politics in Canada) (1992), also including elements from Montpetit (2009), Wilsford (1991) and others. For the purposes of this discussion, 'organized medicine' will specifically refer to the Canadian Medical Association and its provincial divisions, which collectively represent over 76 000 practicing physicians, residents and medical students (CMA n.d. 'History'). As previously discussed, organized medicine seeks to maintain not only influence but also direct control over certain aspects of health policy; this, using Pross' definition of a pressure group (1992, 13), means that it occupies a grey area between pressure group and government agency, and can be difficult to study as a traditional interest group. However, it is still possible to examine why their pressure tactics have been so successful throughout Medicare's history. This necessitates a review of general discussions of Canadian pressure politics that suggest ways in which organized medicine is unique.

Montpetit differentiates between two types of policy networks: pluralist and corporatist (2009, 277-8). Traditionally, Canadian policymaking has been defined by a prevalence of the pluralist dynamic, in which a large number of interest groups compete for influence at a given time; Montpetit writes that groups in purely pluralist policy networks typically find that influence is difficult to obtain due to the sheer number of groups competing (277). However, the explicit empowerment of physicians in high-level decision-making (1999, 56, 205) suggests that the dynamics of health care policy actually contain some elements of corporatism, in which

policy discussions purposefully incorporate certain interests in order to take advantage of their expertise (278; Pross 1992, 222-3). Some argue that this kind of relationship creates a larger sense of responsibility for the system as a whole, encouraging doctors to make more responsible decisions (Wendt et al 2013, 93). Nevertheless, interest groups involved in this kind of network naturally benefit from a large amount of influence (Montpetit 2009, 278). It could even be argued that, in some situations such as negotiations of fee schedules (Tuohy 1999, 205), the policy network dynamic actually approaches clientelism, in which discussions are limited to the state and a single interest group. Montpetit writes that this kind of relationship actually renders the government subservient to the group with which it is negotiating (2009, 278-9).

This position, established at the inception of Canadian Medicare (Tuohy 1999, 56), is then where a great deal of the influence of the CMA and its provincial divisions stems from. This is connected to what Pross describes as “institutionalization:” the degree to which an interest group becomes an institution, highly able to address the demands of its members by influencing government policy (1992, 95). Such institutionalization grants a group the credibility it needs to actually be invited to partake in the policymaking process (ibid). It is clear from the privileged position of organized medicine in the policymaking process that the CMA and its divisions are highly institutionalized – a lot of this is simply by virtue of being a professional association, which are typically granted a favourable position vis-a-vis the policymaking process (Wilsford 1991, 88). However, there are many qualities that contribute to the preservation of institutionalization which must be considered. First, there is the obvious strategic component: interest groups must make smart decisions in order to gain and maintain influence (102). In order for such strategic decisions to be effective, however, there must be a high degree of

organizational sophistication (105). Pross highlights an organization's ability to mobilize membership in this discussion (*ibid*); this is a major advantage of organized medicine. Despite having no formal ability to call strikes (professional associations do not have the same power as unions), job action by physicians has been a defining feature of doctor-state relations since before Medicare was even established (Sibbald 1999, 1505; Reid et al 2003, 3; Tuohy 1999, 53). To use a recent example of this kind of behaviour, in their study of Reduced Access Days in British Columbia Reid et al find that the British Columbia Medical Association (BCMA) succeeded in convincing almost 60% of physicians to scale back services from 1998 to 1999 – a significant achievement for a representative body with no official authority to pressure doctors into voluntarily reducing their paycheques to make a political point (2003, 6). Using Pross' approach to interest group power, this ability to mobilize membership has significant implications for organized medicine's ability to influence decisions.

Pross also highlights the “intangible resources” held by organized interests as key to their institutionalization (108-9). With respect to Canadian physicians, the most notable of the resources he lists is cohesion, which is the degree to which those in a group are united (109). Lewis writes that, even though fee schedules typically favour specialists over primary physicians, physician organizations have been remarkably adept at keeping the profession united under the CMA banner (Lewis 2008a, §1-§3). He writes that it is difficult to know exactly why specialties that are consistently “shafted” by physician representatives, “stay with the medical herd” (§3), but speculates that it could have something to do with a love of self-regulation, a sense of being better off represented by the medical association than not represented at all or

even governments' preference to only deal with one representative group rather than many³ (§4-6). Regardless, Pross argues that united groups fare better in pressure politics (1992, 109). Wilsford's comparison of organized medicine in the United States with that of France backs this point up; he concludes that, due to their "organizational particularism," physicians in France have historically been far less powerful than their unified American counterparts (1991, 85).

In addition to these elements, Pross notes that there are certain factors that affect interest group power that are more or less uncontrollable, mostly relating to features of a groups' membership. He writes that membership size and economic power are crucial (94); however, he believes that what is really important with respect to membership size is 'domain:' the portion of the latent group represented by the organization (ibid). The CMA and its provincial counterparts are by far the dominant physician representative, despite membership being voluntary (CMA n.d. 'History'); in Alberta, for example, the Alberta Medical Association reports that it represents 95% of practicing physicians (AMA n.d. 'About'). As previously established, physicians are also quite wealthy, giving them significant economic power as a group (OECD 2011, 67). Pross also argues as well that the *knowledge* of the membership with respect to substantive policy issues is crucial to its credibility and therefore its power (1992, 102, 104) – this idea will be further examined in a later section of this chapter.

Interest group literature provides valuable insights into some of the qualities that make organized medicine such a formidable force in Canadian health care policymaking, and is a useful way to understand physicians' power. However, it is not a complete approach, as it does not address factors inherent to physicians such as their popularity (Vogel 2010). This will be

³ This last point is contradicted somewhat by Tuohy, who suggests that in Québec, which actually has historically had separate respective professional associations for specialists and general practitioners, the divided nature of the profession has worked to the government's advantage (1999, 208)

addressed the following section, which explores physicians' massive popularity and their subsequent ability to control the dominant discourse surrounding health policy, which has an enormous affect on their power.

Popularity and Discourse

Interest groups are often distrusted, even demonized, for trying to influence government to serve their purposes (Pross 1992, 1-2 Dryzek & Dunleavy 2009, 108-9). A review of the relevant literature reveals that doctors, however, have the major advantage of enormous public popularity, consistently ranking among the most trusted professions in Canada (see Nonato 2012) while confidence in the state has sunk dramatically over the years (Vogel 2010). This section explores physicians' popularity as a means of understanding their power, focusing on how that popularity affects their ability to control discourse; this adopts some aspects of Pross' framework, expanding on them to demonstrate that, for organized medicine, popularity is perhaps even more important than is normally suggested in general discussions of pressure politics. This demonstrates that an appropriate emphasis on physician control over discourse is essential for a complete understanding of Canadian doctors' power, and therefore must be taken to account when examining whether or not that power is changing.

Vogel cites Lazar as reporting that polling has shown the gap in public confidence between doctors and government to be as high as 30 to 40 percentage points (ibid). This high level of trust in doctors gives physician organizations significant ability to influence public opinion and use it to their advantage (ibid). Pross writes that, when appealing to the public, organized interests typically either aim to, "use an aroused public to dictate a specific decision,

or, through public education...create an environment of ideas and attitudes that will encourage policy-makers to take certain kinds of action rather than others” (1992, 166). Doctors in Canada use their popularity to achieve both of these goals. First, and most simply, they influence and appeal to public opinion during disputes with the state over specific issues, employing tactics such as passing out flyers and launching advertising campaigns (Sibbald 1998, 1506-7). Vogel writes that these initiatives have typically had a high rate of success (2010). Most recently, in the midst of the Alberta Medical Association’s (AMA) high-profile 2011-13 dispute with the Redford government over physician budget cuts, a poll found 55% of the public backing the AMA, while only 8% sided with the government – this despite Alberta doctors earning nearly 30% above the national average at the time (Walton 2012, §3, §10). The vast majority of Albertans supported doctors being involved in high-level health care decision-making; the government’s attempt to force a new budget deal on physicians then did not go over well (§4, §13).

One feature of the Alberta case which is emblematic of the broader tactics of organized medicine in disputes with government is the AMA’s focus on patient welfare, with the organization claiming that their main concern was that budget cuts could adversely affect their patients (CBC 2013b, §8, CBC 2013d, §8). This rhetoric is typical of organized medicine and is essential to the maintenance of the medical profession’s political power; Collier writes that the idea of physician altruism is actually central to the profession’s justification for self-regulation (2012, 1559). The AMA’s website professes that the organization aims to, “support and defend the responsibility of physicians to advocate for their patients” (AMA n.d. ‘Patients First’), while the CMA claims to advocate for, “the highest standards of health and health care” (CMA n.d.

‘History’). There is no way to prove that this assertion of altruism is untrue – regardless, however, it is a clever way of ensuring the public is on physicians’ side when they confront the government.

Pross’ second ‘goal’ – the creation of a favourable policymaking environment (1992, 166) – is more complex. However, it is clear that doctors have had enormous success in influencing the broader discourse surrounding health care decision-making to create an environment favourable to their interests. The most obvious example of this is the widespread acceptance of the idea that Canada needs more doctors (Evans et al 2010, 23; Lewis 2008b, §8). Despite physician colleges’ aforementioned reluctance to allow foreign-trained doctors to practice in Canada (Fierlbeck 2011 134-5), doctors’ groups have spent the last two decades complaining of a physician shortage. (Evans & McGrail 2008, 20). Doctors pin this supposed shortage on a 1991 report written by Barer and Stoddart which recommended reducing medical school enrolments by 10% (ibid) – as provinces have the ability to limit the number of medical school admissions as well as international medical graduates allowed to practice, this is the state’s main way of influencing physician supply (Leonard & Sweetman 2012, 4). The report recommended much more than simple cuts, however, making 53 total recommendations and warning that “cherry-picking” the easiest to implement could have negative consequences (Fierlbeck 2011, 134-5). The provinces ignored this warning, choosing only the cheap and easy recommendations to implement (20-1). This has resulted, according to critics of the report, in a severe physician shortage in Canada (18); the CMA claimed in 2008 that Canada would require 26 000 more doctors to meet the OECD average of physicians per capita (Watson & McGrail 2009, 101). In response to this issue, the CMA launched its “More Doctors, More Care” campaign, intended to

pressure the federal government into taking action towards increasing Canada's physician supply (ibid).

However, many commentators, including Steven Lewis, Kimberlyn McGrail, Robert Evans and others, claim that it is hard to know exactly how many doctors is 'enough' – and statistics actually show that simply hiring more doctors drastically increases costs while doing little to improve quality of care (Evans & McGrail 2008, 20; Evans et al 2010, 23; Watson & McGrail 2009, 101; Fierlbeck 2011, 132; Lewis 2008b, §8). Evans and McGrail note that, despite the Barer-Stoddart report and cries of a worsening physician shortage, medical school enrolment has not fallen and the ratio of doctors to patients has been stable (2008, 21-2). It has been suggested that the perceived physician shortage is actually due to an increased amount of women (who tend to work fewer hours than their male counterparts) entering the profession, as well as new societal emphasis on balancing work and personal life – although these trends then raise the question of why average physician pay has not fallen (Fierlbeck 2011, 134; Evans & McGrail 2008, 23). Regardless, even if access to physicians is indeed a problem, it is questionable if more doctors is the answer. Evans et al argue that increasing physician supply simply lowers productivity while disproportionately raising costs (2010, 23). Similarly, Lewis argues that any serious access problems would be more cheaply solved by more collaboration between health professionals rather than simply by hiring more doctors, and lambasts a recent CMA report for advocating for “more of everything” without taking cost into account at all (Lewis & Edwards 2005; Lewis 2010). It is then far from certain, despite the rhetoric of organized medicine, that a push for more physicians is in the best interests of Canadian health care.

Despite these critiques, a need to hire more doctors has historically been the accepted wisdom in the Canadian health care debate (Evans et al 2010, 23; Lewis 2008, §8). Organized medicine, because it represents future (Canadian-trained) physicians as well as current ones (see CMA n.d. ‘Students’), has an incentive to push this idea, and gains from this discourse remaining dominant. Health economists preferring restraint in physician hiring are demonized within physician circles – Robert Evans in particular has been characterized as the medical profession’s “great Satan” (*Medical Post* in Evans & McGrail 2008, 20). This dogma is not only prevalent in discussions of physician supply, however; organized medicine benefits from all issues of access being solved by simply increasing supply, as this allows doctors to make more money under fee-for-service. If one accepts Lewis’ argument about supply in health care creating demand, this is deeply problematic for Medicare’s long-term sustainability (Lewis 2005, §9). Evans et al write that literature on health care in Canada tends to focus on output, not outcomes (2010, 17) – such a focus is very much to the benefit of doctors, who benefit from providing as much service as possible. In the political sphere, as previously mentioned, the debate over health care in Canada has typically been about increases in funding rather than fundamental reform (see CIHI 2012, 34; FMM 2004); such a focus on capacity rather than structural change is then ultimately beneficial to physicians, who can continue to benefit from the incentives provided under the current Canadian system.

Doctors then not only benefit from the status quo in Canadian health care, but from the way in which health policy has historically been debated. If one accepts Pross’ argument about the benefits of popularity (1992, 166), this is thanks largely to physicians’ ability to appeal to the public. Keeping the health care discussion focused on capacity is an essential way in which

physicians benefit from the immense amount of trust placed in them by the public (Vogel 2010). Popularity is then crucial to understanding Canadian doctors' power. However, it is not unique to Canada – in a 2009 poll, physicians ranked fourth among the top most trusted professions worldwide (GfK 2009). Nevertheless, as this chapter aims to examine all possible explanations for Canadian physicians' power, it is still important to take into account those that are not necessarily specific to the Canadian context. That being said, it is also unclear from surveying the literature on this topic exactly where this popularity comes from. That is the topic of the following section, which examines sociology of the professions, a theoretical explanation for physicians' high stature in society.

Sociology of the Professions

Sociology of the professions is a sociological line of thinking that aims to explain what sets various professions apart from other occupations (Dingwall 1983, 1); as such, it has enormous explanatory potential with respect to physician power. In his chapter for Dingwall and Lewis' *The Sociology of the Professions* on the history of this theory, Freidson explains that the medical profession, the legal profession and the clergy have traditionally been seen as the three main “status professions” (1983, 24). While the concept of professionalism has evolved considerably over the centuries, the medical profession still holds a unique amount of prestige (Horobin 1983, 90). Dingwall, outlining the thought of Hughes, writes that the concepts of “license” and “mandate” have traditionally been seen as contributing heavily to the prestige enjoyed by a particular profession – “license” being the ability to carry out certain tasks that nobody else can and “mandate” being the right to define as a group how their work is to be carried out (1983, 5).

Sociology of the professions has two main implications for physician power, related to license and mandate respectively. The first of these has to do with license's relationship with trust. With respect to Hughes' thoughts on license, it is true that all occupations enjoy some monopoly over certain activities; however, the professions take this to the absolute extreme (ibid). Dingwall writes, "[the professions] exemplify in an extreme form the role of trust in modern societies with an advanced division of labour" (ibid); this suggests that people trust doctors to do their jobs properly because the role of physicians in society actually *requires* such trust, as doctors perform tasks of life-or-death significance that nobody else can. This necessary trust that the public places in doctors then gives the medical profession its prestige, contributing significantly to doctors' popularity (ibid; Horobin 1983, 90; see also Vogel 2010). Rueschemeyer writes that physicians' chief competence is the possession and application of medical knowledge – this is what underlies their license to perform such tasks (1964, 21). This monopoly on the legitimate use of medical knowledge is the source of physicians' importance in society and is then key to their popularity. As previously mentioned, Pross emphasizes the importance of a knowledgeable membership in his discussion of what makes a pressure group powerful, as that knowledge gives the group significant credibility in the eyes of both government and the public (1992, 102, 104). In emphasizing knowledge, sociology of the professions can then help one understand the advantage doctors hold when they engage in pressure politics.

The second implication of sociology of the professions for understanding physician power has to do with the previously-mentioned idea of mandate. Evidently, mandate is inherently related to professional autonomy, as it permits the medical profession to self-regulate (Dingwall 1983, 5). Once again, physicians' mandate is grounded in their control over knowledge. As

previously mentioned, professional autonomy is typically justified with the idea that only doctors hold the expertise to make certain decisions effectively⁴ (Collier 2012, 1559) – this argument supports the idea that knowledge is key to doctors’ power. Horobin writes that such autonomy, having its foundation in physicians’ monopoly on medical knowledge, shields doctors from “lay criticism” and creates a situation in which, “medical work is what medical workers say it is” (1983, 90). Some commentators employ the idea of “market shelters” when discussing sociology of the professions, a concept, first outlined by Freidson, which is highly connected to professional autonomy and specifically self-regulation (Timmermans 2008, 164, 179).

Timmermans writes that market shelters, created when the state grants a profession a mandate to self-regulate due to a particular skill set that the profession holds (165-6) essentially shield professions from market forces, giving professions a unique and important advantage in modern society (164-5, 179). According to Timmermans, these shelters enable professions to, “to hold competitors at bay, thwart off meddling third parties, and control who qualifies based on training and skill” (165). The medical profession clearly enjoys a market shelter in Canada as the state gives it the ability to regulate itself, sheltering its members from external competition.

Sociology of the professions holds that doctors’ knowledge underlies both their exclusive license to perform certain medical tasks, which is central to the high level of trust placed in them by the public, and their mandate to self-regulate and therefore shelter themselves from market forces (Dingwall 1983, 5; Rueschemeyer 1964, 21; Horobin 1983, 90; Timmermans 2008, 165-6). This is the most satisfactory and intriguing explanation discussed thus far for physicians’ extraordinary power, as it is actually inherent to the profession itself. However, physician control

⁴ As previously mentioned, Collier writes that there is a moral dimension here as well, as the perception that doctors have patients’ best interests at heart is also used to justify the direct control the medical profession has over many elements of health care regulation (2012, 1559)

over knowledge is not at all unique to Canada, nor is any of the literature outlined in the section applied to the Canadian context. This is of course problematic for addressing why Canadian doctors are so uniquely powerful. The next section outlines how Carolyn Tuohy combines the assumptions of sociology of the professions with an historical institutionalist account of Canadian health care, which she argues has historically been dominated by the relationship between doctors and the state (1999, 30).

Tuohy and Institutionalism

Tuohy accepts the idea that physician influence rests on expertise. She refers to doctors' "principal-agent" or "agency" relationship with the state (2003, 196-7; 1999, 16; 2012, 624), in which the state delegates to physicians significant responsibility for decisions relating to the regulation and distribution of health services (2003, 197). Tuohy's description of this fundamental physician-state relationship is highly reminiscent of the assumptions of sociology of the professions; she argues that this privileged relationship with the state was initially, "trust based...[and] established to overcome information gaps" (2003, 196). For Tuohy, then, the base of physician power in Canada is indeed knowledge, as information was the initial justification for empowering doctors in Medicare.

However, as previously discussed, this explanation cannot account for why physician power is more of an issue in Canada than elsewhere. Tuohy is well aware of this; she spends the entirety of her 1999 book *Accidental Logics* describing the differences between the historical dynamics of health care policymaking in Canada, the US and the UK, arguing that, "[i]n Canada, more than perhaps any other nation in the late twentieth century, the health care system

functioned according to the logic of an accommodation between the medical profession and the state” (203). The central thesis of the Canadian portion of *Accidental Logics* is that Canadian health care has avoided major change since Medicare’s inception (102) – this argument is deeply tied up with the idea that doctors’ power has persisted, as it is that power that, in Tuohy’s mind, defines health care governance in Canada (30).

In order to understand why Canadian health care has been stagnant (preserving physicians’ power), Tuohy employs the theoretical framework of historical institutionalism (107). Historical institutionalism is a branch of neo-institutionalism, which emerged as a reaction against the behavioural revolution, attempting to re-emphasize the role of institutions in political discourse and assert that the state is itself an actor with interests (Steinmo 2001, 2, 5-6). The most prominent feature of historical institutionalism in particular is the logic of path dependency it employs to explain the ‘stickiness’ of institutions, which are defined as rules; essentially, once a decision is made, it is likely that similar decisions will be made in the future, establishing institutional patterns that resist changes in circumstance (1-2, 7-8). This means that, the vast majority of the time, institutional change is incremental (Brown 2010, 645-6). However, on occasion, there will arrive a ‘critical juncture,’ a moment at which major change is possible due to a number of factors coming together perfectly at the right time (Tuohy employs the term ‘window of opportunity’ to mean essentially the same thing) (Steinmo 2001, 8; Tuohy 1999, 107). This allows commentators to paint a clear picture of when and why institutional change does or does not occur.

Historical institutionalism has become so prevalent in discussions of health care that so-called theoretical discussions of health policy now mostly just serve to discuss the pros and cons

of this branch of neo-institutionalism (Starke 2010, 487; Cacace & Frisina 2010, 450-3). The complicated nature of health care explains why historical institutionalism has remained so dominant, as the theory's flexibility stands out as particularly beneficial. Historical institutionalism is extremely vague, emphasizing the importance of institutions, both formal and informal, as well as everything that contributes to critical junctures, which can look quite different from one another (Tuohy 1999, 107-8). These extremely general rules allow for all important factors to be neatly sorted into those contributing to and those hindering critical junctures; instead of focusing on one particular variable, historical institutionalism allows for everything important to be discussed when describing change or stability in the complicated field of health policy.

This conception of the importance of timing is critical to historical institutionalists' understanding of major change in all arenas, and *Accidental Logics* – perhaps the most famous utilization of historical institutionalism in discussions of Canadian health policy (Boychuk 2008, 14) – is no exception, with Tuohy arguing that meaningful change in health policy in the US, the UK and Canada was made possible by the opening of windows of opportunity (Tuohy 1999, 107). She cites the circumstances leading up to the birth of Medicare in Canada as constituting one such window of opportunity, circumstances which would define the system that emerged (102). Before Medicare was introduced federally, there was significant experimentation with various systems of medical insurance at the provincial level (Tuohy 1999, 53). In 1962, Saskatchewan became the first province to introduce legislation to establish its own system of universal medical insurance (ibid). Even though the provincial government explicitly ruled out any changes to the structure of health care delivery or the fee-for-service method of remuneration

(ibid), organized medicine staunchly opposed the plan, preferring instead a system of subsidized insurance for low-income individuals that would keep the government at more of a distance from health service provision as well as doctors' paycheques (52, 54). Despite this strong opposition, the legislation passed, resulting in a nasty and high-profile 23-day doctors' strike that demonstrated the determination of the physician lobby (53). This strike resulted in the key concession that doctors could bill patients above what the state insurance scheme would cover, a practice known as "extra billing" (ibid).

Despite the initial controversy surrounding the Saskatchewan plan, in 1966 the Canadian government successfully instituted a nationwide system by which provinces could opt to provide universal medical insurance, receiving federal funds so long as their systems met certain criteria – as health care is constitutionally provincial jurisdiction, this was the heaviest role the federal government could legally take in health care matters (54). The federal law mirrored the Saskatchewan experience in maintaining the status quo for health service delivery and physician remuneration. Rather than take the radical approach of the United Kingdom, which essentially made doctors state employees, Canada allowed its physicians to retain nearly all of their original autonomy, merely substituting private insurance for a public version (53-4, 203). This empowered physicians while simultaneously drastically restricting the role and power of private insurance companies, as private insurance was not permitted to cover the same services as the public scheme (55). As in Saskatchewan, extra billing was tolerated in every province with the notable exception of Québec, which immediately took an unusually statist approach to Medicare (207). The success of the Saskatchewan initiative softened physician opposition to nationwide state-provided medical insurance; as physician incomes did not fall in Saskatchewan in relation

to the rest of the country, organized medicine was more open to a similar compromise with the federal government (54).

Tuohy argues that, as Medicare began with organized medicine as its primary antagonist, it has since, “rested...on a fundamental accommodation between the state and the medical profession” (30). The compromise that was reached, “froze in place the health care system that existed in the 1960s, in which...the distribution of health care was determined by the decisions of independent medical practitioners subject to the norms of the professional group” (31). This allowed physicians to keep much of their professional autonomy with respect to clinical decision-making and self-regulation – however, physician organizations were also given a privileged seat at the negotiating table in higher-level policy discussions. As such, Tuohy writes that Medicare, “placed physicians at the heart of the decision-making system at all levels” (1999, 56). Overall fee schedule changes were explicitly contingent upon negotiations with organized medicine (205). However, doctors have also traditionally been granted a privileged seat at the negotiating table in discussions of physician supply, privatization of certain services – essentially any change in policy that would affect how the system functions (217-22). As previously discussed, a further way in which physicians have been empowered since the foundation of Medicare has to do with the liberal regulatory framework from which they benefit. Steven Lewis criticizes Canadian health care for granting doctors, “autonomy without accountability” (Lewis 2008b, §13); such independence is a natural consequence of Medicare merely substituting private insurance for public insurance, a dynamic which has persisted since the system’s inception.

In discussing the role of doctors in Canadian Medicare through an historical institutionalist lens as does Tuohy, what is most important for explaining the subsequent power of doctors is the nature of the critical juncture that produced the current situation. In the Canadian case, Medicare grew out of an accommodation with the medical profession and a simultaneous crippling of private insurance (55-6). The political climate of the time and the recent history of physician militancy in Saskatchewan allowed for Medicare to take this particular shape, defining it for decades to come (50-4). However, also important to the political power of doctors is the path dependency (and necessary lack of critical juncture) that characterizes the persistence of that power. It is then important for Tuohy to discuss what has contributed to the path dependency that has preserved physician power in Canada.

Path dependency does allow for some *incremental* change, which certainly has occurred, often to doctors' disadvantage. Tuohy writes, "over time...the terms of the accommodation between the state and the profession were progressively elaborated to constrain increasingly the entrepreneurial discretion of physicians while...seeking to maintain their clinical autonomy" (205). However, doctors have not seen any fundamental restructuring of their relationship with the state. Even the *Canada Health Act*, which banned extra billing across Canada in the most significant symbolic blow to physician autonomy since the birth of Medicare, was only implemented in many provinces after major concessions were made to compensate doctors (94). When discussing what contributes to path dependency in the Canadian physician-state relationship, Tuohy adopts a holistic approach, attempting to take into account everything that has historically preserved the status quo. This means taking into account factors such as doctors' political organization; for example, she argues that one key difference between the

Canadian and British experience is the cohesion of organized medicine in Canada (42).

However, she focuses much of her attention on the role of institutions, keeping in line with her neo-institutionalist framework. As mentioned in the introduction to this project, Tuohy blames federalism, perhaps the defining institutional feature of Canadian health policy, for much of Canada's health care stagnation, writing that it has historically been extremely difficult for the provinces to come to any agreement on pan-Canadian change (106). However, federalism is specifically important to physician power for another reason: physician mobility. At the provincial level, retention of doctors is consistently seen as crucial to ensuring high-quality health care (McDonald & Worswick 2012, 1582). McDonald and Worswick report that each year from 1978 to 2006, 1% of physicians moved to a new province (ibid). This number may not seem particularly impressive, but the phenomenon is highly concentrated in Atlantic Canada and the prairie provinces, with physicians typically leaving these areas to settle in Ontario and British Columbia (ibid).

It is intuitive that higher-income populations such as doctors would be especially mobile, and Finnie confirms this in a 2004 study on which demographics tend to move around within Canada (2004, 1777). His general conclusion is that, regardless of demographic, Canadians tend to move based on economic incentives (ibid); this means that Canadian doctors have a clear incentive to relocate when fee schedules are more generous elsewhere. Moreover, this dynamic forces provinces to essentially compete for physician supply, which is to physicians' advantage regardless of whether or not they might choose to move. The CMA celebrates the high degree of mobility Canadian doctors enjoy (CMA 2002, 1). This mobility grants doctors significant leverage in negotiations with the government; provinces essentially lack the power to lower

physician pay to a point where it is no longer competitive with that of their neighbours. It is in Tuohy's account of the difference between Québec and the rest of Canada that the importance of federalism to physician power is most apparent; she writes that the relative lack of mobility of French-speaking doctors⁵ has historically allowed Québec to pursue its uniquely 'statist' approach to health care with fewer consequences than would be expected elsewhere – Québec was able to ban extra billing almost immediately after the introduction of Medicare, for example, and introduce back-to-work legislation ending the subsequent specialists' strike (1999, 207-8). While there are certainly other factors at work here – the political culture of Québec, the division of Québec general practitioners and specialists, etc. (208) – contrasting the Québec case with that of the rest of Canada allows for an assertion that inter-provincial mobility does indeed contribute to physician power.

Tuohy's account of the lack of change in Canadian Medicare is the most satisfying explanation for physician power explored thus far, combining the sociological basis for physician power everywhere with an historical institutionalist account of the particularities of the Canadian situation. However, it is not perfect – there are certain elements of her approach that must be supplemented. This will be explored in the section that follows, which builds on Tuohy's approach to develop a satisfactory explanation for Canadian physicians' power that can then be used to answer the question of whether or not that power is changing.

⁵ McDonald and Worswick report that French-speaking physicians are 66% less likely to relocate than their Anglophone counterparts (2012, 1582).

Building on Tuohy's Framework

In general, Tuohy's argument is fairly comprehensive. However, there are certain problems with respect to this project which should be addressed. Tuohy's argument rests on historical institutionalism, which is being increasingly criticized. In trying to highlight everything important, some argue that historical institutionalism ends up actually explaining very little. Path dependency boils down to, 'major change is hard, except when it is not; when major change is not hard, it is because certain things at that particular point in time made it easier' – this is hardly a revolutionary claim. The advantage of this kind of ambiguous theory is that it can be made to fit any situation. However, historical institutionalism is so ambiguous that it winds up revealing very little of interest in terms of causality; simply pointing out that something had to happen in order to allow for something else to happen is too vague to be at all enlightening. In his harsh critique of this framework, Brown describes path dependency as, "too shallow to be false" (2010, 643) – while historical institutionalism is too flexible to be wrong, the general claims it makes are too obvious to be useful either in making causal claims or in any kind of prediction (ibid).

Brown continues his critique of historical institutionalism, adding that the distinction between 'incremental change' and 'critical juncture' is ultimately meaningless, as, "whether the transition from A to B can plausibly be dubbed incremental depends on how the observer opts to characterize the two points in question and the distance between them" (646). The decision of what qualifies as meaningful change seems to be left to the commentator, despite the distinction between incrementalism and major change being at the very heart of path dependency and historical institutionalism more broadly. According to critics such as Brown, this lack of clear

definition is a problem that has major implications for historical institutionalism's usefulness (2010, 646).

Tuohy largely overcomes the first of these problems with her suggestion that physician power is originally based on knowledge. Although Tuohy's historical institutionalism does not really explain anything with respect to the origins of physician power, her discussion of the principal-agent relationship demonstrates that she has already accepted the sociological argument that physicians were empowered thanks to their control of medical knowledge (Tuohy 1999, 16; 2003, 196-7). In implicitly accepting this as the original base of physician power, her discussion can then serve to show the various ways in which that power is either enhanced or suppressed from jurisdiction to jurisdiction. Her historical institutionalist lens is highly appropriate for framing this discussion, as there are naturally many different factors that affect the expression of doctors' power. As she has already established a strong theoretical base of physician power, she should not be punished for attempting to be comprehensive her historical discussion; the numerous historical factors she discusses demonstrate that the reality of health care policymaking is simply too complicated to fit neatly into a framework less flexible than historical institutionalism.

Brown's second criticism, however, is more of a problem for Tuohy, as her discussion of windows of opportunity does indeed fail to define a clear difference between incremental and major change (Tuohy 1999, 6-7). Part of this is due to the fact that her book deals with extremely broad questions of health policy as a whole. However, the question being posed in this study is specific enough to allow for (and demand) a clear definition of major change. As physician power is central to the current stagnation of Canadian health care, major change for the purposes

of this study can be defined as change in the physician-state relationship that is significant enough to allow for the systemic problems that plague Medicare to be addressed. This enables historical institutionalism to be used in addressing the research question at hand.

However, there remain certain gaps in Tuohy's approach for the purposes of this project. Tuohy focuses most of her attention on the direct relationship between physicians and the state (see Tuohy 1999, 203). However, writings on sociology of the professions as well as many of the other sources discussed in this chapter suggest that relationships with other sets of actors must also be considered as contributing to physicians' power. First, it is clear that the medical profession's relationship with the general public is central to its power, with multiple commentators asserting the importance of doctors' popularity and control over public discourse (Vogel 2010; Lewis 2008b, §8; see also Pross 1992, 166); accepting the assumptions of sociology of the professions, this relationship depends heavily on physicians' control over knowledge (Dingwall 1985, 5). However, Tuohy pays little attention to control over public discourse and the broader relationship of doctors with the general public; to overcome this gap, it is useful to apply sociological institutionalism, which also developed at the same time but independently of the other neo-institutionalisms (Hall & Taylor 1996, 946). Sociological institutionalists emphasize the role and persistence of informal institutions such as cultural norms in shaping "non-rational" human behaviour (Steinmo 2001, 6-7). While humans are still largely rational and goal-oriented according to this view, what they see as rational is shaped and constrained by norms and beliefs (Hall & Taylor 1996, 948-9). These ideas can be used to explain the less formal areas of physician power, such as their control over the prevailing discourse in health policy.

Secondly, as Tuohy spends the bulk of her argument focusing on the physician-state relationship (Tuohy 1999, 203), she largely fails to take into account the dynamics of health care provision itself. However, the doctors' relationship with other health care professionals is key to a complete understanding of physician power for two reasons. First, sociology of the professions emphasizes the importance of physicians' control over knowledge to their political power; this depends on doctors being allowed to perform tasks *that nobody else can perform* (Dingwall 1983, 5). Therefore, if doctors' dominant position on top of the health care hierarchy were to be compromised, so too would the basis of public trust in the medical professions. Secondly, if lower-paid professions were to be allowed to perform more tasks, their control over knowledge would increase, further increasing their importance and subsequent bargaining power vis-a-vis the state. If lower-paid professionals' bargaining power were to increase at doctors' expense, the once-dominant medical profession would see its historically unique political power seriously compromised. As such, this project pays significant attention to the dynamics of health care provision itself, specifically how physicians relate to lower-paid health providers, in an effort to paint a complete picture of how physician power may be changing.

This project then considers three relationships – physicians and the state, physicians and the general public and physicians and lower-paid health professionals – in an effort to provide a more complete analysis of the medical profession's power than does Tuohy. However, as this project also aims to analyze organized medicine's reactions to any changes in its power, there is one more issue with Tuohy's approach which must be overcome. While she addresses actors' motivations on a case-by-case basis, Tuohy does not provide a theoretical base for explaining how actors behave; while this may not be a problem for her more general comparative analysis

of health policy, when dealing explicitly with issues of power (as this question does) it is useful to employ a framework that gives more weight to actors' pursuit of their interests. The third neo-institutionalism, rational-choice institutionalism, which also developed at the same time but independently of historical institutionalism (Hall & Taylor 1996, 942), is useful to this end. Rational-choice institutionalism holds that actors behave strategically within institutional boundaries in pursuit of self-interest (942-3), balancing the unpredictability of rational-choice theory with the stability provided by institutionalism (Blyth 2003, 696).

Rational-choice institutionalism has in the past largely focused on the effects of Congressional rules and procedures on voting patterns in the United States Legislature (Hall & Taylor 1996, 943-4). However, it can also be used to explain the motivations of actors in a more specific way than does historical institutionalism, which traditionally cites institutions as the source of preferences (Blyth 2003, 700) (although this is not prominent in Tuohy's writing). Applied to the physician lobby, rational-choice institutionalism is a strong explanatory framework; organized medicine certainly does seem to pursue its material self-interest within the bounds of Canadian federalism and Medicare. It can also be used to explain why general practitioners continue to affiliate with provincial professional associations despite those associations' routine favouring of specialists over those, to use Lewis' words, "at the bottom of the medical politics food chain" (2008a, §1-3); while it may seem to be in the GPs' best interest to pursue their interests separately from the professional associations, the institutionalized relationship between the association and the state shifts their incentives towards staying with the rest of the medical pack. For the purposes of this project, rational-choice institutionalism is

employed in Chapter 4 to explain the medical profession's various responses to changes that could threaten its power. To this end, it is a nearly ideal supplement to historical institutionalism.

Implications

In summary, Tuohy's approach is the most complete way of understanding physician power surveyed in this chapter. However, as previously discussed, it cannot be adopted without modification for the purposes of this study, which asks the more specific question of whether or not changes are occurring in Canadian doctors' power. Drawing from the previous critique of Tuohy as well as the other literature surveyed in this chapter, the following approach is taken to understanding physician power, which allows the research question to be examined in the most comprehensive way possible. First, the political power of doctors in Canada is accepted as problematic; doctors benefit enormously from the status quo, to the detriment of both the taxpayer and the patient (Lewis 2008b; Vogel 2010; Picard 2012). Then, it is assumed that the physicians' privileged position originally comes from their control of medical knowledge; this argument is theoretically-grounded (Dingwall 1983) and is shown in Tuohy's historical discussions to be convincing in the Canadian context (Tuohy 2003, 196; Tuohy 1999, 16). This is inherently related to physicians' societal mandate to self-regulate, as well as the license to perform highly-complicated medical tasks (Dingwall 1983, 5). Doctors' relationship with the state is important here, as physicians were originally empowered by the government to, "overcome information gaps" (Tuohy 2003, 196). However, the concept of license is also particularly important to the high level of trust society places in doctors (see Nonato 2012; Vogel 2010), which grants them the control over discourse they need to create a favourable

environment for decision-making (Pross 1992, 166). Finally, doctors' control of medical knowledge is highly related to their dominant position on top of the health care hierarchy, which provides them with the license to carry out tasks that no other health professionals can and grants them much of their bargaining power in negotiations with government.

However, the argument that doctors' power comes from knowledge, drawing from international discussions of sociology of the professions (Dingwall 1983, 5), is not at all specific to Canada and is therefore unable address the idea that Canadian doctors are *uniquely* powerful (Tuohy 1999, 203). To overcome this gap, it is important to recognize the specific ways in which physician power has manifested itself in Canada. First, the nature of the 'critical juncture' at which Medicare was first established in Canada was such that doctors were able to secure a privileged position in the policy network. The recent history of physician militancy in Saskatchewan and the weakening of the private insurance lobby clearly defined organized medicine as Medicare's main antagonist; this meant Medicare was founded on a compromise between the state and the medical profession, a relationship that has largely endured (Tuohy 1999, 50-6). Second, Canadian organized medicine in Canada has many favourable characteristics as an interest group: it is uniquely unified, granting it significantly more power in its negotiations with the state than some of its international counterparts (Tuohy 1999, 42; Wilsford 1991, 85), is highly adept at mobilizing its membership (Pross 1992, 105; Reid et al 2003, 3) and enjoys a high level of institutionalization (Pross 1992, 95; Tuohy 1999, 56, 205). Finally, federalism has been a useful tool for Canadian physicians, as their mobility gives them significant leverage when they clash with provincial governments (Tuohy 1999, 207-8; Finnie 2004, 1777).

Theoretically, this study adopts a largely historical institutionalist framework for understanding physician power; in addition to emphasizing the fact that the state does have interests in this case (namely reducing physician power), this is useful for asking if a ‘critical juncture’ in the physician-state relationship in Canada could be approaching. However, this approach is supplemented with both other neo-institutionalisms. Sociological institutionalism, which allows for informal institutions such as norms and beliefs to be accounted for in full (946), is particularly important for overcoming one of Tuohy’s main weaknesses – her neglecting of the relationship of physicians to the general public – and fully explore the cultural power of Canadian physicians. Rational-choice institutionalism necessitates the prioritization of incentives facing physicians and other health care workers (Hall & Taylor 1996, 942); this is important for explaining why physicians and the organizations that represent them make the decisions that they do in discussions of how the profession is reacting to changes in its power. In drawing from all three neo-institutionalisms, this study presents a novel theoretical approach to understanding physician power that attempts to take account of all of the ways in which that power is expressed.

It then becomes necessary to ask what counts as proof in answering this research question. As this study has accepted control over knowledge as the underlying source of physician power in Canada, any changes in that control, whether it be in relation to the state, other health professionals or the general population, will serve as evidence of changes in the original source of that power. At the same time, it is important to look at the particularities of the Canadian situation, and examine how any changes there may enhance or mitigate fluctuations in physician control over knowledge. It is also important to take into account how Canadian doctors

are responding to any changes that are identified. All of these points will be addressed in the two chapters that follow, which explore whether or not the original source of Canadian physicians' considerable power is shifting.

Chapter 3

Are the Conditions Underlying Physician Power in Canada Changing?

There is at least one reason to suggest that physician power in Canada may actually increase in coming years. In 2007, the premiers agreed to apply the 1995 Agreement on Internal Trade (AIT) to regulated professions (Silversides 2009, E192). According to Industry Canada, the Agreement, “aims to reduce barriers to the movement of persons, goods services and investments within Canada” (Industry Canada 2012, §1). One of the original intents of the AIT was to provide various professionals with the ability to use their certification across Canada; however, for many years it was uncertain whether or not the Agreement applied to medical licenses (Wharry 2001, 1335). This frustrated physician advocates, who maintained that the rules and agreements in place for physician mobility were needlessly complicated (ibid). The 2007 expansion of the AIT then prompted steps towards pan-Canadian rules governing physician mobility (Silversides 2009, E191); Fleming and Mathews write that these new rules would allow doctors to move freely from province to province provided they are, “in good standing with their professional regulatory body” (2012, e8). Today, the AIT has indeed made it relatively easy for physicians to switch jurisdictions; for example, the College of Physicians and Surgeons of Alberta reports that, even if an out-of-province physician does not meet all of the Alberta requirements for licensure, they can obtain a license provided they pass a standardized assessment in their home province (CPSA n.d.).

Because of the afore-mentioned effect of physician mobility on negotiations with the state (Tuohy 1999, 207-8), it can be assumed that increasing that mobility would constitute an

increase in physician power. This kind of change does indeed matter, as the particularities of the Canadian situation are what set Canadian doctors apart from their counterparts abroad. However, such fluctuations in the particularities of the Canadian physician-state dynamic do not affect the very base of doctors' power – their knowledge – and therefore should not be overemphasized, especially in light of recent developments that do serve to undermine doctors' power at its source. Beneath the surface of the Canadian physician-state relationship, a fundamental shift is taking place, as doctors' control over knowledge is increasingly being compromised. As the following sections demonstrate, physicians' relationships with the state, their patients and their coworkers are changing in ways that demonstrate that the medical profession no longer has the same kind of monopoly on medical knowledge it enjoyed decades ago. This examination will begin in the following section with an examination of how the direct physician-state relationship is shifting in such a way that doctors have lost some of the original justification for their power.

Doctors and their Government: Reducing the State's Reliance on Physicians for Information

When searching for any major change in physicians' power, it is natural to start with the area in which that power is expressed most prominently: organized medicine's relationship with government. This is where Tuohy largely focuses her efforts, as it is the most directly related to the formal institutions on which she concentrates. The starting point for this discussion is Tuohy's assertion that physicians were originally empowered in decision-making because only they held the necessary expertise to make certain decisions (Tuohy 2003, 196). This is backed up theoretically by sociology of the profession's concept of 'mandate,' which is the idea that a

profession's control over relevant knowledge gives it a unique ability to regulate itself (Dingwall 1983, 5; Collier 2012). This is what underlies the medical profession's right to divvy up fee schedules, establish drug formularies, set licensing standards, etc. (Tuohy 1999, 205; Fierlbeck 2011, 145; see also Pross 1992, 137). In addition to this direct control, physicians' expertise is what justifies their heavy influence over governmental decision-making in health policy (Tuohy 1999, 217-22). As such, if doctors' control over knowledge vis-a-vis the state were to be eroded, so too would the justification for their direct control over those areas of decision-making as well as their privileged seat at the negotiating table whenever government considers any major changes.

Towards the end of the 20th century, the IT revolution brought massive changes in how governments receive and process information; with the arrival of the internet and vast improvements in data processing technology, measuring the performance of all aspects of health care provision and governance has become unprecedentedly easy (Smith et al 2009, 3-4). Policymakers have stopped asking what is worth measuring and have started asking how best to summarize and report data in a coherent manner (4). With the proliferation of such data comes an expectation from the public that the government would collect and respond to this information appropriately to improve health care at all levels, from governance to front-line provision (ibid). This is part of a move towards "evidence-based policy," which has become something of a buzzword in health care decision-making and politics more broadly (Moore 2006, 678). The proliferation of this kind of data is also argued to enhance accountability by empowering the public to make more informed demands and by spelling out in purely objective terms whether or

not a government has lived up to its promises to improve system performance (Smith et al 2009, 5-6).

This kind of data is extremely useful in international comparisons, which allow Canadians to see how their health care measures up internationally and give policymakers the opportunity to learn from instances of success or failure abroad (OECD 2011, 5). International organizations such as the OECD and the WHO compile ranked lists of how different countries perform according to a variety of health care performance indicators (OECD 2011, WHO 2012). It is not sufficient to simply describe one health care system as better or worse than another – in a given country, for example, emergency care might be extremely effective while preventative care is lacking, a problem that would be specifically reflected in indicators such as prevalence of cervical cancer (which is usually prevented upon regular screening) (OECD 2011, 118). These kind of detailed, objective comparisons are key to evidence-based policymaking, as they highlight the potential for specific aspects of Medicare to improve; for example, Canada's relatively poor performance on waiting times demonstrates that this is an area which could (still) be improved significantly, perhaps by mimicking the practices of higher-performing countries (145). Internally, cross-provincial comparisons have served essentially the same purpose, allowing various governments to learn from one another and allowing residents to see firsthand how their province compares (Fierlbeck 2011, 67).

Since the IT revolution, there has been a clear movement by federal governments to seek out information to help the provinces make informed decisions. Funding research and evaluation is one of the only roles (other than financing the provincial systems) that the federal government can actually play in Canadian health care (50), so it is perhaps unsurprising that governments

generally took to this task so enthusiastically. In fact, the development of common indicators for use in cross-provincial comparisons and general evaluation was a condition imposed on the provinces for funding transfers in the 2004 Accord, which aimed to ‘renew’ health care across Canada by incentivizing improvement in key areas (Fierlbeck 2011, 67; FMM 2004). The Accord was preceded by the creation of trusted bodies for the collecting and reporting of relevant information. In 1994, the Canadian Institute for Health Information (CIHI) was established (Tuohy 2003, 206). CIHI is an independent, non-profit corporation that defines its mandate as, “[t]o lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care” (CIHI n.d., §3). Tuohy writes that CIHI has “established itself as a credible source of data on various dimensions of health system performance” (2003, 206). The organization boasts that, since its creation, it has (among other things) drastically expanded health data in Canada, built and maintained 27 pan-Canadian databases that allow for easy data comparison and analyzed various health care-related issues (§1). Each year CIHI publishes a report detailing its activities and accomplishments, including the comprehensiveness of the data it holds at that time (CIHI 2012, 6, 8). Governments have come to rely heavily on CIHI to inform decision-making. For example, the Institute worked in collaboration with the provinces and territories to develop acceptable indicators to be used in the 2004 Wait Times Initiative, which aimed to incentivize wait time reduction across the country in priority areas; CIHI would then report annually on those indicators (HCC 2013, 2).

While CIHI is independent, the Canadian Institutes of Health Research (CIHR) are actually an arm’s length agency of the federal government created by an act of Parliament in

2000 (CIHR 2011). CIHR is essentially the research investment agency for the Canadian government, defining its mission as, “to create new scientific knowledge and to enable its transaction into improved health, more effective health services and products, and a strengthened Canadian health care system” (CIHR 2013, §2). The agency consists of 13 institutes and boasts supporting over 14 thousand researchers and trainees across the country (§3). Like CIHI, CIHR was deeply involved in the Wait Times Initiatives, working with the provinces and territories to determine medically-acceptable wait time benchmarks (HCC 2013, 2).

In addition, the Canadian Foundation for Healthcare Improvement (CFHI) – originally called the Canadian Health Services Research Foundation (CHSRF) – was created in 1996 to identify and respond to health service information gaps through the funding of research (CFHI n.d. ‘History,’ §1). While it no longer provides grant funding, the Foundation does undertake research related to major health care issues (CHFI n.d. ‘FAQ,’ §5), its main stated goal being to facilitate health care improvement by, “[collaborating] with governments, policy-makers and health system leaders to convert evidence and innovative practices into actionable policies, programs, tools and leadership development” (§4). In other words, it seeks to serve as the link between evidence and policy, making it easier for decision makers to respond directly to evidence. CFHI boasts a unique ability to foster collaboration by working with a variety of partners, all with the goal of improving health care system performance (§6). The Foundation has also recently expanded its efforts beyond purely applied health services research (hence the name change) to include issues such as improving the financial efficiency of health care governance (§1).

It is necessary as well to acknowledge the work of the Health Council of Canada (HCC), which was also extremely important following the 2003 and 2004 First Ministers' Accords. Established in 2004 following the recommendations of the Romanow Report (Galloway 2013, §2; CFHCC 2004, xxiv), the organization, while independent of government, was funded by Health Canada in part to monitor the implementation of the Accords – although the organization has reported on other issues as well throughout its mandate (Galloway 2013, §2-3, HCC n.d.). However, the Harper government has eliminated the HCC's funding in light of the 2004 Accord's imminent expiry, pledging to instead divert more funding to CIHI while emphasizing the fact that health care is provincial jurisdiction (Galloway 2013, §3-4). Critics claim the defunding threatens national Medicare, as the HCC's reporting on the Accords was meant to ensure pan-Canadian standards for care (§1).

Regardless of the HCC's fate, it is clear that Canadian governments have responded to the IT revolution by taking advantage of the newfound ease with which data can be collected and interpreted. While bodies explicitly funded for researching health care are the most visible examples of this trend, Statistics Canada, which enjoys a broader mandate, also directly collects and interprets health care data, its health analysis division actually publishing a peer-reviewed journal of health research called *Health Reports* (Statistics Canada 2013). StatCan describes this journal as “designed for a broad audience that includes health professionals, researchers, policymakers and the general public” (ibid). New articles are published online every month and the journal's online catalogue is freely available to the public, receiving over 500 000 views annually (ibid). The health analysis division of StatCan also publishes discreet working papers

and has its analysts featured in other journals (Statistics Canada 2009, §3-4). The division frequently collaborates directly with governments in its research (§10).

CIHI, CIHR, CFHI, the HCC and StatCan have all increased the government's power to collect and interpret information. Combined with the added accountability the increased ease of data collection provides (Smith et al 2009, 5-6), this trend creates a situation in which governments are empowered and expected to respond directly and effectively to information. Whether it be through funding exploratory research or creating policy in response to objective performance indicators, the way policymakers make decisions has changed dramatically since Medicare's inception. The use of quantitative indicators in tracking system performance is particularly notable, as such indicators enable governments to react directly to changes in data; as previously discussed, this means government is clearly responsible for its response or lack thereof.

Menabde strongly endorses the use of performance indicators in evidence-based decision-making in health care, arguing, “[w]ithout performance information, there is no evidence with which to design health system reforms; no means of identifying good and bad practice; no protection for patients or payers; and, ultimately, no case for investing in the health system” (2009, ix). However, such data was not always so easy for governments to obtain – and yet, health policy was still developed. In fact, before the IT revolution, doctors were the obvious solution to most of the problems Menabde outlines. Originally, Tuohy writes that governments were required to empower and place a great deal of trust in doctors in order to overcome gaps in information, as only doctors held the necessary expertise to make certain decisions (2003, 196). Today, that original “principal-agent” relationship largely persists – doctors are partners with the

state (205), and the medical profession is empowered to establish licensing rules, drug formularies, clinical guidelines and the details of fee schedules (Fierlbeck 2011, 134-5, 145; Lewis 2008b, §5).

With the proliferation of data and governmental research via institutions such as CIHI, CIHR and CFHI, however, it is questionable whether the state will continue to need doctors to fill many of these roles. As well, governments are now increasingly directly responsible for their responses to data; advocates for performance indicators argue that the accountability aspect of such indicators puts pressure on governments to respond directly and effectively to information (Smith et al 2009, 5-7). This has major implications for the physician lobby's ability to influence government decisions, as implicit in this argument is the diminution of the importance of interest group influence. The public not only expects government to respond directly to objective information, but would theoretically also expect them to give less weight to organized interests such as the physician lobby, whose expertise becomes less necessary when policy decisions are made. This has the potential to threaten doctors' privileged seat at the negotiating table in discussions of health policy (Tuohy 1999, 217-22)

Tuohy writes that worldwide, "the development of information technology, together with administrative databases gave governments an information advantage countervailing that of health care providers" (2003, 199). For some countries, this combined with an increasing need to control costs facilitated significant movement away from the principal-agent dynamic (199). Canada, she writes, is a major exception to this trend, as doctors have maintained their principal-agent relationship with the state established at the founding of Medicare (205). Perhaps this should not come as a surprise, as Canada has been unusually slow to take advantage of the new

technologies for data collection and interpretation brought by the IT revolution (Fierlbeck 2011, 74). This is largely due to federalism, as it was not until the 2004 Accord that there was any agreement to facilitate a pan-Canadian approach to data collection and interpretation (74-5). Since 2004, problems have persisted on this front. Provinces still maintain control over key elements of data collection and interpretation, there is still significant disagreement between provincial governments over specific comparative indicators, data collected is not always analyzed or reported, privacy laws impede data collection and there is a notable lack of oversight (75).

However, the fact remains that there is a clear trend towards government gaining control over information, overcoming the gap that originally necessitated the empowerment of doctors in health care decision-making (Tuohy 2003, 196). This undermines the argument supporting physicians' current position in which they have direct control over certain elements of health policy (Fierlbeck 2011, 145) and a privileged seat at the negotiating table for other policy discussions (Tuohy 1999, 217-22). Doctors' loss of control over knowledge vis-a-vis their government then potentially has very real consequences for their power, as it essentially reduces their importance. As governments are more and more equipped to make decisions without doctors, the original justification the medical profession's privileged role in policymaking is being increasingly undermined.

Doctors and their Patients: Diffusion of Knowledge to the Population

As previously discussed, public opinion exerts a significant effect on a group's political power (Pross 1992, 166). Physicians are no exception to this rule; Lazar, quoted by Vogel, argues that

the massive gap in trust between doctors and government has granted physicians significant clout when they seek to impede reforms they find unsavoury (2010). As previously discussed, this popularity gap informs doctors' tactics when they clash with the state, with physician associations attempting to shape and appeal to public opinion by launching advertising campaigns, even asking individual doctors to pass out flyers in their offices (Sibbald 1998, 1506-7). Doctors' popularity also enables them to shape the debate around health care policy, keeping discussions focused on building capacity in such a way that establishes a favourable policymaking environment for the medical profession (Pross 1992, 166; Lewis 2005, §9; Lewis & Edwards 2005).

Sociology of the professions holds that the public's opinion of a profession is inherently related to the concept of 'license,' which is what members of that profession are able to do that nobody else can (Dingwall 1983, 5). This is necessarily related to control over knowledge (Freidson 1983, 25); in short, the public trusts doctors to do their jobs properly because physicians' control over knowledge requires such trust (Dingwall 1983, 5). This trust to perform certain tasks then translates into a high level of prestige (ibid; Horobin 1983, 90), contributing greatly to a profession's overall popularity. In order to maintain its popularity advantage, the medical profession must then be viewed as uniquely qualified to perform the tasks it does. This is the starting point for this discussion, which holds that, if doctors' control over knowledge vis-a-vis the general population were to decrease, so too would the public's confidence in the medical profession, which would have a significant effect on the power of organized medicine to sway public opinion and keep the general health care discussion focused on areas favourable to its interests.

There is significant literature on changing opinions of the medical profession; however, it is generally American, and does not explicitly connect public trust with political power⁶. Employing sociology of the professions allows for this discussion to make that connection in a way that is theoretically grounded. In her Canadian discussion of the doctor-state relationship, Tuohy largely neglects trust and discourse, focusing instead on the formal relationship between doctors and the state in line with the typical approach of historical institutionalism (Tuohy 1999, 203); as such, it is useful to supplement her approach with sociological institutionalism, which places emphasis on informal institutions such as cultural norms (Steinmo 2001, 6-7). Under this approach, the prestige of the medical profession can be considered a cultural norm which influences the population's behaviour in a non-rational way – for example, inclining them to side with physicians during organized medicine's disputes with the government (ibid; Hall & Taylor 1996, 948-9).

It is then possible to look at how public attitudes regarding the medical profession may be changing, assuming control over knowledge to underlie trust in physicians. When considering public opinion, it is useful to examine the relationship between doctors and their patients, as it is in this context that the general public interacts with physicians most of the time. Once again, technology is a natural place to start, as the internet has exerted a major effect on how physicians interact with patients. Ethical problems arise for doctors who find themselves connected with patients via social media, with physicians sometimes engaging in inappropriate and unprofessional online behaviour such as crass humour or even breaches of confidentiality (Devi 2011, 1141). As well, while patients are increasingly frustrated when they are required to see a

⁶ It is possible to use American literature in this discussion, as it centres around a phenomenon that is not country-specific.

doctor in person in order to receive even the simplest information (Erdem & Harrison-Walker 2006, 390), many physicians fear interacting with patients via email may lead to problems of increased workloads without appropriate compensation as well as liability issues (Klein 2007, 29).

However, it is the effect of the internet on patient trust in physicians that is of most concern here. In a 2002 American study, 67% of respondents describe the physician-patient relationship as either extremely or very important (Erdem & Harrison-Walker 2006, 389, 392); Erdem and Harrison-Walker argue that this demonstrates that the role of trust in this relationship is absolutely critical (389-90). However, with the proliferation of websites offering answers to any health care question one could pose, the internet has brought about the age of the ‘informed patient’ (Kivits 2006, 270). This has serious implications for the physician-patient relationship. Kivits explores the question of why people turn to the internet for answers to their health care question through 31 qualitative interviews (269). She comes to the conclusion that there are two main reasons for this phenomenon: a desire to use the internet to take responsibility for improving everyday health, and dissatisfaction with how doctors deliver information (279). It is the second of these that is particularly notable. One respondent reported that her doctor did not explicitly tell her what her blood pressure results meant, while another felt her doctor did not have time to give her all the information she feels she needs (273). This is in line with the argument of Erdem and Harrison-Walker, who suggest that the internet provides answers for frustrated patients who feel they are entitled to more information than they typically get at the doctor’s office (2006, 388). Those that use the internet typically “[feel] they could manage their

own health” thanks to the information they receive, a clear sign that the internet has made people feel empowered to deal with their everyday health issues (ibid).

Kivits reports that many internet information-seekers justify their online activity with the argument that it allows them to be more prepared for their visits with their physician; one participant even described coming to her physician with binders full of research on her particular ailment (Kivits 2006, 277). Kivits writes that direct encounters are still extremely important to information seekers; in other words, the internet is not about to replace visits to the doctor’s office (280). Indeed, it may actually increase them. Lee and Hornik examine the effect of internet use for health information on the amount of physician visits of patients with varying levels of trust in the medical profession, finding that, among participants with both high and low levels of trust in physicians, heavy internet use correlates with a higher number of visits to the doctor’s office (2009, 70, 74). They speculate that this is because the internet often prompts participants to physically see a doctor in order to address an ailment (74). However, Erdem and Harrison-Walker write that this can be problematic for physicians, as patients can become frustrated when their doctor fails to prescribe as they may have expected following their internet research (2006, 389). Given this trend, it is not fair to suggest in the age of the internet that a physical visit to the doctor means a patient actually trusts the medical profession. Indeed, Lee and Hornik find that, given a high level of internet use for health information, those who trust doctors and those who distrust them visit physicians with similar frequency – in contrast, for participants with low internet use for health information, trust appears to be a clear deciding factor in determining whether they will visit a physician (2009, 74).

Erdem and Harrison-Walker suggest that the internet has “levelled the playing field” between doctors and their patients (2006, 388), making patients far less dependent on physicians for information; trusting an individual doctor completely for all of one’s health care information is simply no longer necessary. Patients have been increasingly diagnosing themselves as the so-called “self-care” industry has grown (389). However, not everything on the internet is entirely accurate. Kivits writes that information-seekers are well aware of that fact, but often believe that “common sense” and “instincts” are all that is necessary to distinguish the good from the bad (2006, 276). Nevertheless, the inaccuracy of much of the information found online is likely what is behind somewhat counterintuitive data released at a 2010 National Cancer Institute news briefing which suggests that, for cancer patients, trust in physicians has actually *increased* slightly as internet use has become more widespread (Eastman 2010, 43; Hesse & Moser 2010, 859-60). At the same time, trust in the internet has decreased slightly (Hesse & Moser 2010, 860). Those behind the study argue that “data smog,” the massive amount of sometimes contradictory information that exists online, has caused confusion among cancer patients, who prefer consulting with their physician to get clear, straight answers (Eastman 2010, 43). However, according to this study, 34% of respondents still report preferring to consult the internet when they have a strong need for an answer to a cancer-related question (ibid). It is also important to keep in mind Kivits’s argument that the internet is mostly used for questions about “everyday” health (2006, 279) – urgent questions about cancer hardly fall into this category, and it is therefore not unexpected that cancer patients would still prefer to consult with a physician.

While searching for information online may be less than reliable at times, the internet comes with other potential means of empowering patients as well. Perhaps the most promising

use of the internet in Canadian health care provision is electronic health records (EHRs), which have the potential to allow patients to become more active partners in their health care management by giving them constant online access to their personal medical records – EHR advocates often argue that these should be used in conjunction with email communication with one’s GP in order to facilitate patient self-management (Winkelman et al 2005, 306). EHRs also have the potential to save physicians significant time; Lewis writes that in Denmark, which has a universal system of EHRs, physicians estimate they save an hour every day by not having to manually search for written test results, charts, etc. (2007a, 26). The cost savings of shifting to a system of EHRs are extremely high as well (Fierlbeck 2011, 309-10). As such, in 2001 Canada Health Infoway was established to work with provincial governments with the aim of creating a consistent system of EHRs across the country, available to all Canadians by 2016 (McLeod 2013, §3, §24). However, Infoway has hit numerous snags since 2001, most recently being denied additional funding in the 2013 federal budget despite only just over half of Canadians having access to EHRs at the end of 2012 – well behind most other Western nations (§1, §25, §27).

However, given worldwide trends, the use of information technology in health records appears inevitable, providing Canadian patients with yet another tool through which they can expect to become more informed about their health in the future. There is then a trend towards patients being able to access health information on their own, without physically visiting a doctor’s office. It is then clear that the information gap between physicians and the general public is shrinking, somewhat reducing physicians’ importance in the doctor-patient relationship. Employing the assumptions of sociology of the professions, which holds that power comes from

control over knowledge (Rueschemeyer 1964, 21), this has serious implications for how the public views the medical profession. Indeed, Collier writes that more and more people have become sceptical of expertise, arguing that this should worry organized medicine (2012, 1559). Sociology of the professions holds that control over expertise is absolutely essential for maintaining a profession's prestige, a major determining factor in its popularity (Dingwall 1083, 5). As previously discussed, the medical profession relies on physician popularity both as a tool in its disputes with the state and for focusing the policymaking environment on increasing capacity rather than fundamental reform (Pross 1992, 166; Vogel 2010; Evans et al 2010, 23; Lewis 2008b, §8). While the empowerment of patients is certainly not about to make doctors unnecessary, it does lower their control over knowledge relative to the general population. If knowledge is indeed central to public trust in physicians, which is subsequently central to the profession's prestige, popularity and ultimately its political power, this could challenge the cultural institution of physicians' high popularity, undermining the profession's control over discourse and creating a less favourable policymaking environment for organized medicine.

The assumptions of sociology of the professions appear to hold true in this case, as this patient empowerment, which reduces physicians' importance, is happening at the same time as a clear decline in public trust of doctors. A 2012 Ipsos-Reid poll demonstrates a steady decline in public trust in the profession since 2003; Ipsos Reid senior vice-president John Wright suggests that this is due to an increasingly sceptical public, empowered by the ease of accessing information via the internet (Nonato 2012, §1-5, §8). Such a decline in trust could conceivably have serious implications for doctors' overall popularity and subsequent ability to shape public

opinion and control discourse, compromising one of the largest advantages held by organized medicine.

However, it could be argued that what really affects physician power is their *relative* popularity. While physicians have seen a decline in public trust, Ipsos Reid finds that they remain the second most trusted of the professions included in the survey, only slightly less so than pharmacists (Nonato 2012, §2). Moreover, politicians remain at the bottom of the list, among the likes of car salespeople and CEOs (ibid). Despite Ipsos Reid's initially startling numbers, then, the effect of the declining confidence in physicians could very well be negligible if the profession remains near the top in terms of public confidence. Nonato reports that Wright believes the professions ranking highest in the survey are so popular because they "are entrusted with the security and well-being of others" (§3) – this is perfectly in line with sociology of the profession's assertion that the public has confidence in a profession because of their ability to perform certain essential tasks that nobody else can (Dingwall 1983, 5). It is then perhaps more useful to look at the medical profession's position in the health care division of labour to examine how its relative stature may be changing – after all, the only professionals ranked higher than physicians in Ipsos Reid's study are pharmacists (Nonato 2012, §2). This is what is accomplished in the section that follows, which examines changes in scope of practice rules that empower lower-paid health professionals and loosen Canadian doctors' once-tight control over medical knowledge.

Doctors and their Coworkers: The Expanding Scope of Practice of Lower-Paid Health Professionals

As previously discussed, sociology of the professions holds that a great deal of what gives a profession its stature is members' monopoly on the legitimate performance of certain tasks – this is the concept of *license*, which is necessarily related to control over knowledge (Rueschemeyer 1964, 21; Dingwall 1983, 5). One implication of accepting control over knowledge as the base of physician power is the importance of the dynamics of health care provision itself; this area is underemphasized in Tuohy's discussion, which heavily prioritizes the direct physician-state relationship (Tuohy 1999, 203). However, in discussing whether or not physician power is changing, it is crucial to look for any changes in the relationship between doctors and other health professionals such as pharmacists, nurses and nurse practitioners. If those other professions are seeing their licenses expand to include elements of health provision that were once exclusively performed by physicians, it will be clear that doctors' control over knowledge vis-a-vis their coworkers is weakening. This would have significant implications for physicians' political power, as doctors' overall importance to health care provision and subsequent leverage over the state would be diminished. This would mean they would be less able to take advantage of provinces' competing for physician supply (as a high physician supply would be less essential) and would see their argument for a privileged position at the negotiating table weakened as the bargaining power of lower-paid professions would increase. In addition, accepting the assumptions of sociology of the professions (Dingwall 1983, 5), a weakening of physician control over knowledge vis-a-vis other health professionals could prompt a decline in public trust

in doctors relative their coworkers. This would then reduce doctors' ability to mobilize public opinion and control discourse when their interests collide with those of pharmacists, nurses, etc.

Unlike the previous two discussions in this chapter, this one begins not with technological advances but with a fiscal crunch – albeit a fiscal crunch that is in part caused by technological advances. As new, more expensive treatments have become available, Canadians have been quick to request them and doctors have had every incentive to provide them (Lewis 2007b Lewis 2005, §9). This has driven up costs in prescription drugs and hospital spending, which Marchildon writes are much more consequential cost-drivers than the oft-discussed aging population factor (2012, xvii). As a result, health care costs have skyrocketed over the past few decades at rates that far exceed increases in government revenues (7). This is compounded by the increased pool of doctors that has become available, a consequence of the backlash to the alleged physician shortage following the Barer-Stoddart report – as more doctors have been hired, payments have naturally increased (Evans et al 2010, 17; Lewis 2008, §8; Kondro 2009; see also CIHI 2013). Furthermore, since the 1970s there has been a clear overall trend of the federal government pulling back health funding, forcing provincial governments to make up for this loss of revenue (Tuohy 1999, 90; Payton 2011, §1-2). This puts the long-term sustainability of Medicare in jeopardy, forcing provincial governments to make difficult decisions in order to make ends meet (Marchildon 2012, 7).

At the same time, however, access problems have increasingly plagued health care provision across Canada, with long wait times and poor access to primary care being major complaints of patients (Fierlbeck 2011, 132; Marchildon 2012, 134-5). The question then becomes how to reduce those access problems in the context of a long-term fiscal climate of

restraint. The fact that doctors are an extremely expensive means of increasing capacity has already been discussed extensively in Chapter 2, and, as previously mentioned, increasing the size of the physician pool contributed to the fiscal crunch in the first place (Evans et al 2010, 23; Kondro 2009). It is also true that, despite this fact, organized medicine has historically been extremely adept at arguing that what the system really needs is more doctors (Evans et al 2010, 23; Lewis 2008b, §8). However, the recent fiscal climate of restraint appears to have finally created an environment in which this argument cannot succeed all the time. Governments are forced by circumstance to explore alternative means of improving access to health care (CMA & CAPA 2012, 5), which can come with serious consequences for the medical profession.

Changes in scope of practice of lower-paid health professionals are one such means of improving access more cheaply than simply hiring more doctors. Essentially, scope of practice is what tasks a given health professional is licensed to carry out – it is the embodiment of sociology of the profession’s concept of ‘license’ (Chadi 2011, 44; Dingwall 1983, 5). Alterations in scope of practice can be used as a means of tackling access problems by ‘downloading’ certain responsibilities from doctors onto ‘cheaper’ health professionals such as pharmacists, nurses and nurse practitioners, who can be paid less for performing the same tasks (Chadi 2011, 44; Sinnema 2012, §3). By simply allowing lower-paid providers to perform more tasks, doctors can spend less time doing things like prescribing and giving routine injections and more time performing more complex procedures (Leader-Post 2008). Proponents argue that the kind of collaborative care fostered by utilizing the full capacity of lower-paid professionals is necessary for modernizing health service provision and improving efficiency (Chadi 2011, 44-5). Notably, the Romanow Report strongly recommended exploring changes to scope of practice as a means

of confronting health care inefficiencies across the country (2002, xxvii, 126). The old, rigid rules requiring only doctors to perform even some menial tasks such as renewing basic prescriptions are ever more being recognized as out-dated and inefficient; scope of practice changes are increasingly viewed as necessary for the sustainability of the Canadian model of health care delivery (Chadi 2011, 44).

Scope of practice reforms have taken different forms from province to province. Support for these reforms from those involved in health care provision, even among the professions they seek to empower, has also varied (De Witt & Ploeg 2005, 117; Pringle 2009, 1; MacKay 2004). However, the trend remains that across the country, lower-paid health professionals are being empowered further than ever before. In 2007, Alberta expanded pharmacists' scope of practice to include the most generous prescription rights in the country in an initiative known as 'collaborative prescribing,' which would allow pharmacists to renew prescriptions independently and initiate them in emergency situations (Schindel & Given 2012, 1; Law et al 2012, 18). Pharmacists with appropriate education could even initiate prescriptions for minor ailments in non-emergency situations (ibid). Since then, many other provinces have updated their scope of practice rules to imitate the Albertan experience; in addition, pharmacists are increasingly being permitted to order tests, interpret lab results and give injections (CPA 2013). Nursing scope of practice has also recently been under examination. For example, in 2009 the British Columbia government announced an expansion of nurses' responsibilities to include ordering ultrasounds and X-rays as well as the administration of prescription medication in emergencies (Pringle 2009, 1). In March of 2013, Québec nurses saw their scope of practice expanded to include more responsibilities in treating patients with chronic diseases (Health Edition 2013a). Across the

country, highly-educated nurse practitioners are increasingly being permitted to perform many of the tasks traditionally restricted to physicians (CFHCC 2002, 106; Edwards et al 2011, 4); for example, nurse practitioners in Saskatchewan recently gained the right to prescribe controlled substances (French 2013).

In Nova Scotia, the empowerment of lower-paid professionals has taken the form of a shift towards team-based emergency care⁷. In response to access problems in rural areas, in 2011 the province announced the opening in Parrsboro of the first of several planned Collaborative Emergency Centres (CECs) (Premier's Office of Nova Scotia 2011, §1). The government reports that in Parrsboro the local emergency room was closed 1277 hours in 2009-10 and 525 hours in 2010-11; as well, residents often had to wait between two and three weeks for an appointment to see a GP (§3). The CEC was designed to respond to this classic case of rural access problems, as it would be open 24 hours a day, 7 days a week (ibid). At night, the CEC would be staffed with paramedics and other providers, although there would be a physician accessible by phone at all times (ibid; CBC 2013c, §3). During the day, patients without scheduled appointments would be assessed and then treated by the professional most appropriate to their needs – for example, instead of a doctor, a patient may be directed to a nurse practitioner if that is all that is deemed necessary (Government of Nova Scotia 2013, 1). This innovative, team-based approach to emergency care allows for the full scope of practice of various health professionals to be taken advantage of in a way that allows for improved access to emergency services without simply increasing physician supply. By relying more heavily on lower-paid professionals for emergency care, Nova Scotia has also cut down on wait times for primary care appointments, as doctors are

⁷ A similar team-based strategy is being pursued in Ontario and Alberta in their 'Health Links' initiatives (Government of Ontario 2012; Government of Alberta n.d.).

free to hold more hours in their regular offices (CBC 2013c, §4). CECs have earned praise in particular from Prince Edward Island and Saskatchewan, both of which have made gestures towards adopting the model (Government of Saskatchewan 2012; CBC 2013c).

It should be noted that Electronic Health Records could make this kind collaborative care as well as general scope of practice reforms more effective in the future, as lower-paid health professionals could easily gain direct and immediate access to a patient's medical records without necessarily going through a physician. The empowerment of lower-paid professionals such as pharmacists, nurses and nurse practitioners could then soon become an even more attractive option for countering access problems. This could greatly concern organized medicine. If sociology of the professions is correct about where power comes from, then the ubiquity of scope of practice reforms and collaborative care models suggests that doctors' power is being undermined as their monopoly on the legitimate use of medical knowledge weakens. This trend has two main consequences: these kinds of reforms increase the bargaining power of lower-paid professions at the expense of doctors, and they have the potential to lower the public's trust in doctors relative to other health providers. Both of these consequences are related to the simple fact that these reforms make doctors less important than they used to be. It is this importance that is ultimately to thank for any leverage organized medicine holds over the state in negotiations and it is this importance, according to sociology of the professions, that underlies the unique popularity of the medical profession (Dingwall 1983, 5).

It is then clear that doctors' control over knowledge is declining vis-a-vis the state, the general population and other health professionals, both as a result of technological advances and the fiscal crunch facing health care in Canada. In focusing not only on the direct physician-state

relationship but also on the relationship between physicians and the general population (most notably with respect to physician popularity and control of discourse) and the shifting dynamics of health care provision itself, this chapter has adopted a comprehensive approach to physician power. The observed changes occurring in all three key relationships – physicians and the state, physicians and their patients and physicians and lower-paid health professionals – all reduce doctors' importance and collectively have serious implications for both the license and the mandate traditionally held by the medical profession, two concepts which Dingwall writes are essential to any profession's clout (1983, 5). With respect to license, doctors no longer have a clear monopoly over medical knowledge and certain medical tasks, as patients are becoming more and more informed and the scope of practice of lower-paid professionals is increasingly encroaching on what was once exclusively physician territory. With respect to mandate, as the state increasingly has direct access to information for which it once required doctors, the argument for physician self-regulation (in addition to organized medicine's privileged seat at the negotiating table when change is on the agenda) is being severely undermined.

There are other factors that may cause certain surface-level fluctuations in Canadian doctors' power; for example, an increased pool of physicians (Kondro 2009) could conceivably put pressure on governments to reduce payments to individual physicians in order to keep overall physician costs more or less steady. However, it is the factors affecting physician control over knowledge that are most significant. Assuming the beliefs of sociology of the professions are accurate (and, as previously discussed in detail, there is strong theoretical and empirical support to suggest the base of doctors' power is indeed knowledge), the developments discussed in detail this chapter erode the very base of doctors' power. They should then be considered far more

consequential than surface-level changes such as fluctuations in the dynamics of federalism or even fiscal pressures to reduce physician fees. To answer the research question established at the beginning of this project, it can be asserted that there are indeed changes occurring beneath the surface of physician power in Canada, as doctors' control over knowledge is being eroded in multiple areas, undermining the base of the profession's political influence. However, this is not yet a completely satisfying or comprehensive answer, as it opens up the question of how the medical profession is responding to these developments. One should not be so quick to assume that these changes are completely unstoppable or irreversible, nor should one assume that the medical profession is unable to take any steps to maintain its power in the face of these changes. Examining the medical profession's response to doctors' declining control over knowledge is then the task of the following chapter, which argues that organized medicine's response actually signals that these sorts of changes will likely continue to alter the conditions underlying physician power.

Chapter 4

How have Doctors Responded?⁸

When exploring how physicians and the organizations that represent them are responding to the erosion of doctors' control over medical knowledge, it is important to consider to what extent, if any, relationships of cause and effect can be established. This is crucial for asserting that physicians' actions are in fact responding to something. As previously discussed in Chapter 2, rational-choice institutionalism can be employed to explain actors' motivations, asserting that people behave strategically within institutional constraints in pursuit of long-term objectives (Hall & Taylor 1996, 942). What is particularly important to this chapter is rational-choice institutionalism's emphasis on strategy in determining action, which differs from historical institutionalism's logic of path dependency in that it grants individual actors considerably more autonomy (945). In order to claim that Canadian doctors are responding to their base of power being undermined, one needs to assume that they act strategically, and that a great deal of their actions are in pursuit of self-interest.

Rational-choice institutionalism then provides the theoretical base for this kind of discussion. Empirically, a quick glance at the history of physician job action in pursuit of financial concessions provides ample evidence that physicians do indeed act in pursuit of self-interest a great deal of the time (Reid et al 2003, 3). However, while rational-choice institutionalism combined with organized medicine's history of acting in self-interest do allow for a strong *suggestion* that certain physician actions are done strategically in pursuit of doctors'

⁸ Portions of section one of this chapter (the 'Resistance' section) have been taken from a paper written for POLI 5228 at Dalhousie University

interests, motivations are still ultimately extremely difficult to *prove* as it is hard to know with any certainty exactly what a particular actor is thinking. In addition, actors will typically want to portray themselves as favourably as possible. In certain cases, doctors' groups claim their actions are for the good of the patient rather than motivated by self-interest; as such, it is necessary to provide evidence to suggest why, on a case-by-case basis, actions may not be motivated by what doctors claim and are instead part of a strategy to maintain power in the face of diminishing control over knowledge.

The previous chapter was organized by relationship: physicians and the state, physicians and their patients and physicians and other health care professionals. However, the 'responses' described in this analysis do not fall neatly into those categories; each has specific implications for specific relationships, but there is significant overlap at times. There is also not a clear identifiable response to each and every threat to physician control over knowledge outlined in the previous chapter – perhaps most notably, there is no clear *direct* response to the threat posed by an increasingly-informed government to the medical profession's mandate to self-regulate. As such, it does not make sense to separate sections in the same way as in Chapter 3. Instead, individual sections will deal with different instances of physicians and the organizations which represent them taking steps to maintain power in the face of unfavourable change, via attempts either to halt reforms or to mitigate their negative effects. The discussion begins with a discussion of how doctors have openly resisted the expansion of cognate professions' scope of practice, which compromises the the medical profession's monopoly on many aspects of prescribing. This is then followed by an account of doctors' more typical strategy – co-optation –

which demonstrates that, at least to some degree, Canadian physicians have accepted that their control over knowledge is shifting.

Physicians' Resistance to Scope of Practice Changes

The most intuitive response to a threat to one's power would be to confront it directly. This has historically been a favourite strategy of doctors, as the physician lobby has not typically shied away from clashes with the state (Reid et al 2003, 3; Sibbald 1998, 1505). With respect to the threats to control over knowledge discussed in the previous chapter, one prominent example of such a clash took place in Alberta beginning shortly after the turn of the century, when the Alberta College of Pharmacists (ACP) began lobbying intensely for expanding prescribing rights (Mackay 2004). Proponents touted such an expansion as beneficial for a number of reasons: such 'collaborative prescribing,' as mentioned in the previous chapter, would take advantage of highly-educated pharmacists' potential to serve as health care providers rather than mere drug dispensers (Yuksel et al 2008, 2128), improve efficiency and access (CBC 2007, §11) and allow physicians to spend more time with patients with more complicated health issues (Leader-Post 2008, §10). It would also save the government a significant amount of money, as Alberta could pay pharmacists less than doctors for renewals of common prescriptions (Sinnema 2012, §3). Put simply, this is a classic example of a scope of practice reform designed to solve access problems in the cheapest way possible.

The legislation, formally proposed in 2006, aimed to expand pharmacists' prescription rights to be the most generous in the country (Law et al 2012, 18). That being said, it is important to note that nobody was proposing pharmacists become as empowered as physicians in this

matter. The kind of prescribing outlined in the 2006 legislation was not the same kind performed by doctors; the ACP merely sought the authority to renew prescriptions independently, alter them when necessary (under very specific circumstances) and initiate new prescriptions in an absolute emergency (Law et al 2012, 18; Leader-Post 2008, §5-7). Non-emergency prescription initiations would be limited to pharmacists with appropriate education, and would not be permitted for narcotics or controlled substances (Yuksel et al 2008, 2127-8). In other words, pharmacists were not about to become doctors – the legislation was only intended to allow them to make use of what medical knowledge they possessed (2128).

Nevertheless, the Alberta Medical Association (AMA) and the CMA came out strongly against the proposed legislation – in fact, the CMA had already made its position on collaborative prescribing clear back in 2003 (Mackay 2003). As usual, discourse figured strongly in the profession’s strategy, with the AMA and CMA framing the issue as one of patient safety; only doctors, they argued, have the necessary training to take on the responsibility of prescription (Schindel & Given 2012, 5-6). Then-AMA President Dr. Tzu-Kuang Lee argued, “you can’t prescribe in isolation – prescribing is part of a total package of caring for a patient” (Priest 2006, 464). Lee also claimed that collaborative prescribing would cause confusion over accountability if a prescription resulted in serious side effects (463). As well, doctors frequently publicly voiced concerns of conflict of interest, suggesting it was ethically questionable to allow the person selling drugs to tell the patient what drugs he or she needs (463) – this despite the fact that the same logic can be and has been used against doctors who gain financially from ordering far more consequential and expensive procedures under fee-for-service (Boyle 2013, §6).

Despite the AMA and CMA's attack on the pharmacists' qualifications, collaborative prescribing did indeed come into effect in Alberta in 2007 (Schindel & Given 2012, 1); the famously effective physician lobby had failed in its efforts to stop the legislation. There are several potential explanations for why this occurred. Prescribing by pharmacists had already been tried in other countries without disastrous results (Yuksel et al 2008, 2126); this certainly undermines Alberta doctors' gloomy predictions of unaccountability, conflict of interest and danger to patients. As well, in this case doctors were in direct confrontation with pharmacists – the one group that ranked higher than physicians in Ipsos-Reid's poll of most trusted professions (Nonato 2012, §2). This could conceivably have made physicians' attempts at persuading the public less effective. Still, Schindel and Given report that public reception of pharmacist prescribing was mixed, meaning the doctors' strategy was likely at least somewhat effective (2012, 8). As such, perhaps the provincial government had simply decided that the benefits of the policy outweighed the risks of physician backlash; while physicians were certainly able to sway public opinion to some degree, the government may have decided that, given the benefits of the policy, it was worth a short-term sacrifice of a couple points in opinion polls.

Whatever the reason for this defeat, after pharmacists in Alberta gained prescribing powers organized medicine had to move on to new battles. The CMA turned its efforts towards stopping collaborative prescribing from becoming a national trend; at its annual convention later in 2007, delegates voted to officially oppose the practice in a move that deeply disappointed pharmacist groups (CBC 2007). Whether this had any effect on slowing the spread of collaborative prescribing is difficult to tell; however, it certainly did not halt or reverse the trend. As of 2012 most provinces had granted pharmacists at least some prescribing powers, with

Newfoundland and New Brunswick going as far as Alberta in allowing for pharmacists to initiate prescriptions under certain circumstances (Law et al 2012, 18, 21).

Scope of practice reforms, as discussed in Chapter 3, threaten doctors' control over knowledge and ultimately their political power. The physician lobby enthusiastically opposed this particular scope of practice reform in Alberta. However, in order to establish that this opposition was a *response* to a perceived threat to physician power, organized medicine's motivation in opposing collaborative prescribing must be discussed. If one believes their discourse, the AMA and CMA were simply looking out for patients' interests. As previously mentioned, this is typical of the medical profession, with Collier going so far as to say that perceived altruism is essential to doctors' justification for professional autonomy (2012, 1559). For its part, the AMA has an entire section of its website dedicated to how it "[advocates] for Patients First®" (AMA n.d. 'Patients First'). There is no real way to prove that this was not in fact doctors' motivation in opposing collaborative prescribing; however, there is ample reason to be sceptical. The assumptions of rational-choice institutionalism as well as organized medicine's history of boldly advocating for physician interests suggest that it is likely that the AMA and CMA were not simply being altruistic (Hall & Taylor 1996, 942; Reid et al 2003, 3). In addition, despite the AMA's claim to advocate not only for doctors but for patients as well, their membership is ultimately limited to practicing physicians, resident physicians and medical students (AMA n.d. 'About'). It is simply not justified to assume that the AMA and CMA are any more than they appear on paper: advocacy organizations for physician interests. There is nothing inherently wrong with this, but it is important to acknowledge that such advocacy organizations

tend to pursue the interests of their members. There would then need to be some self-interested reason why doctors would oppose collaborative prescribing.

However, such a self-interested reason is not immediately apparent. It is difficult to see what doctors could lose materially in the expansion of prescribing rights to pharmacists. It is also conceivable that doctors could actually *gain* financially from such scope of practice reforms. One of the primary arguments in favour of collaborative prescribing in Alberta was that, with patients going to pharmacists for certain prescription needs, doctors could spend more time on more complex health issues, or simply spend less time working – a frequent complaint of physicians, after all, is that they are badly overworked (Leader-Post 2008, §10; Sibbald 1998, 1507-8). Under the fee-for-service method of payment, more complicated procedures are naturally generally more lucrative than simple prescription renewals, injections, etc. (see Alberta Health 2012). As previously discussed, Lewis explains that in the case of state-funded health services supply tends to create demand (Lewis 2005, §9). This means that Alberta doctors are not going to have to worry about making enough money; they will continue to be able to find patients if they choose to keep as busy of a schedule as they did before the change. In addition, Alberta employs several alternative payment plans for certain situations, most notably a form of capitation; as capitation compensates doctors based on how many patients are on their roster regardless of whether or not they seek treatment (CIHI 2013, 203), collaborative prescribing would free up such physicians' time while still allowing them to receive payment. Finally, the AMA voices mild concerns about potential confusion over liability when scopes of practice of lower-paid professionals are expanded (AMA 2013). However, there is reason to believe here as well that doctors could gain financially, as liability is now spread between doctors and pharmacists rather

than just being confined to doctors. As such, there are material incentives that would seem to actually encourage doctors to support expanding pharmacists' scope of practice.

Protection of control over knowledge is then the only clear explanation for the AMA's actions in this case. Accepting the assumptions of sociology of the professions, it is therefore possible to suggest quite strongly that organized medicine was acting to protect physicians' control over health care provision and therefore their importance to the system. While individual physicians may indeed have been thinking of their patients, it is important not to lose sight of the AMA and CMA's mandate to represent the medical profession. However, it is nevertheless impossible to *prove* that the AMA and CMA were defending doctors' control over knowledge – all one can do is point out that there was indeed a strong incentive for them to oppose collaborative prescribing on these grounds.

Given Canadian doctors' history of clashes with the state (Reid et al 2003, 3; Sibbald 1998, 1507-8), the AMA's reaction to the threat collaborative prescribing posed to physician control over knowledge may seem more or less normal. However, this strategy of resistance to scope of practice reforms has not actually been the norm in this area. Perhaps this should not come as a surprise, given the notable failure of organized medicine's opposition to the Alberta reforms. The kind of collaborative care facilitated by scope of practice reforms goes beyond pharmacists and takes many forms, from the promotion of midwifery to the empowerment of nurse practitioners. Chadi writes that such changes are increasingly being recognized across the country as key to improving health care provision (2011, 44). It is then becoming harder and harder to argue against them, as the more scope of practice reforms and collaborative care become ubiquitous, the more difficult it is to directly oppose these sorts of changes. Another

example of organized medicine directly opposing this kind of reform serves to further illustrate this point; despite the AMA's strong opposition to collaborative care centres in Alberta, the the Redford Government's plan to open these clinics has been the governing Progressive Conservatives' not popular campaign pledge of 2012 (Wingrove 2012b, , §1-2, §7). Given that this kind of reform is so difficult to effectively oppose, doctors must then consider how they can react to a phenomenon that appears unstoppable. How doctors have been dealing with this reality is explored in the section that follows, which discusses how the profession has been attempting to co-opt scope of practice reforms and the broader collaborative care movement in order to mitigate any effects they might have on physician control over knowledge.

Their Acceptance (and Co-optation) of Certain Reforms

In light of the increasing popularity of scope of practice reforms and collaborative care models, the approach of organized medicine in this area has typically been much less confrontational than it was in the case of collaborative prescribing in Alberta. Again, scope of practice expansions are not confined to pharmacists, with nurses, nurse practitioners, midwives and many other professionals being empowered in collaborative care arrangements – while doctors have had different reactions to specific proposed reforms, their posture towards collaborative care more generally has been quite positive. In 2007, as previously mentioned, the CMA voted overwhelmingly to oppose pharmacist prescribing on the grounds that only a physician should be ultimately responsible for the medications a patient may receive (Picard 2007, §7). However, even at the time, the CMA's general position on collaborative care structures was that they can indeed benefit Canadian health care provision (§11); while the organization opposed pharmacist

prescribing, it did not officially oppose the principles behind the practice. The official CMA policy on scope of practice, adopted in 1999, is notably vague, emphasizing the need for scope of practice expansions to be appropriate to education and based in evidence (CMA 1999, 2). As such, the CMA leaves itself open to opposing or accepting reforms on a case-by-case basis.

While one might expect organized medicine to oppose any changes with negative implications for physician power, the CMA and its provincial divisions have opted not to do so. Strategically, this makes sense, as certain collaborative care reforms may simply be too popular or have too much evidence in favour of them for the organization to oppose them without losing significant credibility as an advocate for patients and Canadian health care in general. In theory, one would then expect the CMA to simply accept such unstoppable reforms as they arise, but not take any active steps to encourage them. However, this is generally not what has occurred. Organized medicine has actually in many cases been a vocal *proponent* of expanding the scope of practice of lower-paid professionals and facilitating collaborative care. This trend has become especially visible in recent years. For example, in 2012, CMA president Dr. Anna Reid applauded the recent rise to prominence of the physician assistant position in Canada, characterizing the CMA as, “an advocate of collaborative care” and acknowledging the role of physician assistants in countering health human resource shortages (Reid 2012b, §1). This is a far cry from simply advocating for more doctors regardless of cost.

At the provincial level, organized medicine has adopted a similar posture. In British Columbia, the BCMA’s official policy on nurse practitioner scope of practice reads, “[t]he BCMA welcomes building a collaborative relationship with nurse practitioners (NPs) as part of a multidisciplinary approach to the provision of health care in BC” (BCMA 2012, 1). Across the

country, Doctors Nova Scotia endorsed the provincial government's Better Care Sooner plan which first proposed the CEC model (Bonang 2012, 14). While pharmacist prescribing has historically been staunchly opposed by organized medicine across the country – the Ontario Medical Association once compared it to letting flight attendants fly planes (Leslie 2009) – it is beginning to appear as if such opposition to scope of practice expansions is not exactly normal; in many instances, organized medicine, at least in its rhetoric, has actually come out strongly in favour of the empowerment of lower-paid health professionals.

At this point, it may seem tempting to throw out much of what has been written thus far and accept these developments as evidence that either control over knowledge is not actually central to physician power or that organized medicine is actually acting solely in the public interest, supporting reforms they believe to be beneficial to Canadian health care while opposing those that they deem harmful to patients. Indeed, it is difficult to see what, if one accepts the assumptions of sociology of the professions, the medical profession could gain from actually endorsing (often quite strongly) these kinds of proposed reforms rather than simply taking them in stride when they appear inevitable. However, there is an explanation for organized medicine's actions that is in line with both sociology of the professions and the idea that doctors' groups tend to act in the interests of their members. It can be safely assumed that, even in cases where they feel they could overcome physician opposition, governments would prefer to have doctors on their side when they propose change. Therefore, in making its support conditional, the physician lobby can then still shape the debate to a limited extent – this is potentially a much more effective strategy than opposing initiatives that are highly likely to pass anyway.

In fact, organized medicine's support of scope of practice reforms and collaborative care structures typically does come with conditions. As might be expected, these conditions tend to protect as much of physicians' control over knowledge as possible. This typically means ensuring doctors will remain clear leaders in any arrangements which may emerge; the CMA has emphasized its belief that physicians should be clinical leaders in collaborative care structures and that there should be clear limitations on the scope of practice of lower-paid health providers (Picard 2007, §11). In 2007, Canadian Nurses Association president Marlene Smadu (quoted by Picard) remarked that physicians' position on collaborative care is essentially that, "[doctors are] in favour of teamwork so long as [they] can always be the quarterback" (§12). Doctors' position as leaders is extremely important to organized medicine; in branding themselves as collaborative care advocates, physicians are able to steer such reforms in a direction that protects as much physician leadership as possible.

In cases of specific reforms, the leadership demanded by physicians can fall into two categories: professional and political. With respect to professional leadership, the CMA has secured a role on the Physician Assistant Certification Council, ensuring that doctors have a direct say in the governance of that profession (Reid 2012b, 2). In British Columbia, the BCMA has insisted that, the vast majority of the time, multidisciplinary care teams should have a general practitioner as a clinical leader; that physician would then be ultimately responsible for patient care (BCMA 2012, 1). In addition, the BCMA holds that physician involvement in collaborative care structures ought to be voluntary (*ibid*) – this is a clear instance of organized medicine attempting to protect professional autonomy. With respect to political leadership, Dr. Reid, in her inaugural speech as CMA president, asserted the right and responsibility for organized medicine

to act as a leader in health care reform efforts (Reid 2012a, 3). More specifically, in Nova Scotia, Doctors NS insisted in 2012 that organized medicine be intimately involved in the implementation of the Better Care Sooner plan, warning that, if there is not adequate physician input in the establishment of CECs, doctors may be discouraged from joining such structures (Bonang 2012, 14).

One of the most recent developments on this front has been the Council of the Federation's creation of the Health Care Innovation Working Group, which, among other things, seeks to establish a common approach to scope of practice reforms (Kondro 2012b, E178). In 2011, the Harper government unilaterally announced changes to the federal-provincial funding arrangement instead of a renegotiation of the 2004 Accord set to expire in 2014, a move which amounted to both a reduction in annual funding increase as well as a pullback of the federal government from health care policymaking (ibid; Payton 2011). In response, the provinces formed this Working Group in an effort to maintain a pan-Canadian approach to key challenges (Kondro 2012b, E178). This group has already resulted in some provinces expressing significant interest in learning from Nova Scotia's CEC model, for example (HCIWG 2012, 14-15; see also Government of Saskatchewan 2012, CBC 2013c).

The collaborative intergovernmental process set up by the CoF represents a fundamental shift in how health policy is made, as will be discussed further in the concluding chapter of this project – as such, it is unsurprising that organized medicine wishes to be heavily involved. The Working Group's first report, released in July of 2012 to coincide with the CoF meeting, suggests that organized medicine is embedding itself in the new arrangement, listing representatives from the Canadian Medical Association and its provincial counterparts as key contributors (2012,

18-19, 26). Interestingly, the involvement of the CMA in the Working Group is one reason being cited for Québec's high-profile withdrawal from the organization in 2013 (Health Edition 2013b, 1). This is a clear example of the physician lobby inserting itself into a process that could affect doctors' interests; if the Group does result in a more nationwide approach to scope of practice reforms, organized medicine would surely want to steer those reforms in such a way to mitigate any effect on physician control over knowledge.

While there are certainly some cases in which organized medicine does oppose scope of practice reforms and collaborative care, the CMA's general posture towards this trend has been positive (Picard 2007, §11; Reid 2012b, §1). We then see a strategy of co-optation from the medical profession in response to the increasing emergence these kinds of reforms. In essence, doctors are responding to a seemingly inevitable trend by branding themselves as its champions so as to steer it in the least unfavourable direction possible. However, doctors' control over knowledge will still surely decrease at least somewhat as a result of these reforms. While co-optation may be an effective strategy for mitigating the effects of unfavourable reform, it basically amounts to an admission that physicians' control over knowledge, and therefore their political power, is going to be compromised to some degree. In a way, in choosing co-optation over confrontation, the medical profession has accepted the idea that some reduction in its power is likely to occur.

As was the case in the previous section, it is not possible to prove outright that physician groups' conditional endorsement of certain scope of practice reforms and collaborative care structures is a direct response to the threat those reforms pose to their control over knowledge and ultimately their political power. However, this course of action makes sense as a strategic

response given the seemingly unstoppable trend towards using scope of practice changes as a means of combatting access problems. Accepting the assumptions of rational-choice institutionalism and sociology of the professions and keeping in mind organized medicine's history of defending physician interests, it is then possible to suggest quite strongly that the medical profession's co-opting of certain reforms is indeed a response to the seemingly unstoppable expansion of lower-paid health professionals' scope of practice.

Their Reaction to Technology

The medical profession in Canada also employs this strategy of co-optation in response to the threat advances in information technology pose to its control over knowledge. It may not seem this way at first glance, however, as individual doctors have been far more resistant to technological change than has organized medicine as a whole. As previously discussed, Lewis complains that individual physicians have been slow to adopt new technologies (2007b, 103). Professional autonomy allows physicians to make their own decisions about many aspects of how they practice medicine; as such, they do not have to accept a new technology if they feel it threatens their interests. This is particularly visible with respect to communications; in 2013, Taylor reported that, "Only 6 per cent of Canadian physicians allow patients to book appointments electronically, just 11 per cent refill prescriptions online, and only 11 per cent answer medical questions through e-mail" (§4). This puts Canada in last place of the twelve high-income countries included in the study; however, Canadian physicians defend their reluctance to engage in electronic communications, citing legal and confidentiality concerns as well as worries about being overworked without fair compensation (§2-3). The same thing is true

with respect to technologies that have clearer impacts on physician control over knowledge, such as EHRs, which (as previously discussed) reduce the ‘knowledge gap’ between physicians and their patients as well as that between physicians and their coworkers. While there are a multitude of reasons for Canada’s relatively poor performance in EHR implementation, McGinn et al report that one important barrier is physicians’ reluctance to adopt them, a reluctance which they claim stems in part from the potential for EHRs to act as a way for management to infringe on individual doctors’ professional autonomy (2011, 7). This is one example of how individual doctors’ foot-dragging, permitted by their professional autonomy, has slowed the adoption of technologies that would erode their control over knowledge, subsequently (intentionally or not) slowing the undermining of the base of physician power.

This widespread foot-dragging certainly seems more along the lines of resistance that co-optation. However, as discussed in the previous chapter, information technology is not about to go away; foot-dragging is then not the most effective response of the medical profession to the threat such technology poses to their control over knowledge and subsequently their political power. A more interesting strategy is that being pursued by the CMA, which has taken a far more co-optative posture towards information technology. In 2010, it unveiled its 5-year strategy for health information technology (HIT) investment; this was released in conjunction with *Health Care Transformation in Canada*, which constituted the CMA’s general health policy recommendations (CMA 2010b). In this report, officially titled *Toward Patient-Centred Care* but commonly referred to as the ‘Five-Year Strategy’ (ibid, CMA2010c), the CMA deplores the well-documented difficulties in implementing a Canadian EHR system – this despite the previously-discussed role of physician foot-dragging in slowing the process down (McGinn et al 2011, 7;

CMA 2010c, 7). In response to Canada's poor performance on HIT, it suggests shifting investment away from "top-down" and "large-scale" HIT programs and towards front-line services that deliver more "tangible benefits" (CMA 2010c, 5-6).

Most importantly, this recommendation involves shifting resources away from Electronic Health Records and towards Electronic Medical Records (EMRs) (7). The difference between EHRs and EMRs is actually quite significant.⁹ Lombardi quotes Dr. Anne Doig, the CMA president at the time, as distinguishing the two as such: "[EHRs are] broadly accessible records of information about a patient that are accessible across medical practices and contain information that might be germane to any practitioner looking at the individual. An EMR is a longitudinal record of a patient that a doctor maintains over time, and is the equivalent of a chart" (2010, §2). The CMA argues that investing in EMRs at the "point of care" would more accurately reflect how care is actually provided, in contrast to the current centralized EHR agenda, which the organization describes as high-cost and high-risk (CMA 2010c, 13, 17). In promoting ground-up development of an EMR system, governments could theoretically then eventually integrate EMRs into regional or even provincial systems without any of the risks of trying to build such a system from the top down – however, this kind of integration would not be mandatory (13).

Notably, one advantage of investment in the grassroots, point-of-care EMRs outlined by the CMA is lowered physician resistance, which currently hinders progress on EHRs (13; McGinn et al 2011, 7). This is unsurprising, as such a refocusing of HIT investment towards EMRs would necessarily mean giving individual physicians more discretion in how they employ

⁹Despite this distinction, it should be noted that the term "EMR" is often used to describe what is essentially an EHR (Lombardi 2010, §2; Winkelman et al 2005; Price et al 2011)

such technology and would keep control over records firmly in the hands of the physician, somewhat preserving their control over knowledge vis-a-vis their patients and lower-paid providers (CMA 2010a, 23). The CMA membership values physician choice quite highly in this area; in a policy statement on EMR adoption in clinical ambulatory practices, the association writes that physicians are only likely to adopt EMR systems that respect professional autonomy, are completely voluntary and are non-discriminatory – that is, not tied to any specific products or type of practice (CMA 2008, 1-2). The CMA also consistently reasserts the role of the physician as “steward” of a patient’s information (which has indeed been established by the courts), demanding that physician privacy – and therefore control over any electronic records – be respected (1; CMA 2009, 2-3).

While individual doctors have been dragging their feet on adopting new technologies which may compromise their control over knowledge, then, the Canadian Medical Association has publicly championed health information technology – until recently, the CMA even owned a software company for EMRs (Canadian Press 2013b, §1). However, the type of technological integration championed by the CMA very much limits infringement on physicians’ professional autonomy and control over knowledge – this mirrors organized medicine’s approach to certain scope of practice reforms. Instead of a top-down system of EHRs, the CMA has been arguing in support of investment in EMRs, which leave control over information more firmly in the hands of the individual physician (CMA 2010a, 23; CMA 2010c, 13, 17). The CMA does not shy away from this aspect of HIT, repeatedly reasserting doctors’ current legal status as “stewards” of medical records (1; CMA 2009, 2-3). In short, the CMA has been attempting to co-opt the HIT movement, steering it towards a more physician-friendly position. It claims that this is for the

good of Canadian health care, as the EHR strategy has not been working (CMA 2010c, 1); however, even the CMA admits that one major reason why EHRs have not been implemented as quickly as hoped is individual doctors' reluctance to adopt them (CMA 2010c, 13; see also McGinn et al 2011, 7). This implies that the CMA's plan is indeed largely geared towards serving physician interests, as it is through appealing to physicians that the CMA believes Canada can solve its HIT problem (CMA 2010c, 13). One of those interests is preserving physician control over knowledge, which is essentially what the CMA is advocating for when it describes the threat EHRs pose to physicians' stewardship of medical records (CMA 2008, 1; CMA 2009, 2-3). One then only needs to look at what the CMA says to demonstrate that they are motivated by their mandate to protect doctors in this particular case.

At this early point, however, it is difficult to tell how well the CMA's strategy is working. Infoway has indeed been investing money into a more "ground-up" system of EMRs (CHI 2013), but the EHR initiative has persisted (ibid; CHI n.d.). Regardless, Infoway's future as an organization is now in limbo, as they have not received any new funding in the latest federal budget (McLeod 2013, §1). While the exact impacts of the CMA's strategy may then as of yet be unclear, this approach of co-optation once again signals an acceptance on the part of organized medicine that changes in technology are inevitable; the one thing the CMA can do in response is try and steer the changes so as to mitigate any negative effects on physician control over knowledge. Even the grassroots system proposed by the CMA lessens physician control over knowledge in that it would allow patients to access their medical information without physically visiting a doctors' office and would allow for easier implementation of collaborative care structures (CMA 2010c, 8, 12). This means that the CMA is actually proposing a system that

would actually lessen physicians' control over knowledge; it is only in contrast to the EHR option presented by the state that this makes any sense as a strategy. In accepting HIT as inevitable and instead trying to direct it in the least unfavourable direction possible for physicians, the CMA has essentially accepted that this technology is bound to change the traditional role of the doctor, weakening the profession's control over knowledge at least somewhat.

Mitigation, not Confrontation: What this Response Means for the Future of Physician

Power

Given the enormous failure of the AMA and CMA's opposition to the 2007 collaborative prescribing law and the subsequent inability of the CMA to stop this kind of reform from spreading across the country (Schindel & Given 2012, 1; Law et al 2012, 18, 21), it is safe to say that confrontation has not always proved to be a particularly effective response to the erosion of physician control over knowledge. More effective has been the strategy of co-optation employed in other cases where scope of practice reform and/or collaborative care structures are on the table; such an approach, while constituting an admission that physicians are going to lose control over knowledge to some degree, can be more fruitful than staunchly opposing the very base of a proposal that was going to pass no matter what, as physicians are able to affirm their place as leaders in health care (Reid 2012b, 2; Bonang 2012, 14). A similar argument can be made in favour of physicians' attempts at co-opting advances in health information technology; as it is impossible to fight such clearly beneficial technological advances, the best organized medicine can do is try to steer those changes in such a way that mitigates their effects on physician control

over knowledge. While federal budget clawbacks, which have seriously affected HIT investment, mean it is at the moment unclear as to how effective the strategy has been in this case (McLeod 2013, §1), it is certainly more advantageous than trying to argue that technological innovation is somehow a bad thing.

Co-optation is a necessary strategy because of the inevitability and popularity of the changes that threaten doctors' control over knowledge. It is important to note once again that not every threat to physician control over knowledge has produced a clear and direct response from the medical profession. However, even such a lack of clear response is notable, as it signifies a lack of will or ability to engage in confrontation – indeed, it is hard to see how organized medicine could 'combat' the creation of CIHI, for example, despite the threat CIHI poses to physician control over knowledge vis-a-vis the government. Where there has been a response, co-optation has been the most popular and effective strategy employed by organized medicine. This has major implications for physician power, as it signals that the medical profession is aware that the forces undermining its control over knowledge cannot be openly fought. This means that while doctors may succeed in limiting, slowing, or steering certain changes so they affect physician control over knowledge as little as possible, they will not be working to halt or reverse these trends.

If Chapter 3 established that the base of physician power is being weakened, then this chapter has established that that weakening is likely to continue, as the tactics employed by doctors in response demonstrate that the medical profession recognizes the futility of attempting to halt this trend entirely – all doctors are able to do is steer changes in the least unfavourable direction possible. While one should be careful not to underestimate the physician lobby's ability

to do this effectively, this strategy nonetheless constitutes a significant departure from the medical profession's traditional confrontational tactics, employed most famously in response to the initial emergence of Medicare in Saskatchewan and the implementation of the *Canada Health Act* across the country (Tuohy 1999, 52-4, 94). Doctors' strategy of co-optation suggests that the base of physician power will likely continue to weaken in Canada; this is perhaps an even more consequential conclusion than the one reached in Chapter 3. While doctors have historically been absolutely central to Canadian health care policymaking and have wielded enormous political power thanks to their control over medical knowledge, the base of this power is being increasingly compromised – and this trend shows no sign of reversing, as doctors are opting not to confront these changes directly but rather simply attempt to mitigate their effects when possible. The possible consequences of this trend will be discussed in the subsequent and final chapter of this project, which also summarizes the discussion that has taken place and explores the counterargument to the proposition presented in this project.

Chapter 5

Conclusion

This project has determined that there are indeed significant changes occurring beneath the surface of Canadian physicians' power, the original source of their political clout being undermined as their control over knowledge weakens. First, it was established that the medical profession's power is based in knowledge; the circumstances surrounding the inception of medicare, doctors' uniquely effective political organization and the leverage federalism grants to organized medicine in their negotiations with the state then magnify this power in Canada (Tuohy 1999, 42, 50-6, 207-8; Finnie 2004, 1777; see also Wilsford 1991, 85). The idea that physician power is based in knowledge is widely accepted (Tuohy 1999, 16; 2003, 196-7; Collier 2012, 1559; see also Pross 1992, 102, 104). Sociology of the professions provides the theoretical base for this assumption, emphasizing the importance of license and mandate to a profession's political power – license being the ability of a profession to perform tasks that nobody else can, and mandate being a profession's right to self-regulate (Dingwall 1983, 5). A profession's unique control over knowledge is what justifies both of these attributes (ibid; Horobin 1983, 90).

Carolyn Tuohy provides the most complete explanation for Canadian physicians' power thus far, combining the assumptions of sociology of the professions with an historical institutionalist framework of path dependency and critical junctures (Tuohy 1999, 16, 107; 2003, 196-7). However, in focusing on formal state institutions (203) she neglects the role of physicians' relationship with the general public, underemphasizing public discourse as a determinant of power. To overcome this gap, this study has included elements of sociological

institutionalism, which emphasizes informal institutions such as cultural norms (Hall & Taylor 1996, 946). Tuohy also underemphasizes the dynamics of health care provision itself; in contrast, this study has paid significant attention to how doctors relate to other health care providers. Finally, to suggest motivations in discussing how physicians have responded to certain developments, this study has employed rational-choice institutionalism, which suggests that actors pursue their own interests within institutional constraints (942-3).

This approach means that, when asking if physician control over knowledge is changing, three relationships had to be considered: physicians and the state, physicians and the public and physicians and other health care professionals. With respect to doctors' relationship with the state, governments have responded to advances in information technology by setting up agencies through which they can get information directly without consulting the medical profession, undermining the original justification for physician empowerment (Tuohy 2003, 196). With respect to doctors' relationship with the public, the diffusion of medical knowledge to the general population via the internet and other technological advances has come with a decline in trust in the medical profession, which is perfectly in line with the assumptions of sociology of the professions (Nonato 2012, §1-5, §8; Dingwall 1983, 5; Horobin 1983, 90) – however, perhaps more significant than this absolute decline is the medical profession's position relative to other stakeholders. This leads to the third relationship considered, which is that of physicians and lower-paid health professionals. Nurses, pharmacists and other health care professionals have seen their scopes of practice expand to include tasks that were traditionally exclusively performed by physicians, and governments have been increasingly empowering lower-paid professionals in collaborative care structures; this suggests that doctors' dominant position on top

of the health care hierarchy has become somewhat shaky (Chadi 2011, 44). Accepting the assumptions of sociology of professions, this undermines their exclusive license to perform certain tasks and therefore the justification for their political power (Dingwall 1983, 5), as it impacts both their relative bargaining power vis-a-vis the state and their relative public popularity.

The medical profession's response to these phenomena suggests that the weakening physicians' control over knowledge is likely to continue at least somewhat. Instead of confronting those developments that threaten their power, the profession has largely chosen a strategy of co-optation, endorsing technological developments, scope of practice changes and collaborative care structures while steering them in such a way that mitigates their effects on physician control over knowledge (see Bonang 2012; CMA 2010c for examples). In contrast to the initial emergence of Medicare in Saskatchewan or the passing and implementation of the *Canada Health Act* (Tuohy 1999, 52-4, 94), then, doctors have chosen to attempt to co-opt rather than openly fight many of the changes that are currently serving to undermine the original source of their power. While it is important not to underestimate the medical profession's ability to do this effectively, this strategy of co-optation and mitigation still amounts to an admission that many of the threats to physician control over knowledge cannot be confronted directly; in accepting reforms such as collaborative care structures given certain conditions, doctors concede that their control over knowledge will be weakened to some degree. This suggests quite strongly that not only is the base of physician power being undermined, but also the forces undermining their power are likely to persist.

The Counterargument

This conclusion might appear to be extremely vulnerable to criticism. In the introduction to this project, two reasons were given as to why doctors can be considered uniquely powerful in Canada: physicians are relatively wealthy despite the fiscal crunch that plagues Canadian health care (OECD 2011, 67, 149, 151), and organized medicine has historically been uniquely central to health care policymaking in Canada, so much so that commentators such as Tuohy have described Canadian health care as fundamentally defined by the relationship between doctors and the government (Tuohy 1999, 30, 67; see also Katz et al 1997, 1414). Using those criteria, doctors are still extremely powerful. The original data cited in the introduction was initially collected around 2008-2010, after most of the changes discussed in this project were well underway (OECD 2011, 67). In addition, Leonard and Sweetman present data which demonstrates that per capita spending on physicians has continued to rise in Canada since the turn of the century – this in contrast to a notable dip in the mid-1990s (2012, 2, 14). Finally, CIHI reports that, as of 2013, average annual physician pay ranged from \$236 000 in Prince Edward Island to \$350 000 in Alberta (2013, iii). It is clear, then, that doctors' pocketbooks show no sign of any decrease in physician' power.

Even more importantly, doctors are still absolutely central to Canadian health care policymaking and continue to exercise this importance to their advantage. In 2012, Tuohy reported that the physician lobby has continued to successfully preserve the fee-for-service method of remuneration, significantly slowing the rise of alternative payment plans despite those plans' popularity (626-7). The medical lobby also recently flexed its muscles in Alberta. As previously mentioned, the Redford government spent much of 2011-2013 in a high-profile

budget dispute with Alberta physicians, who combatted planned cuts using just about every tactic in their playbook, from appealing to public opinion to threatening to sue the province over what they perceived as a lack of consultation (Walton 2012, §3-4; Layton 2013) – this despite Albertan physicians being the most generously compensated in the country (Walton 2012, §10). After several severe setbacks (Wingrove 2012; Komarnicki 2013), in April of 2013 the AMA and the Alberta government struck a deal that gave doctors a lump sum bonus totalling \$68 million and backed off of certain cuts in exchange for a three year pay freeze (Wingrove 2013, §2; Parrish 2013, §6). In addition, doctors would be further empowered in health care decision-making, with the Redford government pledging, among other things, to work in collaboration with the AMA on primary care reform and EMRs (CBC 2013a, §8) – these concessions are quite significant considering the strategy of co-optation of certain reforms discussed in this project. While it may appear undesirable at first glance, the pay freeze that was agreed upon is far from the \$275 million cut initially demanded by the Redford government, which the AMA claimed would amount to a 22.5% cut in remuneration (Komarnicki 2013; Parrish 2013, §8). With 93.5% of responding AMA members voting to ratify the proposal and AMA president Dr. Michael Giuffre sounding positively triumphant in his subsequent letter to physicians, it is clear that Alberta doctors were quite pleased with the final result of the dispute (Giuffre 2013).

The Alberta case demonstrates that the physician lobby is still a force to be reckoned with. However, the divided and weak nature of Redford's Alberta Progressive Conservative Party (Cryderman & Walton 2013) was undoubtedly a major contributor to the dispute's outcome – one should not assume that the AMA's success in the negotiations was entirely due its own strength. That being said, it is hard to argue that doctors are currently seeing a substantive

decline in their power. The fact remains that they are still extremely wealthy and are still an extremely effective lobbying force, preserving the key elements of health care that favour their interests and proving to be extremely effective at resisting the state. In contrast to the conclusion reached by this project, then, it is conceivable that some may feel as if organized medicine's future could not be brighter.

Perhaps it should not come as a surprise that Canadian doctors are still powerful – after all, their unique political power, which has historically hindered meaningful reform in Canada, was in part the impetus behind this study to begin with. However, it is important to note that their persistent political power does not contradict the findings of this study, which only serves to demonstrate that the original base of that power is being eroded. Historical institutionalism would suggest that physicians, whose privileged position in policymaking has become something of an institution in Canadian health care, would be able to maintain its power regardless, as path dependency holds that institutions generally endure through changes in circumstance until the arrival of a critical juncture. Given that the physician-state relationship is perhaps the single most important institution in Canadian health care (Tuohy 1999, 30), it is unsurprising that a weakening of physician control over knowledge on its own is not enough to constitute a critical juncture at which physician power can be challenged. Other factors that could contribute to or impede such a critical juncture will be discussed in the section that follows.

One must then be careful when examining evidence that may support or contradict this project's conclusions. Instead of looking at Leonard and Sweetman's data on physician remuneration, for example, it would be more useful to examine their data on physician consultations, which more accurately reflects the importance of doctors to health care provision

and therefore the base of their political power (Leonard & Sweetman 2012, 5, 18). This reveals that Canada is unique in experiencing a steady decline in physician consultations per capita (ibid); one might suggest that this is evidence of Canadians relying more on lower-paid health professionals for primary care, which is one of the main effects of scope of practice reforms. While Leonard and Sweetman's data supports the notion that physicians are still quite materially wealthy, then, it also contains evidence that the base of their power is being undermined.

This project has not suggested that physicians' power is decreasing, concluding only that the base of that power is weakening. It is conceivable, then, that physicians would not see their political power decrease substantively until such a time at which other factors provide an opportunity for the state to act. The possibility of such an opportunity approaching in the near future will be discussed in the section that follows, which suggests that the Health Care Innovation Working Group strongly resembles what Tuohy would describe as a window of opportunity for major change in the physician-state relationship.

The Importance of this Study: The Possible Critical Juncture

The Council of the Federation's Health Care Innovation Working Group has come up occasionally throughout this project. Formed in response to the Harper government's pullback from the health care negotiating table, the Group is a means by which the provinces can share best practice and work towards setting common standards for many areas of health policy (Kondro 2012a, E699; HCIWG 2012). As previously discussed, these include scope of practice reforms, but the Working Group has also vowed to tackle health human resources and clinical practice issues (Kondro 2012b, E178) – all of these areas of discussion would be of serious

concern to physicians. The Group's mandate is also extremely flexible; it could conceivably be used as a vehicle for collaboration between the provinces on any number of health care-related challenges. While this initiative has run into challenges – most notably the controversial withdrawal of Québec (Health Edition 2013b) – the Group signals a clear shift away from the federal government seeking to set and enforce a pan-Canadian approach to health care challenges and toward a more collaborative, intergovernmental dynamic.

Chapter 4 discussed briefly how organized medicine has inserted itself in the process, with members of the CMA being listed in the first HCIWG report as key contributors (2012, 18-19, 26). However, the Group still has the potential to work as a vehicle for reform. Path dependency holds that institutional arrangements persist until the arrival of a critical juncture (Steinmo 2001, 8). Given that the Group is a sharp shift away from the standard dynamics of policymaking, it could provide such an opportunity for major change. As defined in Chapter 2, major change for the purposes of this study is change in the physician-state relationship that is significant enough to allow for the systemic problems that plague Medicare to be addressed. Such major change could conceivably occur as a result of the Working Group. The provinces will be using this new structure to reconsider much of the status quo of health care in Canada, many aspects of which (e.g. scope of practice reforms) directly affect doctors – one could easily suggest that, now that the base of organized medicine's political power is weakening, more tangible aspects of physician power could also be up for reconsideration. In fact, there have already been hints that the process could be used to physicians' material disadvantage. In 2012, former Ontario Premier Dalton McGuinty urged his counterparts across Canada to act together to reduce physician fees in some areas and suggested the Working Group be used for this purpose,

as the provinces acting together on this would counteract the potential for physicians to move to provinces maintaining more generous fee schedules (Kondro 2012c, E489).

However, for critics of the status quo in the Canadian physician-state relationship, mere budgetary restrictions would not be satisfactory – what is needed is a reduction in the amount of direct control given to both physicians and the organizations which represent them. As previously discussed, commentators complain of the extent to which professional autonomy has been stretched in Canada to allow individual physicians independence without accountability and give organized medicine direct control over many elements of the system (Lewis 2008b, §5, §13; Greer 2008, 1). Now that physicians’ control over knowledge has decreased, both the justification for that position and the medical lobby’s ability to defend it have been weakened. Fee-for-service is perhaps the most reviled aspect of the physician-state relationship, having persisted since the inception of Medicare despite heavy criticism (Marchildon 2012, 21, 78). Given the undermining of the base of physician power that has already taken place, if payment reform were to make it onto the Health Care Innovation Working Group’s agenda Canada would see the most promising opportunity for major change in this area to date – to use the language of historical institutionalists, this would resemble a critical juncture. This is why this study is particularly important at this moment in history – not only is the base of physician power being weakened in Canada, but that weakening could actually result in substantive consequences that could finally break the cycle of stagnation in Canadian health care policy.

However, it is important not to treat this ‘critical juncture’ as implying that such change is inevitable, or even necessarily likely. When Tuohy discusses critical junctures, she refers to them as ‘windows of opportunity’ (Tuohy 1999, 107), a term which emphasizes the fact that actors

have to be willing to take advantage of an opportunity of major change. The CoF Working Group represents an opportunity for governments to work in a coordinated fashion to take on the physician lobby across Canada. However, at the moment, despite Dalton McGuinty's original hopes, the Group shows no sign of taking such action, as there is no mention of a coordinated approach to reducing doctors' pay anywhere in its first report (HCIWG 2012). New Brunswick is unique at the moment in directly confronting physicians (Canadian Press 2013a) – there does not seem to be much appetite amongst other provincial governments at this time to challenge the medical profession. As previously mentioned, Alberta just got out of a bruising battle with the AMA, which would undoubtedly dissuade the Redford government from jumping into a coordinated approach to confronting the physician lobby. Ontario's minority government is still troubled by scandal, and also recently concluded talks with its own doctors (Benzie 2013; Toronto Star 2012). While other provinces may have different reasons for not wanting to take on doctors at the moment, the trend remains that there is little political will to coordinate a Pan-Canadian approach to changing the physician-state relationship. That being said, the Working Group still has potential to serve as a vehicle for such action if, in the coming months and years, the necessary political will were to emerge.

Over the decades since the inception of Medicare in 1966, doctors have dominated Canadian health care policymaking. The medical lobby is exceptionally powerful in Canada, thanks in part to the nature of the situation which produced Medicare, doctors' effective political organization and the leverage federalism grants to organized medicine in its negotiations with provincial governments (Tuohy 1999, 42, , 50-6, 207-8; Finnie 2004, 1777; Wilsford 1991, 85). That being said, it generally accepted that knowledge is the original source of physician power

(Tuohy 1999, 16; 2003, 196-7; Collier 2012, 1559; see also Pross 1992, 102, 104). Given this foundation, it is extremely significant that physicians' control over knowledge is decreasing on all fronts, with the state, the general population and lower-paid professionals all seeing themselves more empowered to make decisions without physician input (Tuohy 2003, 196; Nonato 2012, §1-5, §8; Chadi 2011, 44). This severely compromises physician importance, undermining the base of the profession's political power. Organized medicine has responded with a strategy of co-optation (see Bonang 2012; CMA 2010c), which signals an acceptance that doctors' control over knowledge is bound to decrease at least somewhat. All of this contributes to a situation in which physician interests may be more vulnerable than ever, as a critical juncture may be approaching at which it could finally be possible, if provincial governments were to opt to take advantage of this opportunity, to roll back some of the ways in which the current system benefits doctors at the expense of the taxpayer and the patient.

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