

**Medical Disinterestedness:
An Archaeology of Scientificness and Morality in
the Canadian Medical Profession**

by

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Abstract

In this dissertation I consider the emergence of and the shifts in the scientific and moral standards in the Canadian medical profession, or what I call medical disinterestedness. I examine editorial content from medical journals as a discursive space in which professional norms are constituted. I draw on the works of Pierre Bourdieu in order to argue that doctors are enmeshed in a unique system of rewards that cannot be explained by an economic model based on profit. I investigate three crisis moments during which Canadian doctors faced accusations from the public, the media and the government for not acting with scientific and moral judgment. The first crisis moment I examine occurs in the nineteenth century when doctors faced a hostile government that refused them the right to govern all aspects of medicine. During this time, doctors drew on middle-class masculine codes of etiquette and their privileged access to university education in order to claim that they were learned gentlemen acting on behalf of the public. This claim was called into question during the 1950s-1960s, however, when the Canadian media shamed the medical profession for opposing the proposal for a universal health care system. In this second crisis moment, in order to restore their moral credibility, doctors upheld general practice and public health as humane forms of medicine and adopted media relations strategies aimed at improving their image. Opening the doors to the media created complications, however, as demonstrated in the third crisis moment when the editors at the top Canadian medical journal were fired in 2006. This event revealed that the supposedly pure intellectual space of medical science collides with media-market forces, professional politics and journalism in ways that have troubling ramifications for medical practice. My analysis of these crisis moments demonstrates that morality, objectivity and ethics are not fixed concepts but are rather shaped in relation to historical, social, cultural, political and economic factors. This dissertation extends ethical discussions in medicine to include the ways in which doctors define and communicate what it means to act with integrity in relation to the state, professional politics and the media.

Keywords: Medical ethics; medical science; medical profession; history of medicine; discourse analysis; Pierre Bourdieu

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Chapter 1. Introduction: Science and Morality

In February 2006, the senior editors of Canada's most prestigious medical journal, the *Canadian Medical Association Journal*, were fired. Neither the owner of the journal at the time, the Canadian Medical Association Holdings Inc., nor the dismissed editors gave reasons for the firing but it was widely surmised in medical journals world-wide that the editors were fired due to the ways in which the intellectual and journalistic pursuits of the editorial board challenged the political and economic interests of the journal owners. Many writers and editors of prominent medical journals around the world rallied behind the dismissed editors, which spurred the Canadian Medical Association to implement an external review of the journal's editorial autonomy, events that resulted in the de-privatization of the journal in addition to other organizational changes. The editorial writings in the *CMAJ* and other medical journals regarding this incident adopted an intensely moralized discourse that consisted of accusations against the journal owners of violating editorial autonomy for the purposes of political and economic gains. The onslaught of outcry against the actions of the journal owners was palpable, making its way into national newspapers in Canada, indicating that a tremendous wrong had been committed, one that was a moral as well as a scientific transgression. Existing norms and established rules within medicine, such as the professional code of ethics and codes of bioethics, appear inadequate to account for, let alone arbitrate, this incident. The Canadian Medical Association's (CMA's) Code of Ethics¹ is a four-page document that contains very general guidelines with respect to doctor-patient relationships, professional responsibilities and duties in public health. It also gestures toward notions of informed consent and ethics boards with regard to research but on the whole it remains very vague and recommends, instead, that physician receive additional training in ethics. Bioethics tends to emphasize the notion of "do no harm" and primarily concerns itself with issues

¹ Canadian Medical Association, "Code of Ethics", *Canadian Medical Association*. March 2012.
<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>

that pertain to medical decision-making, biomedical research and public health emergencies.² The dismissals at the *CMAJ* concerned issues of professional conduct of both the journal editors and the journal owners, which could not be accounted for by CMA's code of ethics or by bioethics, despite the fact that the incident was framed both in scientific and moral terms.

The notion that the scientific and moral integrity of medicine can be violated by external self-interested forces is not a new idea in the history of medicine. Politics, economics and finances as well as journalistic biases have been part of the development of professional medicine in Canada and elsewhere: the formation of autonomous self-regulating professions of doctors through medical laws required considerable political efforts at various levels of government³; the Canadian Medical Association launched the Registered Retirement Savings Plan for its members in 1957 and MD Management (now MD Physician Services) to manage members' pensions,⁴ and to this day doctors are perceived as one of the highest earning professions; and peer-reviewed medical journals face issues relating to conflict of interest among researchers and among members of editorial boards who may have ties to the for-profit sector, such as the pharmaceutical and biotechnology industries.⁵ Despite these historical and ongoing brushes with the state, the market economy and the media—many episodes that are as familiar to the public as to doctors—the notion that medicine can and must maintain scientific objectivity and moral purity is a fixture in contemporary societies in which medicine has gained a significant degrees of cultural, political and social credibility. Despite scandals of malpractice and abuse of patients by individual doctors, and despite the well-known trope of the excessively wealthy specialist, the ideal image of a doctor as benevolent, altruistic, morally upright and scientifically objective looms large in contemporary imagination. From romantic physician heroes in popular novels during the nineteenth

² See Nancy S. Jecker, Albert R. Jonsen and Robert A. Pearlman, *Bioethics: An Introduction to the History, Methods and Practice, 2nd Edition* (Toronto: Jones and Bartlett Publishers, 2007).

³ See Ronald Hamowy, *Canadian Medicine: A study in restricted entry* (The Fraser Institute, 1984).

⁴ MD Physician Services, "Our History: Putting physicians first since 1957", <https://mdm.ca/about-md/who-we-are>. Accessed on December 12, 2012.

⁵ See Bernard Lo and Marilyn J. Field, Committee on Conflict of Interest in Medical Research, *Conflict of Interest in Medical Research, Education, and Practice*, (Washington DC: National Academies Press, 2009) for an example of the range of issues regarding conflict of interest in medicine.

and twentieth centuries,⁶ to the doctors of Doctors Without Borders who risk physical harm in order to provide essential medical care in isolated or war-torn regions,⁷ the image of a medical doctor untainted by self-motivated interests and a profession of doctors free from political or economic motivations are alive not only in the minds of the hopeful public but also of many medical students and practicing doctors. These scientific and moral images of the doctor and the profession have tremendous cultural currency in garnering public support and in recruiting new members. Thus, there exists a tension in medicine between the necessary evils of depending upon the market economy and state politics for sources of monies and legislative support, and medicine's genuine investment in the pursuit of moral integrity, scientific innovation, objectivity and neutrality.

At the same time, the standards of what is scientific are historically constituted in relation to social, political, economic and cultural forces within and outside of the realm of what is strictly medical. Scholars in science and technology studies and social studies of science, technology and medicine have long argued that ideas of what is scientific have been inflected by cultural norms and discriminatory ideas related to race, gender, sexuality and criminality.⁸ Moral standards, too, have been affected by and impacted upon scientific and quasi-scientific ideas around hygiene, intellect and social deviance.⁹ The interdependence of scientific and moral discourses with respect to the constitution of

⁶ Some examples are Dr. Allan Woodcourt in Charles Dickens' 1852 novel, *Bleak House*, who "exemplifies a distinct moment in mid-century medical heroism by his charitable work as well as by impeccable personal integrity" [Tabitha Sparks, *The Doctor in the Victorian Novel* (Burlington, VT: Ashgate, 2009), 17], Dr. Yuri Zivago of *Doctor Zhivago* (1957) by Boris Pasternak, and Sir Arthur Conan Doyle's Dr. John Watson from the Sherlock Holmes novels in the late nineteenth and early twentieth centuries.

⁷ The principles of Doctors Without Borders is to "[provide] independent, impartial assistance in more than 60 countries to people whose survival is threatened by violence, neglect, or catastrophe, primarily due to armed conflict, epidemics, malnutrition, exclusion from health care, or natural disasters" (Medecin sans frontier / Doctors Without Borders, "History & Principles", <http://www.doctorswithoutborders.org/aboutus/> accessed December 21, 2012).

⁸ See Evelyn Hammonds, "New Technologies of Race" in *Processed Lives: Gender and Technology in Everyday Life*, ed. Jennifer Terry and Melodie Calvert (New York: Routledge, 1997), 108-121; Marita Sturken and Lisa Cartwright, "Scientific Looking and Looking at Science" in *Practices of Looking: An introduction to visual culture* (New York: Oxford University Press, 2001), 279-314; Geoffrey Bowker and Leigh Starr, *Sorting Things Out: Classification and its Consequences* (Cambridge: MIT Press, 1999); and Lisa Cartwright, *Screening the Body: Tracing Medicine's Visual Culture* (Minneapolis: University of Minnesota Press, 1995).

⁹ See Nyan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (University of California Press, 2009); and Kirsten Ostherr, *Cinematic Prophylaxis* (Durham: Duke, 2005).

particular, often marginalized, groups of people as the objects of scientific and medical gaze has been extensively analyzed by this type of work. However, there has been comparatively little work with respect to how scientists and doctors engage with both types of discourses in order to represent themselves as a group of experts in order to deal with internal struggles within the group, and in order to present themselves as professionals to those outside of the profession. The controversy surrounding the dismissals at the *CMAJ* in 2006 was not about strictly “medical” issues, that is it was not about faulty clinical decision-making or about the validity of biomedical research per se. Instead, the incident was about whether or not the political and economic conditions under which medical knowledge is disseminated and represented are scientifically and morally legitimate and not just about the loss of scientific integrity in medical publishing due to the privatization of scientific journals. When the dismissals triggered the suspicion that the *CMAJ*'s objectivity and neutrality could be under serious jeopardy, the event made possible and made necessary certain kinds of scientific and moral claims in order to ensure that medical publishing as a whole could be seen as a legitimate intellectual enterprise that could be and must be free of market and political forces. Hence, the debates about the dismissals demonstrated the ways in which scientific and moral standards are constituted and shaped in relation to specific historical moments and forces that may not be part of medicine proper.

In this dissertation, I set out to trace the historical emergence of and the developments in the moral and scientific standards in medicine in order to situate the 2006 controversy at the *CMAJ*. In particular, I pay close attention to the spaces where the moral and scientific ideals of medicine may collide with the ideals and concerns in worlds outside of medicine, primarily the law, elective politics, the media and journalism. My goal is to examine the ways in which doctors make sense of these tensions and even legitimize irreconcilable contradictions between their own moral/intellectual ideals and the political/economic motivations that they come up against when they look to the state for legislative authority and to the media, particularly journalism, in order to disseminate their research findings. My goal is to examine the kinds of scientific and moral claims that were made possible and necessary by the specific concerns of professional medicine during a historical moment in which its claim to being a scientific and virtuous group of

experts came under threat. In order to accomplish this goal, I must look at various moments in history where the moral and scientific integrity of doctors was put into question, such as at the *CMAJ* in 2006, and the ways in which they responded to the potential loss of their legitimacy as a moral and scientific body of experts.

Literature on Doctors and Professional Medicine

History of Medicine

The early documentations of doctors in Canada, or medical men as they called themselves, were written by doctors¹⁰ and these texts often served political purposes for the emerging profession as it struggled to gain legitimacy, both in the eyes of the newly established governments and of all medical men whom it claimed to represent. For example, William Canniff's *The Medical Profession in Upper Canada, 1783-1850*, which was published in 1894, is decidedly conservative and pro-British, emphasizing the legislative triumphs by British medical men to raise the status of medicine. The tone of this text is reflective of the historical moment in which it was published: in 1894, medical men of Upper (Ontario) and Lower (Québec) Canada were struggling to gain autonomous status for professional medicine and to oust “quacks” or non-medical practitioners, such as homeopaths, from the protection of provincial medical laws. In addition, the tensions between the French and the English were still high and a primarily British-centric historical account would have served as a way for English-speaking medical men to establish a sense of their common history as a group in the political struggles with the French-speaking medical men.¹¹ H.E. MacDermot's *History of the Canadian Medical Association, 1867-1921* was first published in 1935 by the Canadian Medical Association and echoes Canniff's narrative structure: he documents the trials faced by early medical men at the late nineteenth century as they struggled against what he describes as rampant

¹⁰ S.E.D. Shortt has conducted an excellent review of this early literature in his edited volume, *Medicine in Canadian Society: Historical Perspectives* (Montréal: McGill-Queen's University Press, 1981). (“Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada”, 1-18).

¹¹ Canniff begins his text with “the conquest of General Wolfe in 1759” and the American War of Independence. He emphasizes that “as with the other learned professions, the cream of the medical men in the several revolting colonies remained loyal to the British flag” (12).

quackery and ignorance among the masses. Both Canniff and MacDermot highlight the life and work of certain individual medical men as examples of nobleness within the profession. In their accounts, medical men appear already united as a profession with a common set of goals and ideals such as the dominance of Anglo medical men and of the British system of professionalization which emphasizes strict entry into the profession and a hierarchy within the profession between physicians and surgeons. They attribute the rise in dominance and credibility of medical men over other practitioners to scientific innovation and progress. The politically blatant tone of these writings has earned the criticism by later academic historians and sociologists that the historical accounts written by the early doctors are self-congratulatory glorification of the profession and are uncritical accounts that lack objectivity and rigour.¹² Yet, these texts serve as surviving accounts of the early days in Canadian medicine and as such are invaluable historical documentation.¹³ While these texts may be unreliable in terms of portraying an accurate account of what was happening among medical men and between medical men and other practitioners at this time, the explicitly self-edifying tone of these texts points to a sense of urgency among medical men to establish a historical origins of their group as part of their effort to develop a semblance of legitimacy as a profession with respectable beginnings.

This tradition impacted upon academic scholarship as well. While there were sporadic academic writings, the 1980s saw a surge of writing in the history of medicine by academic historians in Canada, which followed the inauguration of the Hannah Institute for the History of Medicine¹⁴ in 1974. The money that came through the Institute

¹² Wendy Mitchinson, "Canadian Medical History: Diagnosis and Prognosis", *Scientia Canadensis*, 12 (1982): 125.

¹³ In addition, these early works normalized the importance of doctors documenting their own history as part of their professional practice such as the works of Charles M. Godfrey (*Medicine for Ontario*, Mika Publishing Company, 1979), a professor of rehabilitative medicine at the University of Toronto, and of C. David Naylor (*Private Practice, Public Payment* (Montreal & Kingston: McGill-Queen's University Press, 1986)), a former Dean of the Faculty of Medicine at the University of Toronto.

¹⁴ The Institute is an arm of the Associated Medical Services (AMS) which during the Depression era established a physician-sponsored pre-payment medical insurance plan. When the provincial governments took over the matters of health insurance, AMS turned its attention to the study of the history of medicine by establishing Chairs at five medical schools in Ontario and the Hannah Institute for the History of Medicine. See G. R. Paterson. "The Hannah Institute: promoting Canadian history of medicine" in *CMAJ*, 128 (June 1, 1983): 1325-1328.

funded several major historical research and publications such as *Medicine in Canadian Society: Historical Perspectives* edited by S.E.D. Shortt in 1981, and *Health, Disease and Medicine: Essays in Canadian history* edited by Charles G. Roland in 1982. The articles in both texts as well as other scholarship around this time on the medical profession roughly fall under three different categories in terms of content and argumentative style. The first of these consists of demographic profiles and lists of medical men practicing in a particular region during a particular historical period.¹⁵ The second type of scholarship reviews the legislative changes and professional conflicts and activities, an argumentative style that is in keeping with that of Canniff and MacDermott and which tends to be the most popular type of historical work on the medical profession.¹⁶ These works focus on particular regions (i.e. provinces and territories) and historical periods or examine conflicts between groups, such as between the French and the British. These works problematize the assumption that medical men have always been united as a homogenous group by pointing to the conflicts among medical men in interesting ways. However, they too position science as relatively separate from the history of the profession except to act as the ultimate arbiter of what is good and bad medicine. The third type of scholarship consists of a few works that examine the scientific, political and social constraints and possibilities in which medical men practiced.¹⁷ In these works, the limitations in medical remedies at the time play a crucial role in the struggles faced by

¹⁵ Toby Gelfand, “Who Practised medicine in New France?: A Collective Portrait”, in *Health, Disease and Medicine: essays in Canadian history: proceedings of the first Hannah Conference on the History of Medicine, McMaster University, June 3-5, 1982*, ed. Charles G. Roland (Toronto, 1982), 16-35; Jacques Bernier, “Le corps médical québécois à la fin du XVIIIe siècle”, in Roland, *Health, Disease and Medicine*, 36-64.

¹⁶ R.D. Gidney and W.P.J. Miller, “The Origins of Organized Medicine in Ontario, 1850-1869”, in Roland, *Health, Disease and Medicine*, 65-95; Barbara R. Tunis, “Medical Licensing in Lower Canada: The Disputes Over Canada’s First Medical Degree”, in Shortt, *Medicine in Canadian Society*, 137-164; Hilda Neatby, “The Medical Profession in the North-West Territories”, in Shortt, *Medicine in Canadian Society*, 165-188; Veronica Strong-Boag, “Canada’s Women Doctors: Feminism Constrained”, in Shortt, *Medicine in Canadian Society*, 207-236; Barbara Tunis, “Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change”, *Histoire sociale / Social History*, 27 (May 1981), 67-91; Sylvio Leblond, “La médecine dans la province de Québec avant 1841”, *Cahier des Dix*, 35 (1970), 65-95.

¹⁷ S.E.D. Shortt, “‘Before the Age of Miracles’: The Rise, Fall and Rebirth of General Practice in Canada, 1890-1940”, in Roland, *Health, Disease and Medicine*, 123-152; Colin D. Howell, “Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism”, in Roland, *Health, Disease and Medicine*, 105-122; Geoffrey Bilson, “Canadian Doctors and the Cholera”, in Shortt, *Medicine in Canadian Society*, 115-136.

medical men as they sought to establish legitimacy in relation to other practitioners and to win public trust during epidemics that they could not understand or bring under control. Yet, even in these texts, the social and political constraints faced by the medical profession are claimed to be resolved by the miracle of scientific innovation and progress in the twentieth century. For example, Colin D. Howell writes that doctors in the nineteenth century could not agree on what counts as legitimate medical knowledge nor were doctors substantially different from untrained practitioners in their therapeutic approaches and rates of clinical success, but he concludes that doctors ultimately rose to their eventual expert status by accepting “popular notions of the value of science and responsible social management”¹⁸ as though “the value of science” and “responsible social management” were concepts that already existed during this time that doctors simply needed to accept. Departing from this trend in history of medicine, S.E.D. Shortt argues in his 1983 essay that the trend in historiography of medicine to unproblematically link “the professionalization of medicine in a causal fashion to a growth in scientific knowledge requires substantial modification”¹⁹ and subsequently describes the ways in which science as a form of “polite knowledge”²⁰ was a tool for Victorian middle-class physicians in the Americas to forge a group identity vis-à-vis upper-class men, and thus situates scientific discourse in the relational space of class struggles, morality and legitimacy. On a similar vein, Paul Underhill’s analysis of the medical reform movement in Britain demonstrates that the social and political conflicts among British medical men overlapped with disputes about the very nature of medicine as a body of knowledge and practice.²¹

Sociological and Ethnographic Studies of Medical Professions

The social and political dimensions of the medical profession, past and present, are central to sociological works on the medical profession which fall under either

¹⁸ Howell, “Elite Doctors” , 106-108.

¹⁹ S.E.D. Shortt, “Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century”, *Medical History*, 27 (1983), 52.

²⁰ *Ibid.*, 61.

²¹ Paul Underhill, “Alternative Views of Science in Intra-Professional Conflict: General Practitioners and the Medical and Surgical Elite, 1815-58”, *Journal of Historical Sociology*, 5(3) (1992): 322-350.

structural approaches that are rooted in the concept of medical dominance or symbolic analyses that treat the profession as a type of culture. Medical dominance approaches engage with Eliot Friedson's work on professions²² and Marxist perspectives of labour and class and tend to focus on the profession's power "over the content of their own work (characterised as autonomy) and its power the work of other health care occupations (authority) as institutionalised experts in all matters relating to health in the wider society (sovereignty)."²³ The foundational writings on medical dominance emerges in the English-speaking world around the same period as the boom in historical scholarship on medicine²⁴; for sociological scholarship, this surge of interest in the medical profession is attributed to the centrality of health in public discourse and the apparent power that the profession had on matters of health care which, it has been argued, has since declined in an age of neo-liberal policies and patient-centered care.²⁵ The foundational scholarship on medical dominance in Canada include David Coburn, George M. Torrance and Joseph M. Kaufert's essay, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?" (*International Journal of Health Services* 13 no. 3(1983)), Ronald Hamowy's *Canadian Medicine: A Study in Restricted Entry* (The Fraser Institute, 1984), George M. Torrance's historical introduction to *Health and Canadian Society: Sociological Perspectives* (Fitzhenry & Whiteside, 1987), and David Coburn's "Canadian Medicine: Dominance or Proletarianization?" (*The Milbank Quarterly* 66 suppl. 2 (1988)). These texts trace the emergence of medical dominance to the early days of the profession in the nineteenth century during which medical doctors battled and won against alternative practitioners. Similar to the historical works on the medical profession, the works on medical dominance trace the legislative decisions and professional structures but they also situate these events in the existing sociological models of social

²² Eliot Friedson, *Profession of Medicine: A study of the sociology of applied knowledge*, (Chicago: University of Chicago Press, 1970).

²³ Evan Willis, "Introduction: Taking Stock of Medical Dominance", *Health Sociology Review*, 15 (2006): 421.

²⁴ In Australia, Evan Willis first published *Medical Dominance: The Division of Labour in Australian Health Care* (Allen & Unwin) in 1983; in the United Kingdom, Vicente Navarro wrote *Medicine under Capitalism* (Prodist) in 1976; and in the United States, Paul Starr's *The Social Transformation of American Medicine* (Basic Books) appears in 1982.

²⁵ David Coburn. "Medical Dominance Then and Now: Critical Reflections", *Health Sociology Review*, 15 (2006): 432.

change, such as the shift from primary economy to industrialization²⁶ and from a free-market-based payment system to a health insurance system (private and then public)²⁷ and the changing conditions in which doctors work in ways that undermine their authority.²⁸ The lines of inquiry tend to revolve around whether or not the medical profession has dominance and the degrees to and aspects of which may have been eroded. In the structural analyses of doctors as a profession, ethics/morality and science are either mute points or vehicles for the profession's more pressing concerns in establishing and maintaining structural power. In this literature, science is taken up primarily in the form of medicalization, or the adoption of formerly non-medical issues into the realm of medical knowledge and expertise, a process that serves to reinforce the authority and dominance of professional medicine.²⁹ Indeed, Hamowy goes as far as to state that “[i]t is foolish to suppose that their occupation exalts them above using the means at their disposal to act in their own private interests”, a view he diametrically opposes to the medical profession's own assertion that “its dedication is the public's interest” and “that [doctors] have never sought legislation or acted for selfish ends.”³⁰

Certain ethnographic studies of doctors differently engage with notions of science and morality by positioning these ideas as parts of the professional culture of medicine. These works emphasize the ways in which doctors at various stages in their careers—including as medical students³¹ and junior doctors³²—and in various working contexts—

²⁶ Deborah A. Stone. “The Doctor as Businessman: The Changing Politics of a Cultural Icon”, *Journal of Health Politics, Policy and Law*, 22(2) (April 1997): 533-556.

²⁷ David Coburn, “Canadian Medicine: Dominance or Proletarianization?”, *The Milbank Quarterly*, 66 Suppl. 2 (1988): 92-116.

²⁸ David Coburn “State authority, medical dominance, and trends in the regulation of health professions: The Ontario case”, *Social Science & Medicine*, 37(2) (July 1993): 129-138; Nicky Britten, “Prescribing and the defense of clinical autonomy”, *Sociology of Health and Illness*, 23(4) (2001): 478-496; John McKinlay and Joan Arches, “Towards the Proletarianization of Physicians”, *International Journal of Health Services*, 15 (1985): 161-195; Vicente Navarro, “Professional Dominance or Proletarianization?: Neither”, *The Milbank Quarterly*, 66 Suppl. 2 (1988): 57-75.

²⁹ In this literature, the emphasis is on bodies and concepts that are medicalized, such as women's bodies, race, poverty, criminality, etc.; doctors may be agents of medicalization, particularly in doctor-patient interactions in which they generally exercise authoritative power.

³⁰ Hamowy. *Canadian Medicine: A study in restricted entry*, 8.

³¹ Howard S. Becker et al. *Boys in White: Student Culture in Medical School*. (Transaction Publishers, 1977).

³² Haida Luke. *Medical Education and Sociology of Medical Habitus: It's Not About the Stethoscope!* (Kluwer Academic Publishers, 2003).

such as emergency wards³³—conduct themselves in relation to expectations from patients, other doctors and managers. These works emphasize behaviours and perceptions held by doctors and medical students in relation to the situations and conflicts in which they find themselves³⁴ in the context of a hierarchized professional culture.³⁵ Some of these works take up Pierre Bourdieu’s concept of *habitus* in order to describe a medical *habitus* which is primarily cast as doctors’ identity³⁶ and embodied clinical practices³⁷ and is seen as being shaped via encounters with professional and health care institutions. In these works, the structures of professional culture, among which are scientific practices and moral standards, largely shape the professional identities and embodied practices of doctors. David Armstrong³⁸ stands out among this group for dealing explicitly with the moral and ethical issues as embedded in clinical practice. He finds that doctors observe professional etiquette as a communicative strategy that helps them to mediate conflicts around prescribing treatments without compromising clinical autonomy which he defines as the ability of a doctor to make clinical decisions free from intervention by others including other doctors. Armstrong³⁹ has also analyzed the significance of the early medical professional codes of ethics (nineteenth century onward) in terms of the socio-political concerns of the profession at various time periods. For instance, he finds that the nineteenth century code demonstrates a metaphoric parallel with the public health approaches at the time that were concerned with monitoring the boundaries of the body—the public body, the individual body and the professional body—from contaminants—diseases and unfit doctors.

³³ Renady Hightower, “Ethnography of the habitus of the emergency physician”, PhD Dissertation.(Wayne State University, 2010).

³⁴ Becker et al., *Boys in White*, but also doctor-patient interaction studies, such as Candace West, “When the Doctor is a ‘Lady’: Power, status and gender in physician-patient encounters”, *Symbolic Interaction* 7, No 1 (Spring 1984):87-106; and Sally E. Thorne, Susan R. Harris, Karen Mahoney, Andrea Con, and Liza McGuinness, "The context of health care communication in chronic illness", *Patient Education and Counseling*, 54 (2004): 299-306.

³⁵ Luke, *Medical Education and Sociology*.

³⁶ Ibid.

³⁷ Sarah Nettleton, Roger Burrows, Ian Watt. “Regulating medical bodies? The consequences of the ‘modernisation’ of the NHS and the disembodiment of clinical knowledge”, *Sociology of Health and Illness* 30, no. 6 (April 2008): 333-348.

³⁸ David Armstrong and Jane Ogden, "The role of etiquette and experimentation in explaining how doctors change behavior: a qualitative study", *Sociology of Health and Illness*, 28, no. 7 (2006): 951-968.

³⁹ David Armstrong, “Embodiment and ethics: constructing medicine’s two bodies”, *Sociology of Health and Illness*, 28, no. 6 (2006): 866-881.

Social Studies of Science and Medicine

Works in social studies of science and medicine, an interdisciplinary area that is marked by influences from the sociology of knowledge, cultural studies and the history of science and medicine, actively engage with scientific knowledge and practices as part of the social, cultural and political lives of scientists and health professionals. Michel Foucault, particularly through his *Madness and Civilization* and *Birth of the Clinic*⁴⁰, has been influential in developing a unique approach to the historical study of illnesses and of medicine that moves away from established narratives of scientific progress, discoveries and innovations and from investigation of origins and causes of medical theories and practices. Instead, he emphasizes patterns of discursive formation, such as the development of new objects and lexicon of medical knowledge, of institutional networks and of new ways of seeing and organizing what is knowable. His concept of the medical gaze was an alternative to medicalization⁴¹ as a way to understand the power of the physician, which he saw as the capacity and the authority to draw on the entire discourse and institution of medicine when using his/her gaze and touch in clinical practice. Foucault's work has inspired a vast range of works that examines the discursive impact of medical techniques and knowledge, such as visualizations of the body⁴², diagnostic strategies and clinical categories.⁴³ It is also at the basis of much of the cultural studies work produced during the early years of the HIV/AIDS epidemic in North America that examine the ways in which biomedical and media-science discourses dealt with the confusion and uncertainties that surrounded the illness by drawing on existing cultural lexicon around sexual deviance and moral dangers that were presented as rational and

⁴⁰ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. by Richard Howard (New York: Vintage Books, 1965); Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. by A. M. Sheridan (London: Routledge, 2003).

⁴¹ Thomas Osborne. "Medicine and epistemology: Michel Foucault and the liberality of clinical reason", *History of the Human Sciences*, 5(2) (1992): 63-93.

⁴² Cartwright, *Screening the Body*; Paula Treichler, Lisa Cartwright and Constance Penley, *The Visible Woman: Imaging Technologies, Gender, and Science* (New York: New York University Press, 1998); Anne Balsamo, *Technologies of the Gendered Body: Reading Cyborg Women*, (Durham: Duke University Press, 1996).

⁴³ See Ian Hacking, *The Social Construction of What?* (Cambridge; London: Harvard University Press: 1999); Annmarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (Abingdon, Oxon, New York: Routledge: 2008).

objective facts.⁴⁴ Feminist and critical race works on health and medicine have also been affected by Foucault's approach to biomedical discourse and emphasize the production of particularly gendered and racialized bodies and subjectivities in medical knowledge and practices.⁴⁵ More generally, there are also a number of writings that take the clinic as a site where the human body and particular (marginalized) bodies are imagined and worked on in order to produce docile bodies⁴⁶, new regulatory regimes⁴⁷ and new ways for medicine to know what it knows.⁴⁸ In investigating these processes, works in the social studies of science and medicine have highlighted the ways in which medical thinking is heterogeneous and often inconsistent across time and across disciplinary boundaries.⁴⁹ In these studies that span across methodological and disciplinary concerns, physicians figure as a particularly influential node (among others such as nurses, managers, counsellors, occupational therapists, pharmacists, etc.) at which patients encounter disciplining and normalizing discourses of medicine.

⁴⁴ Sander L. Gilman, "AIDS and Syphilis: The Iconography of Disease" *October* 43(Winter 1987): 87-107; Jan Zita Grover, "AIDS: keywords", in *AIDS: Cultural Analysis, Cultural Activism* edited by Douglas Crimp (Cambridge: MIT Press, 1988) 17-30; Susan Sontag *AIDS and Its Metaphors* (New York: Farrar, Straus, Giroux, 1989); Cindy Patton *Sex and Germs: The Politics of AIDS* (Boston: South End Press, 1985) and *Inventing AIDS* (New York: Routledge, 1990); Paula Treichler's *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS* (Durham: Duke University Press, 1999).

⁴⁵ Evelyn Hammonds, "Towards a Genealogy of Black Female Sexuality: The Problematic Silence", in *Feminist Theory and the Body: A Reader*, edited by Janet Price and Margaret Shildrick, (New York: Routledge, 1997): 245-59; Adele Clarke and Virginia Olsen, *Revisioning Women, Health and Healing: Feminist, Cultural, and Technoscience Perspectives* (New York: Routledge, 1999); Susan Wendell, *Rejected Body: Feminist Philosophical Reflections on Disability*, (New York: Routledge, 1996).

⁴⁶ P. Lealle Ruhl, "Liberal Governance and Prenatal Care", *Economy and Society* 28 (1999): 95-117; Lorna Weir, *Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subject*, (London: Routledge, 2006); Suzanne Fraser and Kylie Valentine, *Substance and Substitution: Methadone Subjects in Liberal Societies*, (New York, Basingstoke: Palgrave MacMillan, 2008).

⁴⁷ Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007); Adriana Petryna, Andrew Lakoff and Karthur Kleinman (eds), *Global Pharmaceuticals*, (Durham: Duke University Press, 2006); Samantha King, *Pink Ribbon, Inc.: Breast Cancer and the Politics of Philanthropy*, (Minneapolis: University of Minnesota Press, 2006).

⁴⁸ Cindy Patton, *Rebirth of the Clinic* (Minneapolis: University of Minnesota Press, 2010); Troy Duster, *Backdoor to Eugenics* (New York: Routledge, 2003); Bruno Latour, *Pasteurization of France*, (Cambridge: Harvard University Press, 1988).

⁴⁹ Marc Berg and Annmarie Mol, editors, *Differences in Medicine: Unravelling Practices, Techniques and Bodies*, (Durham: Duke University Press, 1998); Cindy Patton and John Liesch, "In Your Face", in *Cosmetic Surgery: A Feminist Primer* edited by Cressida J. Hayes and Meredith Jones (Farnham, England, Burlington, VT: Ashgate, 2009), 209-224.

Patients thus tend to be the focus in this body of literature; works that take doctors as their main object of analysis are fewer in number, much fewer those that focus on the moral dimensions of their practices. Lianne McTavish has examined medical treatises written by male midwives in nineteenth-century France who deployed visual and textual self-representative practices that helped them gain credibility during a time when women dominated midwifery. She argues that male midwives often represented themselves as gender hybrids in order to downplay the danger of their presence in the birthing chamber and yet still access their gendered privilege as men who were considered to be more theoretically competent than women.⁵⁰ In a similar time period, Robert Nye (drawing on the works of science historians Steven Shapin⁵¹ and Mario Biagioli⁵² on early modern scientists for whom personal honour was closely associated with scientific credibility) finds that Victorian scientists and medical men adopted the old duelling codes among aristocratic men in order to appropriately engage in conflict between one another over scientific views.⁵³ Hence, McTavish and Nye demonstrate that doctors used moralized strategies around gender and class in order to gain credibility and these practices were also related to scientific standards and norms of the time. Dealing with more recent times, Kathryn Montgomery⁵⁴ combines literary analysis of doctors in fictional narratives with ethnographic observations of medical students in order to examine the ways in which doctors come to think the way they do, particularly as they navigate the uncertainties and messiness of medical practice. She argues that clinical judgment is more often based in non-scientific knowledge and practices⁵⁵ and asserts that the moral and the clinical are intertwined in the context of medical practice; for example, she describes the clinical encounter as based in a moral obligation on the part of the physician to attend to the patient.⁵⁶ Montgomery makes a sharp distinction between science (under

⁵⁰ Lianne McTavish, *Childbirth and the Display of Authority in Early Modern France*, (Ashgate, 2005).

⁵¹ Steven Shapin, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, (Princeton: Princeton University Press, 1985).

⁵² Mario Biagioli, *Galileo, Courtier: The Practice of Science in the Culture of Absolutism* (Chicago: University of Chicago Press, 1993).

⁵³ Robert Nye, "Medicine and Science as Masculine 'Fields of Honor'", *Osiris*, 12 (1997): 60-79.

⁵⁴ Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford; New York: Oxford University Press USA, 2006).

⁵⁵ *Ibid.*, 29-41.

⁵⁶ *Ibid.*, 159-162.

which she includes clinical trials, Newtonian physics and biology) and rationality (under which she includes clinical judgment). She also distinguishes between the art of medicine—which includes moral obligations but also an embodied sense of dealing with uncertainty of medical practice—and the science of medicine in order to argue that there is more to medical practices than keeping up-to-date on the latest biomedical studies.

Rationale of Study

This dissertation is rooted in social studies of science and medicine and makes gestures toward the contributions as well as the gaps in the areas of history of medicine and of sociological approaches to the study of doctors and medical professions. In social studies of science and medicine, McTavish, Nye and Montgomery provide insights into how doctors negotiate moral and scientific standards in the way that they engage with others in the profession as well as those outside of it, namely patients. There is also a great value in Shortt's and Underhill's attention to the ways in which class-based struggles in the nineteenth century shaped norms with respect to what constitutes the morally and scientifically appropriate structure and ethos of the medical profession. The emphasis on socio-political struggles between doctors and between doctors as a group and the rest of society explored in the medical dominance framework is useful for thinking about both the internal dynamics among doctors as a group and the group's relationship to external worlds, such as the law and the elected governments. Armstrong's approaches to etiquette among contemporary doctors and to past versions of the professional ethical code are somewhat disjointed but nonetheless make room for thinking about the ways in which the two historical concerns may be linked under a broader framework of morality in professional medicine. These contributions provide jumping-off points for examining the specific scientific concerns and moral pressures faced at different time periods by what we now understand to be the medical profession. While the above works begin to ask interesting questions about doctors and professional medicine and identify interesting sites of analysis, such as medical publications, medical schools and conference proceedings, their conclusions with regard to the relationship between science, morality and professional medicine are limited in depth and scope.

Across these works, there is a underlying tension between a theoretical and methodological approach that emphasizes the discourses and norms around what it means to be a scientific and virtuous doctor and an approach that takes doctors as a social group, which is embedded in political and social relations of a given time and space. This tension is characterized by a rift between symbolic and structural approaches. The symbolic approach situates professional medicine primarily as a type of culture and being a doctor as a type of embodied identity, whether it is a scientific identity or a class identity, and focuses on the interactions between individuals (e.g. between doctors as colleagues or between medical students and their teachers). In this approach, ideas around science and morality empirically emerge as specific aspects of medicine as a culture as either a social norm that is constituted through social interactions or a norm that is imposed on doctors which they either embrace or reject. In this approach, there is little discussion of how these cultural norms may relate to how doctors govern themselves structurally via medical laws, medical curriculum or licensing requirements. These structures constitute the backdrop to the interactions which are the primary sites of analysis. Meanwhile, a structural approach looks to doctors as a socio-political group and medicine as an especially powerful institution. The studies that take this approach locate class struggles, legislative changes and control over labour conditions as primary sites of analysis. This approach empirically situates ideas around science and morality as strategies used by doctors in class struggles, whether they are the struggles between different classes of doctors vying for dominant positions in the profession or struggles of doctors as a group to pressure the government to legislate medical laws in their favour. Across the literature, notions of science and morality appear as pre-existing standards that govern doctors' interactions with various constituents or as completely arbitrary claims that doctors invoke in order to augment their social and political positions.

My project departs from such tendencies to treat science and morality as external to what doctors do and how they think of themselves, and instead looks for the kinds of claims about science and morality that were made possible during different historical moments. Hence, my goal is not to write a history of the medical profession in Canada, nor is it even to write a history of science and morality in Canadian professional medicine, but to look for historical, social, cultural, political and economic conditions

under which certain statements about science and morality became possible with respect to doctors and the medical profession in Canada. I take both science and morality as ideas that fluctuate in accordance with conditional factors and as such recognize that what are considered to be matters of science and of morality and ethics today may not have been thought of as such in other historical moments; conversely, what were thought of as matters of scientific and moral importance in other historical moments may not be recognized as such today.

Foucault's method of archaeology provides an ideal historical framework for my project. He breaks with the conventions in traditional history that establish a continuous narrative of history, that find causal linkages between events and that trace the origins of certain ideas. Instead, he specifically highlights discontinuities and ruptures in history for ideas, concepts and ways of thinking that have been discarded and forgotten or that remain with us today but emerged out of an entirely different set of concerns than what the current narrative of history tells us. Following Foucault's approach, I jump over various historical periods and instead examine together what may appear to be unrelated controversies with regard to the medical profession in Canada: (1) when doctors in nineteenth century Canada struggled to distinguish themselves from other non-medical practitioners, such as homeopaths, from whom they did not differ much in therapeutic principles or success rates, and to persuade law-makers who saw doctors' request for a stricter medical licensing as an attempt to monopolize medicine that doctors were in fact acting in the interests of the public; (2) when the profession faced intense public criticisms for opposing a tax-funded, state-administered health insurance system to the point of withholding their services on a day-long walk-out which may or may not be called a strike; (3) and when the dismissals at the *Canadian Medical Association Journal* jeopardized the Canadian medical profession's claim to a scientific and objective publication. During these three moments, doctors' claims to expertise, to public responsibility and to neutrality from non-medical interests, all ideals that integrate notions of science and morality in particular ways with respect to doctors' relationship to patients, the public, the state and the media, were put into question. Not only did doctors face a great difficulty in defending their legitimacy in the eyes of non-doctors, these crisis

moments⁵⁷ also greatly challenged doctors' belief in their own claims to scientific and moral credibility. It is my aim to hold both types of crises—a crisis in how others see one's position and a crisis of how one sees one's own position—together without resorting to a primarily structural (i.e. medical dominance) or phenomenological synthesis. In examining these crisis moments, I look for specific aspects of these moments that best demonstrate the ways in which doctors strategized in order to regain credibility as a scientific and moral group in a way that aligns with their existing perceptions and beliefs about what it means to be scientific and moral. At the same time, I also look for aspects of these crisis moments for instances where doctors had to modify

⁵⁷ Some historians have problematized the concept of crisis in historical research. For instance, in the area of the history of gender and gender relations, scholars have problematized the notion of a “crisis of masculinity” that some claim to have taken place at the turn-of-the-century. Gail Bederman, for example, writes that “to imply that masculinity was in crisis suggests that manhood is a transhistorical category or a fixed essence that has its good moments as well as bad, rather than an ideological construct that is constantly being remade” (p. 11). Instead, she suggests thinking in terms of changes in the gender system rather than crises per se. I agree with Bederman's critique: I, too, move away from understanding morality and scientificness as fixed measures of good or bad medicine but rather look for the factors that allow certain practices and ideas in medicine to be legible as morally or scientifically legitimate or problematic. However, there is still a value in using crises as a way to frame historical shifts. In a lecture he gave in Brazil in 1974 entitled “The Crisis of Medicine of the Crisis of Antimedecine?”, Foucault criticized the notion of a crisis in medicine, in his case with respect to the plight of social medicine in Latin America at the time in relation to the forces of economic and political development that were coming from Europe and the United States. He states that this crisis should not be seen as the threat of bad corporate-model medicine of the twentieth century to social medicine, but rather as the problematic contradictions and ambiguities in the initial constitution of medicine, which has been in crisis since its origins” (p. 7) as far back as in the eighteenth century, as having both technological and political/economic functions. Hence, he does not do away with the notion of crisis but rather situates the crisis, not in the social problem that is immediately legible in a given (present) moment—i.e. the threat to social medicine—but rather in the culmination of historical shifts and in the factors that are inherent to the idea of modern medicine. I take note of critiques by Bederman and other historians of gender and also follow Foucault's approach in order to situate the crisis moments among doctors in Canada in instances where the inherent ambiguities and contradictions in the doctors' ability to claim an entirely moral and scientific position were made explicit and hypervisible. I have identified the three moments as crises because these were moments when doctors, with great difficulty, first established the logic of their fundamental moral and scientific imperative (which was the case in the nineteenth century) and then faced difficulty when particular ambiguities and contradictions in this moral and scientific logic were highlighted as being so problematic to the point where doctors could not readily persuade others or even themselves of the legitimacy of their moral and scientific claims (which was the case in the mid-twentieth century with regard to doctors' claim to be socially responsible and in the early 2000s with regard to medicine's claim to be an objective and neutral science). Hence, crisis moments function in my project in Foucault's terms as a way to historicize the formation of a discourse (i.e. the discourse of moral and scientific legitimacy of doctors) and I have mapped these moments according to the areas and the extent to which the discourse of legitimacy was problematized and then had to be reworked in order for its inherent ambiguities and contradictions to be returned to their implicit and unproblematized state. To borrow Bederman and Foucault's formulation, doctors' moral and scientific legitimacy may be in constant crisis but are legible as such in particularly critical moments.

their perceptions about what constitutes scientific and moral integrity in response to external pressures. In this way, this project is a historicization of scientific and moral standards in professional medicine, rather than a history of the medical profession, of medicine or of medical ethics.

In examining the social, political and economic conditions through which statements about expertise, public responsibility and neutrality become possible as claims to scientificity and virtue, I gesture toward major shifts in politics, economics and social relations relevant to each historical moment. However, I avoid folding the crisis moments into existing political, economic and social narratives, such as the emergence of the liberal Canadian state in the nineteenth century, the rise of welfare governance in the mid-twentieth century and the shift toward privatization and neoliberal market logic in more recent times so that I may avoid the risk of synthesizing the three moments according to existing narratives of a continuous political, economic and social history or of losing sight of the historical specificities of each moment.⁵⁸ For instance, framing doctors in the nineteenth century as a professional lobby, medicine as a professional monopoly or as an apparatus of the liberal state to manage the population cannot adequately account for the ways in which medical men during this time could not clearly distinguish themselves from non-medical practitioners whom they called “quacks”, did not have a cohesive or effective theory of disease and did not have the support of the state to take control over the Medical Law. Hence, an emphasis on liberalism as a political and social rationale cannot be attentive to the tremendous amount of discursive work that was required in order for doctors to legitimately claim the position of experts. Similarly, framing the tensions between the provincial government and the medical profession in

⁵⁸ In *The Birth of Biopolitics: Lectures at the Collège de France 1978-1979* (New York: Palgrave Macmillan, 2008), Foucault demonstrates that the rise of what may be called liberalism (as an art of governance that is grounded in the assumption that the state must limit itself and the question becomes how much) varied significantly across state contexts. Extending Foucault’s argument, Cindy Patton, in her introduction to the edited volume *Rebirth of the Clinic* (Minneapolis: University of Minnesota Press, 2010), cautions against using the term neoliberalism as catch phrase for any practice or process that individualizes and marketizes social and political life, a type of governmentality that is specific to the Anglo-American context, in which the deregulation of the market was merged with neoconservative moral politics in post-Regan America. An overemphasis and an unproblematized use of the term neoliberalism can “result in the conviction that neoliberalism is more successful than it actually is” (xix) and can therefore obscure the particular instances and spaces where, in the context of Anglo-America, the alignment between market logic and conservative moral politics is weak or no longer exists.

Saskatchewan in terms of the rise of welfare governance will lead to questions of whether or not the province's Medical Act of 1962 ultimately reflected doctors' push for a more privatized health insurance system or the provincial government's push for a public system and whether or not doctors have the ethical and legal right to strike. However, such an approach cannot address how the public shaming in the media compelled doctors to see the increasing scientization and specialization in medicine as a failure to be attentive to the needs of the public. Indeed, this shaming fundamentally re-oriented professional medicine and deeply affected doctors' vision of what medicine should be, scientifically and morally. Finally, the dismissal of the senior editors of the *CMAJ* in 2006 has been primarily discussed in terms of the violation of editorial freedom and the threat to intellectual science in a political and market climate where scientific journals are increasingly becoming privatized. An attempt to trace the neoliberalization of medicine will fail to account for the ways in which the incident raised grave questions regarding the fundamental contradiction between the ideals of scientific objectivity, as a moral and scientific virtue, and the financial and political realities of medical publishing, as well as the incompatibilities between the standards of objectivity in biomedicine and in journalism—tensions that are not necessarily related to issues of privatization specific to neoliberal policies.

Nor do I then revert to a primarily symbolic analysis by treating professional medicine as a kind of culture and being a doctor as a type of social identity so that notions of science and morality become mere cultural traits that shift over time to be donned or rejected by individual doctors. Instead, I examine the ways in which social, cultural, historical, political and economic factors affecting the medical profession at a given time also affected how doctors saw themselves and what doctors understood to be the appropriately scientific and moral domain of medicine (and what is not). Conversely, the ways in which doctors saw themselves and saw what is an appropriate medical concern also affected their relationship with each other in the profession and with those outside of the profession, i.e. the state, the public and the media. In all three historical moments, I avoid imposing current standards of science and ethics in order to judge whether or not doctors acted scientifically and morally during these historical episodes. Thus, I am able to be attentive to the specific scientific and moral priorities of each

moment and to how certain priorities may have been abandoned at the end of the moment or may have lingered on into another historical moment to help doctors rationalize a very different scientific and moral dilemma. I am attentive to and move away from Montgomery's distinction between science (as a body of knowledge) and rationality (as an embodied epistemic posture toward knowing scientifically) or between the art and science of medicine. While I agree with her position that doctors engage in much more than learning biomedical science when they exercise clinical judgment, I do not take this complexity to mean that science must be seen as a separate aspect of medical practice from clinical practice. Here, I turn to Lorraine Daston and Peter Galison's study⁵⁹ of objectivity in the history of Western scientific observation as a way to differently address Montgomery's concern about the multifariousness of medical practice. Daston and Galison suggest that, historically in Western science, the standards of what constitutes an objective manner by which a scientist may observe and represent a phenomenon to other scientists were entwined with ideas around moral integrity and self-cultivation of the scientist, namely in his ability to control the subjectivity of his gaze and to follow the established procedures of observation at the time⁶⁰; scientific ways of seeing have thus always been inseparable from moral ways of being scientific.

In order to develop the relationship between the moral and the scientific in a more systematic manner, I turn to Pierre Bourdieu's concept of disinterestedness, which is a form of social investment that is governed by honour and credit, in order to argue that professional norms are enmeshed in a unique system of rewards that cannot be explained solely by an economic model based on self-interest and on a calculating subject or by an ahistorical and apolitical view of morality in terms of altruism and pure selflessness. Bourdieu has used the term disinterestedness to describe the world of artists, priests and scientists, and as such it is a general social concept rather than one that is specifically scientific, artistic or religious. In addition, Bourdieu's notion of the field is a particularly useful way to think about the internal dynamics among doctors as a group (which may include debates about medico-scientific knowledge and practices as well as socio-

⁵⁹ Lorraine Daston and Peter Galison. *Objectivity* (MIT Press, 2010).

⁶⁰ Ibid.

political struggles) in terms of the struggles within a field. At the same time, a Bourdieuan framework allows me to think about the medical profession's relationship to the world outside of what is strictly medical (such as state bureaucracies, governments and the media) in terms of struggles that take place between fields. In addition, Bourdieu's writings compel me to keep in mind that the very definition of the group, i.e. the medical profession, and the definition of what is medical (and what is not) are also often the object of struggles within medicine and between medicine and other social worlds, such as the law, the government and the media. I also take up Bourdieu's notion of *habitus*, not just as a synonym for identity as in some sociological works on doctors but, as a set of embodied dispositions and perceptions that doctors as a group acquire and that they deploy but also rearticulate in order to make sense of the various moral and scientific struggles in which they find themselves.

My line of inquiry also allows me to look at texts written by doctors in an entirely new way, particularly editorial content in medical journals, which includes editorial columns, commentary and letters to the journal by readers who are also doctors. Rather than seeing these texts as transparent representations of doctors as a type of culture or as ideological documents that hide doctors' political and economic agenda beneath their surface, I take these documents as a collection of possible statements that doctors could make about their scientific prowess and moral obligations during a given historical moment. These documents are written and published by members of the medical profession and have as their audience the same members. In addition, these sections of medical journals are not part of the strictly scientific content—i.e. clinical reports about diseases and therapies or randomized control trial articles—and contain discussions of issues that pertain to professional activities, the public and the media, state legislations, etc. In other words, these sections deal with questions of what it means to be a doctor, what it means to be a medical profession and what it means to do medicine in the broader social context, and as such these documents are also sites of struggles about the definition of the group and of what is medical and what is not. I also look to the existing historical and sociological literature about the three historical moments for the elements of social, cultural, political and economic factors that help to map out the conditions under which the scientific and moral statements that appear in the editorial sections of Canadian

medical journals became possible and even necessary for doctors during these crisis moments.

Combining Foucault's approach to history with Bourdieu's social theory of field and *habitus* allows me to trace the moral and scientific standards in medicine and the ways in which they vary over time according to the preoccupations, pressures and concerns regarding these standards. The combination also helps me to examine each historical moment more closely for the ways in which the standards may change or vary in significance in accordance with the socio-political struggles specific to the moment. In this dissertation, the concept of medical disinterestedness will act as an conceptual term for understanding the relationship between morality and scientificness in medicine and the entire study will hinge upon its emergence and the changes in its contours, limits and content. Such a framework can provide an alternative to the approaches that are found in bioethics or medical ethics in order to understand the moment in which the dismissal of the *CMAJ*'s senior editors took place. My aim is not to constitute a history of the Canadian medical profession or even a history of science and morality in Canadian medical profession. My aim is specifically to historicize the emergence of and the shifts in the moral and scientific standards in medicine in relation to the preoccupations and pressures that professional medicine faced from within and from outside the group at a given historical moment. I also seek to avoid positioning the scientific and moral concerns of the profession as a mask for selfishness and self-interest or taking at face value the narratives of scientific progress and altruism that the profession may use to represent itself. Instead, I want to frame doctors' claims to moral and scientific integrity as both genuine and strategic moves that they deploy in order to make sense of and to maintain their legitimacy as a professional group.

Chapter 2. Analytic Framework

Bourdieu's life work began as an intervention into two major intellectual traditions in his time: phenomenology and linguistic structuralism, which he respectively groups under subjectivism and objectivism in the opening pages of *Outline of a Theory of Practice*.⁶¹ He breaks from phenomenology because it relies on a notion of a rational subject as the primary author of practice, whose intentions, thoughts and motivations hold the answers to social phenomena and from linguistic structuralism because it assumes that norms and rules, particularly those of formal language (*langue*), are what primarily dictate and define the social. Bourdieu is a bit more sympathetic to linguistic structuralism than phenomenology but is critical of the former's denigration of the practice of language, or speech acts (*parole*), as inferior by-products of formal language; he argues that by doing so the approach loses sight of a gamut of practices that do not fall under the logical outcomes of formalized norms or rules such as idiosyncrasies, improvisations and common-sense which are integral and at times central aspects of practice rather than mere exceptions to the norm, and that cannot be reduced to the uniqueness of individuals but rather is dependent on a complex relationship between social structure and practice. To this end, he calls for an analysis of the "logic of practices"⁶² which does not look to the subject's consciousness or the internal composition of structures for explanations of social phenomena but instead emphasizes the relational space between social structures and groups that operate within the structures. It is out of this critical stance vis-à-vis phenomenology and linguistic structuralism that field, capital and *habitus*, the central concepts of his theoretical framework, emerge. Bourdieu's adoption of an entirely different set of terminology indicates his concerted break with the two traditions and as such *habitus* is not

⁶¹ See Pierre Bourdieu, *Outline of a Theory of Practice* (Cambridge, MA: Cambridge University Press, 1977), 1-16.

⁶² Bourdieu, *Outline of a Theory of Practice*, 14.

interchangeable with the phenomenological notion of the subject and field is not synonymous with the structuralist notion of rules or norms. Positioned rather in a relational framework, the terms become meaningless and inoperable without each other: the field is a field of forces and struggles observable only via practices that emerge from the *habitus*; the *habitus* is a set of dispositions and systems of perceptions which is in turn observable only through practice in the field of struggles.⁶³ Hence, Bourdieu's social inquiry is not reducible to either the subjective nor the objective but must account for both and their specific relation and mutual constitution in the context of the social space under analysis. The co-constitutional relationship between *habitus* and field can be best explained by the analogy of a game, which Bourdieu often uses across the span of his works⁶⁴ in order to describe the practical logic of social spaces: all social games have stakes (capital), rules that define the stakes and appropriate strategies to acquire them (field), and players who are invested in the game and understand its rules (*habitus*); one cannot explain the full complexity of the game without any one of these components.

Bourdieu's work has been taken up in diverse fields of study: his ethnographic work in Kabyla, Algeria, particularly on gift economy, is part of introductory theory in many anthropology departments⁶⁵; his work on cultural production (such as literature, art and journalism) is popular in cultural studies and media studies⁶⁶; and his analysis of taste often appears in sociological studies of class.⁶⁷ However, his work on science and the

⁶³ See Bourdieu, *Distinction: A Social Critique of the Judgment of Taste* (Cambridge MA: Harvard University Press, 1984), 101.

⁶⁴ Bourdieu refers to game theory in *Outline of a Theory of Practice*, 12-14; and to game as a way to explain the relationship between the field and the *habitus* in *Distinction*, 250; *Practical Reason* (Stanford, CA: Stanford University Press, 1998), 79-82; *Science of Science and Reflexivity* (Chicago, IL: University of Chicago Press, 2004), 61-62, 82-83.

⁶⁵ For example, Seth Low's "Ethnography of Space and Place" at the City University of New York (Fall 2012), Gordon Matthews' "Graduate Seminar in Anthropological Theory" at the Chinese University of Hong Kong (Fall 2009), and Christina Wasson's "Anthropological Thought and Praxis I" at the University of North Texas (Fall 2005).

⁶⁶ See Rodney Benson and Erik Neveu, *Bourdieu and the Journalistic Field* (Cambridge; Malden, MA: Polity, 2005); Bridget Fowler, *Pierre Bourdieu and Cultural Theory: Critical Investigations* (London: Sage, 1997); John Myles, *Bourdieu, Language and the Media* (New York: Palgrave Macmillan, 2010).

⁶⁷ See Terry Lovell, "Bourdieu, Class and Gender: 'The Return of the Living Dead'?", *The Sociological Review*, 52 (2004), 35-56; Simon J. Williams, "Theorising Class, Health and Lifestyles: Can Bourdieu Help Us?", *Sociology of Health and Illness*, 17, no. 5 (1995), 577-604; Elliot B. Weininger and Annette Lareau, "Translating Bourdieu into the American Context: The question of social class and family-school relations", *Poetics*, 31, no. 5-6 (2003), 375-402.

scientific field has received relatively little attention in social studies of science, technology and medicine,⁶⁸ despite the fact that his field theory of science provides a unique approach to the analysis of scientific struggles, including those in medicine, that place equal importance on the pursuit of intellectual science and the struggle for dominance in the scientific social space. I begin my discussion of Bourdieu's work with field and capital, their composition and types, and his theory of social spaces and power more generally, before moving on to some lesser known auxiliary terms, such as disinterestedness and *nomos*, that are relevant to my discussion of the field of medicine. To conclude, I discuss the methodological possibilities that emerge for my historicized analysis of medical professional norms at the junction of Bourdieu's field theory and Foucault's archaeological approach to discursive formations.

The Field

Field Effects

Bourdieu's field is both a field of struggles and a field of forces,⁶⁹ suggesting that the field is a map of relations and struggles that is bounded by a set of structural constraints and possibilities which he calls field effect.⁷⁰ Social struggles are primarily driven by the need and desire for capital, which is any object, skill or decree that is deemed to be of value. The objective structures in the field, through explicit and implicit rules and norms, determine the species of capital that are of value, the most strategic ways to acquire and conserve them, and the exchange rate to and from other species of capital. Capital in and of itself has no value outside of the field in which it operates,

⁶⁸ His essay, "The Specificity of the Scientific Field and the Social Conditions of the Progress of Reason", is republished as part of *The Science Studies Reader* edited by Mario Biagoli in 1999. There has been sporadic attention to this work: K.D. Knorr-Cetina, "New Developments in Science Studies: The Ethnographic Challenge", *The Canadian Journal of Sociology*, 8, no. 2 (1983): 153-177; Hélène Miallet, "The 'Righteous Wrath' of Pierre Bourdieu", *Social Studies of Science*, 33, no. 4 (2003): 613-621; Michel Callon "Four Models for the Dynamics of Science" in *Handbook of Science and Technology Studies*, Sheila Jasanoff, Gerald E. Markle, James C. Peterson and Trevor Pinch (eds) (Thousand Oaks, CA: Sage, 1995).

⁶⁹ Bourdieu, *Distinction*, 94; *Practical Reason*, 32; *Science of Science and Reflexivity*, 35; Pierre Bourdieu *The Social Structures of the Economy* (Cambridge: Polity 2005) 199.

⁷⁰ Bourdieu, *Distinction*, 113; *Science of Science and Reflexivity*, 9.

which is to say that its value is historically constituted and socially agreed-upon to the point where its value as capital appears natural and matter-of-fact; an integral part of social analysis is to trace the genesis of the constitution of capital as capital.⁷¹ There are many types of capital across the span of Bourdieu's works but they ultimately pare down to five most fundamental types, each with a corresponding field effect—economic, cultural, educational, social and symbolic—which are central to his analysis of 1960s French society in *Distinction*. In this text, economic capital is anything that is a measurement of wealth, including personal and family income and inheritance, and is particularly important in industrial and post-industrial societies that are dominated by capitalist logic because it is the central currency by which one procures other species of capital in this structure: in capitalism, wealth takes the form of money and has become closely associated with the ability to afford education, cultural activities, leisure and status. Cultural capital includes the possession and the ability to appreciate certain cultural objects and activities that are deemed valuable, such as knowledge of books and cultural references, appreciation for music and art, and competency in languages and sport that are considered to be appropriate for the struggle. One accumulates cultural capital through family upbringing, or social origins, where one is first exposed to cultural objects and also through formal training in various cultural practices. Educational capital includes degrees, diplomas and certifications that allows one to access certain employment positions that can then be converted into economic capital in the form of income. Educational capital, particularly in the form of school curriculum and extracurricular activities, such as sports and band, allows the procurement of cultural capital. Social capital encompasses affective and supportive relations, such as family, friends and acquaintances,⁷² and symbolic capital includes honour, prestige, status, titles and family name, all of which are exclusively tied to an individual and cannot be

⁷¹ For Bourdieu's discussion about the relationship between educational capital and cultural capital, see *Distinction*, 112-114. For his discussion about the relationship between these two forms of capital with respect to the constitution of the state, see *Practical Reason*, 49.

⁷² Bourdieu's social capital is markedly different from Robert Putnam's concept of social capital. Putnam focused on the value of social connections for the specific purpose of promoting civic engagement and as such his concept of social capital has an explicitly positive political purpose (see Bob Edwards and Michael W. Foley, "Civil Society and Social Capital Beyond Putnam", *American Behavioral Scientist*, 42, no. 1 (1998): 12). Meanwhile, for Bourdieu social capital is a neutral concept and makes sense only in the context of a field as one species of capital that exists in relation to other species of capital.

transferred to another.⁷³ The objective structures of the field determine the rates of conversion between species of capital and social agents mobilize what is available to them in order to attain and to secure other species of capital. For example, in the 1960s French society, Bourdieu finds that there is a complex system of conversion between economic, cultural and educational capitals: a person from a wealthy family can afford the time and money to acquire post-secondary education as well as exposure to costly cultural activities, such as sailing; a person from a family of modest wealth but with high cultural competencies, such as a home library, exposure to musical instruments and theatre, can translate his or her cultural capital into degrees that can lead to a well-paying job. The flow between capital is dynamic and is dependent on the objective structures that allow conversions to and fro.⁷⁴

Capital is unevenly distributed in the field and social agents are differently positioned in relation to capital distribution so that some groups tend to already possess, or are already in a strategic position to eventually possess, differing amounts and species of capital, while others struggle to take that position. Hence, the field is a map of difference both in terms of distribution of capital and the positions of social agents who partake in the struggle.⁷⁵ Social agents are also more likely to take certain positions and to partake in certain struggles based on their social origins and the trajectory of their social lives, both of which are roughly determined the composition of capital that is at their disposal. Hence, a study of a field must take into account not only where social agents in various groups are positioned at any given time, but also the possible and probable positions that they may take as part of the social struggle.⁷⁶ Bourdieu's way of accomplishing this is through statistical representations, such as charts and tables, of the range of possible and probable position-takings of any given social agent in any given group positioning.⁷⁷ Social agents generally tend to follow the rules of the game because

⁷³ Bourdieu, *Practical Reason*, 47, 85; *Outline of a Theory of Practice*, 41, 179-181; *Practical Reason*, 47+; *Science of Science and Reflexivity*, 52.

⁷⁴ Bourdieu, *Outline of a Theory of Practice*, 180, 196; *Distinction*, 80-82, 282, 310; *Practical Reason*, 42-43.

⁷⁵ Bourdieu, *Distinction*, 110-11.

⁷⁶ Bourdieu, *Practical Reason*, 6-7, 12-15.

⁷⁷ One of the most widely cited chart is Bourdieu's mapping of "the space of social positions" in terms of cultural capital, economic capital and the volume of each in *Distinction*, 128-129.

the greater the fit between the rules and one's actions, the greater the chances of procuring or securing capital. In this sense, the range of possible and probable position-takings are bounded by the possibilities and constraints offered by the field. At the same time, however, these rules are also at stake in social games and as such are shaped by social struggles: social agents may strategically alter the rules of the game in a manner that is favourable to their existing position in the field, whether it is by changing the rate of conversion between species of capital or changing the central unit of capital in the field. For example, when the French Revolution toppled the aristocracy and the monarchy, it also restructured the capital conversion system by severely devaluing family name and status (symbolic capital) and significantly increasing the value of intellectual work and learnedness (cultural capital) so that the possession of education, not blue blood, became the symbol of status (symbolic capital).⁷⁸ In addition, social agents, who had once been barred from the game because they did not possess what was considered to be the proper composition of capital to be competitive in the field may also strive to have their particular set of assets, skills and knowledge recognized as viable species of capital that can then be translated into competitive positions in the field; conversely, those who had once been part of the game may be pushed out if their set of capital is no longer recognized as having any value. These latter struggles occur mostly at the limits of the field, where the field effects diminish or disappear, and as such they are the sites where the objective structures of the field are most likely to be negotiated, altered and even, though rarely, subverted. The limits of the field are not static, are in a state of flux, are often porous and need to be constantly maintained, and as such are one of the major stakes in social struggles.⁷⁹ Those who are in the most strategic positions in the field usually strive to maintain the limits while those who are in less strategic positions often struggle to change them. Hence, the field is dynamic both within its limits, through the different positionings and position-takings of social agents already in the game, and at its margins where its effects are the weakest, and the rules of the game are open to negotiation and change at both fronts of the struggle. As such, the field is not a pre-existing object that can be studied but is a means, for the sake of inquiry, of constructing

⁷⁸ Bourdieu, *Practical Reason*, 23-24.

⁷⁹ Loïc J. D. Wacquant, *An Invitation to Reflexive Sociology* (Chicago: University of Chicago Press, 1992), 100-101; *The Social Structures of the Economy*, 204.

a representation of a range of probable position-takings and limits that are in part constrained by objective structures, such as rules and norms, and that simultaneously allow a range of possible ways by which the objective structures may be subject to change via struggles. Hence, it is not enough to study rules, regulations and codes in order to understand the workings of the field but to examine the ways in which these objective structures are also questioned, interpreted and altered as part of social struggles.

The terms positioning and position-taking are Bourdieu's way of reimagining Marx's idea of class as a pre-existing group consciousness and unity against other classes, or what Bourdieu calls "class-on-paper."⁸⁰ Bourdieu points out that theoretical understandings of class cannot be confused with how class struggles unfold in real life. In particular, he warns that to invoke theoretical class as real class can assume unity in groups that are more differentiated than homogenous and, more importantly, lose sight of the underlying system of differentiation that allows the articulation of social difference in terms of class.⁸¹ In other words, the logic of class depends not only on the different distribution of wealth and status but also the ways in which social difference is measured in terms of wealth and status. This latter approach to class avoids seeing class difference as pre-existing and natural categories that are somehow inherent to the ways in which social agents are grouped. At the same time, however, Bourdieu does not call for the elimination of class altogether because such a move would support a politically conservative position that insists that the field is a homogenous space of equal opportunities and just desserts, rather than as a space of difference. Hence, he calls for an entirely different way of imagining what is commonly—both in academic traditions and in popular thinking—known as class struggles, not in terms of pre-existing categories, such as working, middle- and upper-class, or as non-categories, but in terms of the different—and similar—ways in which people are positioned in a given social space of struggles and forces.⁸² The terms position and position-taking enable a departure from class-on-paper to class-in-real-life as part of the practical logic of difference and similarities across a field of struggles and forces. The most extensive example of this

⁸⁰ Bourdieu, *Practical Reason*, 11.

⁸¹ *Ibid.*, 15.

⁸² *Ibid.*, 32.

approach is in *Distinction* where Bourdieu examines the dynamics between what are widely recognized as the upper-class, middle-class and the working class in 1960s France and discovers that class struggles are most commonly found, not between classes that are farthest removed from one another, such as the upper-class and the working class as would be expected in a Marxist framework of class struggles, but between the closest class rungs. In particular, he finds the greatest amount of difference and struggle among what is generally called the middle-class, which is made up of groups with different compositions of economic and cultural capitals that struggle with one another to define what constitutes the appropriate species and composition of capital of the middle-class.⁸³ The everyday struggles between these groups unfold as a struggle to determine what is tasteful/distasteful and distinguished/vulgar when it comes to art, music, books, sports and food rather than as a conscious group struggle based on a group identity. Hence, the terms position and position-takings orient social inquiry in a different direction to one that analyzes not only social categories that are different from class-on-paper, or any other theoretical social categories, but also of struggles in which the command over the very system of differentiation is at stake. Bourdieu argues that, while Marx's class-on-paper tends to correspond to class-in-real-life, when the latter calls upon the workers to unite, he makes an untenable logical leap from class-on-paper to class-in-real-life in a manner that obscures the practical reality that class is not a pre-existing fixed reality, neither in the mind of social agents of the class or in the objective structures of the field, but is something that is enacted and negotiated through everyday struggles, as seemingly insignificant as what counts as tasteful taste in food.⁸⁴ The terms positioning and position-taking also allow a broader understanding of social difference and struggles in all social spaces that are bounded by a particular field effect, be they corporate firms, the family or artistic work, allowing a more general framework for the analysis of difference and systems of differentiation, class or otherwise.

Although Bourdieu does not often use the term power, he frequently uses the terms dominant and dominated to qualify difference in a given social space in terms of a

⁸³ For example, see Bourdieu's table that illustrates the different rankings of what is a beautiful photo made by different groups among the middle-class (*Distinction*, 59).

⁸⁴ Bourdieu, *Practical Reason*, 11.

theory of power. The struggles for capital and for determining the structuring of capital are the most prevalent day-to-day type of struggle in a given field, but struggles can also unfold where the very perception of reality is at stake. This perceived reality, or *doxa*, is the range of all that is, was and could be possible, thinkable and imaginable and that is tacitly agreed upon without an explicit discussion.⁸⁵ All practice and thought in a given space, including position-takings, are contained within *doxa*. Bourdieu argues that *doxa* is not knowable unless in retrospect, that is not until all that was once deemed impossible to think otherwise becomes available for debate; for example, the notion that the Sun revolves around the Earth was the all-encompassing tacit view of reality until well after Galileo's postulate that the Earth revolves around the Sun, at which point the *doxa* was no longer a taken-for-granted view of reality and could be discussed in explicit terms. Some of the fiercest and most far-reaching social struggles tend to focus on the ability to command the objective structures of the field that in turn shape the vision of reality and Bourdieu argues that *doxa* tends to be shaped according to the position and position-takings of the dominant group in a field that has the greatest control over the objective structures of the field. When the dominated groups push back against *doxa*, that is to say that they "expos[e] the arbitrariness of the taken for granted,"⁸⁶ *doxa* becomes something that the dominant group must defend as the natural vision of the world. When the dominated groups are successful in mounting a campaign against the dominant group, *doxa* becomes orthodoxy—the status quo but no longer taken-for-granted—in relation to the emerging heterodoxy that challenges the status quo with an alternate view of reality; for example, Galileo's heterodox position that the Earth along with the other planets revolves around the Sun transformed the *doxa* that the Sun revolves around the Earth into the orthodoxy of the Roman Catholic Church. Major changes in social worlds can be effected as a result of the dynamic relationship between orthodoxy and heterodoxy, but changes at this scale are extremely rare and difficult because those who are able to effect the greatest amount of change to the structures of the field are normally in dominant positions and are more likely to preserve the status quo, and those who are most likely to question the status quo are normally in dominated positions and are less likely to be able

⁸⁵ Bourdieu, *Outline of a Theory of Practice*, 159-171.

⁸⁶ Bourdieu, *Outline of a Theory of Practice*, 169.

to effect the structural changes necessary to the point of exposing the arbitrariness of the taken-for-granted. Hence, the power to organize the objective structures of the field, which includes the means of securing economic and cultural capital and ensuring that they are dominant species of capital, can lead to the power over representation of reality, but the power to organize the perception of the world can also lead to the power to organize the world itself.⁸⁷ Bourdieu calls this alignment of the objective structures of the field and the *doxa* symbolic violence and the resulting relation of dominant/dominated a doxic submission,⁸⁸ and this is the closest that he comes to a theory of oppression. However, unlike theories that centre on emancipation of the humanist subject from the shackles of an oppressive force, Bourdieu's notion of symbolic violence is not necessarily enacted by force against the will of the dominated, but shapes the will in accordance with the interests of the dominant but under the semblance that the dominated is acting in its own interest. To do so requires a close alignment between the objective structures of the field (as the organization of the world) and the *doxa* (as the perception of the world), which in turn requires a long time and a considerable amount of work to become a taken-for-granted reality. Once established, however, *doxa* is extremely difficult to dismantle—the dominated are led to genuinely believe in the existing world-view and come to become invested in it as part of their own world-view. Hence, it requires a substantial misfit between the objective chances of the dominated to play the game and their belief that the game is possible for them in order for the relation of domination to come under question.⁸⁹ Thus, the status quo has a considerable degree of inertia and *doxa* often goes long unquestioned even by those who have a lot to gain by questioning it.

Inter-field Effects

Although Bourdieu generally approaches the notion of symbolic violence through class and struggles for the means of economic production and domination, symbolic violence is a much more pervasive concept that can be applied to any situation where the

⁸⁷ Bourdieu, Pierre. "Social Space and Symbolic Power." *Sociological Theory* 7, no. 1 (Spring 1989): 21-22.

⁸⁸ Bourdieu, *Practical Reason*, 55-56.

⁸⁹ Bourdieu, *Distinction*, 168.

perception of reality and the power to dictate the representation of the world are at stake and where the struggle is more nuanced than an opposition between oppression and emancipation. The struggles over symbolic power is particularly complex in societies where there are several fields in effect and where the dominant groups in each struggle in turn struggle with one another over the power to define reality on a much larger scale that is beyond their immediate field. New terminology emerges in Bourdieu's work as he moves from his early ethnographic site in Kabylia to his own society in France: the former is a relatively contained world in which there is generally a single field effect—that of gift and honour—that dominates the entire society, whereas distinct economic, cultural, educational and political fields operate simultaneously in his study of French culture in the 1960s, each with its own set of effects, rules, stakes and position-takings. Bourdieu qualifies the difference between such worlds in terms of differentiation—the former is a relatively undifferentiated society while the latter is a highly differentiated society—based on the number of positions and position-takings and dispositions of the *habitus* that are possible in the struggle.⁹⁰ In a highly differentiated society, a multitude of field effects operate simultaneously and unevenly so that various species of capital are part of several different systems of valuation; there are many, at times conflicting, rules of the game in effect; and there are an exponentially higher number of possible positions and positing-takings that can have different consequences in different fields. The terms differentiated and undifferentiated are substitutes for such concepts as modern and pre-modern, civilized and primitive, and (post-)industrialized and pre-industrialized that tend to be enmeshed in colonialist notions of hierarchy between societies that focus on technology, expansion and economic development. Instead, the terms differentiated and undifferentiated locate these differences across societies in the space(s) of the field which includes the economy but also other dimensions of social life such as culture. The object of analysis becomes not the place of a society in an implicit or explicit hierarchy of societies (based on moralized notions of development, civilization, progress, etc.), but the range of different possibilities and limitations offered by any given society at any given

⁹⁰ Bourdieu refers to “the culture of little-differentiated or undifferentiated societies” in which “culture... cannot function as cultural capital, i.e. as an instrument of domination” because “cultural heritage is fairly well distributed” so that there is little or no way of mapping a field of positionings (*Distinction*, 228).

time. The term differentiated is particularly relevant in societies where the means of exercising symbolic violence are fought over across fields, resulting in complex, dynamic and even interdependent relations between fields. For instance, the effects, stakes and *habitus* of the fields of politics and journalism are entwined with one another in the struggles by the dominant group in each field to secure symbolic power—elections are heavily affected by news coverage of them, just as access to political news gives broadcasters a competitive edge in the media market, while the dominant groups in both fields strive to gain dominance over the means to represent political reality. The fields of politics and industry are similarly interlinked—industries rely on legislations and policies to regulate the market just as politicians rely on industries to bolster employment rates that would garner voters’ support, while the dominant groups in both fields struggle to represent economic reality in their own terms. Each of these fields alone demonstrates a complex set of relations, positions and position-takings and rules of the game that interact in ways that cannot be explained through the lens of one field alone. Bourdieu argues that the explanation of relations between fields cannot be reduced to the interaction between individuals from each fields, or even the structural influence of one field upon the other—for example, the effects of funding and corporate sponsorship on news reporting cannot fully explain the particular logic of the journalistic field. The relation between fields must be considered in terms of the relation between positions and position-takings and rules of the game in each field even when examining two individuals from two different fields interact, which is in fact one field talking to another field.⁹¹

In order to make sense of the multitude of ways in which different fields may interact with one another, Bourdieu contemplates two terms: the field of power and autonomy. The field of power is a field of struggles between those who hold dominant positions in their respective fields for their particular positioning and composition of available capital to be translated as equally dominant across other fields⁹² and, more importantly, a struggle for the legitimate position from which to claim a representation of reality. In highly differentiated societies, struggles related to symbolic violence most

⁹¹ Bourdieu, Pierre. “The Political Field, The Social Science Field, and The Journalistic Field.” In *Bourdieu and the Journalistic Field*, edited by Rodney Benson and Erik Neveu (Cambridge: Polity, 2005), 31.

⁹² Bourdieu, *Practical Reason*, 42.

commonly take place in relation to the state which is at the junction of all fields in such societies.⁹³ In “Rethinking the State: Genesis and Structure of the Bureaucratic Field,” Bourdieu traces the rise of the modern French state in order to demonstrate that the bureaucratic space of the state is the result of a gradual concentration of different species of capital, each with its corresponding field of struggles and forces: physical force (such as the military and police), economic capital (particularly through taxation), cultural capital (such as information about the social body and standardized language), juridical capital (in the form of decrees, laws and the entire judicial system) and symbolic capital (such as the compulsion of nationalism and loyalty to the state).⁹⁴ These species of capital became differentiated in the first place through the state: they become incorporated into diverse structures, discourses and processes until these effects coalesce to form a unique field of forces and struggles. The state is also the legitimate site where the rate of conversion between these species of capital are determined. Seen in this way, the state is not a pre-existing or a tangible body that exerts power from without but rather a distillation of structures, discourses and processes which are driven by the forces of the field of power which is in turn shaped in terms of all the various fields of struggles that it contains, such as the economy, the military, the cultural field and the law; it is something to be worked on as an object of struggles at the same time that it operates as a structure that imposes. The relationship between fields can thus be analyzed in terms of their relation to the field of power: the investment of the players, particularly those in dominant positions in each field, in the convertibility of their capital into dominant position in the field of power and the play of forces within and between fields that allow or disallow this move—put in another way, “the power to decree the hierarchy and ‘conversion rates’ between all forms of authority in the field of power.”⁹⁵ The bureaucratic space of the state in turn can be seen as a field of struggles between representatives of each field, as evident in Bourdieu’s analysis of the housing industry

⁹³ Bourdieu warns that the field of power is different the political field; the latter is a particular field of struggles between state bureaucrats—elected politicians, diplomats, ministers and ministries—with its unique set of rules and stakes, while the former is a kind of “meta-field” (Loïc Wacquant, *An Invitation to Reflexive Sociology*, 18) that contains at least some parts of all fields in a given (highly differentiated) society. See also Wacquant’s note about the field of power in *An Invitation to Reflexivity Sociology*, 76.

⁹⁴ Bourdieu, *Practical Reason*, 41-45.

⁹⁵ Wacquant, *An Introduction to Reflexive Sociology*, 17-18.

and regulation in France in the 1960s which was a struggle between those from construction companies both large and small, bureaucrats from various departments and services and elected officials who claim to act on behalf of their constituents over the question of housing reform that would result in the construction and purchase of single family homes at the expense of larger commercial buildings.⁹⁶ He finds that the agents involved in this struggle are positioned along a continuum between anti- and pro-reform and that these positions are distributed according to multiple factors, such as the relations between departments and the relations between agents within each department who are from different educational backgrounds, so that the dominant species of capital in each space, be it seniority or technical knowledge of construction and the banking sector, were mobilized in order to gain control over the terms of the debate and thus the outcome of housing reform.⁹⁷ Ultimately, Bourdieu finds that neither the social origin of each individual player nor the economic or political power of those involved alone could fully explain the dynamics of this struggle—it had to be both in tandem—a point that he uses to explain some of the unexpected alliances that cannot be accounted for by one of these factors alone.⁹⁸ He also finds that each agent sought to influence the debate in such a way that their specific department, agency or industry union would not become irrelevant to the question of housing reform and thereby continually establish their respective fields as a viable space from which to claim a representation of the world, in this case of housing.⁹⁹ The relations between fields cannot be predicted based on the various components of what is at stake, nor can they be fully understood in terms of the logic of one field, but on the specific relation as it unfolds in the field of power as a struggle to determine which field effect dominates the means of exercising legitimate symbolic violence.

⁹⁶ Bourdieu, *Social Structures of the Economy*.

⁹⁷ See Bourdieu, *Social Structures of the Economy*, 98-110; 116-118.

⁹⁸ *Ibid.*, 105-108; 128-131.

⁹⁹ Bourdieu refers to the tension between “the bureaucratic capital of experience” (i.e. seniority and relationships within the firm) and the “technically-based bureaucratic capital” (i.e. statistics, surveys and mathematical modelling) in the bureaucratic field of the state. These two forms of the bureaucratic capital are linked to age and education and they may be mobilized by different groups (e.g. younger technically trained civil servants mobilize the technical information while the older more experienced civil servants mobilize their seniority). Bourdieu concludes that the “innovators” of housing policy won over the existing administrators in the finances department by highlighting their technical mastery. See *Social Structures of the Economy*, 116-118.

The bureaucratic space of the housing reform is an example of a highly autonomous field of higher civil service: despite its dependence on extraneous fields—such as the economic field of housing construction to produce single family homes, the economic field of banking for systems of loans and financing for the homeowner, and the political field of elected politics that would constitute home ownership as a political issue—the debates remained unaffected by the effects of these fields. The capital and competencies held by each representative in their respective home fields had to be translated and mobilized in order to meet the rules of the game of higher civil service and the stakeholders in each of these fields, such as voters, had no immediate impact on the struggle within the bureaucratic space.

Bourdieu differentiates between autonomous and heteronomous fields and between autonomous and heteronomous poles within fields, a distinction that is particularly salient to his discussion of the journalistic field.¹⁰⁰ He identifies two kinds of spaces in the journalistic field: the autonomous space of “pure” journalism where cultural capital of the pursuit of news for democratic visions of news reporting is the dominant logic that is independent from external forces; and the heteronomous space of journalism that is most affected by and dependent upon economic and political forces, such as audience ratings and competition for news coverage. He identifies journalistic, political and social science fields as spaces where the power to define what is a legitimate political issue, how the problem should be addressed and who should address it take place, and the dominant groups or representatives from each field are differently positioned in the field of power to secure the means of representing political reality on a broader scale. He finds that these fields depend on one another to gain legitimacy in the field of power: politicians and social scientists rely on media appearances to influence representations of political reality; politicians and journalists rely on social scientists to provide scientific legitimacy to their position; and journalists and social scientists rely on politicians in order to make or prevent changes in the political field that would affect the success and recognition of their version of reality. Journalism’s function, or potential and intended function, as a vehicle for democratic debate and participation in the field of power is

¹⁰⁰ Bourdieu, “The Political Field, The Social Science Field and The Journalistic Field.”

complicated by its precarious autonomy with respect to the political and social scientific fields, as well as the economic field. On one level, a low degree of autonomy supports a democratic vision of the political world by allowing non-journalists to partake in the struggle, or to lower the condition of entry into the field of journalism, in the name of democratic access to the means of knowledge production; on another level, however, the lack of autonomy opens the space to the forces of other fields so that the rules of the game of journalism may shift to support versions of reality other than democracy, such as economic bottom line, sound-bite format of news and meeting consumer demand. Seen in another way, a high degree of autonomy can indeed risk elitism of the press. The example of the heteronomous space of journalism demonstrates that autonomy and conditions of entry of a field are points of analysis of the field of power where the position from which to determine legitimate representation of reality is at stake.

Disinterestedness, Nomos and the Scientific Field

Another space of struggle for the power to represent reality is medicine, as a subspace of Bourdieu's scientific field. Medicine, as a collection of bodies of knowledge and of practices, is involved in the field of power because those who partake in this field struggle to define health, illness and treatment that in turn affect broader social, cultural, economic and political realities. The scientific field is characterized by a unique logic that is different from most other social worlds that are dominated by the logic of economic capital. In *Practical Reason* and *Social Structures of the Economy*, Bourdieu cautions the reader against projecting the logic of the economic field in its current form and context upon every social universe because to do so runs the risk of reifying interest in narrow terms (i.e. economic interest of the atomized self), a move that erases the historical conditions, such as colonial and capitalist expansions and modernist projects, that once constituted the economic field, with its "spirit of calculation,"¹⁰¹ which eventually became the ubiquitous and naturalized version of the world. To reify motivations solely in terms of economic interests also obscures other possible forms of interest that defy economic definition of the term, such as the affective bonds of the family, religious calling of priests, aesthetic visions of artists and objective commitments

¹⁰¹ Bourdieu, *Social Structures of the Economy*, 5-6.

of scientists. In his lesser known works on these worlds, Bourdieu explains that certain micro-worlds—or “anti-economic”¹⁰² universes—operate by a logic that is the complete reversal of the economism of the economic field—the logic of symbolic capital. Symbolic capital is perhaps the most ambiguous species of capital. Bourdieu very broadly defines symbolic capital as recognition, honour, credit and prestige¹⁰³ and links it with the possession of economic and cultural capitals.¹⁰⁴ However, symbolic capital’s more interesting quality lies in the fact that it operates by an entirely opposite logic to that of economic capital while at the same time relying on economic capital to function properly. Symbolic capital first appears in *Outline of Theory of Practice* in Bourdieu’s extensive study of gift economy in the village of Kabylia in Algeria where he conducted his first ethnographic work.¹⁰⁵ He observes that the villagers engage in a concerted yet unspoken effort to ensure that the act of giving a gift assumes a counter-gift but that this economy is not perceived as a barter exchange but one of gifting by maintaining a time lapse between the gift and the counter-gift—according to the unspoken norms, to give the counter-gift too soon after the original gift is to suggest a barter, rather than a gift economy, and therefore amounts to a serious insult to the original gift-giver. Hence the symbolic economy of the gift in this society is predicated upon an explicit denial of this economy as an economy.¹⁰⁶ However, there is also an unspoken expectation that there must be a counter-gift. Hence, symbolic capital in this case operates as a kind of credit, as something that is owed, but also denied as such because instead it must be thought of as a gift. The lapse of time between the gift and the counter-gift constitutes a system of credit in which the original gift-receiver is beholden to the gift-giver and is thus positioned in a relation of obligation toward the latter during the period between gifting and counter-gifting.¹⁰⁷ In his own society of 1960s French culture, Bourdieu finds a similar economy at work among the professional class, who convert its reputation and respectability into political positions, such as doctors and lawyers who mobilize their public image to run as

¹⁰² Bourdieu, “The Production of Belief: Contribution to an Economy of Symbolic Goods”, *Media, Culture and Society*, 2 (1980): 261-293.

¹⁰³ Bourdieu, *Outline of a Theory of Practice*, 179.

¹⁰⁴ Bourdieu, *Distinction*, 291.

¹⁰⁵ See Bourdieu, *Outline of a Theory of Practice*, 4-8.

¹⁰⁶ *Ibid.*, 171-173.

¹⁰⁷ *Ibid.*, 180-181.

political candidates.¹⁰⁸ Bourdieu further develops this concept of symbolic capital among the modern nobility in “Social Space and Symbolic Power” where he argues that the professional and the ruling classes mobilize their economic and cultural capital (i.e. their educational credentials) to procure symbolic capital in the form of respectability and the collective recognition that they are honourable. This group deploys its symbolic capital in order to influence and shape the perception of the world and the structures of the field. Hence, while symbolic capital is “nothing more than economic or cultural capital when it is known and recognized,”¹⁰⁹ it is somehow bigger than the sum of these two species of capital in the sense that the person who possesses symbolic capital commands recognition without having to exert force and can constitute a view of the world simply by claiming to speak on behalf of those who provided recognition in the first place; the credentials of the professional and the ruling classes functions as a credit which automatically demands recognition, similar to a counter-gift to the original gift in Kabylia. In *Practical Reason* Bourdieu expands this power of symbolic capital with Weber’s concept of charisma as a kind of magical power to mobilize and shape collective expectations and repressions without having to exert physical force. The charisma of the state—leader(s), dictator, parties, etc.—can engender submission without having to explicitly demand it by relying on feelings of honour, recognition and credit, or symbolic capital which serve to obscure the economic and physical forces (e.g. monopoly, military) through which the state acquired and maintains its symbolic capital in the first place.¹¹⁰ Hence, symbolic capital is based on an apparently contradictory co-existence of a collective repression of the fact that there is an economy at work—whether it is an exchange of goods and services as gifts or the translation of economic capital into symbolic violence on a mass scale—and a collective expectation that the credit must be honoured in a manner that does not suggest that it is indeed an economy.

Scientific capital is grounded in this contradictory logic of the symbolic capital: the intellectual work of science is based on a genuine pursuit of knowledge for the sake of knowledge, common good and progress, and yet individual scientists, laboratories and

¹⁰⁸ Bourdieu, *Distinction*, 291.

¹⁰⁹ Bourdieu, “Social Space and Symbolic Power,” *Sociological Theory*, 7, no. 1 (1989): 21.

¹¹⁰ Bourdieu, *Practical Reason*, 102.

institutions compete with one another for research funding, recognition, publication record and other rewards for the intellectual work—practices that are not external to science but are integral to them—for example, without funding intellectual work is severely constrained and even impossible and recognition from other scientists adds intellectual value to any scientific work. In order to account for investments and motivations that cannot be accounted for by the economic logic of calculated interest, Bourdieu considers the term *invested disinterestedness* as a genuine collective denial of the existence of an economy and even of any kind of struggle but which is underpinned by a tacit collective understanding that there is another structure at work that rewards honour, credit, prestige and status for which social agents compete with one another—simply put, *disinterestedness* is a denial of the game as a game. For example, a scientist who is able to procure funds from respectable sources, navigate the demands of the institution (usually a university) and publish an amount that is appropriate to his or her career status and is still able to maintain to his or her peers that intellectual pursuits are his or her primary goals would be quite successful in the scientific field; in contrast, a scientist who is known by his or her peers to shape projects based on the demands of funders (such as industries or state bodies) or to compete too aggressively with his or her colleagues for promotion and status would not be as successful. Still yet, a scientist who maintains intellectual pursuits as the central goals of his or her practice but is unable to procure funds, publish or to produce sufficient research would also be relatively unsuccessful. Hence, it is not that there is an absence of economy and of struggle in anti-economic universes but that there is a different kind of economy in place, one that is based on a firm collective denial of the struggle but also a tacit and implicit collective understanding that there are, indeed, stakes, rules and competition. While an economic universe functions by a well-known fact that social agents are engaged in a struggle and that they mobilize their capital and follow the rules of the game in order to become strategically positioned in the field, an anti-economic universe requires that social agents deny the game as a game and uphold *disinterestedness* as the primary virtue in order to be rewarded in the game.

Disinterestedness appears sporadically across Bourdieu's works and it is a quality that is linked to a dominant position, particularly in the aftermath of the breakdown of

aristocracies and monarchies and the rise of the bourgeoisie as the ruling class. In *Distinction*, he argues that while the aristocracy of the old world relied on spectacles of consumption in order to enact its dominance over the peasants, the bourgeoisie enacted its position in the class struggle through restraint that was only possible in a condition of affluence. The availability of a large amount of wealth allowed the luxury of not being concerned with everyday necessities, such as making a living, putting food on the table and paying the bills, giving way to “ease” and leisure.¹¹¹ Hence, this group emphasizes such activities as taking a walk, the art of conversation and exercise, choosing wine or holiday decorations,¹¹² which are devoid of function in terms of everyday necessities but rather for enjoyment and are predicated on the availability of free time that is not spent on working. The bourgeoisie is thus invested in displaying disinterestedness as a marker of distinction that sets it apart from the working class whose time and activities are more closely aligned with life necessities. The bourgeoisie replaced the aristocracy and monarchy of the old world in Europe as the ruling class and its disinterestedness based on leisure and ease was further translated into a notion of civil service. In *Practical Reason*, Bourdieu explains that sections of the aristocracy and the emerging bourgeoisie became invested in notions of the public and common welfare¹¹³ as well as in education to give way to a new class of state nobility, the *noblesse de robe*, that mobilized its cultural and educational capital and played a pivotal role in the French Revolution as its intellectual inspiration. The state nobility became the ruling class according to a new logic of power, that of the universal, which allowed this class to make claims and act in the name of public and universal welfare in the form of civil service, differentiating itself from the repressive rule of the aristocracy and monarchies of the old world, all the while reserving the power to constitute what is universal by virtue of its cultural and educational capital. Disinterestedness of the *noblesse de robe* is based on the claim to act on behalf of another and to be compelled by something that is greater and stronger than the self—“it is stronger than me”¹¹⁴—a logic that spread into other micro-worlds, such as the literary field, the artistic field and the scientific field. Thus, the disinterestedness of the scientist,

¹¹¹ Bourdieu, *Distinction*, 55.

¹¹² *Ibid.*, 56.

¹¹³ Bourdieu, *Practical Reason*, 23-24.

¹¹⁴ *Ibid.*, 87.

Bourdieu notes in *Science of Science and Reflexivity*, does not emerge from a social vacuum but is the result of a particular social position and family origins that steers a scientist-to-be toward the disinterested profession; in fact, he finds that scientists who attended more theory-based schools of higher learning, as opposed to technical scientific colleges, tend to come from families with one or more members who are already part of the scientific field.¹¹⁵ Scientific disinterestedness is thus historically linked to the rise of the bourgeoisie and its struggle to define a set of virtues that sets it apart from the repression of the aristocracy and the monarchy as well as the working class which it sought to rule. Disinterestedness as an unfaltering concern for the universal that is beyond the self became the central guiding principle of this group which was made possible in the first place by a dominant position in the economic and cultural fields that provided the luxury to move away from immediate life necessities and to contemplate the universal, common welfare, aesthetics and the pursuit of knowledge.

The seemingly contradictory symbolic logic of disinterestedness that is based on a system of rewards for disinterested acts is held together and maintained through *nomos* of the field which is a system of vision and division or a principle that orders discourse, practice and relations in a given struggle. *Nomos* is a law of the field that is not imposed in explicit terms, limiting and constraining and thus available for debate and refusal, but that is naturalized and embodied as common sense and that produces a vast array of strategies, discourses, objects and possibilities. *Nomos* is particularly important in social worlds that are governed by disinterestedness, such as the scientific field, because their logic runs opposite to that of most other social worlds that surround them which are governed by explicit investment and engagement in the game and whose *nomos* include such axioms as “business is business” and “in business there’s no room for feelings”¹¹⁶; *nomos* in disinterested fields must be extensive, robust and able to withstand the pressures of fields that surround them. There are two most notable discussions of *nomos* in Bourdieu’s work that shed some light on what this may look like, one with respect to the family and the other regarding symbolic domination. In “On Family as a Realized

¹¹⁵ Bourdieu, *Science of Science and Reflexivity*, 53.

¹¹⁶ Bourdieu, Pierre, *The Field of Cultural Production*. Edited by Randal Johnson (Columbia University Press, 1993), 62.

Category,” Bourdieu finds that the category of the family operates as *nomos* that produces “a matrix of countless representations and actions,”¹¹⁷ such as the image and object of the home, legal and social bonds of marriage, ceremonies and occasions where family gathers, and filial relations of obligation and affection, to name just a few, that are based on a prevalent and uncontested belief in family as a natural social and affective social unit. Family takes on such a high degree of naturalness and obviousness due to a very close alignment between the objective structures of the field and the belief and affective investments of the *habitus* in the family, so much so that the fact that the very notion of family was once historically constituted is forgotten and obscured. In *Practical Reason* Bourdieu explains that political domination—here in the form of submission to the state—occurs when there is an alignment between the perceptions and affective investments of the people and the objective demands of the state structure; at the same time, however, the alignment is possible because the investments of the people have been more or less shaped, over a long period of time, through a complex symbolic mechanism, which includes standardized language, taxation and decrees, that produces a feeling of national unity and a perception of moving toward civility. This is why, Bourdieu argues, some politically dominated groups, both historical and contemporary, do not perceive themselves as dominated because the fact that their view of the world is that of the dominant group has been systematically erased and naturalized as a self-evident fact. Hence the system of vision and division that is *nomos*, which orders the world and presents the world in terms of a particular version of reality that cannot be disputed, is a product of history and yet is collectively denied as such so that it persists as a common sense vision of the world that cannot be imagined as otherwise. This common sense, as law and belief, is highly positive in that it produces a complex array of strategies, discourses, relations and objects that reaches the far corners of the social world within which it operates, thereby reinforcing the perception of its self-evidence. Fields that rely heavily on symbolic capital—whether it is family feeling, political charisma, or the impulse of doing science for the sake of science—require a considerable amount of work

¹¹⁷ Pierre Bourdieu, “On the Family as a Realized Category”, *Theory, Culture and Society* 13, no 3 (1996): 19-26.

in order to maintain their precarious logic vis-à-vis the effects of the economic field in particular.

Fields that reward disinterestedness must be sufficiently autonomous from other fields, particularly the economic field, in order to maintain their unique logic based on a symbolic economy of game as not a game and *nomos* of disinterestedness. Bourdieu argues that the autonomy of the scientific field is based on a balance between what he recognizes as two forms of scientific capital: temporal and scientific.

Because the autonomy is never total and because the strategies of the agents engaged in the field are inseparably scientific and social, the field is the site of two kinds of scientific capital: a capital of strictly scientific authority, and a capital of power over the scientific world which can be accumulated through channels that are not purely scientific (in particular, through the institutions it contains) and which is the bureaucratic principle of temporal power over the scientific field such as those of minister and ministries, deans and vice-chancellors or scientific administrators.¹¹⁸

The purely scientific falls under the logic of symbolic economy in which scientific work and products function as credit and honour, while the bureaucratic principle more closely follows the economic logic of government subsidies to universities, industry funding for research, political organization of universities, etc. Bourdieu asserts that a scientific field in which the purely scientific dominates over the bureaucratic and temporal tends to be more autonomous, though autonomy is never complete and the temporal effects of the bureaucratic principle always looms over the purely intellectual work of science. Kyung-Man Kim provides an example of a scientific struggle in his study of a nineteenth century conflict in British biology between traditional Mendelian genetics and then newly-emerged theory of biometry.¹¹⁹ Using Bourdieu's idea that scientific capital is at once intellectual and bureaucratic, Kim argues that the proponents of biometry succeeded in overthrowing Mendelian geneticists because they were able to translate their political motivations (to gain dominance in their area) into intellectual terms that made sense to fellow geneticists that biometry was a viable scientific alternative to classic Mendelism.

¹¹⁸ Bourdieu, *Science of Science and Reflexivity*, 57.

¹¹⁹ Kyung-Man Kim, "What Would a Bourdieuan Sociology of Scientific Truth Look Like?", *Social Science Information*, 48, no. 1 (2009): 57-79.

Kim's analysis demonstrates that the intellectual is inseparable from the socio-political in science and, in fact, the two aspects depend on one another. While this argument is not new in science and technology studies, Bourdieu's work provides an alternative view that both the symbolic/intellectual and the social/political investments of scientists must be taken seriously without one (political motivations) eventually dictating the other (intellectual pursuit) which tends to be the conclusion in cultural analyses of scientific work.¹²⁰ It is the task of the analyst to document the precise circumstances in which the logic of symbolic/intellectual capital may outweigh social/political capital—and vice versa—and how these instances affect the ways in which the scientific field is structured.

Kim's work draws on the dynamic of intellectual science and politics within the borders of the scientific institution—the discipline of biology. Bourdieu touches on the pressures of external demands, particularly in biomedicine, which he recognizes as being tied to economic stakes in biotechnology industry and patent laws, but concludes the short discussion by deferring to the disinterestedness of the scientific *habitus* in order to claim that disinterestedness ultimately dominates over external pressures.¹²¹ Meanwhile, the structural relationship between intellectual science and external bureaucratic principles is highly contentious for the logic of disinterestedness; for instance, the pursuit of intellectual science is often expensive, requiring costly technology, such as electronic microscopes and magnetic resonance imaging (MRI), which means that the disinterested work of intellectual science directly relies on the temporal effects of a healthy stream of funding and university bureaucracy. Meanwhile, the disinterestedness of the bourgeoisie that foregrounds Bourdieu's discussion of scientific disinterestedness provides a clearer explanation for the relationship between pure intellectual science and bureaucratic principle: the bourgeoisie distinguishes itself from other lower classes by its disinterest in necessity and its disinterested investment in common welfare, but its ease and self-effacement are made possible by external conditions, namely its dominant position in the

¹²⁰ The question of what drives scientific work (purely intellectual pursuits, social and political motivations of individual or groups of scientists, the motivations of those outside of science) emerges as a problematic in social analysis of science across various traditions. For an overview of these issues across the various traditions within science studies, see Sergio Sismondo, *An Introduction to Science and Technology Studies* (Malden: Blackwell, 2004).

¹²¹ Kim, "Bourdieuian Sociology" 52-53.

economic and cultural fields which it claims to disavow. Similarly, the scientist is able to claim a disinterested investment in science for the sake of science, a practice that is beyond the self and that transcends immediate necessities, precisely because the necessities, such as funding and resources, have already been secured by external and temporal forces which the scientist claims to reject. From this approach, autonomy of the scientific field is predicated on both intellectual science and on bureaucratic principle but requires that the former dominates in appearance so that the collective denial of the game as a game may continue. *Nomos* of the scientific field must account for this tenuous contradiction and order the system of vision and division in a way that can maintain a division between intellectual science and bureaucratic principle which then ensures the autonomy of the field vis-à-vis the rest of the world, particularly the economic field.

The scientific field is my starting point for thinking about the struggles in which doctors are situated in various time periods. One could argue that medicine is as much or more of an art than it is a science, but it is undeniable that scientific capital, however it is organized, imagined and valued at a given moment, plays a significant role in what doctors do, how they see themselves and how they relate to one another and to non-doctors. Thinking about science in terms of a field of struggles that is governed by a unique system of awards and strategies which are based in disinterestedness helps me to move away from notions of science versus art in reified and antithetical terms. Instead, the notion of the field—particularly the scientific field—allows me to grapple with the tensions between the intellectual (atemporal) and the bureaucratic (temporal) concerns in medicine as part of its struggle to solidify and to maintain its *nomos* of disinterestedness. The logic of disinterestedness is never fixed or guaranteed due to fluctuations in the field and so it must often be defended and rearticulated in accordance with the struggles in the field and in the field of power. In this dissertation, I look for instances where doctors as a group responded to such moments of flux, particularly where the bureaucratic pressures overwhelmed the intellectual pursuits of medicine, through structural accommodations of the field.

The *Habitus*

Bodily Hexis and a “Feel for the Game”

The *habitus* is a set of dispositions of the body and an embodied sense of what is tasteful, possible and sensible, as well as what is distasteful, impossible and insensible, in a given social situation. It is not tied to a single individual as an innate and unique quality but is characteristic of a social group, which can be defined as a group of individuals who have similar composition of capital and therefore are similarly positioned in the field. Embodied dispositions, or what Bourdieu also calls bodily hexis,¹²² are more or less shaped by the structures of the field, or by the differential distribution of capital and the valuation of capital and its rate of conversion to and from other form of capital. In *Outline of a Theory of Practice*, Bourdieu argues that the dispositions of a group *habitus* tend to align with the demands and rules of the field in the sense that social agents tend to develop dispositions that are rewarded by the field. This argument is apparent in his empirical analysis of 1960s France in *Distinction*, in which Bourdieu finds that a person who is born into a working class family is likely to develop an appreciation for meals that are hearty and large-portioned because this type of food is necessary for a life of physically challenging work that tend to be more readily available to this social group.¹²³ The composition of economic and cultural capital that is made available to this group compels the members of the group to value larger servings and nutrition which are made necessary by the field as markers of virtue, i.e. tasteful food. Conversely, he finds that a person born into an upper class household is likely to develop a taste for smaller-portioned and highly-flavoured foods because members of this social group do not need to engage in physical labour—and indeed, such labour would be looked down upon as vulgar—and are not constrained by a necessity for larger servings and nutritional value in food. In fact, he argues, this dominant class group would seek to distinguish itself as superior to the working class by developing a preference and appreciation for types of food that are not readily accessible for the latter group. These embodied dispositions, as immediate as a taste in food, may feel to the individuals as

¹²² Bourdieu, *Distinction*, 474; Bourdieu, *Outline of a Theory of Practice*, 87-88, 93-94.

¹²³ Bourdieu, *Distinction*, 190-191, 194-196.

something innate and unique to themselves but they are born out of the composition of capital which is accessible or inaccessible to the family of origin and ultimately, and more significantly, to the social group as a whole. He describes this process, particularly for dominated groups, as “necessity made into a virtue” or “to refuse what is anyway refused and to love the inevitable.”¹²⁴ In Bourdieu’s work, the notion of social group emerges in relation to his critique of Marxist application of the term class, or more specifically “class on paper”: the *habitus* is not a united consciousness that exists prior to or is external to social structures but is constituted in accordance with the effects of a particular field, including the distribution of capital and the range of positions and position-takings that are possible. This is particularly evident in his analysis of class factions in 1960s French society and in the above example of different tastes in food. The working class person and the upper class person find the other’s food preference distasteful and insensible: the working class person is puzzled by a preference for small portions that does little to fill you up, and the upper class person is repulsed by a preference for large portions. It is these everyday forms of “tastes and distastes, sympathies and aversions, fantasies and phobias... more than declared opinions, [that] forge the unconscious unity of class.”¹²⁵ In other words, class distinction is not solely about an explicit declaration of a class consciousness posed against another class, usually in the form of a working class consciousness that is declared against the middle or upper class. Instead, what becomes articulated as class is based on the deeply embodied dispositions of the body that are specific to a group as a result of the group’s access to a particular composition of economic, educational and cultural capitals. Everyday class struggles involve distinguishing one’s own (group’s) dispositions of the *habitus* and one’s positioning in the field from those of another group.

The *habitus* is not characteristic of an individual, distinct and unique, but refers to a set of dispositions of a group in a field. As such, the *habitus* always and necessarily entails a temporality: it is constituted historically through years of a group’s struggle in a field and it is durable, enduring and not inclined to change easily. Conversely, the

¹²⁴ Bourdieu, *Outline of a Theory of Practice*, 77.

¹²⁵ Bourdieu, *Distinction*, 77.

habitus includes the capacity to respond to situations that one may not have yet encountered. In *Outline of a Theory of Practice*, Bourdieu refers to the *habitus* as “history turned into nature”¹²⁶: through generations and even centuries of being more or less consistently positioned in the same manner in a field—i.e. having access to consistently the same composition of capital—social groups tend to develop a corresponding set of bodily dispositions that over time seem natural, matter-of-fact and even common-sensical. The members of a group, via generations of passing on the practical know-how of living within the constraints and possibilities that are offered to them by the structures of the field, forget the historical circumstances through which the group’s positioning and its bodily hexis were constituted in the first place. Indeed, it is impossible to speak of a group *habitus* in a given field without considering the historical and generational processes by which this *habitus* was shaped in relation to the fluctuations in the corresponding field. The economic *habitus* is commonly placed in ahistorical relation to an ahistorical understanding of the economic field. In *The Social Structures of the Economy*, Bourdieu argues that dispositions of the economic field as they appear now, such as the inclination to work, to consume and to save money, are the product of very specific historical effects of the economic field. One of the functions of this field is to make these dispositions appear as timeless, matter-of-fact and natural; it is the task of the analyst to work against this “amnesia of genesis” and to historicize the process by which the economic game has been constituted as well as the dispositions of the *habitus* that tend to be rewarded by this game.¹²⁷ In addition to being historically constituted into a durable set of dispositions, the *habitus* also entails an anticipation of future events, or what Bourdieu calls “a feel for the game,”¹²⁸ which he describes as follows:

Having the feel for the game is having the game under the skin; it is to master in a practical way the future of the game; it is to have a sense of the history of the game. While a bad player is always off tempo, always too early or too late, the good player is the one who *anticipates*, who is ahead of the game. Why can she get ahead of the flow of the game? Because

¹²⁶ Bourdieu, *Outline of a Theory of Practice*, 78.

¹²⁷ Bourdieu, *The Social Structures of the Economy*, 5.

¹²⁸ Bourdieu, *Practical Reason*, 80.

she has the immanent tendencies of the game in her body, in an incorporated state: she embodies the game.¹²⁹

The player, or a social agent, derives her “sense of the history of the game” not only from her own encounters with the game but also from her entire group’s past and present encounters, both successful and unsuccessful. This practical mastery of the game is passed on through generations—directly as family wisdoms and vicariously as children mimicking their parents, all as part of “history turned into nature”—so that when a social agent in a given time and space encounters a social situation in which she must make a decision (e.g. what to say, how to act, what to think, etc.), she draws upon an entire history of decisions made by people who came before her who had been similarly positioned in the field. This practical sense of anticipation is not a conscious calculation: a social agent does not list all the options and their consequences before making a decision in a social context, but rather she reacts without thought. Hence, the part of the *habitus* that anticipates the game operates very much like common sense, an embodied feel for the game and reflexes of the body.

Illusio and Principle of Vision and Division

While the *habitus* is durable and enduring, it is also not inert, nor is it a prescription made permanent by the rules of the game or a destiny from which no one can escape. While the idea that the *habitus* is constituted in direct relation to the field can appear as though all social phenomena are already (pre)determined by field effects, one must remember that the field is not a fixed concept but is subject to fluxes and shifts, however minimal and gradual, and so the corresponding *habitus*, too, is subject to fluxes and shifts. Yet this cannot lead to the notion that the *habitus* may be fundamentally altered in a manner that is similar to waking up from a false consciousness; the basic framework of the *habitus*, acquired and inculcated since birth, remains durable and enduring. In his early work, Bourdieu describes the habitus as “structured structures predisposed to function as structuring structures”¹³⁰: the *habitus* is a structured structure

¹²⁹ Ibid., 80-81.

¹³⁰ Bourdieu, *Outline of a Theory of Practice*, 72.

because it is constituted in relation to field effects and one's positioning (and one's social group's positioning) in the field; it is a structuring structure because it allows and compels the social agent to perceive, to describe and then to respond to the social world with the embodied dispositions into which she has been inculcated. It is this latter capacity of the *habitus* to shape one's perception of the world in relation to one's embodied perceptions and dispositions that allows the social agent to have a feel for the game: she may draw on the practical knowledge of her social group and of her own previous social encounters in order to strategically respond to (new) social situations. Bourdieu calls this part of the *habitus* the principle of vision and division: social agents draw from an embodied system of classification which they have acquired in early stages of their lives that allows them to perceive (vision) and distinguish between (division) what is sensible/insensible, possible/impossible, tasteful/distasteful and reasonable/unreasonable, and use this system in order to make sense of new situations, practices, ways of being and thinking. The classificatory system is highly generative: it modifies itself and adapts as it encounters various social situations so that even in instances where one's embodied sensibilities face direct contradictions and challenges, the tendency of the *habitus* is to absorb these anomalies into the existing classificatory system—the *habitus* “makes coherence and necessity out of accident and contingency.”¹³¹ Hence, the *habitus* is extremely resistant to significant alterations because it contains the capacity to produce representations and perceptions of the world that fit its already-embodied principle of vision and division. At the same time, however, the principle of vision and division does not operate as rigid rules that directly regulate action and thought, but rather in terms of a range of possible strategies.¹³² Similar to *nomos* which is a social law that does not operate in terms of rules that make explicit what is forbidden, but rather offers a range of what is (im)possible, (in)sensible and (un)reasonable, the *habitus* operates as a guiding principle that functions more as an embodied disposition to comply with the rules of the game, rather than as an explicit decision to avoid what is forbidden: it is much more common for people to say or think “this is more sensible than that” or “this is rather insensible,” at the same time that they

¹³¹ Ibid., 87.

¹³² Ibid., 73.

would say “that is completely outlandish” or “that is just silly,” much more often than they would say “one cannot do that.” The *habitus* does not guide social action in terms of absolutes and extremes of what is permissible and what is not in regulatory terms but through notions of what is tasteful, sensible and possible—in other words, in terms of common-sense.

The *habitus* as a set of dispositions also includes a pre-disposition to value the stakes in a field that allows or compels the social agent to partake in the game in the first place. In other words, the guiding principles for thought and action also guides one to see a social game as worth the struggle in the first place. This pre-disposition includes an investment in the stakes of the game, primarily the forms of capital that correspond to a field, and an embodied sense and belief in the rules of the game as worth following in order to attain or to conserve capital. Bourdieu calls this belief that the game is “worth the candle”¹³³ *illusio*: it is not an illusion, as in something to be awoken from and something in opposition to what is true and what is real, but rather it is a genuine investment in the stakes of a field without which the social agent would not—in fact, cannot—participate in any type of social struggle. Bourdieu refers to the Dutch historian, Johan Huizinga’s use of the term *illusio* as “the fact of being in the game, of being invested in the game, of taking the game seriously”¹³⁴ in terms of the Latin root, *ludus*, which means a game. *Illusio* is that part of the *habitus* which allows a social agent to recognize the game as something in which it is worth participating. Bourdieu gives the allegorical example of a quarrel of hats¹³⁵ in which the players argue who should bow first, a game that would appear to be strange and ridiculous to someone who was not born and raised in a court society, yet for those who were inculcated in the rules and stakes of the court, the quarrel is not only natural but also quite serious. Part of the mechanism of *illusio* is that a social agent would not see the quarrel as merely a game—“social games are games that are forgotten *qua* games”¹³⁶—but as a serious endeavour of securing stakes that are and have always been worthwhile and valuable. *Illusio* enables the social

¹³³ Bourdieu, *Practical Reason*, 76

¹³⁴ *Ibid.*, 77.

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*, 77.

agent to forget that the stakes and the rules of the game were once constituted as a result of social struggles to the point that to question their naturalness is genuinely unsettling, nonsensical and unthinkable. *Illusio* follows the contours of *doxa* in the sense that a social agent will partake in a game and be invested in a game so long as the game is within the parameters of accepted perception of reality in her immediate social world¹³⁷. One of the most prevalent form of *illusio* in contemporary global reality is the investment in the economic field which compels social agents to work, to acquire qualifications to work, to spend or to save money, etc. The pre-disposition to be invested in a field, like other forms of bodily hexis, is inculcated in the social agent through one's family of origin and through other social institutions and affective bonds. Through these processes and spaces, the social agent learns to appreciate certain forms of capital as capital (i.e. something of value, a stake), certain objects as tasteful, certain practices as enjoyable and certain ways of living and being as natural and ethical. Ultimately, this constellation of dispositions which were inculcated through the social group to which one belongs compels the social agent to become invested in the social struggles that her social group had and continues to partake in, without a formal or explicit consensus that it is a mutual struggle of the group.

Despite the complex set of cognitive features of the *habitus* that binds it to the objective structures of the field, change, though tending to be minimal and gradual, is possible. Social reproduction tends to occur where there is a high degree of homology or alignment between the *habitus*—embodied dispositions, *illusio* and the principle of vision and division—and the field—*doxa* and the distribution of capital and possibilities. A homology between the *habitus* and the field also provides the ideal condition under which symbolic violence takes place, i.e., when a dominant group imposes a perception of the world onto dominated groups in such a way that the dominated groups forget that what they believe about the world was once imposed on them. Change may take place where there is a significant misalignment between them, i.e., a breakdown in the correspondence between the aspirations of social agents and the chances that are made

¹³⁷ Wacquant, *Invitation to a Reflexive Sociology*, 98.

available to these agents that realistically result in the attainment of these aspirations.¹³⁸ In such cases, social agents may work within their existing dispositions and perceptions of the world to alter the rules of the game in their favour, which may be to throw off the existing hierarchy of values—i.e., alter the conversion rates between capital or to introduce a new form of capital into the struggle—or to vie for the legitimate position from which to claim reality, or *doxa*. The former may be part of everyday struggles that result in the usual fluxes and shifts in a field; the latter form of struggle would be much rarer because it entails a vision of the social world that contradicts existing *doxa* which tends to be engrained in the *habitus*—struggles between orthodoxy and heterodoxy would fall under this category. Yet to state that a doxic struggle is possible where there is a change in the *habitus* would overlook the fact that the heterodox groups' *illusio*—investment in the game—remains intact; in fact, if members of this group were not invested in the game as part of the pre-dispositions of their *habitus*, they would not bother with the struggle against orthodoxy in the first place but walk away from the game altogether. This type of struggle is perhaps the most evident in Bourdieu's discussion of reflexivity in *Science of Science and Reflexivity* and later in *Sketch for a Self-Analysis* in which he traces the development of his own dispositions and principle of vision and division with respect to the academic field. In these texts, he describes the process by which he move across social worlds—having been born in a small rural village to a father who became a junior state employee, having attended boarding school and eventually having occupied one of the most elite positions in the academic world—and the way in which this life trajectory instilled in him a sense of assurance of having crossed class boundaries as well as a sense of revolt against an educational institution that he found to be hypocritical. In boarding school, he found a contradiction between the intellectual world of the classroom during the day and the harsh realities of class discrimination among his male boarding-mates during the evening, a discrepancy that instilled in him an ambivalent disposition toward the academy—what he calls a cleft *habitus*—which compelled him to pursue lines of inquiry and studies that went “against the tide” of intellectual trends in an explicit revolt—yet he also maintained his investment in the game as worth playing. Hence, instead of envisioning a process by which a *habitus* may

¹³⁸ Bourdieu, *Distinction*, 168.

change in order to account for a broader social change, drawing on the notion of a cleft *habitus* as an ambiguous disposition toward the game—which maintains both *illusio* and a heterodox suspicion—compels an analysis of a historical trajectory and movements across fields and positionings within fields in order to account for the discrepancies between the *habitus* and the field.

Double Habitus, Euphemisms and the Scientific Habitus

To speak of a scientific *habitus* is to locate scientists in a field of struggles and of distribution of capital, similar to the notion of class as a *habitus* that is based on bodily hexis, dispositions and tastes. Bourdieu explains that scientists often describe what they do as “practice requiring experience, intuition, skill, flair, a ‘knack’, all things difficult to set down on paper, which can only really be understood and acquired by example and through personal contact with competent persons.”¹³⁹ Such practical mastery of scientific practice, including knowing how to coordinate one’s body to work various types of instruments and to follow chemical “recipes” to “cook” compounds,¹⁴⁰ is initially derived from formalized rules and knowledge regarding experimentation, observation and theorizing, but eventually becomes an embodied sense and know-how—“a ‘craft’, ‘knacks’, an ‘eye’”¹⁴¹—that cannot be explicitly explained, nor does it need to be explained in order for it to work. A would-be scientist is required to believe in the scientific game as worth playing—i.e. *illusio*—and to become educated in technical language and skills—namely mathematics or mathematized knowledge—in order to enter into the field. While the education process is a way for a would-be scientist to secure the appropriate form and amount of cultural capital that is required to enter into the scientific field, it is also a process of inculcating a scientific *habitus*, through which the would-be scientist begins to develop a practical mastery—a craft, a knack, an eye—for proper scientific practice and comportment; for example, a senior science student no longer explicitly thinks in terms of a scientific method, which is the foundational *nomos* of modern scientific practice and which she may have learned step by step up to secondary

¹³⁹ Bourdieu, *Science of Science and Reflexivity*, 39.

¹⁴⁰ Ibid.

¹⁴¹ Ibid., 40.

education, and instead she implicitly follows it as though it is a reflex that is engrained in her body and that no longer needs explaining. Once in the field, the scientist's competence is measured by her ability to readily draw upon a pool of scientific knowledge that has been accumulated and worked upon for centuries, but also by her embodied sense of what are the interesting and important scientific problems to pursue in the first place. It is for this reason that Bourdieu argues that "A scientist is a scientific field made flesh"¹⁴²: the bodily hexis of scientists is so closely aligned with the structures of the field to the point that it is difficult to distinguish one from the other and it is possible to speak of science as an acting subject—"Can science prove the existence of God?"¹⁴³—as a short-hand for the cumulative work of individual scientists over years and even centuries.

The scientific *habitus* as a genuine belief in and a practical mastery of what is scientific that is a thorough embodiment of the structures of the field helps to understand why the scientific field maintains such a high degree of autonomy: the scientific *habitus* as "the scientific field made flesh" works to generate and secure the value of the intellectual capital of science vis-à-vis the temporal bureaucratic capital of science, and thereby helps to maintain the *nomos* of disinterestedness in the field. Yet the high degree of coherence in the scientific *habitus* should not be confused with the notion of a scientific community because the latter, like "class on paper", tends to unify and homogenize scientists into a self-evident and pre-existing group.¹⁴⁴ To speak of a scientific community can obscure the long history of scientific struggles, errors, trials, disappointments, dead-ends, successes and upheavals that led to the constitution of the scientific field and the corresponding scientific *habitus*; indeed, scientific institutions seek to turn scientific history into a timeless and nameless face that can be any and every scientist. Bourdieu argues that the intellectual capital of science is enmeshed in a *nomos* that links together rules about how scientists may interact with one another in the field with rules about how best to do science in the most objective manner: "Epistemological

¹⁴² Ibid., 41.

¹⁴³ Johnson, George. "Can Science Prove the Existence of God?", *The New York Times*, (11 November 2003). Accessed online: <http://www.nytimes.com/2003/11/11/science/can-science-prove-the-existence-of-god.html>

¹⁴⁴ Bourdieu, *Science of Science and Reflexivity*, 45.

rules are the conventions established for settling controversies: they govern the confrontations of the scientist with the external world, that is, between theory and experiment, but also with other scientists, enabling him to anticipate criticism and refute it.”¹⁴⁵ He points to the rules of argumentation as the central mode by which the social-intellectual life of scientists are calibrated to the *nomos* of the field: scientists are constantly in conversation with other scientists—past and present—in all that they do as part of their intellectual practice which includes following or continuing the work of others who came before, showing one’s work to one’s peers, criticizing the work of others and responding to criticisms from others. Hence, Bourdieu argues, the scientist is

inhabited by collective super-ego, inscribed in institutions which constantly reassert the rules, and placed in a peer group that is both very critical—the group for whom one writes, and the most daunting of audiences—and very reassuring—the group that underwrites and backs up (with references) and provides guarantees of the quality of the products.¹⁴⁶

The “collective super-ego” is the scientific *habitus* which is so aligned with the field that it is nearly interchangeable with it. The scientific field is able to maintain its autonomy—i.e., the dominance of the intellectual scientific capital over the bureaucratic scientific capital—by collapsing the social rules of interaction between scientists onto the intellectual rules of what is proper science and therefore what is objective and reasonable.

The rules of social-intellectual interaction between scientists are based in a mastery of the game of argumentation and a “collective super-ego” of the scientific *habitus*. While the field’s demand of a *habitus* based on a collective intellect may help to secure the autonomy of the scientific field, the threat of the bureaucratic capital of science looms large, particularly in areas such as biomedicine. In the scientific field, not only can the economic logic of the market and funding streams subvert the dominance of the intellectual scientific capital, but it can also erode the investment in the pursuit of science for the sake of science in the scientific *habitus* so that scientists may entertain the possibility that they may sacrifice intellectual imperatives for better funding. Indeed, the

¹⁴⁵ Ibid., 83.

¹⁴⁶ Ibid.

impact of an economic logic is the concern of all fields that struggle to maintain autonomy from the economic field via a disinterested *nomos* and symbolic forms of capital: artists and religious figures face similar problems. In *Practical Reason*, Bourdieu discusses how priests of the Roman Catholic Church calculate the labour of volunteers and employees of the Church in terms of monetary value but when it comes to their own contributions to the Church, the same priests reject the description of their work in terms of labour in the economic sense.¹⁴⁷ The fact that the Church is a big business is denied throughout and it is precisely through this collective denial that the economy of the Church is able to primarily function as an institute of devotion and faith. Yet Catholic priests as managers of the Church, which is a business-denied-as-such, and as disinterested religious leaders, must occupy two very contradictory *habitus*es, one that corresponds to the economic field and the other that is situated within a disinterested field of religion. Bourdieu describes this contradictory co-existence of an economic *habitus* and a disinterested *habitus* as a double *habitus*: priests require a genuine investment in the Church as a business in order to properly manage the books; but they also require a genuine denial of their services as part of a business as well as a belief instead that they—and the Church as a whole—are acting primarily in the name of faith and devotion. Bourdieu cautions that the double *habitus* is not based on a lie, but

rather a gap between the objective truth, repressed rather than ignored, and the lived truth of practices, and that this lived truth, which hides, through agents themselves, the truth brought to light by analysis, is part of the truth of practices in their complete definition. The truth of the religious enterprise is that of having two truths: economic truth and religious truth, which denies the former.¹⁴⁸

Similar to *illusio*, which does not reduce the investment in a social game to mere illusion or a false consciousness but takes seriously the sincerity of this belief, the double *habitus* also does not reduce the paradoxical investment in two opposite types of field logics to a lie that requires the analyst to expose as false. Instead, the analyst must take both investments—economic and disinterested—as genuine at the same time that she seeks to

¹⁴⁷ Bourdieu, *Practical Reason*, 116.

¹⁴⁸ Bourdieu, *Practical Reason*, 114.

understand their contradiction and the mystery of their co-existence. Since the double *habitus* is associated with a disinterested field—whether it is religious, artistic or scientific—its analysis also cannot reduce its explanation to one of the two fields: the economic interest of the priest is not the “true” *habitus* at work, and neither is the disinterestedness of the priest, but rather the analyst must describe the space of their contradiction and co-existence. For Bourdieu, this means examining the discourse in the field that strives to rearticulate the economic field effect into an effect of a disinterested field, such as “two words, superimposed on each other as if in a musical chord: apostolate/marketing, faithful/clientele, sacred service/paid labour, and so forth.”¹⁴⁹ In the double *habitus* of a disinterested field these couplets are able to exist in harmony because the economic side is transformed into its disinterested couple and is therefore euphemized. For example, Bourdieu suggests that religious service is always conceived in familial terms so that exploitation (i.e. work without compensation as per the economic field) becomes volunteerism (i.e. disinterested work that is its own reward).¹⁵⁰ This euphemism is established via an enduring and durable disposition of a religious *habitus* as well as the rules of the field of religion that allows this discursive slippage as genuine and matter-of-fact.

This description of the double *habitus* of the priest can be extended to describe the double *habitus* of the scientist and by extension the medical doctor: the truth of the medical enterprise is that of an economic truth, that medicine is expensive and that doctors need to get paid, and also of an intellectual truth which is concerned with knowledge for the sake of knowledge and which denies the economic truth and establishes itself as the primary concern, at least on the surface. Hence, competition for dominance (which makes the struggle explicit) is euphemized as a well-grounded criticism (which makes the struggle implicit) and corporate sponsorship (which makes explicit a direct line between intellectual work and the market economy) becomes a donation, partnership or funding (which establishes at least some euphemistic distance between the two fields). In a scientific field, and by extension the medical field, in which

¹⁴⁹ Ibid., 114.

¹⁵⁰ Ibid., 116.

the bureaucratic capital of science is particularly strong in relation to the intellectual capital of science, such euphemisms are weakened and the discursive slippages are disrupted which opens up the field and the *habitus* to explicit questions of whether or not scientists or doctors are truly disinterested, questions that may come internally or from external bodies (e.g. the state, the media, etc.) and the latter can lead to threats to the autonomy of science and medicine. In this dissertation, I focus on the specific discursive events that indicate incidents of such threats for doctors in Canada and the discursive strategies that function as practices that seek to re-establish the validity of the euphemism and thereby render the tensions of the double *habitus* implicit once again.

An Archaeological Approach to Medical Disinterestedness

Foucault's archaeological method provides the framework for the historical approach that envelopes this entire dissertation, in particular two of his interrelated strategies which I take up here: the selection of the object of study and an attention to discursive formations. Foucault asserts that one must select the object of study not based on contemporary concerns about history or the categories that we use in the present, but based on the specific concerns and perspectives of the historical era in question.¹⁵¹ For example, Foucault's object of study in *Madness and Civilization* is not the origin of modern psychiatry but the idea of madness and of the madman. His object of study prompts him to examine the emergence of the idea that such individuals must be contained in sanatoriums along with lepers, criminals and the poor, and then the ways in which the madman emerged as unique among this group as the symbol of unreason during a time when European thinking was increasingly becoming preoccupied with reason. Hence, the book becomes more than a study of psychiatry or of madness and instead the emergence of the ideas of reason and unreason in Europe and the ways in which psychiatry became a privileged discursive space in which to grasp, to contain and to manage the boundary between reason and unreason. Following Foucault's approach, I depart from the notions of bioethics and medical ethics, both of which are now

¹⁵¹ Michel Foucault, *The Archaeology of Knowledge & The Discourse on Language*, (New York: Pantheon Books, 1978), 47-48.

formalized disciplines that have produced a specific set of objects, questions and concerns and that have already charted their own histories largely in terms of the history of scientific progress—medical ethics and bioethics are seen as a sign of moral maturity in medicine and biomedicine.¹⁵² Instead, I look to the different definitions and domains of the moral and the scientific that are appropriate to a given moment and that may or may not coincide with contemporary concerns in medical ethics or bioethics.¹⁵³ I begin my archaeology in the nineteenth century which is often referred to as the origin of the modern medical profession as a closely-knit group of experts who have a high degree of occupational autonomy. However, this moment is more significant as a moment that marked major shifts in the ways that doctors thought about what they did in scientific and

¹⁵² Historical accounts of bioethics often provide lineages that date back to the antiquities and that culminate in what are seen as the unique challenges posed by the technologies of modern medicine. For example, see Albert R. Jonsen, “A History of Bioethics as Discipline and Discourse” in *Bioethics: An Introduction to the History, Methods and Practice*, Nancy S. Jecker, Albert R. Jonsen and Robert A. Pearlman (eds), (Sudbury MA: Jones and Bartlett, 2007), 3-16.

¹⁵³ The terms *moral* and *ethical* have many different usages in various disciplines. For instance, in the social studies of science and history of science, Daston and Galison distinguish between ethical and the moral thusly: “... *ethical* refers to normative codes of conduct that are bound up with a way of being in the world, an *ethos* in the sense of the habitual disposition of an individual or group, while *moral* refers to specific normative rules that may be upheld or transgressed and to which one may be held to account” (*Objectivity*, 40). Their use of the term ethical as *ethos* is in keeping with the how the term is used in rhetorical theory. Rhetorician of science, Lisa Keränen, explains that *ethos* is an element of persuasive rhetoric that points to the character and habitus of the speaker (and the group to which the speaker belongs) as the grounds for the trustworthiness of an argument. She points out further that *ethos* is determined by the appearance of goodness and the extent to which one can claim trustworthiness by virtue of one’s character, rather than an innate and absolute quality of goodness in the speaker (*Scientific Characters* (Tuscaloosa: University of Alabama Press, 2010), 26). For Daston and Galison, ethical concerns about what is good and trustworthy emerge socially while moral concerns have to do with what is and must always be good and trustworthy across time and space. Since their work concerns the shifting standards of how a scientist may claim to be virtuous and trustworthy, they opt to use the term ethical. However, often the norms, codes and rules that Daston and Galison argue are in the realm of the ethical because they are “bound up with a way of being in the world” claim and assert the universal and ahistorical that the authors argue are in the realm of the moral. Indeed, codes of ethics, for instance those of the *Canadian Medical Association*, underwent several revisions since its adoption in 1868 by the Canadian Medical Association, suggesting that such codes of conduct are bound up with changing ideas with regard to ways of being in the world. However, these codes are meant to stand up as universal and normative rules that must “be upheld or transgressed and to which one may be held to account.” The boundary between what Steven Shapin describes as what scientists do in descriptive terms and what scientists should be in terms of normative ideals is often unclear and it is often precisely this gap that is at the centre of many scientific controversies (*The Scientific Life* (Chicago: University of Chicago Press, 2008), 10). I use the term *morality* and its grammatical variations, rather than *ethics*, in order to distinguish my approach from that of (bio)ethics as a discipline. Through Bourdieu’s concept of disinterestedness, as both part of the habitus and the *nomos* of doctors, I hold in tension what Shapin identify as “the domain of the ‘is’ and the ‘ought’” (ibid.) of science.

moral terms and also in the ways that they related to one another and to non-doctors: this was before medicine commanded automatic credibility and respect as the authoritative discourse on matters of disease, illness and the human body and doctors were primarily private physicians who had very little to do with one another except as competitors for patronage. Taking ideas of morality and science as my object, rather than ethics or bioethics, allows me to examine the discourses of morality and sciences that already existed at the time and the ways in which the two were mobilized as doctors struggled to form themselves as a united profession of medical experts.

As part of his archaeological method, Foucault also seeks to describe discursive formations by looking for the conditions in which certain statements¹⁵⁴ and ideas are possible while others are not. This may involve looking to institutional and structural supports, such as laws, technologies and facilities, but, more importantly for Foucault, this also involves looking for discursive regularities, or the unspoken conventions of thinking and of making connections between different ideas that in turn shape how one can legitimately make statements, especially statements that make claims to truth. Discursive regularity, or what he also calls *episteme* earlier in his career, is not the same as what one may call the spirit of an age, nor is it a type of knowledge, but a kind of grid that underwrites all kinds of thinking in a given moment and can span across different discursive domains. For instance, in *The Order of Things*, Foucault finds that across the studies of the natural world, of commerce and of numeracy, there is a discursive regularity in the classical era with respect to the relationship between the representation (e.g. coin) and that which is represented (e.g. wealth). He argues that what history calls humanism, as a marker of progress in thinking, is the result of a general crisis in representation across these discursive domains—for instance, the coin could no longer act as a stable sign of wealth—which was momentarily resolved by the introduction of the human subject—e.g. the labouring subject. Hence, Foucault’s attention to historical ruptures and discontinuities allows an analysis of the conditions in which new and different kinds of statements and ideas become possible and plausible. Following Foucault’s approach, I look for moments in the history of doctors in Canada where new

¹⁵⁴ By statements Foucault does not mean linguistic combinations of words but as events of speaking or writing. By conceptualizing statements as events, Foucault situates discourse in historical specificity.

kinds of statements related to morality and scientificness became possible, plausible and necessary: namely the moments in which doctors' claim to moral and scientific integrity came under question. Hence, in addition to the formation of the medical profession in the nineteenth century, I also examine the 1950s-1960s during which the medical profession faced intense public criticisms for being elitist and for acting in self-interest by opposing the proposal for a tax-funded, state-administered health care system. Finally, the circumstances surrounding the dismissal of the *CMAJ*'s senior editors in 2006 becomes more than an episode in which editorial freedom was threatened but an incident that reveals deep-seated contradictions between the ideals of scientific objectivity as a moral and scientific virtue, and the financial and political realities of medical publishing. In all three historical moments, I look for the emergence of new possibilities of claiming morality and scientificness, such as the introduction of new medical objects, new medical practices and new positions from which to claim medical knowledge.

The following three chapters first examine the field for the struggles that took place and the forces that were in effect during these incidents and then move on to look at the challenges that doctors faced at the level of the *habitus* in order to forge, embody and maintain the dispositions and systems of vision and division that are necessary to ensure medical disinterestedness. The final sections of these chapters take up analyses that more closely correspond to Foucault's method of discourse analysis in which he looks for regularities and ruptures in discursive formations; in particular, I look for any new objects, practices or epistemic positions of medical knowledge and practices that emerged as part of doctors' efforts to respond to the threats to the ideal and belief in medical disinterestedness. The overall dissertation follows Foucault's archaeological structure and takes as its object not the history of medical ethics or bioethics but the conditions in which it was possible for medical disinterestedness—as an imperative to be scientific and moral as theorized by Bourdieu—to emerge and to persist under different socio-political conditions. I treat the three time moments in which medical disinterestedness came under threat as individual archaeological layers which are bounded by a particular discursive regularity when it comes to talking about the connections between morality and science in medicine. I also treat these archaeological layers as different iterations of the field of struggles within medicine in order to understand the ways in which doctors as a group

strategized in order to weather the threat during each moment.¹⁵⁵ My archaeological approach to medical disinterestedness is grounded in a textual analysis of editorial writings in medical journals such as the *Canadian Medical Association Journal*, the *British America Journal*, the *Dominion Medical Journal* and *Open Access*. While these publications contain mostly biomedical writings, they also contain editorials, letters and journalistic news article that act as spaces in which doctors discuss and debate what it means to be a group of moral and scientific experts. I have examined editorials and letters in major medical journals in Canada for each of the three historical moments—1840s-1860s, 1950s-1970s and 1999-2006—for language and rhetoric that suggest particular engagements with ideas around science and morality that would have been of

¹⁵⁵ There are many points of congruence between Bourdieu and Foucault. Bourdieu's concepts of the field and the *habitus* necessarily contain historicity which he does not examine to the fullest extent but that nonetheless readily invites a historical analysis. Foucault focuses on historical discontinuities and ruptures at the level of the discursive formations, and the latter is organized in terms of fields (of discursive objectives and practices) and domains of knowledge. While Foucault's method of archaeology provides a framework for a study that spans across various historical moments for broader moments and breaks, Bourdieu provides a way to more systematically examine what happens at each moment at the level of the discursive field. Both theorists caution that one must not choose an object of study based on the existing social and cultural categories if one is to examine the conditions in which these same categories emerge. There are strong resonances between Foucault's notion of discursive regularities (as opposed to laws of linguistics) and *nomos* (as opposed to laws and codes in anthropology and sociology). Foucault's assertion that discourse must be understood as historically specific events that also emerge out of what has become discursive possibilities through time (*The Archaeology of Knowledge*, 99) are conceptually homologous to Bourdieu's conceptualization of the *habitus* as the culmination of perceptions and dispositions of an entire historical group which is then enacted within specific conditions of the field at a given moment. Bourdieu's and Foucault's usage of the term *field* are also quite similar: just as Bourdieu conceives the field in terms of struggles, forces, positions and position-takings, Foucault, too, describes the discursive field as a field of possibilities (ibid, p. 66) and constraints and that is also "active throughout" (ibid, p. 145) to generate new ways of speaking (and therefore thinking and being). Whether or not the two terms are identical warrants a closer look at Bourdieu and Foucault's respective engagement with such theoretical predecessors as Marx, Durkheim, Weber and Nietzsche, an analysis that is beyond the scope of this dissertation. For instance, there may be a tension between Foucault's insistence on discontinuities which is at the basis of his methods of archaeology and genealogy, and Bourdieu's focus on mechanisms of social reproduction which grounds his concepts of the field and the habitus. There is also the issue that Bourdieu has been consistently critical of approaches that are grounded in what he calls "semiological vision of the world" and "textism" (*Science of Science and Reflexivity*, 28) under which he appears to have included Foucault's approach to discourse. Staf Callewaert has also pointed to the ways in which Bourdieu has explicitly and implicitly criticized Foucault, a position that the author grounds in the struggles within the French academic field in which Bourdieu as a social scientist and Foucault as a philosopher may have been opposed to one another despite their shared criticisms about their respective disciplines and the similarities in their interventions in the history of knowledge ["Bourdieu, Critic of Foucault: The Case of Empirical Social Science against Double-Game Philosophy", *Theory, Culture & Society*, 23 (2006): 73-98]. For the purposes of this study, I work from the conceptual homology in their works and use Foucault in order to historicize Bourdieu's approach and extend Bourdieu's notion of the field into Foucault's archaeological "layers."

concern for doctors during these times. To accomplish this goal, I read the editorial writings side by side with existing literature on each moment in order to tease out the range of statements that emerged when doctors faced various political, social, scientific and moral problems. I also pulled out statements that suggest scientific and moral concerns that may contradict or may tell a different narrative about the medical profession than what appears in existing literature. I then grouped the statements according to the kinds of insights they allow with regard to the field and the *habitus* of medicine as doctors struggled to establish or to maintain their claim to medical disinterestedness. I frame the editorial writings as discursive events, in the Foucaultian sense, and practical strategies, in the Bourdieuan sense, that can then elucidate the types of concerns and preoccupations that doctors faced as a group, as well as the kinds of moral and scientific claims that were deemed possible and plausible to make at a given moment.

Chapter 3. From Medical Men to Scientific Gentlemen

The modern medical profession as a politically, socially and culturally powerful institution did not yet exist in nineteenth century Canada: doctors, or medical men as they often called themselves, were not yet organized into Colleges that standardized medical education and controlled medical licensing, and existing medical laws did little to restrict unlicensed medical practice.¹⁵⁶ Also, scientific medicine, with its miraculous pharmacological cures such as penicillin, did not mesmerize the public until the twentieth century.¹⁵⁷ After the victory of the British over the French in the year 1759, the majority of French medical men returned to France and those remaining were pushed out to rural areas as British military surgeons and licensed physicians gained dominance in the urban centres.¹⁵⁸ These British medical men's connections to the Empire gave them automatic authority¹⁵⁹ and they encountered little competition in a small colonial population. This changed by the nineteenth century, however, with an influx in immigration from Europe and the emergence of competitive medical schools in North America that challenged the dominance of British education. In addition, medical men as a whole were threatened by a growing popularity of alternative practices, particularly homeopathy and Thompsonianism. The nineteenth century was a highly unstable time for medical men in Ontario and Québec as they aggressively sought to mobilize the elected governments in order to be able to better enforce the medical law and regulate membership, but these attempts were thwarted due to parliamentary resistance as well as disagreements among

¹⁵⁶ There were numerous attempts made by the medical professions of Upper and Lower Canada throughout the nineteenth century. For detailed account of this legislative process, see Ronald Hamowy, *Canadian Medicine: A study in restricted entry* (The Fraser Institute, 1984).

¹⁵⁷ Medicine in the twentieth century, particularly the first half of the century, is largely characterized by developments in pharmacology, diagnostics and other laboratory-based biomedicine. See Julius M. Cruse, "History of Medicine: The Metamorphosis of Scientific Medicine in the Ever-Present Past", *The American Journal of the Medical Sciences*, 318 (1999): 171+

¹⁵⁸ Barbara Tunis, "Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change", *Histoire sociale / Social History*, 27 (May 1981): 70.

¹⁵⁹ Hamowy, *Canadian Medicine: A study in restricted entry*, 19.

medical men on the terms of their self-government. These struggles in the two largest provinces in Canada took place alongside similar unrest in organized medicine in Continental Europe, Britain and the United States, where medical education and certification, the structural organization of medical men, the relationship between organized medicine and the state and the question of what constitutes medical knowledge and practice were being configured and reconfigured. The effects of these changes were also felt in Canada, but they were refracted through social, political, geographic and economic factors that were specific to nineteenth century Canada as a British colony. As a whole, nineteenth century medical men struggled with the question of what constitutes a medical profession, both in its organization and its scientific and moral character.

Sociological and historical literature that refer to this historical moment in medicine tends to frame the conflicts among medical men and between medical men and alternative practitioners in one of two ways: the most popular thread of analysis focuses primarily on class conflicts between the entrepreneurial class of physicians and university-educated British medical men as well as between the British and the French¹⁶⁰; another much less prominent thread of analysis examines the codes of gentlemanly conduct among medical men which rearticulated class-related traits into a moral discourse of honour.¹⁶¹ Although these frameworks have individually yielded rich insights into the structural and interactional workings of power, the approaches have remained distinct from one another along a rift that is analogous to what Bourdieu points out as the antagonism between objectivist and subjectivist approaches to social inquiry¹⁶²: the class conflict model adopts a primarily structural approach, examining the class barriers and access to medical education and certification, while the gentleman code studies prioritize the interaction between medical men. There is little or no room for an

¹⁶⁰ Barbara Tunis, "Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change", *Histoire sociale / Social History*, 27 (May 1981): 67-91; Rainer Baehre, "The Medical Profession in Upper Canada Reconsidered: Politics, Medical Reform, and Law in a Colonial Society", *Canadian Bulletin of Medical History / Bulletin canadien d'histoire de la médecine*, 12 (1995): 101-124; Hamowy, *Canadian Medicine: A study in restricted entry*.

¹⁶¹ For example, see S.E.D. Shortt, "Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century", *Medical History*, 27 (1983): 51-68; Robert Nye, "Medicine and Science as Masculine 'Fields of Honor'", *Osiris*, 12 (1997): 60-79.

¹⁶² Bourdieu, *Outline of a Theory of Practice*, 3-4.

analysis of morality and virtue in the class conflict model—moral claims about what it means to be a legitimate medical man are seen as empty claims to augment or to secure one’s class status. While the gentleman code studies situates such moral claims to virtue as part of class struggles between different classes of medical men, this analysis occurs primarily at the level of establishing class identity and embodied norms with little attention to the struggles themselves. Also, in both approaches discussions about science are markedly absent: science is seen as a development that is independent of struggles over the constitution of the medical profession or not yet in existence because this is the era before what is considered to be scientific medicine by contemporary standards. In this chapter, I seek to synthesize the two approaches using disinterestedness as a conceptual hinge that allows me to examine simultaneously and relationally the structural ways in which ideals of scientificness and gentlemanliness shaped and justified the conditions of entry into the group and the symbolic ways in which medical men developed a group ethos that corresponds to their emerging structural organization. In my examination of the field and the *habitus* of medicine, the standards of science specific to this era operate as a form of capital that medical men of various stripes deployed in order to accrue or to secure a strategic position in the field. I demonstrate that the invocation of particular notions of scientificness go hand in hand with the attempts to restrict or to loosen the conditions of entry into the medical profession. Overall, I trace how medical men as a group went from seeing themselves primarily as a disparate group of individual medical men with, at times, incompatible socio-political differences and conflicting views of what a medical profession should be, to introducing the possibility of seeing themselves as a united and cohesive brotherhood of scientific gentlemen whose mission is to protect the interest and well-being of the public. This shift was not easy, nor was it a natural or obvious progression in which Enlightened doctors overcame their differences for the good of science and for the public which sat waiting for doctors to come to their senses. The notion of a brotherhood of elite scientific gentlemen was one among several different and competing articulations of how science and virtue may be linked at the level of a group ethos and the notion of the public was constituted as part of this ethos. I use the terms *medical men* and *scientific gentlemen* to point to what I argue to be a fundamental shift in both the structural conditions under which medicine constituted a profession and

the set of dispositions, scientific and moral, that were systematized as part of a group sensibility and ethos that correspond to the structural conditions. In this struggle emerge the criteria for scientificity that at once operate as an organizing principle that underpinned the positions and strategies adopted by medical men, as well as an object that must be shaped to support these positions and strategies.

Restricting Membership: Gentlemen of Elite Learning

In the nineteenth century, the question of what constitutes the profession was fought out and determined on multiple fronts: there were external pressures from alternative practitioners, such as Thompsonians and homeopaths, whose popularity threatened the orthodoxy that medical men are the only legitimate experts in matters of medicine and healing; internally, there was a marked increase in the number of medical men in the country with incompatible and at times competing ideas of what constitutes a learned medical profession, perceptions that were protracted through social and political differences which were based on social class and ethnicity. The implicit understanding that medical men in Canada were British came under challenge so that British elite medical men struggled to defend their orthodoxy in relation to the heterodoxy of alternative practitioners—namely Thompsonians and homeopaths—and American and French-Canadian medical men as well as Anglo-Canadian medical men who no longer wanted to rely on the Empire in order to legitimately train and certify physicians in Canada. Their struggles resulted in a reconfiguration of what it means to be a learned medical profession, a question that hinged on the invocation of a particular notion of scientificity as rational practice of a rational mind, which was in turn conflated with class-based ideals of gentlemanliness and honour. Each group struggled to determine the particular form of educational capital that would translate to cultural and scientific capital in the emerging field of medicine: the orthodox group sought to maintain the dominance of university-based medical education in Britain and Continental Europe as the only legitimate form of qualification while the heterodox groups fought to expand the definition of legitimate medical education to include self-learning and non-university-based medical degrees. The British elite medical men's struggle adopted a joint criteria

for scientificness and gentlemanliness that provided a new grammar to discredit homeopaths and Thompsonians in government politics, particularly in relation to medical law, and to restrict and monitor the entry of undesirable groups into medicine by controlling medical examinations.

The first comprehensive medical law that was legislated in what is now Canada was in 1788 by New France which was the first to prohibit anyone from practicing physic, surgery or midwifery without a successful examination by a board; the law was enforced through criminal law and penalty consisted of a fine.¹⁶³ Subsequent versions of the medical law in Upper Canada (now Ontario), Lower Canada (now Québec) and later in the Dominion of Canada (joint territory of Ontario and Québec) more or less followed this framework varying on the amount of fine and the composition of the examining board.¹⁶⁴ Medical law until later in the nineteenth century was very loosely enforced, however, allowing practitioners of all kinds to develop and proliferate, most of whom were self-taught practitioners of various types of healing which included medicine but also homeopathy and a new type of botanical medicine called Thompsonianism. The origin of the latter practice is attributed to Samuel Thompson, an American farmer without formal education who produced a widely popular volume, *New Guide to Health*, in 1822.¹⁶⁵ The book came with a document that certified the reader as a Thompsonian, which meant that anyone could become a practitioner by virtue of purchasing the book, a system of certification that was the complete opposite of that of medical men who could only receive their degrees from university-based medical schools after long years of study. Thompsonians and homeopaths gained much popularity in the early part of the century, particularly among those who could not afford the services of medical men—“Under my very nose lives neighbour B., who bleeds and extracts teeth at exactly half the professional charge”¹⁶⁶—but also among those who were skeptical of medicine.¹⁶⁷

¹⁶³ Hamowy, *Canadian Medicine: A Study in Restricted Entry*, 13.

¹⁶⁴ Tunis, “Medical Education and Medical Licensing in Lower Canada”, 71.

¹⁶⁵ Thompson’s remedies involved using various botanicals—such as *lobelia inflata* (a.k.a. Indian tobacco) and red pepper—and steam baths. He opposed the mineral-based remedies of orthodox medicine. (Starr, *Social Transformation*, 51).

¹⁶⁶ “Correspondence”, Editorial, *British American Journal of Medical and Physical Science*, 3 (1847): 81.

Medical men were extremely hostile to these practitioners, calling them quacks and impostors who prey on the public. However, medicine in the late nineteenth century was hardly a comprehensive or even a coherent set of knowledges and practices that could be clearly set against non-medical practices. Medicine at this time consisted of a mishmash of practices based on diverse theories of disease: at the same time that clinical disciplines such as anatomy and physiology were emerging in Europe, in North America an aggressive form of practice came in fashion, what later historians called heroic medicine. Indeed, heroic medicine was conceptually more similar to Thompsonianism than it was to anatomy and physiology. Heroic medicine was based on an older and at this time more established conceptualization of health which organized the body in terms of a balance of humours: illness was due to a bodily imbalance, which can be rectified using aggressive remedies, such as purging the body of excess through bloodletting using leeches and inducing vomit with purgatives in order to restore bodily equilibrium, practices that often led to patient death.¹⁶⁸ Under the heroic system of medicine, symptoms were the direct and self-evident manifestation of illness-as-imbalance and thus drove the selection of treatment.¹⁶⁹ The emerging disciplines of anatomy and physiology began to organize the body, disease and symptoms in an entirely different way: illness was no longer due to an imbalance but could be traced back to a specific locus in the depths and surfaces of the body; symptoms were no longer a transparent representation of illness-as-imbalance but “assume[d] shape and value only within the questions posed by medical investigation”¹⁷⁰ and suddenly could be the signifier for a multitude of possible diseases. Between these two poles within medicine of the late nineteenth century, Thompsonianism was more closely aligned with heroic medicine: it was based on the principle that “all disease was

¹⁶⁷ The support for Thompsonians came from communities, consisting of petitions from various districts and churches, including reverends, to the Legislative Assembly in Ontario (“Thompsonian Petition to the Legislative Assembly”, *British American Journal of Medical and Physical Science*, 3 (1847): 80. *The Sherbrooke Gazette*, a local newspaper that irked medical men for writing against a stricter regulation of medical practice. See “Quacks and the ‘Sherbrooke Gazette’”, *British American Journal of Medical and Physical Science*, 5 (1850): 249; “The Sherbrooke Gazette”, *British American Journal of Medical and Physical Science*, 5 (1850): 276).

¹⁶⁸ According to Howell, the heroic theory was so deeply entrenched among physicians that many were reluctant to let go of this basis of treatment even with the introduction of scientific medicine, such as germ theory (see Howell “Elite Doctors”, 110.)

¹⁶⁹ Starr, *The Social Transformation*, 38.

¹⁷⁰ Michel Foucault, *The Birth of the Clinic*, 199.

the effect of one general cause and could be removed by one general remedy”—“Cold was the cause; heat, the remedy.”¹⁷¹ Indeed, many medical men experimented with Thompsonian remedies as part of their practice despite the risk of much scorn from their peers and even reprimand from their professional body,¹⁷² demonstrating the degree to which orthodox medicine and Thompsonianism were compatible. By the mid-century, homeopaths and Thompsonians began to petition to Ontario’s elected parliament, the Legislative Assembly of Ontario, to extend the legal protection of the medical law to their practices using the rhetoric of liberal democracy to persuade the legislators that they should be given the equal legal right to practice their craft: “they asked for equal rights but nothing more, they desired the privilege of receiving pay for their services, and if those services were valuable he could see no reason why they should not be paid... In the U.S. the Thompsonian doctors were allowed to practise and the same right should be accorded to them here, to enable them to give their system a fair trial.”¹⁷³ Medical men insisted that they themselves be allowed to enforce the medical law rather than have the government rely on the hitherto ineffective penal code to punish unlicensed practice, but the elected government saw this request as a move toward monopolization and instead agreed to legislate the protection of Thompsonians and homeopaths as part of medicine under law.¹⁷⁴

Medical men resisted the perception of their practice as a trade, which can then be opened up to a market of potential competitors, by insisting that a special kind of preparation and character development are required in order to appropriately administer to the sick:

The properly educated practitioners, after years of toil and mental exertion, entailing upon him at the same time a pecuniary outlay, which

¹⁷¹ Starr, *The Social Transformation*, 51.

¹⁷² Howell relates the story of Dr. Frederick W. Morris of Halifax who was expelled from the Medical Society for treating smallpox with an indigenous remedy and then endorsing it in public. (Howell, “Elite Doctors”, 105.)

¹⁷³ “Debate on the Thompsonian Bill”, Editorial, *British American Journal of Medical and Physical Science*, 5 (1849): 25.

¹⁷⁴ Homeopaths and Thompsonians (also called eclectics) had representative seats on the Council of College of Physicians and Surgeons until 1960 (George M. Torrance, “Socio-Historical Overview” in *Health and Canadian Society: Sociological Perspective* eds. David Coburn, Carl D’Arcy and George M. Torrance (Fitzhenry & Whiteside, 1987), 12).

would form sufficient capital to commence almost any description of business, acquires his Profession, and from his every education scorns to resort to the low chicanery by which the Empiric forces his nostrums upon the ever-gullible public; he treats with contempt the boasted pretensions of the quack.¹⁷⁵

Medical men sought to link formal education with a sense of moral duty and medical judgment which they argued the unlicensed practitioner is incapable of fulfilling because he has not been appropriately trained. Since during this historical moment training for medical men consisted primarily of university-based education,¹⁷⁶ they linked the proper virtues of a practitioner with proper scientific knowledge which in turn could only be attained via a university education. Hence, it was a class-based argument that linked middle-class morality with middle-class access to medical schooling in Britain: “a set of ignorant and despicable pretenders are to be allowed, by lawgivers, to prey upon society, and sport with human life... In fine, no class of persons can be more devoid of knowledge in science.”¹⁷⁷ Medical men argued that “the ignorant pretender” could get away with mistakes and malpractice because a court or a jury could “not presumed to be one whit better informed” about the details of medicine, while “[t]he educated and licensed practitioner, when danger threatens his patient, is required by a sense of moral obligation, by custom and rules of his profession” to seek help and to make a rational decision about whether or not he had made an error.¹⁷⁸ In other words, he has the necessary virtues to govern himself via the moral dispositions he acquires through his professional training and does not need an external governance structure, i.e. the penal code. Meanwhile, the “quack” could not be trusted for self-regulation.

Reverend Gentleman—Once upon a time I had a cousin, of the name of Thomas Gamble.

¹⁷⁵ “Medical Men and the Coming Election”, Correspondence, *British American Journal of Medical and Physical Science*, 7 (1851): 363.

¹⁷⁶ Geoffrey Bilson, “Canadian Doctors and the Cholera”, in Shortt, *Medicine in Canadian Society*, 120.

¹⁷⁷ “Debate on the Thompsonian Bill”, *British American Journal of Medical and Physical Science*, 5 (1849): 26.

¹⁷⁸ “Medical Politics”, Editorial, *Upper Canada Journal of Medical, Surgical and Physical Science*, 1 (1851): 158-168 (reprinted in Ronald Hamowy, *Canadian Medicine*, 88).

Homeopathist—And sure enough I am the boy, jist out from Ireland.

Rev. Gent.—And how do you get along, Tom? When I last saw you, you were a Methodist.

Homeopath.—I now calculate I am a Baptist, and manage to keep my family quite well; I have eighty patients and have cured them all.

Rev. Gent.—Sure, Tom, it is just showing them the physic you are.

Homeopath.—That is all that is necessary now-a-days, for when they's really sick they don't come to me, but when they fancies themselves sick, I manages to cure them quite readily. They are the best patients; they tries to humbug me, but, I humbugs the cash out of them and that's the point you know.¹⁷⁹

In what appears to be a humour piece, the homeopath in question not only confesses to deliberately cheating his patients but also speaks in a manner that betrays his class origins, i.e. below that of the gentleman, and his admission of having transferred from one religious sect to another also contribute to his characterization as fickle and lacking integrity.

Yet, in the absence of a clear therapeutic difference between medical men and the unlicensed “quacks” both in terms of treatment methods and in terms of clinical outcomes, the claim that medical men are superior to the “fraternity of empirics” and the “horde of quacks”¹⁸⁰ had to go beyond just a class-based argument. Indeed, medical men invoked a particular kind of scientificness, one that was based on little more than a very general concept of rationality.

And since the time of the deservedly-great *Hippocrates*, centuries before the coming of the Saviour, we trace its march, step by step, to its present state of perfection; and very many of the great names in modern history

¹⁷⁹ “Homeopathic Conversation”, *British American Journal of Medical and Physical Science*, 7 (1851): 93.

¹⁸⁰ “Debate on the Thompsonian Bill”, *British American Journal of Medical and Physical Science*, 5 (1849): 26.

are found enrolled among the faculty—men renowned for their genius and research.¹⁸¹

Enlightenment notions of history (the tradition of medicine back to the ancient Greeks, who are considered to be the originators of all modern thought), progress and the genius of the individual comprised medical men's claim of their scientificness. Thompsonians in turn drew on the democratic values of Enlightenment rationalism in order to argue that common sense was superior to elite learning and sought to explicitly merge politics of class conflict with medicine.¹⁸² Hence, orthodox medicine sought to maintain that scientific capital is only attained through elite learning so as to limit the condition of entry into medicine, while heterodox medicine struggled to connect scientific capital with a broader range of educational capital so as to delimit the condition of entry. The two camps fought viciously to discredit one another's science in terms of moral character and rationality, most notably in the Ontario Legislative Assembly, but scientificness in this struggle was not about medical judgment based in empirical evidence or observation, criteria that characterize scientific medicine of the twentieth century. Instead, it was about the manner in which one acquires the knowledge of medicine. While some historians have concluded that the way in which one invoked science and controlled knowledge was more significant than actual science during this historical moment of medicine,¹⁸³ a Foucaultian approach to knowledge formations asserts that form and content are inseparable in the ways in which expert discourse gains and exercises power. Lorraine Daston and Peter Galison's account of visual objectivity in Western science demonstrates that in the nineteenth century one could claim objectivity based on a strict adherence to established and agreed-upon procedures of observation¹⁸⁴; the interference of the self through interpretation could be tempered by the scientist's moral and rational competency as a result of rigorous training, self-cultivation and selflessness.¹⁸⁵ For medical men, adherence to established procedures meant a university medical education

¹⁸¹ Ibid.

¹⁸² Paul Starr, *The Social Transformation*, 52-53.

¹⁸³ See S.E.D. Shortt, "Physicians, Science, and Status"; Paul Starr, *The Social Transformation*.

¹⁸⁴ Lorraine Daston and Peter Galison. *Objectivity* (MIT Press, 2010), 185.

¹⁸⁵ Ibid., 198-205.

through which they acquire the virtues and rational aptitudes that legally and morally qualify them as practitioners of medicine:

Who are these ‘educated, skillful, and successful physicians?’ Are they men who, having acquired their profession honorably, have complied with the requirements of the law in this country, requirements which they well knew, and then quietly settled themselves down in practice; or are they otherwise?¹⁸⁶

Meanwhile, Thompsonians and homeopaths argued, “had not many valuable lives been also sacrificed by the regular physician? The only difference was that one [i.e. Thompsonians and homeopaths] sacrificed life contrary to law, the other [i.e. licensed medical men] according to law”¹⁸⁷, claiming that what is considered to be legal and legitimate form of medicine and what is not are arbitrary constructs. Medical men, however, claimed that their elite learning signified moral uprightness and scientific competence that are grounded in rationality, whereas, they argued, Thompsonians relied on their own interpretations through common sense and by this definition were incompetent as healers.¹⁸⁸ Indeed, medical men often used the words *quack* and *empiric* interchangeably, indicating that a sole reliance on experimentation and observation is both unscientific and immoral compared to judgments based on formal learning.¹⁸⁹ In this way medical men sought to reposition the Thompsonians’ advocacy for common sense as acts of deliberate deception in order to establish once and for all that elite learning is the only legitimate criterion for scientificness.

The same argument for elite learning as the gateway to scientific rationalism was deployed by British elite medical men in order to discredit other forms of medical

¹⁸⁶ “The Sherbrooke Gazette”, *British American Journal of Medical and Physical Science*, 5 (1850), 276.

¹⁸⁷ “Debate on the Thompsonian Bill”, *British American Journal of Medical and Physical Science*, 5 (1849): 25.

¹⁸⁸ In the Ontario Legislative Assembly, Dr. Nelson tries to disgrace Thompsonians and homeopaths by quoting Paracelsus, the “prince of Quacks”, a disgraced physician during the Renaissance: “the very down on his bald pate had more knowledge than all the writers; the buckles of his shoes more learning than Galen and Avicenna; and his beard more experience than all the universities” (ibid., 26).

¹⁸⁹ “... would admit a student to practice without having touched a subject or heard a lecture, except upon clinical medicine and surgery: and *this is the mode in which the profession is to be ameliorated!!* Dr. G. will excuse us from ‘joining their united appeal’ for any such reform, which savours strongly, to our mind, of demolition” (“‘ Et Tu, Brute!’”, *British American Journal of Medical and Physical Science*, 5 (1849): 25.

education and notions of scientificness that were emerging in Western medicine in the nineteenth century. The British elite medical men who had dominated the field of medicine until the early nineteenth century found unwanted competition among the graduates of the newly established medical schools in North America. American schools were first established in the 1810s and 1820s but, very different from medical schools in Britain and in Europe, they were tied to universities and colleges in name only, maintained very loose requirements for courses, theses and examinations, and generally modified the certification structure relative to student demand, upon which the schools relied heavily to pay the faculty.¹⁹⁰ Conservative British medical men in Canada, who sought to emulate the British system of centralized self-regulation and medicine as elite practice,¹⁹¹ saw the explosion of American medical schools as a threat to this ideal: “the evil and danger of the young men of Upper Canada going to the United States for a medical education.”¹⁹² Meanwhile, the American schools became a popular destination for Canadian students, particularly French-Canadians who were predominantly from working-class and rural families who could not afford to study in Europe.¹⁹³ Medical schools were slower to develop in Canada due to resistance from Britain, which struggled to maintain its hierarchical relationship to the colony, including the proper education and certification of doctors in the colony: the Montreal Medical Society (which became the Ecole de Médecine at McGill University) was established in 1824¹⁹⁴ but was not able to grant degrees recognized by law until 1834¹⁹⁵; and King’s College in York (now Toronto) established its medical faculty in 1839 after long years of struggle with the

¹⁹⁰ Paul Starr, 41-43; Thomas N. Bonner, *Becoming a Physician: Medical Education in Great Britain, France Germany, and the United States, 1750-1945* (Cary, NC: Oxford University Press, 1996), 150.

¹⁹¹ In Britain, there was an intra-professional conflict among medical men who were divided along political and scientific lines: conservative men sought to maintain medicine as the practice of elite class of university-educated men, while reformist pushed to dismantle the hierarchy between medicine and surgery and to steer medical education toward a more clinical and practical direction. (Paul Underhill, “Alternative Views of Science in Intra-Professional Conflict: General Practitioners and the Medical and Surgical Elite 1815-58”, *Journal of Historical Sociology*, 5 (September 1992): 322-350.

¹⁹² Canniff, *The Medical Profession in Upper Canada*, 53.

¹⁹³ Barbara Tunis, “Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change”, *Histoire sociale / Social History*, 27 (May 1981): 70.

¹⁹⁴ Hamowy, *Canadian Medicine: A Study in Restricted Entry*, 80.

¹⁹⁵ Ibid.

conservative Lieutenant-General from Britain.¹⁹⁶ There were strong anti-Empire sentiments, particularly among the French and working-class British, and among the rebels were influential medical men. The dominance of conservative British medical men was threatened from both south of the border and from within its borders and these conflicts were played out through the Medical Board which examined candidates who were not educated in a recognized British medical school. The requirements for license and the decisions made by the Medical Board with regard to candidates suggest particular criteria for what was considered to be the proper scientific and class-based character of a medical man, a combination of which allowed the restriction of certain undesirable groups into the profession. These examinations highlighted what were perceived as the essential qualities of a learned profession: gentlemanliness and scientificness. The social, political and ethnic conflicts among medical men in Canada resulted in a particular interpretation of these ideals to be then imposed as the condition of entry into the group.

The Boards exercised a considerable amount of power: during the 1820s and 1830s, the Ontario Board granted an average of about twenty-five licenses per year while failing candidates on seventy-three occasions between 1830-1837, six of whom had applied more than once.¹⁹⁷ Candidates were rejected based on three main defects: disloyalty to the British crown and lack of integrity, deficiency in Latin and an incompetency in anatomy. Demonstration of loyalty was mostly ceremonial except when it came to American-born candidates, who were required to prove their loyalty and their family's loyalty to Britain during the War of Independence.¹⁹⁸ Family origins in the United States was generally a grounds for suspicion of character:

But after a time, in Upper Canada, there came, now and then, persons from the United States professing to possess medical skill. They came generally, not for attachment to the British flag, but to turn a penny. Sometimes they had a degree of medical education which had been acquired in the United States medical schools; sometimes they knew a

¹⁹⁶ Charles M. Godfrey has documented this struggle in *Medicine For Ontario: A History* (Mika Publishing Company, 1979), 46-58.

¹⁹⁷ Rainer Baehre, "The Medical Profession in Upper Canada Reconsidered", *Canadian Bulletin of Medical History / Bulletin canadien d'histoire de la médecine*, 12 (1995): 108.

¹⁹⁸ *Ibid.*, 106.

little about the use of drugs; but too frequently they only knew how to deceive the people by arrant quackery.¹⁹⁹

Hence, loyalty to Britain was conflated with integrity and good moral standing, implying that a learned gentleman must also be pro-(conservative) Britain. The same learned gentleman must also be a cultivated man who has undergone university education, not a practical learning such as a Thompsonian or in privately-run schools in the United States which were considered to be more concerned about profiting from tuition than on quality of education.²⁰⁰ Although the Medical Board claimed that Latin was required by the candidates in order to write prescriptions and to read medical texts²⁰¹, training in the obscure language meant that the candidates must be educated in a classical university program. This criterion mean that graduates of American medical schools, including many French-Canadian candidates, could not pass the Medical Board examination.²⁰² The Board's insistence on Latin was also linked to the conservative position in Britain, where anti-reformists maintained that medicine must be an art of the gentleman and, as such, should uphold classical teachings in universities²⁰³; Latin was the language of gentlemen and thus performed a symbolic role of imparting this quality upon medicine as a requirement of the learned profession.

¹⁹⁹ Canniff, *The Medical Profession in Upper Canada*, 15-16.

²⁰⁰ For these reasons, American medical school were often derogatorily called "proprietary schools", although, as Thomas N. Bonner argues, such for-profit schools also existed in Britain (*Becoming a Physician*, 151).

²⁰¹ See Canniff, *The Medical Profession in Upper Canada*, 59-61.

²⁰² Sylvio Leblond describes an incident in 1832 where the Quebec Board of Medicine refused to grant medical licenses to four French candidates who received their medical diplomas at the University of Vermont at Burlington on the grounds that their three-month education does not meet the Board's requirement for five years of study in medicine ("La médecine dans la province de Québec avant 1841", *Cahier des Dix*, 35 (1970), 81-84). Canniff documents cases where American-educated candidates were rejected by the Ontario Medical Board: for example, in July 1836 a candidate "from the United States, educated at the University of Maryland and Pennsylvania" was rejected because he "exhibited a total ignorance of the Latin language, and seemed to be as uninformed of English grammar" (*The Medical Profession in Upper Canada*, 85); and in April 1834 another candidate who "presented certificate of attending a course of lectures at Dartmouth, in New Hampshire, and of his proficiency in the Latin language" was rejected because he was "found to be quite ignorant of Latin grammar and was therefore advised to pursue his studies" (*ibid.*, 78).

²⁰³ Paul Underhill, "Alternative Views of Science in Intra-Professional Conflict: General Practitioners and the Medical and Surgical Elite 1815-58", 5 (September 1992): 322-350.

By the 1820s candidates were often rejected for incompetency in anatomy²⁰⁴, a relatively new subject that was linked to the rise of clinical medicine and hospitals in Europe, particularly in France, that steered medical education toward clinical teaching and dissections. Competency in anatomy would have been difficult for American graduates who were at a disadvantage due to a general lack of hospitals and clinical teaching in the country as a whole.²⁰⁵ Anatomy was much debated in Britain at the time as medical reformists pushed to include the subject in the medical canon, while the conservatives, who sought to maintain a hierarchical separation between surgery and medicine, resisted the move by insisting that the use of hands is the work of the underclass and not fitting for a learned gentleman.²⁰⁶ Interestingly, the Medical Boards in Canada emphasized both Latin, a component of classical education that British conservatives advocated, and anatomy, the new radical subject of the reformists. The paradox can be explained through Underhill's work: when anatomy and physiology gained scientific authority, the conservative medical men in Britain began to embrace the subjects as legitimate part of medical education but only as supplement to a classical university education²⁰⁷; in other words, they used the scientific value of bio-medicine to strategically position themselves as simultaneously scientific and gentlemanly. In Canada, Latin and anatomy became ways to maintain British-centrism and to prevent the influence of American free trade model of medicine; they also became ways to restrict the entry of French-Canadians into medicine so as to further ensure British dominance. Indeed, it is curious that the Medical Board would insist on knowledge in anatomy while medical men in the country were practicing heroic medicine, resulting in an apparently unproblematic coexistence of two vastly different approaches to medicine that were based in entirely different theories of disease. Also, the examinations were verbally administered,²⁰⁸ which runs contrary to the tenet of anatomy as practical discipline as much as a theoretical one. Hence, science was deployed strategically and unevenly in

²⁰⁴ See Canniff, *The Medical Profession in Upper Canada*, 51, 56-57.

²⁰⁵ Bonner, *Becoming a Physician*, 150; Starr, *The Social Transformation*, 42.

²⁰⁶ Underhill, "Alternative Views of Science", 324.

²⁰⁷ Ibid.

²⁰⁸ See Sylvio Leblond's description of open public examinations for medical candidates, which included an audience consisting of medical men, students, parents of candidates and the curious public ("La médecine dans la province de Québec", 82).

order to lend credibility to the Medical Board and ultimately to all of medical men inducted via the Board as a scientific group of learned gentlemen, all the while restricting membership from undesirable groups, such as Americans, French-Canadians and radicalized Anglo-Canadians, by claiming that they are ungentlemanly and unscientific.

The elite British military surgeons and physicians saw their dominance threatened from both without and from within and addressed these forces through structural means of restricting entry into the field of medicine by defending a medical law and a system of medical examinations that would define legitimate medicine as only that which is based on British medical education. While this struggle was largely based on a class conflict between the British elite, who held the dominant position in the field, and those who challenged their dominance—entrepreneurial Thompsonians and homeopaths as well as American and French-Canadian medical men who were trained in North American medical schools—what was also at stake was the very definition of scientificness, or the rate of conversion between educational, cultural and scientific capitals. The heterodox practitioners and the dominated medical men advocated for the new democratic discourse of science at this time in order to gain entry into what was a highly restricted field, calling for an expansion in the definition of legitimate education—to include self-learning and non-European medical degrees—that would grant one access to medical practice. Meanwhile, the orthodox British elite sought to maintain the restriction by deferring to science as rationalism that can only be acquired through elite learning with certification from a European medical school. Scientificness as an ideal and quality of an honourable gentleman operated as a form of capital, which the groups strategically deployed in order to lend credibility to their motivations to either alter or maintain the existing structural hierarchy in medicine, often drawing on contradicting notions of scientificness.

The *Habitus* of a Learned Profession

The struggles over what it means to be a learned medical profession became increasingly a question about the moral and scientific quality of its membership, and thus it became necessary for medical men to consider what it means to be a learned medical

man as the seat of rational thought and gentlemanly conduct. The latter quality acquired a particular importance as disputes between the orthodox and heterodox groups often became ugly banter between individuals as well as groups of medical men that escalated to heated exchanges of insults that were even published in medical journals. Such internal strife when trying to convince a reluctant government to grant medical men the ability to self-regulate and to punish unlicensed practice and malpractice became problematic and embarrassing for the group; it painted medical men as divided, petty and unfit to govern themselves. In order to deal with internal conflicts in ways that would facilitate group cohesion for the purpose of greater autonomy but still allow individuals involved to save face, etiquette became an important part of governing the dynamics within the group, especially those conflicts that emerged from the disputes between orthodox and heterodox positions, but also among everyday medical men who competed with one another for patients.

There is scarcely anything in a free country, where competition is nearly unlimited, upon which the respectability of the medical profession is so dependent as the strict preservation of that professional etiquette, which practitioners ought to acknowledge with regard to each other. Nothing can be clearer, than that the best, most scientific, and most enlightened practice must be looked upon with distrust and contempt by the community at large, when they see men engaged in the same pursuits, attempting to secure a livelihood by the same means, of, it may be, equal talents, discrimination and zeal, having recourse to the miserable trick of casting reproach upon each other's practice.²⁰⁹

These informal rules of conduct and professional etiquette were at first messy and clunky in their application but were eventually incorporated into the embodied dispositions of the *habitus* of medical men and into a system of vision and division that categorized their actions and thoughts according to the emerging standards of scientificness and gentlemanliness. These embodied dispositions were then be taken up as a common-sensical understanding among medical men of how to judge oneself or another to be a scientific and moral physician. This gradual consolidation of the medical *habitus*, which eventually became formalized as a code of ethics by the Canadian Medical Association in

²⁰⁹ "Professional Etiquette." Editorial. *British American Journal of Medical and Physical Science*, 1846 1(11): 306-307.

1868, is marked by a shift from the importance of defending personal honour to protecting the interest of the group and the conception of the group as a brotherhood of scientific gentlemen,²¹⁰ marking an important shift from a competitive model of a medical market toward a group ethos of a disinterested profession.

The nineteenth century saw major shifts in Western cultures of Europe and its colonies, including codes of masculinity among white European men: the dismantling of the monarchies and much of the aristocratic class and the emergence of the bourgeoisie meant that a new masculine order and new privileged spaces, both symbolic and physical, needed to be established that were limited to men in newly dominant positions. Such spaces included gentlemen's salons and clubs, which Robert Nye²¹¹ describes as having adapted the ethos of old aristocratic decorum as a way to monitor and withhold membership to women as well as certain types of undesirable men (such as working-class and Jewish men) during an era in which democratic principles made it less fashionable to blatantly discriminate based on class and ethnicity. While duelling was perceived as archaic at this time and there were conflicting views on whether or not they should take place at all, the ethics behind such rules of engagement persisted in disputes among men, even if they often did not actually engage in the physical event of the duel. The format of responding to an insult with a challenge in order to defend one's integrity was a social practice that was familiar and would have been appealing to bourgeois men: it had been part of the honour code of aristocratic men, whose cultural and symbolic capital bourgeois men emulated in order to distinguish themselves from the working-class; at the

²¹⁰ The range of qualities that were organized around rationality and masculine notions of honour meant that certain groups were automatically excluded from the brotherhood of scientific gentlemen. According to Kenan Malik, Victorian race relations in Britain were organized primarily in terms of stratifications within a racial society rather than between different races, so that class-based identification of the poor as a distinctive race, as a group that "could not be considered as part of a common community but should be regarded as a threat to the integrity of society" (Malik, *The Meaning of Race*, 202) became the primary focus for Victorian Britons. Malik argues that colonial racism in the nineteenth century did not develop until the race-based discourse of class was first established (ibid., 92-97). Hence, women, men of colour, Jewish men and Aboriginal healers would not have been perceived as viable players in the struggle for status and dominance among medical men who considered themselves to be a distinct class-race from these subordinate groups. These groups would have been perceived as having no possibility of occupying a viable position in the field of struggles among medical men, as being outside of the limits of the field proper. It is likely for this reason that the few women physicians and midwives who did practice during the nineteenth century did not factor into the debates about the qualities that befits a medical man as a gentleman.

²¹¹ Robert Nye, "Medicine and Science as Masculine 'Fields of Honor'", *Osiris*, 12 (1997): 60-74.

same time, following the ethic of the duel without engaging in the actual physical duel would have been a way for bourgeois men to distinguish themselves from the old aristocracy. The rules of duelling-without-the-duel provided an ethical framework for white European men, including scientists and physicians, to deal with interpersonal conflict, including scientific debates at conferences and symposia that could escalate to personal attacks. The editorial pages of medical journals in nineteenth century Canada became sites where similar kinds of battles were played out among medical men through the pen: elite men trained in British schools sought to defend their dominance over Thompsonians and homeopaths as well as medical men who were trained in Canada and the United States, and these disputes consisted of attacks that conflated scientific and political positions with character and integrity. At the heart of these editorial banter were the terms and criteria for gentlemanly conduct that befit a learned and rational medical man, which was invoked to either gain or restrict membership into the group of medical men.

An example of an editorial banter between medical men is a particularly heated dispute that appeared in the pages of *The Dominion Medical Journal* in 1869 between Dr. Yates, a former member of the Ontario medical council, and Dr. Fields, a concurrent member of the council, over the matter of Thompsonians and homeopaths. When the Ontario government passed an amendment to the Medical Act to legalize the latter's practice through licensing and standardized education, a few medical men suggested that they embrace these practitioners in order to directly influence them and thereby weed them out, an approach which a medical man described as "hugging eclectics to death."²¹² Yates wrote to the editor of the *Journal* to describe why he supported this view, stating that there are bound to be "knaves and fools" in any profession, including medicine, and such inferior "rascals" can be relegated to the lower status of homeopaths and Thompsonians, "two bastard branches of medicine."²¹³ Fields, who was one of the five homeopaths elected into the Ontario medical council after the amendment of the medical

²¹² H.E. MacDermot, *History of the Canadian Medical Association, 1867-1921* (Murray Printing Company, 1935): 13.

²¹³ "The Homeopaths and Eclectics", *British American Journal of Medical and Physical Science*, 1 (1868): 230.

law, took great offense to Yates' use of derogatory terms to describe his homeopath colleagues and accused him of ungentlemanliness. The subsequent banter between the two men involved the manner in which one may define the idea of a gentleman, which they both agreed was that "he may attack any system or doctrine which he believes to be false or dangerous, but must avoid personal or individual abuse"²¹⁴; yet, both Yates and Field accused one another of not upholding these ideals of a gentleman by using personal attacks. What is markedly absent in the editorial banter are debates about medical theories and remedies; the incident became an individualized conflict between two men rather than a disagreement between two groups with different approaches to medicine. Nye explains that in the old rules of the duel what mattered was not so much who was in the right but who is "willing to back up his words with deeds", namely to challenge an opponent to a duel.²¹⁵ Since their duel was only symbolic and executed through writing, Yates and Field could not back up their words with a deed based on physical aggression; instead, the quality of their deed consisted of their ability to invoke the ideals of a gentleman in a manner that successfully demonstrated that they are legitimate members of a learned profession.

Banter between groups of medical men also involved such attacks on character and even on rationality as demonstrated by the case of conflict between British elite medical men and French-Canadian medical men in Quebec. In 1846-1847, medicine in Quebec underwent a significant amount of organizational and legislative change: it established the College of Physicians and Surgeons and made numerous attempts to revise the provincial medical act. French-Canadian medical men felt excluded by the British who spearheaded both initiatives, and accused the latter of illegally naming a College without the input and support of all, i.e., French medical men in the province. British elite medical men responded with insults, dismissing the French for irrationally resisting a process that would ultimately benefit them and called their actions "fitful

²¹⁴ "The Homeopaths and Eclectics", *British American Journal of Medical and Physical Science*, 2 (1869): 27.

²¹⁵ Robert Nye, "Medicine and Science as Masculine 'Fields of Honor'", 63.

phantom of a disordered mind.”²¹⁶ The British also accused the French of jealousy toward those in power and of acting in selfish self-interest to “assert a Franco-Canadian supremacy over the Anglo-Canadian or British,”²¹⁷ combining personal insult with the patronizing expressions of superiority of the British toward the French.

This dispute was slightly different from the banter between Fields and Yates, however, in that it gestured toward the interests of the group rather than relying solely upon the personal integrity of a single individual. In 1846 a contingent of medical men from the Ecole de Médecine at McGill University objected to a medical bill that was being drafted by a group of British medical men because the legislation would require the graduates of the Ecole to undergo examinations by the Medical Board in order to obtain the license to practice, while the graduates of recognized schools in Britain would be granted automatic licenses. A five-page editorial in the *British American Journal of Medical and Physical Science* [BAMPJ] contained severe criticisms of the Ecole for obstructing the legislation on the grounds that the school faculty acted in a misguided self-interest that ran contrary to the “dearest and best interests of the community at large.”²¹⁸ The editor sought to identify the Ecole’s position as that of a hostile minority and to represent the interests of the profession in terms of the position of British medical men. While claiming that the matter “must be viewed through no distorting medium of prejudice, or passion, or interest”, he suggested that

if we can make it appear that the interests of the profession generally, [sic] are the interests which would be really affected by the concession of the power which the School of Medicine is demanding, it will then follow that the School of Medicine is pursuing a course of policy which is hostile to the best interests of that profession from which it claims its support...²¹⁹

²¹⁶ “Counter-petition to the Governor General,” Editorial, *British American Journal of Medical and Physical Science*, 3 (1848): 246.

²¹⁷ “The Doings of the ‘Repeal Association’”, Editorial, *British American Journal of Medical and Physical Science*, 3 (1848): 277.

²¹⁸ “The Medical Bill and the School of Medicine of Montréal”, Editorial, *British American Journal of Medical and Physical Science* 2 (1846): 21.

²¹⁹ *Ibid.*, 22.

And in this goal, he claimed, “*a large, a very large, majority of the British practitioners of Canada*, who desire to see their profession placed on some more elevated and stable position than it now occupies, will fully sustain us.”²²⁰ The contradiction between the editor’s claim to unbiased judgment and his explicit appeal to the interests of his British colleagues demonstrates a calculated move to link the position of the French with self-interestedness and irrationality while implying that the British medical men are the vanguards of disinterestedness and rationality; the appropriate conduct for a medical man would then be to understand that the position-takings of the British coincide with the best interest of the group. Hence, these writings were efforts to shape the emerging medical profession in terms of the orthodox position of the British in ways that would ultimately obscure its orthodox origin and instead become part of the common sense of the group at large. The editor also opened up the possibility to discredit the French opposition without having to resort to individualized insults, which are often passionate, irrational and, therefore, unscientific. By deferring to the rational judgment of the group of medical gentlemen which is dominated by the British, he was able to conclude that the French opposition is self-interested, and therefore unprofessional, not disinterested, unscientific and ungentlemanly.

The adoption of the ethics of duelling by medical men in the nineteenth century in order to settle disputes among them thus shifted from defending one’s personal honour when faced with an accusation by another to gesturing toward the honour of the group in order to seek legitimacy of one’s position. This shift in the emphasis from the individual to the group opened up the possibility of imagining a group of medical men that is a cohesive and united profession to which a medical man may defer in order to make claims about medical practice. The notion of the profession that emerges is able to exercise a considerable power over an individual self by dictating what is to be correct and honourable and by condemning what is not to the point of banishing an individual from the group. The constitution of a group ethos marks a significant moment in the constitution of the medical *habitus*: in order to be considered as part of the group, the individual medical man had to perceive, by a new system of vision and division, another

²²⁰ Ibid., emphasis in original.

medical man and other medical men not simply as individuals that engage in similar practices but as members of a single group with shared goals, visions and aspirations. This system of vision and division required a significant amount of work in order to fuse standards of honour with the standards of science under a single rubric of a professional ethos—that is, of disinterestedness. Hence, questions of honour, disinterestedness and the manner in which a medical man may engage in a dispute with another were framed at this time as matters of medical ethics. The writings in medical journals in Canada in the nineteenth century demonstrate that the connections between scientificness, honour and respectable status had to be established at the level of the group *habitus*, a group that regularly engaged in scientific disagreements and disputes regarding medical opinions, insulted one another’s character and competed with one another for patients. There was a need to create an affective bond between medical men as an embodied sense of honour, trust and brotherhood and to collectivize these feelings and intentions as a gentlemanly code of etiquette among medical men.

Medical practice in the nineteenth century was predominantly conducted as private practice by individual medical men, a system that was premised on competition for patients and that presented the greatest obstacle to establishing affective bonds of brotherhood among medical men. Stories emerged of medical men interfering with another’s relationship with his patient, but more often, however, it would be the case that more than one medical man would be called upon for a medical emergency or a medical man would be approached by the patient of another for consultation, resulting in uncomfortable situations for those involved. Before the establishment of a formal code of conduct or rules to govern unpleasant conflicts and tensions between physicians, the writings in the medical journals turn to bonds of honour between medical men in order to align the interests of the individual self with those of the entire group. The writers advocated a move away from perceiving a neighbouring medical man as a potential rival or competitor to seeing him as a “brother practitioner”²²¹ so that one would be guided by an “honourable feeling”²²² and a respect for “the feelings and opinions of others.”²²³ The

²²¹ “Professional Etiquette”, Editorial, *British American Journal of Medical and Physical Science*, 1 (1846): 306.

²²² Ibid.

first code of ethics by the Canadian Medical Association in 1868 reinforce the familial obligation by insisting that medical men must provide care for another's family free of charge and that they should come to expect such service from their fellow medical men.²²⁴ By framing the relationship between medical men in terms of familial feeling, the writers sought to instate professional etiquette as a natural inclination and affective state so that the gentlemanly rules of honour become an embodied moral compass. The honourable feeling would ideally operate as an internalized rule or a feel for the game of the practice of medicine so that it would become untenable to overstep the bounds of one's practice to infringe upon that of another and they would feel genuinely uncomfortable when a patient of another requests a consultation. For a medical man to violate this unspoken rule would mean that he does not possess this honourable feeling and must be inculcated into it; one writer describes proscription as "the surest and most effective way of teaching them their duty,"²²⁵ suggesting that the affective state of feeling honour-bound is a requisite for the entry into the group of learned medical gentlemen.

The writers in these editorials depicted a medical man's lack of professional etiquette as simultaneously unbrotherly and unscientific: "Every injury thus inflicted on the individual, [sic] is felt by the profession at large, of which he is a member... it cast discredit and disrepute on scientific practice."²²⁶ Yet the affective obligation to harbour genuine honourable feelings toward one's fellow medical men and the scientific obligation to exercise sound judgment did not always coincide. In a two-part series on medical ethics, W. Fraser wrote in the *British American Journal of Medical and Physical Science* about various situations in which medical men may find themselves at odds with one another and in uncomfortable situations with patients. He remains undecided when it comes to the question of whether or not a medical man is justified in interfering if he suspects that the life of a patient of another medical man is in danger due to error in medical judgment. In one instance, he quotes Thomas Percival, a conservative British

²²³ Editorial, "Correspondence", *British American Journal of Medical and Physical Science* 1 (1846): 335.

²²⁴ Canadian Medical Association, "Code of ethics of the Canadian Medical Association", 1868, 8. [Accessed from http://www.archive.org/details/cihm_00948]

²²⁵ Editorial, "Professional Etiquette", *British American Journal of Medical and Physical Science* 1 (1846): 307.

²²⁶ *Ibid.*, 306.

physician and an authority on medical ethics,²²⁷ to state that the medical man has the duty to interfere, so long as the information upon which the medical man intervenes is “well founded” and that “his motives are pure and honorable.”²²⁸ In another instance, Fraser refers to the words of his colleague who insists that interference is inappropriate in any situation because good intentions are not enough, especially when honest mistakes are made about the facts of the case, in which the intervening medical man “will almost infallibly be regarded with a suspicion of self-conceit, which... a rightful minded man would avoid, as calculated to injure his character and impair his usefulness.”²²⁹

According to Fraser, a Percivalian approach looks to the intentions of a medical man in order to assess whether or not a medical judgment is honourable, but his colleague’s position cautions that the perception of honour can overrule the individual’s intentions. The importance of fostering introspection as a way to cultivate honourable feelings toward other medical men at times conflicted with the reality that debate is part of the social practice of medicine as science; there are bound to be diverse opinions on medical judgment, and as scientists medical men are likely to engage in disputes in ways that may compromise honourable feelings toward one another.

What appeared to be the most problematic about the possible collision between the ideals of scientific debate and of honourable feelings of brotherhood was the exposure of this contradiction to those outside of the field of medicine, namely patients and the citizenry at large. There emerged a logic that to act dishonourably and to make public such dishonourable acts toward one another can “degrade the profession in the eyes of the public,”²³⁰ which would result in the loss of credibility and respectability of medical men as individuals and, more importantly, as a group; such degradation could compromise the group’s efforts to acquire greater autonomy. The Canadian Medical Association’s first

²²⁷ Percival’s *Medical Ethics; or a Code of Institutes and Precepts, adapted to the Professional Conduct of Physicians and Surgeons* (Manchester: S. Russell, 1803) became the foundations of the Code of Ethics for the American Medical Association in 1847 and later the Canadian Medical Association in 1868. See P. Sohl and H.A. Bassford, “Codes of Medical Ethics: Traditional Foundations and Contemporary Practice”, *Social Science of Medicine*, 22 (1986): 1175-1179.

²²⁸ Miscellaneous, “Queries in Medical Ethics”, *British American Journal of Medical and Physical Science*, 5 (1849): 155.

²²⁹ Ibid.

²³⁰ “Professional Etiquette”, Editorial, *British American Journal of Medical and Physical Science* 1 (1846): 306.

“Code of Medical Ethics” in 1868 places much emphasis on how the ways in which medical men act toward one another affect public perception of the group as a whole. Referring specifically to private practice, the Code advocates for consistency and unity across the group so as to transform the prevailing perception that medical men are rivals in a competitive medical market into a perception that they are a profession of colleagues who support one another; specifically, the Code asks the wealthy medical man not to undercharge a patient because “his doing so is an injury to his professional brethren”²³¹ and for all medical men to refrain from advertising because it is “derogatory to the dignity of the profession.”²³² These portions of the Code emphasize that medical men must present the honourable feeling as an identifiable quality of the group in order to evoke feelings of respectability and credibility for the group and for the individual medical man.

The quality of group honour comes under challenge during disagreements over medical judgment, such as diagnosis and the appropriate remedy, which can easily escalate to accusations of a lack of character and a violation of the honourable feeling that hold medical men together in a brotherhood. There is a tension between the group’s desire to maintain the honourable feeling toward one another in order to inspire respect from patients and the public and the group’s need to exercise proper scientificness through debate and challenge. The Code repeatedly highlights the importance of dealing with debates, disputes and conflicts behind closed doors away from the public eye: during a consultation, all the attending medical men should “retire to a private place for deliberation”, then discuss the case with the patient “in the presence of all the faculty attending” and nothing should be discussed “which are not the result of previous deliberation and concurrence.”²³³ By conducting deliberations in private, the consulting medical men can present to the patient an appearance of cooperation and confidence in the medical judgment, all the while concealing any possible unpleasantness and differences of opinion that may arise during the discussion.

²³¹ Canadian Medical Association, “Code of ethics of the Canadian Medical Association”, 1868, 13. [Accessed from http://www.archive.org/details/cihm_00948]

²³² Ibid, 10.

²³³ Ibid, 9.

As peculiar reserve must be maintained by physicians towards the public, in regard to professional matters, and as there exist numerous points in medical ethics and etiquette through which the feelings of medical men may be painfully assailed in their intercourse with each other, and which cannot be understood and appreciated by general society, neither the subject-matter of such differences nor the adjudication of arbitrators should be made public, as publicity in a case of this nature may be personally injurious to the individuals concerned, and can hardly fail to bring discredit to the faculty.²³⁴

The above passage warns that medical men must not air their dirty laundry in public because a person who is not trained in medicine would not possess the embodied sense that there are times when scientific debate about medical judgment can lead to less honourable interactions between medical men. Medical men possess the know-how and common sense that allow them to see that such tensions are inevitable part of medical practice but the public may not, and engaging in an open debate in front of a patient can reveal this contradiction and risk the group being perceived as incompetent rather than engaging in proper scientific process. Creating a veneer of consistency and confidence behind closed doors required a separation between a private space where medical men could conduct their internal affairs related to scientific debate and a public space where they could present their conclusive decision to the patient—in other words, autonomy.

The questions of honour, brotherhood, scientificness and disinterestedness of the profession were central to the constitution of a group *habitus* that corresponds to what was emerging and coalescing as a distinct field of medicine in the nineteenth century. The shift from individualized banter between medical men about personal honour to invoking the rational judgment of the profession to determine what is honourable aligned with the structural struggles between orthodox and heterodox positions; both groups sought to configure and reconfigure the group ethos in ways that aligned with their specific positions. Disinterestedness acted as a form of symbolic capital which medical men of various positions in the field mobilized in order to either secure or augment their status. Shaping the contours of the disinterested *habitus* was not only at stake in internal struggles among medical men but also imperative in the group's project to acquire greater

²³⁴ Ibid, 13.

autonomy through a stricter medical law and the ability to enforce it. The latter struggle was marked by a need to present a medical profession as a unified group of scientific, honourable and thus disinterested medical men, who would be worthy of self-regulation and autonomy in the eyes of the state and the people. This need was not only a structural issue of the field, i.e. legislative changes, but also a matter of the *habitus*: medical men had to rationalize, in both practical and formal sense, their need for autonomy and seclusion from the outside world as legitimate part of the disinterestedness of their medical *habitus*.

The Public as a Medical Object

The move away from individual medical men to a brotherhood of learned scientific gentlemen constituted the field of medicine as an increasingly enclosed world to which only the educated elite with the correct moral inclinations could have access. Meanwhile, the imperative of disinterestedness required a justification for the exclusivity; indeed, the legislative government's resistance to granting structural autonomy to the medical profession so that it may control and enforce the medical law as a way to self-govern and self-regulate was based on the suspicion that medical men selfishly sought a monopoly over all matters of medicine and healing. The disinterested medical *habitus* required an external object that would give credibility to medical men's claim to honour, scientificness and selflessness. The shifting understandings of the masses or the people at this historical juncture in the West produced an ideal object to fill this vacuum: the public. Across his works, Foucault writes about the emergence of different types of sovereign power in European history in which the notion of the people holds different significance vis-à-vis shifting organization of sovereign power.²³⁵ Around the nineteenth century, Foucault identifies the emergence of the notion of a population, whose desires, opinions, biological realities and economic functions became the object of the knowledge and power of governing powers, which he saw as going beyond a repressive structure of the state and as including expert discourses and practices, such as psychiatry, the penal

²³⁵ Michel Foucault, *Security, Territory, Population: Lectures at the Collège de France, 1977-1978* (New York: Palgrave, 2007).

system and clinical medicine. In *The Birth of the Clinic*, he argues that medicine acquired a positive significance—as opposed to the negativity of disease and death—by linking up with the state as one apparatus of monitoring and managing the life, health and well-being of populations in a form of governance which he calls biopolitics.²³⁶ However, the writings about public health in medical journals at this time demonstrate that the public as an object of medicine also took on a highly moralized dimension, particularly in the context of struggles among medical men and between medical men and non-medical practitioners. The notion of a public gradually took shape in medicine during the nineteenth century, first as individual patients who required the protection of an honourable and scientific medical man, then eventually as an entire population in whose interest medical men as a professional group would act in a disinterested manner. This concept of a public was then mobilized in order to justify the group’s request for the state to guarantee its autonomy.

The popularity of Thompsonians and homeopaths in the nineteenth century compelled medical men to look more closely at patients as a group with tendencies and temperaments. Despite their claims to their scientific and moral superiority over the alternative practitioners, medical men were losing their grip on the trust of the public. In order to make sense of this problem, a protectionist discourse emerged in the early part of the century that incorporated rationality, vulnerability and honour to organize the relationships between the public, the quacks (an umbrella term for unlicensed medical men, Thompsonians and homeopaths, and other alternative practitioners) and the licensed medical men of the country. The public was portrayed as irrational and ignorant—“the ever-gullible public”²³⁷—unable to make sound judgments when it comes to selecting the most competent healing practitioner, and thus vulnerable to impostors and false promises. The quack was equally irrational and ignorant, due to a lack of proper education and training, but also dishonourable, preying on the ignorance of the public and deceiving them willfully—“they would adopt habit and cunning that respectable men could not

²³⁶ Foucault, *The Birth of the Clinic*, 39-40; *History of Sexuality Volume 1*. (New York: Vintage Books, 1990), 140-145.

²³⁷ “Medical Men and the Coming Election”. Correspondence, *British American Journal of Medical and Physical Science*, 7 (1851): 363.

think of.”²³⁸ The medical man was rational, learned and honourable, and as such could and was obligated to protect the public from the quacks. This euphemistic formula transformed the public’s skepticism toward the aggressive and often ineffective methods in medicine into a misunderstanding by an ungrateful public of the honourable intentions of medical men: “if the physician, despite the most judicious application of his talents, cannot arrest the behest of Providence, immediately he is blamed, censured, and even accused!”²³⁹ By extension, the quack’s popularity can only be explained as luck: “Their modesty prevents them from trumpeting their own praises, but their good fortune makes others do it for them.”²⁴⁰ Medical journals were peppered with self-pitying editorial submissions by medical men but frustrations were particularly high when Thompsonians and homeopaths petitioned the Ontario legislative government to include them in the medical act. The imminent threat of unlicensed practitioners becoming licensed through the Medical Act triggered an outcry from medical men who scrambled to guard their livelihood in ways that contradicted their protectionist stance in relation to the public: medical men, particularly in rural areas, lamented that unlicensed quacks undercharged patients and therefore threatened their medical practice to the point of infringing upon their rights as licensed practitioners²⁴¹; in a debate about the medical bill to include Thompsonians and homeopaths in the Ontario Legislative Assembly, one doctor claimed that the medical man’s “bill, always unwelcome, is greeted with a frown; it is paid, when at all, years after, and with a very liberal deduction!”²⁴² These statements made explicit what must remain implicit in the logic of disinterestedness: an honourable act, to be recognized as such, must take place within an unspoken yet binding agreement between the doer and receiver that the act will be acknowledged and reciprocated through gratitude and, in the case of medical men, discreet but timely payment; but if this assumption is made explicit, as in the case of writings in medical journals, the relation is

²³⁸ William Canniff, *The Medical Profession in Upper Canada*, 64.

²³⁹ “Debate on the Thompsonian Bill”, *British American Journal of Medical and Physical Science*, 5 (1849): 26.

²⁴⁰ “Thompsonian Petitions to the Legislative Assembly”, Editorial, *British American Journal of Medical and Physical Science* 3 (1847): 80.

²⁴¹ *Ibid.*, 81.

²⁴² “Thompsonian Petitions to the Legislative Assembly”, *British American Journal of Medical and Physical Science* 3 (1847): 26.

no longer based in an economy of honour but one of bartered exchange, which is antithetical to the logic of honour and disinterestedness.

The notion of a public interest began to supplant the argument for the rights of medical men and the profession in ways that sought to align the two in a single discourse of disinterestedness of the profession which acts on behalf of the public. The development of public health and its emphasis during and after the cholera epidemic of the 1830s produced a new array of legislative and social concerns that allowed medical men to carve out a role for themselves in relation to the public. Geoffrey Bilson, who wrote extensively on the history of cholera in Canada, argues that medical responses to the epidemic revealed deep inadequacies in medical science and divisions among medical men that worked to the profession's disadvantage,²⁴³ but medical men also navigated the terrain of scientific uncertainty and government instability in interesting and productive ways. Where medical men had limited understandings of the aetiology of cholera, they made up for by claiming urban sanitation as a legitimate medical concern to which medical men had scientific explanations and solutions. This claim to expertise also established a direct link between medicine and legislative politics, during a historical moment in which doctors did not have government support, in which they would function as experts advisors acting on behalf of the public: "The profession will not voluntarily submit itself to the control of a Board in which a lay constitution is so monstrously predominant; and the public will lose all confidence in it from the self-same cause."²⁴⁴ While their recommendations required that public health officials enter the homes of city citizens and dispose of bodies in ways that often violated burial customs, the Board, rather than the profession, took the brunt of public resentment and outcry against these measures.²⁴⁵ Despite the fact that the Board included members of the medical profession, it was primarily positioned as a bureaucratic body of the state. The Board and medical men frequently engaged in feuds: the Board demanded that medical men respond to the

²⁴³ Geoffrey Bilson, *A Darkened House*, (University of Toronto Press, 1980), 3, 164-165.

²⁴⁴ "The Central Board of Health", Editorial, *British American Journal of Medical and Physical Science*, 5 (1849): 75.

²⁴⁵ Bilson documents that the Board of Health administered the health regulations, which included the disposal of bodies during the epidemic, and "the burial of the dead was one of the greatest sources of anger against the health regulations" because "[p]eople deeply resented it when their relatives were carried away to be buried in the unconsecrated ground at potter's field" (*A Darkened House*, 58).

medical emergency with or without pay and open the hospitals to the sick, while medical men resented interruptions to their private practice and outsiders meddling in the affairs of hospitals.²⁴⁶ Although the medical profession was not popular among the public during this time, neither were the Boards of Health, which had very limited power to enforce public health laws and whose conflicts with medical men were perceived as part of their ineffectiveness.

While the cholera epidemic was in many ways embarrassing for medical men because it revealed their therapeutic limitations and internal conflicts, the incident was not entirely disastrous for the profession. Lindsay McGoey argues that scientific uncertainty, contrary to being detrimental for scientific experts, can be highly generative because it allows the proliferation of theories and practices to remedy it, and experts who point out the uncertainty are in a better position to suggest solutions because they are the ones who identified it in the first place.²⁴⁷ Similarly, scientific uncertainty and the lack of a credible authority during the cholera epidemic compelled medical men to configure public health as the legitimate object of medical practice and knowledge. They made themselves vanguards of public health to pressure the governments to observe its laws on sanitation and sought greater input on the Boards of Health in the name of acting on behalf of the public as concerned experts.

We ask the question, should we not be prepared for its [i.e. cholera's] arrival? Should no sanitary precautions be observed? And finally, is it the proper time to adopt them when the disease has manifested itself, and its virulence has been aggravated by the dirt and filth which furnish a nidus for its incubation and its propagation, and which might have been removed at a more opportune period. Yet opposed to common sense and ordinary reason, as would be the negative answers to these questions, the Executive authorities are acting upon these presumptions.²⁴⁸

In other words, medical men used the notion of public health as a legitimate medical concern in order to gain entry into the political arena and thereby exert influence in the

²⁴⁶ See Bilson *A Darkened House*, 29, 38-40.

²⁴⁷ Linsey McGoey, "Pharmaceutical Controversies and the Performative Value of Uncertainty", *Science as Culture*, 18 (2009): 151-164.

²⁴⁸ "The Public Health", Editorial, *British American Journal of Medical and Physical Science*, 5 (1849): 52.

field of power in relation to questions of health. In 1868, the Canadian Medical Association established a committee on vital statistics during its first year of inception,²⁴⁹ reflecting the importance that medical men placed on public health as an object of medical knowledge, practice and organization. Medical men attacked the proliferation of alternative practitioners during the epidemic with the new rhetoric of public health, claiming that “the public at large has an equal interest” in the competency of any practitioner, be he a medical man or a Thompsonian and “has a right to expect”²⁵⁰ that he knows what he is doing. This position is markedly different from the overtly condescending descriptions of the public yet still draws on the notion that the public is vulnerable to quackery and incompetence which requires the disinterested expertise and intervention of medical men. The crucial difference between the two approaches is that the protectionist stance placed medical men on the defense, presenting themselves as victims of public distrust and unchecked quackery, while the discourse of acting on behalf of public interest placed them in an apparently neutral position where their disinterested expertise logically and ethically compelled them to intervene in the matters of the health of the public. Hence, the public was positioned in medicine as both a scientific and moral object of disinterestedness which would in turn serve to justify the legitimacy of the medical profession as a group that is worthy of self-regulation by law.

Yet, the discourse of acting on behalf of public interest did not resolve the thorny issue of payment which was particularly conspicuous in a conflict between medical men of the Central Board of Health in Ontario and the provincial parliament. Two of the Board’s medical men had been paid for their services but two had not and when medical men petitioned the parliament for compensation, they were refused. The angry outcry that followed made explicit the implicit conditions of medical disinterestedness; while medical men may act in the interests of the public, their services are not self-sacrifices per se but are based in an economy of honour as well as payment: “we consider honor and pecuniary emolument, alias ‘sweets of office’, to be intimately blended.”²⁵¹ Medical

²⁴⁹ MacDermot, *History of the Canadian Medical Association*, 91.

²⁵⁰ “The Duties of the Government to Our Profession”, Editorial, *Dominion Medical Journal*, 1 (1868): 49.

²⁵¹ “The Ministry and the Board of Health”, Editorial, *British American Journal of Medical and Physical Science*, 5 (1850): 303.

men were furious at the parliament for not honouring this implicit condition of their participation on the Board and accused the government of dishonour and dishonesty. The public may have the right to protection by knowledgeable and honourable experts from quackery and malpractice as much as from disease, but medical men will honour this right if and only if the public returns the gift with respect and payment: “As a question of equity, the public have no right to services which its members may not individually claim without paying for them.”²⁵² While the public provided an object for the disinterestedness *habitus* of medical men, this logic could not reach a neat closure, particularly in the question of payment for medical services—public interest was always to be held in tension with professional interest.

Conclusion

The struggles within and by what eventually became known as the medical profession in Canada were thus not only based on a class conflict but also mobilized an uneven discourse of scientificness, gentlemanliness and honour that were stitched together in order to convey a sense of disinterestedness by those who vied for dominance in the field of medicine. Science was not only present in these struggles but operated as both a stake in the field and an object to be shaped to improve the positionings and to suit the position-takings of those who partook in the struggles. The nineteenth century was thus a moment of not only structural upheaval in the field of medicine that led to the professionalization of doctors but also a time when the contours and contents of the medical *habitus* was forged and contested in ways that corresponded to the structural struggles over what it means to be a learned profession of scientific gentlemen. This disinterested medical *habitus* was constituted in terms of discourses of gentlemanliness and rationalism and drew on class-based notions of morality and scientificness. However, what eventually became consolidated as the medical *habitus* went beyond a strictly class-based differentiation between the moral and the immoral and between the scientific and the unscientific. Instead, it found its anchor in an external object—the public—on whose behalf medical men were supposed to act and therefore be able to

²⁵² Ibid.

claim their disinterestedness. The same public, which provided a moral and logical justification for the logic of medical disinterestedness and the autonomy of the medical field in the nineteenth century, would later return as the heart of a major problem for the medical profession in the twentieth century. The notion that to be medically disinterested is to act on behalf of public interest would be problematized during the 1940s-1960s with the question of health insurance and universal access to care.

Chapter 4. Opening Doors and Building Bridges

While nineteenth century medical men articulated their disinterestedness in terms of acting on behalf of public interest in matters of health and disease, the question of payment for services lingered as a potential problem in the logic of medical disinterestedness. In the twentieth century, this tension became the subject of a very public controversy in Canadian medicine, the epicenter of which was the province of Saskatchewan. On July 1, 1962 the doctors of the province walked out of their practices in protest of a new Medical Care Act that shifted health insurance from a predominantly private model to one that is tax-funded, state-administered and universal. The walk-out was the culmination of mounting tensions and resentment between the Saskatchewan Medical Association and the Saskatchewan College of Physicians and Surgeons on one side and the Cooperative Commonwealth Federation (CCF) government on the other over the latter's plan for health care reform: the profession insisted on the existing fee-for-service model in which the state would provide some assistance through taxation plans for those who cannot pay for services that would be administered by an independent commission with representation from the College,²⁵³ whereas the CCF government argued for a prepaid insurance plan which would be controlled primarily by the state through which doctors would be paid by a salary.²⁵⁴ The historical work on this moment reports that the journalistic coverage in Saskatchewan on these negotiations and the general question of health insurance was skewed in favour of the profession due to a partisan press and that the provincial profession was by and large under the impression that they had the support of the public.²⁵⁵ The twenty-year negotiations between the Saskatchewan medical profession and the CCF government reached a stalemate and in November 1961 the government passed the Medical Care Act without the final agreement

²⁵³ Naylor, *Private Practice*, 136.

²⁵⁴ Robin F. Badgley and Samuel Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan* (New York: Atherton Press, 1967), 22.

²⁵⁵ *Ibid.*, 88-92.

by the profession; after eight months of unsuccessful negotiations a large number of doctors closed their offices,²⁵⁶ confident that these actions would force the government to repeal the Act. However, national media and the press in other provinces denounced the actions as an illegal strike²⁵⁷ and the civilian demonstrations in support of the doctors on July 11 in front of the Parliament Building in Regina drew less than a third of the expected thirty to forty thousand protesters.²⁵⁸ The strike ended with a negotiation between the two parties and the signing of the Saskatchewan Agreement which legalized the tax-funded universal medical insurance but still allowed doctors to charge fee-for-service on a voluntary basis.²⁵⁹

The events of 1962 have been widely documented and analyzed but primarily in relation to the emergence of the welfare state in Canada²⁶⁰ and in relation to the sociological concept of medical dominance.²⁶¹ The symbolic and moral dimensions of these events have not been framed beyond the ethical question of whether or not doctors have the right to strike, a discussion that often returns to the structural concerns about medical dominance and liberal versus welfare governance.²⁶² As I will demonstrate in this chapter, the doctors' walk-out in Saskatchewan was one event, a rather dramatic one, of a longer moment during which the medical profession went through immense growth and scientific specialization at the same time that it was quickly losing public credibility

²⁵⁶ Naylor, *Private Practice*, 207.

²⁵⁷ See "Doctors Outside the Law", Editorial, *Globe and Mail* (4 July, 1962), 6; "The Democratic Way", Editorial, *Globe and Mail* (7 July, 1962), 6.

²⁵⁸ There are conflicting reports of the number of protesters. The premier of Saskatchewan at the time claimed that there were between 2500-3000 people at the rally, while a police officer reported 4000 and "other estimates" indicated 30,000 ("Crowd size in dispute", *The Province* (12 July, 1962), 1).

²⁵⁹ Gregory P. Marchildon and Klaartje Schirjvers. "Physician Resistance and the Forging of Public Healthcare: A Comparative Analysis of the Doctors' Strikes in Canada and Belgium in the 1960s", *Medical History*, 55 (2011): 219.

²⁶⁰ See Malcolm G. Taylor, *Health Insurance and Canadian Public Policy* (Montréal & Kingston: McGill-Queen's University Press, 2009); Gregory P. Marchildon and Klaartje Schirjvers, "Physician Resistance."

²⁶¹ See A. Paul William, Eugene Vayda, May L. Cohen, Christel A. Woodward, Barbara M. Ferrier, "Medicine and the Canadian State: From the Politics of Conflict to the Politics of Accommodation?" *Journal of Health and Social Behavior*, 36, no. 4 (1995): 303-321.

²⁶² See Badgley and Wolfe, *Doctors' Strike*; Badgley and Wolfe, "The Doctors' Right to Strike" in *Ethical Issues in Medicine: The Role of the Physician in Today's Society*, E. Fuller Torrey (ed.) (Boston: Little, Brown & Co., 1968), 301-321; Stephen L. Thompson and J. Warren Salmon, "Strikes by Physicians: A Historical Perspective Toward an Ethical Evaluation", *International Journal of Health Services*, 36, no. 2 (2006): 331-354.

as a disinterested profession. Hence, beyond the immediate conflict between the medical profession and the provincial government, quiet but dramatic alterations to medicine, both as a body of knowledge and practice as well as a body of experts were underway as doctors became increasingly perplexed and apprehensive about the plummeting popularity of the medical profession as selfish and elitist, in stark contrast to the ongoing respect that patients had for individual doctors. Even before July 1, 1962 and before the intense national and international criticisms against the Saskatchewan medical profession, the medical profession and doctors as a group in Canada began to devise strategies in order to repair their damaged relationship with the public—the public shaming in the media affirmed the murmurings of fears expressed in the writings in medical journals prior to the event and galvanized the strategies full force. One strategy to win back the public was to refrain from prioritizing biomedical research and specialization and instead to establish what had been seen as non-scientific, i.e. social, aspects of health and illness as properly scientific areas of medical research and practice. Another strategy was to embrace public relations and media relations, practices that were considered to be antithetical to the values of medicine as a disinterested practice, as proper concerns of the medical profession. Hence, during this moment, there was an expansion and a reworking of what is considered to be legitimately moral and scientific concerns in medicine. Enmeshed in these disputes over payment was also a struggle between differing conceptualizations of the public and its health held by the Saskatchewan medical profession and the CCF government who vied for the position of acting on behalf of the public and its health. Not all doctors were against the plan proposed by the CCF government: some actively supported it and others did not participate in the walk-out for reasons of ethical obligations toward their patients. The historical work on this subject document that doctors were under strict discipline to project a unified front against the CCF government and any dissent to the Association and the College's official position was suppressed. In this chapter, I use the term *medical profession* to refer to this representative political group, *doctors* to talk about diverse opinions that were allowed to be expressed at the time, and *the group* or *organized medicine* to refer to the medical *habitus* in general. The structural struggles between the profession and the government over the health insurance system had a significant impact on the ways in which medical

practice was conceptualized and reconceptualized by doctors—from a strictly scientific enterprise to one that is and must be socially engaged. These shifts prompted the re-emergence of two areas of medicine that had been diminishing by the mid-century—public health and general practice—and the integration of a new strategy—public and media relations—as legitimate medical practice that is in line with the moral logic of disinterestedness as a way to restore harmonious relations with the public.

Health as a Stake in the Field of Power

The stand-off between the medical profession and the elected CCF government in Saskatchewan with regard to the issue of health insurance was a struggle over the position to act on behalf of public interest with regard to health. This was a struggle between the dominant players in two different fields (i.e. the medical profession in the medical field and the CCF government in the political field) in the field of power (i.e. at the legislative level) over the symbolic power to universally define what is the best way to manage and to ensure the health of the public. The battle over the terms of the provincial Medical Care Act with regard to health insurance and payment for doctor services was underpinned by a symbolic struggle over the meanings of health and the public. Specifically, the medical profession and the CCF government drew on two competing discourses in order to ground each term as part of their rhetorical strategies. The medical profession drew on the the relationships between medical men and their patients that date back to the centuries leading up to the professionalization of medicine. In the nineteenth century, particularly around the time of the cholera epidemic, there were generally two types of medical practice in urban centres of Canada: entrepreneurial physicians with private practices who mostly serviced the middle- and upper-class through a patronage system, and hospital doctors who provided care for the working-class, the poor and immigrants.²⁶³ The medical profession drew from the private practice model in which the public was a group of individual patients and incidentally those who were able to afford medical services of doctor fees. Indeed, the most adamant supporters

²⁶³ See Geoffrey Bilson's discussion of medical services and class in Canadian urban centres during the cholera epidemics in the nineteenth century (*A Darkened House*, 14-15).

for doctors in Saskatchewan were the Keep Our Doctors (KOD) Committees, which were grassroots groups that were started by middle-class housewives, or “anxious mothers,” and “common folk” that were eventually taken over by professional and business interest groups that were opposed to the welfare programs planned by the CCF government.²⁶⁴ By this time, medical professions across the Western and Westernizing worlds, including in Canada, adopted the World Health Organization’s definition of health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity,”²⁶⁵ but the Canadian medical profession maintained that social aspects of health remained an individual issue because health status varies according to the unique physiological, genetic and social make-up of individuals: “it should be made very clear that even the definition of what constitutes health is an individual decision which varies tremendously.”²⁶⁶ In this model, all affairs of health, including illness prevention, diagnosis and treatment, took place as an individualized interaction between a doctor and a patient, the age-old model of medical care that is protected by the ethics of the doctor-patient relationship which includes cautions for privacy and ethics of payment arrangements. A person arrived at a state of health as a direct result of the doctor-patient relationship in which health was an outcome of a symbolic exchange of medical expertise, respect, authority, as well as an economic exchange of payment that was governed by good faith and the rapport between the patient and physician:

Doctor-patient relationship is an individual activity. While it is true today that there is often a third party in the form of prepaid scheme, yet this third party does not play any part in the spiritual and professional relationship between doctor and patient.²⁶⁷

Hence, under this model, doctors were able to claim that the state was intervening in the private contract between individuals thereby infringing on individual rights. This also meant that the medical profession could claim that doctors are obligated to stand up against the state on behalf of the rights of patients and the public.

²⁶⁴ Bagley and Wolfe, *Doctors’ Strike*, 78.

²⁶⁵ Quoted in “Health Education of the public in Canada”, Editorial, *CMAJ* 85 (1961): 1008.

²⁶⁶ L.R. Rabson, “The People’s Health—Whose Responsibility?” *CMAJ* 88 (1963): 198.

²⁶⁷ Harry Baker, “Doctor-Patient Relationship or Doctor-Public Relationship” *CMAJ* 78 (1958): 129.

Meanwhile, the CCF government made health a legitimate object of state bureaucracy by arguing that health is a fundamental human right. The elected government saw the public as those who sought social services that had been established in the earlier part of the century in order to meet the needs of a predominantly agricultural and rural population of the province that was severely affected during and after the Depression. Among these services were union hospitals which were municipally-run hospitals that employed doctors through tax collection and that began in Sarnia in 1914 and increased in number to thirty-two by 1930.²⁶⁸ The union hospitals were the predecessor for co-operatively-run community clinics that employed doctors on a salary basis,²⁶⁹ which eventually became the foundation for the CCF government's model for a tax-funded and state-administered health insurance scheme. Hence, the genealogy of the CCF government's vision of the public was grounded in welfare governance within which the democratic state is obligated to act on behalf of the citizenry in order to ensure equal access to health care. For the medical profession to impede in the arrangement for a tax-funded and state-administered health insurance system could be then seen as a violation of the rights of the public. Thus, the struggle over the terms of the Medical Care Act was not only a structural battle for the economic and political organization of health insurance but also for the control over the fundamental understandings of health and the public that would in turn support the structural change (or a lack of change) sought by the medical profession and the elected CCF government. The two groups' conceptualizations of health and public were in turn the result of particular struggles within their respective fields of medicine and politics: the medical profession's individualized model of health and public was the result of long years of doctors' dependence on the affluent middle- to upper-class for patronage which provided doctors with not only viable income but also status in the medical field. The elected government's welfare governance perspective had been the CCF party's successful electoral platform and strategy in the field of provincial politics.²⁷⁰ The two groups

²⁶⁸ See Badgley and Wolfe, *Doctors' Strike*, 8-10.

²⁶⁹ See C. Stuart Houston, "Saskatchewan's municipal doctors a forerunner of the medicare system that developed 50 years later", *CMAJ* 151 (1994): 1643.

²⁷⁰ See Naylor, *Private Practice* 182-183; Badgley and Wolfe, *Doctors' Strike* 17; Taylor, *Health Insurance* 276-278.

mobilized their dominant position in their respective fields in relation to health and public in order to secure an equally dominant position in the field of power on the same issues. By constituting health as a right to private doctor-patient relationship versus a right of a collective access to health, both groups sought to claim that they are the ones who can best act on behalf of public interest when it comes to health insurance.²⁷¹

While the medical profession and the elected provincial government grounded their arguments for and against a state-administered tax-funded universal health insurance system on incompatible conceptualizations of health and public, their respective fields had been developing an increasingly interdependent relationship in the early part of the twentieth century: hospitals in Saskatchewan were established primarily through public municipal funds; for decades leading up to the negotiations over the Medical Care Act the provincial government provided capital grants to new hospitals in rural areas and even paid individual doctors' salaries through hospitals, rehabilitation centres, inmate health in

²⁷¹ In *The Birth of Biopolitics*, Foucault describes the governing rationale that emerged with the rise of European states after the decline of the monarchy as art of government or governmentality which is not based on the might of the Prince but rather on the simple goal to maintain the state for its own sake and its own ends. It was his attempt to write against an ideology-based framing of the state as an institution of coercion or allowances and instead to suggest that the state is legible only in the practices through which it seeks to know, understand, classify and track its population for the purpose of maintaining itself. In his study of sexuality, Foucault concludes that the knowledge of the life of the population was a key concern for the perpetuation of the state so that non-state and quasi-state entities become enrolled in the art of government. This idea, which he calls biopower or biopolitics, has resulted in a vast area of governmentality studies in health and medicine that examines health knowledges, practices, professions and institutions for how the conduct of populations are managed in order to minimize disease risks and how this form of governing affects (usually in negative ways) the health and lives of people and groups. The tensions between the medical profession and the CCF government in Saskatchewan, however, begs a moment of pause to recognize that the enrollment of medical experts in the state project to manage the health of the population was neither obvious nor straightforward. During this time, which is prior to the introduction of economic logic to health care policy and administration that is often called neoliberalization, we see a strong antagonism from doctors, a key expert group in the health care system, to the idea of becoming integrated into the state apparatus. By focusing on this moment of conflict in its own terms, not in terms of governmentality in health (this would become much more salient in later years when neoliberal programming takes hold), and by using Bourdieu's notion of the field of power, I am able to see this conflict not as one of state versus a profession, but rather as the collision of two dominant groups in their respective fields that found themselves competing one another for the authority to act on behalf of the entire province. This also allows me to tease out the specific strategies that the medical profession and doctors used in order to vie for a dominant position in the struggle while remaining within the range of what is possible in the *nomos* of disinterestedness. Thus, I am able to avoid concluding that the doctors as neither completely selfish nor innocently altruistic and instead examine the tensions in the medical habitus that occurred in relation to this conflict.

prisons and geriatric centres.²⁷² Meanwhile, the practice of medicine shifted from the old model of the physician who serviced families on a diverse array of medical issues to the compartmentalization of medical knowledge and techniques into a multitude of specializations and a much greater dependence on laboratory and clinical research. Medical disinterestedness became more prominently associated with scientific standards, excellence in research and commitment to lengthy education in order to specialize, demonstrating that medicine followed the logic of a scientific field that is ruled by the symbolic economy of intellectual work. On one level, medicine developed highly autonomous spaces in which the intellectual work of medical science dominated the rules, the stakes and position-takings in the field, and on another level it also became increasingly heteronomous precisely in order to develop these autonomous spaces: scientific medicine, such as clinical research and training medical students, required infrastructure and economic capital (i.e. funding and income), particularly in the form of hospitals, which only the state could provide during the Depression. Indeed, Robin F. Badgley and Samuel Wolfe, who wrote extensively about the events in Saskatchewan during this time, observed that “the doctors acted like nineteenth century laissez-faire private entrepreneurs in economic affairs, while spending a large portion of their lives applying the technology of the 1960’s in publicly owned workshops.”²⁷³ Thus, despite its perception of its own autonomy as a scientific institution, organized medicine increasingly found itself to be necessarily heteronomous, particularly susceptible to the effects of the bureaucratic space of the state. Such a paradoxical state of both autonomy and heteronomy in a highly autonomous field is a common development in a highly differentiated society because it is the state that generally decrees and guarantees the independence of fields from other forces,²⁷⁴ and as such a field’s autonomy is always bound to the fluctuations in struggles and forces in the field of power, and the autonomy of a field is thus never complete. The state provides the means of ensuring that the

²⁷² See Malcolm Taylor, *Health Insurance 70-74*; E.A. Tollefson, *Bitter Medicine: The Saskatchewan Medicare Feud* (Saskatoon, SK: Modern Press, 1964), 3.

²⁷³ Badgley and Wolfe, “The Doctors’ Right to Strike”, 311.

²⁷⁴ In *Practical Reason*, Bourdieu notes that the social sciences are obligated to comment on what is taken for granted as social reality and yet are dependent on the state—the very structure through which *doxa* is constituted and propagated across fields—to remain autonomous from the effects of other fields, particularly the economic and the political fields (39-40).

autonomy of a field is part of the *doxa*; for instance, the notion that medicine must be independent from the forces of politics and the economy is at the heart of medical laws that allow doctors to self-govern and self-regulate. In Saskatchewan, medicine's autonomy as a scientific institution was made possible by becoming increasingly enmeshed in the bureaucratic logic of the state which opened up medicine and health as legitimate objects of struggle in the field of power rather than solely within the field of scientific medicine. Thus, when the welfare politic emerged in the political field as a viable position-taking in the aftermath of the Depression, the CCF was able to run and win in the provincial election based on a platform to implement a state-administered health insurance scheme. The combination of medicine's autonomy based on the bureaucratic support of the state and the developments in the political field made such political strategy possible in the first place.

A larger part of the struggles between the medical profession and the elected CCF government over the question of health insurance in the field of power concerned the value of intellectual capital of medical science beyond the space of medicine. The medical profession sought to position itself in the debates as a body of experts in all matters of health and medicine, including health insurance, and tried to take an influential part in the planning procedures for the new health care plan. A significant part of the escalating tensions between the medical profession and the elected government in the province and the long years of stalemate in the drafting of the Act involved competing views of the planning process: the profession wanted an independent commission, which included representatives from the profession, to oversee the administration of health care planning while the government wanted an organization composed of elected members under the public health department of the state.²⁷⁵ The medical profession's overall strategy involved mobilizing the field's autonomy as a scientific institution and promoting the mainly scientific successes of medicine in order to claim that it is the legitimate body of spokespersons for the health of the public: "The monstrous nonsense that 'health is too important to be entrusted to doctors' should be scotched. The task ahead, that of providing more abundant and more equitably distributed health services,

²⁷⁵ Naylor documents the years of negotiations between the Saskatchewan medical profession and the provincial government. See *Private Practice*, 136-143.

can only be assumed by professional people working in free collaboration with responsible citizens from every level in the community.”²⁷⁶ The profession also sought to discredit the CCF government by claiming that the political field is not the legitimate space in which to contemplate health insurance and that its field effects, including the dominant position of welfare governance, must remain exterior to the structuring of the Medical Care Act in order to maintain the quality of medical services: “I lack supreme confidence in the infinite wisdom of government in [health services] or other highly technical fields.”²⁷⁷ Furthermore, those writing in the *CMAJ* against the Medical Care Act consistently referred to “the dictatorial rights and demands”²⁷⁸ of the government if the plan were to pass according to the vision of the CCF government, which would in turn result in the loss of qualified doctors to other provinces and the eventual decline in the quality of medical care. Meanwhile, the elected government maintained that the plan “must be in a form that is acceptable both to those providing the services and those receiving it,”²⁷⁹ demonstrating that it recognized the symbolic capital that the medical profession held in the broader field of power in issues of health, but it also struggled to assert the value of its political capital, particularly its popular electoral platform for universal health care, over the intellectual capital of medicine so that the government would lead the drafting of the Act, a point that irked the medical profession. The CCF government’s strategy is in line with Bourdieu’s observations of the position of intellectual work of science in the bureaucratic field of the state and the corporation. In his account of the genesis of the modern French state, he argues that informational capital, namely statistical information about the citizen body, was an important aspect of the state-project but was one among many other forms of capital, including economic capital, symbolic capital (legitimacy and nationalism) and other forms of cultural capital,

²⁷⁶ “The Hammer and the Heritage”, Editorial, *CMAJ* 87 (1962): 303.

²⁷⁷ A.D. Kelly, “The Saskatchewan Situation: One Man’s View” *CMAJ* 87 (1962): 1113.

²⁷⁸ Daniel Cappon, “CMA Public Relations and the Saskatchewan Affair” *CMAJ* 87 (1962): 625.

²⁷⁹ Naylor, *Private Practice*, 182.

such as standardized language.²⁸⁰ Similarly, his analysis of the housing industry in France in more recent years demonstrates that technical knowledge about the housing industry and technologies constitutes just one of many important forms of capital that operate in the bureaucratic spaces of the industry, which include mastery of the banking system, the housing market, marketing and customer relations.²⁸¹ Hence, the medical profession and the elected government in Saskatchewan differently positioned medical science in relation to health insurance and this discrepancy played a pivotal role in escalating the tension between the two groups during the roughly twenty years of negotiations prior to the passage of the Medical Care Act. The medical profession sought to frame health insurance as primarily a medical issue and to position doctors as the only experts who could legitimately speak about it. Meanwhile, the elected government saw health insurance as a bureaucratic matter for the state in which doctors could take part in its planning merely as consultants, or holders of technical capital.

Despite efforts to frame health as an individual issue and to maintain its status as scientific experts who can rightly act on behalf of the public, the medical profession's argument against publically-funded health insurance was difficult to maintain without being accused of self-interested motivations: foremost, the profession had initially supported state-funded insurance scheme during the 1940s when the province's economy collapsed and patients could not pay medical bills but began to resist it when the economy recovered in the 1950s²⁸²; and by 1959 there were two physician-sponsored

²⁸⁰ Bourdieu, *Practical Reason*, 40-47. By including population statistics as a type of informational capital of the state, it may sound as though Bourdieu is referring to what Foucault calls biopower. It is important to note, however, that Bourdieu never emphasized a biological understanding of the population as a significant aspect of the genesis of the state or in any of the social worlds he studied. It may be because Foucault's objects of study, such as psychiatry, sexuality and clinical medicine, were much more strongly tied to the biological life of the population than were those of Bourdieu. It is also important to note that biopower was an empirical finding for Foucault which resulted from his genealogical approach to the history of these domains; it is not a concept that drives or frames his work from the outset of his analyses. It may be that Bourdieu's rather tangential reference to population statistics as a form of informational capital is analogous to Foucault's notion of biopower but without more writings by Bourdieu on the subject, it would be difficult and erroneous to project one theorist's empirical finding to a tangential statement of another. In fact, I would venture to say that, because Bourdieu grouped population statistics as just one form of informational capital among many other forms and many other forms of capital in general under the purview of the state, for him the biological life of the population was not the driving logic of the state.

²⁸¹ Bourdieu, *Social Structures of the Economy*, 194-195.

²⁸² See Naylor *Private Practice*; Taylor, *Health Insurance*.

private medical insurance companies that covered about one-third of the provincial population.²⁸³ Hence, there were already contradictions within the profession that compelled doctors to express some uneasiness with respect to their position on the issue of health insurance: “It is not enough to say that those insuring bodies which originated with the blessing of organized medicine are different and therefore acceptable because they are controlled by the profession. They are in truth controlled by the contingencies of business competition, and medical control, though present, is largely nominal.”²⁸⁴ When the CCF government tried to disrupt the existing insurance scheme and the profession openly objected to the proposal, the profession made explicit the precarious balance between medical disinterestedness and the profession’s direct involvement in financial matters of health that had once been implicitly understood but left unproblematized. Now that the contradiction was in the open, the medical profession strove to define the work of doctors in ways that both protected their claims to disinterested motivations and ensured the autonomy of the field. Bourdieu explains that, in the religious field, priests deploy euphemisms in order to reconcile and harmonize the contradictions between religious disinterestedness and the realities of the economic world in which they conduct their work; for example, clientele becomes a congregation and labour becomes service.²⁸⁵ Similarly, the medical profession stitched together discourses of service and the rights of the minority in order to euphemize what was widely perceived as a selfish motivation to protect the lucrative income of doctors. Drawing on the prevailing suspicion toward Communism and Fascism, the profession claimed that doctors must be directly accountable to the public; otherwise, doctors will become merely employees of a dictatorial state and therefore unable to freely exercise their scientific expertise and medical judgment that would ensure quality of medical care in the spirit of disinterestedness that currently govern them: “the medical profession in Saskatchewan will, to a critical extent, cease to be a profession any longer. It will become a group of doctors under political direction.”²⁸⁶ By extension, the proposal for state-administered

²⁸³ Gregory P. Marchildon and Klaartje Schrijvers “Physician Resistance” note that Medical Services Incorporated (MSI) insured 217,000 and Group Medical Services (GMS) insured 91,000 (p. 261).

²⁸⁴ J.W. Reid, “Acceptance of Payments from a Third Party”, *CMAJ* 88 (1963): 819.

²⁸⁵ Bourdieu, *Practical Reason*, 112-114.

²⁸⁶ “Unjust Laws Exist”, Editorial, *CMAJ* 87 (1962): 190.

health insurance was framed as “involuntary servitude” and “civil conscription”²⁸⁷ of the medical profession by the state. The notion that doctors are expert leaders who must be free and autonomous from state intervention was conflated with the imperative that doctors must act on behalf of public interest via the available discourses emerging from the fear of Communism and Fascism in North America.²⁸⁸

But the logic of the euphemism failed when it came to the question of whether or not the mass walk-out by doctors in Saskatchewan on July 1, 1962 constituted a strike. Most doctors rejected the term because it positioned their practices in terms of labour in an economic field instead of as an indispensable service to the public and as respectable scientific expertise, and also because a strike as a withdrawal of vital services violated their formal ethical obligation to do no harm.²⁸⁹ The profession instead insisted that the government’s position on health insurance constituted an “inescapable dilemma” where they had no choice but to walk out and that they had “placated [their] individual and collective conscience by establishing a safe emergency medical service to look after the essential needs of the Saskatchewan people.”²⁹⁰ It was a precarious argument but the medical profession as the representative political group as well as doctors as individuals in the province of Saskatchewan were under the impression that they had the public’s support for the walk-out due to the high-profile activities of the Keep Our Doctors Committees and the partisan press in the province that vilified the CCF government and supported the medical profession’s efforts to bar the Medical Care Act. The majority of newspapers in Saskatchewan, including the *Regina Leader-Post* and the *Saskatoon Star-Phoenix*, were owned by the Sifton family which supported the Liberals who lost the

²⁸⁷ G.K. Higgins, “Universal Health Insurance: A Problem of Minority Rights”, *CMAJ* 87 (1962): 1383.

²⁸⁸ The significance of anti-Communism (and anti-Fascism) in these statements should not be over-estimated with regard to the disinterested medical habitus at this time. The historical and political backdrop of the Cold War provided a discourse from which doctors could draw possible ways to articulate their position against what they saw as an erosion of their professional autonomy. Anti-Communist sentiments did not translate into significance position-takings or strategies on the part of doctors when it came to re-working their medical habitus in response to public criticisms against them, as I will demonstrate in the next section of this chapter. In fact, their invocation of Cold War discourse failed to overcome what was perceived as a gross violation of their ethical mandate to do no harm.

²⁸⁹ See Badgley and Wolfe’s quotation from the Declaration of Geneva, which all doctors receive a copy of, which “pledges a doctor ‘to consecrate my life to the service of humanity; I will practice my profession with conscience and dignity’” (“Doctors’ Right to Strike”, 319).

²⁹⁰ A.B. Kelly, “The Saskatchewan Situation: One Man’s View” *CMAJ*, 87 (1962): 1114.

provincial election to the CCF, and editorialized the debates between the medical profession and the government in favour of the former, framing the health care bill as “‘a smoke-screen to divert the electorate’s attention’ from the CCF’s impending transformation into a party dominated by organized labour.”²⁹¹ The medical profession relied heavily on this media support from what turned out to be a small space in a heteronomous space within Canadian journalism and, when the issue caught national attention through the doctors’ walk-out and the unsuccessful civic demonstration by the KOD Committees in front of the parliamentary building, the profession was surprised by the onslaught of criticisms in the national press and the press in other provinces.²⁹² The medical profession had misunderstood the struggles within the journalistic field and had drawn from a highly heteronomous space within journalism—newspapers that were already well-known to be subject to economic and political influences—and thus failed to effectively mobilize the media in order to support its position in the broader field of power.

The ultimate version of the Act that was agreed upon by both the profession and the government was a compromise solution that retained the doctor-patient model through a voluntary fee-for-service system yet allowed the state to control all of the administrative side of universal care, so that the legislative structure supports hybrid notions of health and the public in terms of both individualized and collective models.²⁹³ While these struggles by the medical profession with regard to the health insurance system involved major structural changes within the law, bureaucracy of the state and the insurance industry, the same struggles had a significant impact on the ways in which organized medicine understood medicine as a practice and as a set of dispositions of the medical *habitus*. The failure of the medical profession to exert its effects over the political field, the journalistic field and the broader field of power on the question of how medicine should be administered was an alarming realization for organized medicine that

²⁹¹ Naylor, *Private Practice*, 184.

²⁹² See Joan Hollobon, “A Prairie Doctor and His Conscience”, *Globe and Mail* (4 July, 1962), 7; “UK Medical Journals Oppose MD’s Strike”, *Globe and Mail* (13 July, 1962), 8; “Group Warns MDs To Yield by Friday”, *Globe and Mail* (5 July, 1962), 1; Eddie Keen, “My patients come first, says one non-striker”, *The Vancouver Province* (3 July, 1962), 2. For other examples, see Taylor, *Health Insurance*, 307-313.

²⁹³ See Taylor, *Health Insurance*, 324, 327-330.

the scientific expertise of doctors could not guarantee the autonomy of medicine as a field. This resulted in a reorganization of the medical *nomos*, particularly with respect to what it means to be disinterested in ways that are sympathetic to the needs of the public, as well as a production of a new set of discourses and strategies on how to best enact this law in light of the lack of support from the public and the press.

(Re)Imagining and (Re)Integrating *the Social*

The legislative struggle between the medical profession and the elected government in Saskatchewan over the structural organization of health insurance system was part of a longer and broader trend in professional medicine's relationship to the outside world. In the nineteenth century, discourses of science (in terms of learned rationality) and morality (in terms of gentlemanliness) were joined together in order to establish a logic of medical disinterestedness that could persuade not only the governments and the public of doctors' capacity to self-govern but also to convince doctors themselves of their membership in a professional and scientific brotherhood. However, in the mid-twentieth century, this harmony was disrupted and science was gradually portrayed as a self-indulgence that led medicine astray from its moral responsibilities to the public: "If medicine wants to withdraw into itself and become an esoteric and specialized science, such as atomic physics, the profession will become a follower of public opinion, not its architect, an employee of the public, not a servant of the people."²⁹⁴ Contrary to the elusive science-as-rationality in the nineteenth century, medicine in the early twentieth century fully embraced germ theory and became greatly invested in technical and specialized scientific medicine, fuelled by innovations in pharmacological and surgical technologies, the emergence of new medical specialties and an increased emphasis on medical research. However, when the government of Saskatchewan and the public pressured for a publically-funded health insurance system and accused the medical profession of being selfish and elitist, the resulting disputes challenged the tendency in medicine to turn inward into the esoteric quarters of the ivory tower, far removed from the rest of the world: "Society is interested in the social and

²⁹⁴ L.F. Koyl, "Have We Missed the Boat?" *CMAJ* 74 (1956): 300.

economic aspects of medicine. Doctors tend to withdraw from such strange things into the safety of 17-ketosteroid estimations.”²⁹⁵ In the years leading up to, during and after the Saskatchewan affair, doctors began to wonder whether medicine’s tunnel-vision search for scientific knowledge had created a perception of the medical profession as disconnected from the interest of the public. There was a sense among doctors, at the level of the medical *habitus*, that by shaping medical disinterestedness solely in terms of scientific innovation, progress and the accumulation of knowledge, they had sacrificed the faith of the public without which medical disinterestedness has no meaning in the first place and the medical profession has no authority: “We have, of ourselves, no right to practice medicine. It is a privilege granted by each one of our patients.”²⁹⁶ There was a reassessment of scientific capital (such as medical research and specialization) to the point that doctors began to suspect that an overemphasis on science was detrimental to the ideal of medical disinterestedness on the whole: “*Idolatry*: Here the golden calf is science. Many of us have apparently come to worship it, convinced that it alone is medical science and that when all the rituals of scientific protocol have been observed, the patient has been treated fully and well.”²⁹⁷

The perceived rupture between scientificness and morality, the two essential components of medical disinterestedness, was articulated in terms of a need for a more socially attuned and more humane form of medicine. In this process, there was a heightened attention to issues and topics that were outside of what was strictly “medical” in the era of scientific medicine. For example, there were discussions of the possibility of working with social scientists “so that the social origins and consequences of disease may be studied and counteracted more effectively,”²⁹⁸ to which some responded that “[t]he social scientist is not only groping at the present stage, but is often intimidated by the pressure to conform.”²⁹⁹ Some observed that “[n]o longer does the doctor contend unavailingly with numbers of communicable diseases” but “[r]ather, he is faced with

²⁹⁵ Koyl, “Have We Missed the Boat?”, 299.

²⁹⁶ C.P. Harrison, “Fluoridation” *CMAJ*, 81 (1959): 128.

²⁹⁷ Francis T. Hodges, “Public Relations Forum: Medicine’s Seven Deadly Sins” *CMAJ* 76 (1957): 660.

²⁹⁸ “The Social Scientist and the Hospital,” Editorial, *CMAJ* 72 (1955): 857.

²⁹⁹ F.W. Hanley, “Correspondence: Ethics, the Doctor and the Social Scientist” *CMAJ* 73 (1955): 849.

complex problems of an aging population, accidents and industrial disease, mental illness and many others.”³⁰⁰ Some went as far as to point to the “distortions which are thrust upon us from the advertising market” that lead to “medical matters of social importance” such as suicide, hysteria and illusory ideas.³⁰¹ There were concerns about the representations of health and illness in the emerging mass media, where “doctors are not very effective in presenting their views to the public” but “as a profession we have a responsibility when it comes apparent that the public is not being adequately informed on matters of significance” and when “the coverage of events, which in important respects are medical, is unsatisfactory.”³⁰² One contributor to the journal reminded his colleagues that medicine was originally “the social science with a dynamic concept and with knowledge” before it became “a conservative self-restrictive profession instead of a widely based social science constantly broadening its scope.”³⁰³ Family physicians began to include “a wide range of non-medical activities” among their professional roles and argue that “[t]he good family doctor is able to deal with most of the ills of people, and knows when and where to get help for the remainder”³⁰⁴ These statements demonstrate a mixture of ideas that question the limits and range of medicine and the rightful domain of medicine: what is science and what is non-science; what is medicine and what is non-medicine; and should medicine constitute the objects of its knowledge and practice in a fundamentally different manner; or should it simply integrate what were considered to be the non-medical and non-scientific objects and ideas as part of its domain? Out of these concerns, a concept began to gain traction and increasing solidity, a concept that I will call *the social*, which I use as a category of discourse that refers to moral concerns of medicine at this time, in particular the question of what it means for doctors as individuals and as a professional group to be socially attuned to individual patients and to the public at large. This and other questions about the relationship between science and medicine and between medicine and *the social* unfolded mainly in the domains of public health and general practice, two medical disciplines that had been

³⁰⁰ G.R.F. Elliot, “Teaching of Preventive Medicine in Canada” *CMAJ* 74 (1956): 457.

³⁰¹ “Medicine and Morals”, Editorial, *CMAJ* 81 (1959): 744.

³⁰² “Schoolmasters to the Nation”, Editorial, *CMAJ* 87 (1962): 1030.

³⁰³ L.F. Koyl, “Have We Missed the Boat?” *CMAJ*, 74 (1956): 299.

³⁰⁴ V.W.J., “The Family Doctor” *CMAJ* 74 (1956): 480.

in decline because of their lack of scientificness in an era of specialization and technical innovation. Public health, which had played a pivotal role in establishing the disinterestedness of medicine in the nineteenth century, was in the bottom rungs of the hierarchy of medical specialties³⁰⁵ and faced the threat of being ousted from the medical curriculum. The shift toward scientization and specialization in medicine coincided with what Shortt describes as the golden age of general practice and its sudden demise: the expansion of scientific medicine brought unprecedented legitimacy for physicians but it also quickly placed them in positions of inferiority compared to their specialized peers³⁰⁶; indeed, by the 1950s, general practice was rumoured to become obsolete, to be replaced by teams of specialists working together in clinical settings.³⁰⁷ It was precisely the lack of scientificness and, by extension, the perceived greater moral credibility of these two disciplines as social enterprises that made them the ideal space within which to work through the problem of re-establishing the moral legitimacy of professional medicine. Yet, the goal was not to completely abandon existing scientific ideals of medical research and specialization but to elevate the status of public health and general practice as respectable specialties. Such a move would re-establish a harmony in medicine between scientific standards and moral obligations in a manner that would be acceptable to both the public and the medical profession. Within these two medical disciplines, the discourse of *the social* became inflected through the emerging scientific discourses of the new social sciences, the result of which was that the notion of *the social* took shape primarily in terms of individual behaviour and the psycho-therapeutic value of the doctor-patient relationship. Hence, a moral and scientific articulation of *the social* became a strategy in medicine in order to respond to criticisms about the legitimate and appropriate way to enact medical disinterestedness without having to compromise its scientific objectives.

By the 1950s, there were concerted efforts toward medical education reform that would save public health from becoming cut off from the medical curriculum and to teach the subject in a way that integrated the local governmental and voluntary agencies

³⁰⁵ Alexander Robertson, "The Place of Social Medicine" *CMAJ* 82 (1960): 724.

³⁰⁶ Shortt, "Before the Age of Miracles", 125.

³⁰⁷ V.W.J., "The Family Doctor" *CMAJ* 74 (1956): 479.

for hands-on learning rather than ivory-tower teaching.³⁰⁸ Public health, as a branch of medicine that is concerned with more social aspects of health, such as education and sanitation, presented an existing structural and symbolic framework through which medicine could re-invest its interest in matters of society and “lead the social development of our society.”³⁰⁹ Meanwhile, public health had been developing into an area with a set of knowledge, practices and agents that were independent from medicine: while the late nineteenth century and the early twentieth century saw a convergence between public health and medicine when it came to the former’s emphasis on prevention and the latter’s focus on treatment, after World War II they began to diverge significantly—public health turned to behavioural models of risk and medicine pursued individualized treatments.³¹⁰ This was the dawn of mass media and, while there were public health physicians, much of the public education work in preventive health and hygiene were conducted by a new profession of health educators who were not trained in medicine but were media-savvy. Medical professions, both domestic and international, worked to position doctors at “the apex of the health education pyramid... to ensure the scientific accuracy of what is taught” and to argue that public health education is more than the dissemination of information but “changing attitudes and behaviour,”³¹¹ a task that is most suited for the general practitioner who is able to command respect and credibility in a way that a health educator cannot.³¹² In general, there was a push toward thinking of the social responsibility of medicine in terms of an emphasis on human behaviour pertaining to public health: “An enlightened attitude towards human behaviour may pay bigger research dividends than an electron microscope.”³¹³ Yet, doctors were not experts on such matters—they realized that social scientists were already a group of experts of *the social* and had developed their craft into a credible science which included tracking and quantifying individual social behaviours.³¹⁴ Indeed, the sudden mention of

³⁰⁸ Elliot, “Teaching of Preventive Medicine in Canada”, 459.

³⁰⁹ Koyl, “Have We Missed the Boat?”, 209.

³¹⁰ John Geyman, *The Corrosion of Medicine: Can the Profession Reclaim its Moral Legacy?* (Monroe ME: Common Courage Press, 2008), 51.

³¹¹ “Health Education of the Public” Editorial, *CMAJ* 77 (1957): 135.

³¹² *Ibid.*

³¹³ “The Social Scientist and the Hospital” Editorial, *CMAJ*, 72 (1955): 857.

³¹⁴ Alexander Robertson, “A Commentary on Sociology in the Medical School” *CMAJ* 84 (1961): 704.

social scientists in the *CMAJ* during this moment and the debates about whether they could be seen as colleagues or consultants in matters of public health, or be ignored altogether as ultimately not disinterested³¹⁵, demonstrate the degree to which doctors felt insecure about their lack of legitimate expertise in social matters.

The trend toward imagining *the social* primarily in terms of individual behaviour emerged from the meeting of two approaches in public health—preventive medicine and social medicine—that were grounded in quite different sets of epistemological and political tenets. Preventive medicine continued and built upon older public health practices, such as sanitation, public works and vaccination, and were concerned to prevent the spread of disease and illness which by the mid-twentieth century were predominantly chronic illnesses rather than communicable diseases.³¹⁶ Hence, by this time an active involvement by professional medicine in health education was perceived as a way “to indicate [to the public] that the medical profession has a genuine interest in preventive medicine in addition to its interest in ‘prophylactic medicine.’”³¹⁷ Meanwhile, social medicine emerged through various social reform movements in the late nineteenth century that positioned medicine as having a political role as a type of social science. Dorothy Porter argues that while in Latin America social medicine became detached from academic disciplines and became interlinked with Marxism-inspired political movements resulting in an attention to structural issues of health such as access to medicine, in Anglo-America, particularly in the United States, social medicine struggled to maintain its disciplinary status and in the process was influenced by medicine’s biomedical and therapeutic approaches. Thus, Anglo-American social medicine adopted a more behaviourist model of individualized life-styles and risk factors for chronic illnesses.³¹⁸ The Anglo-American version of social medicine is at the basis of the Department of

³¹⁵ F.W. Hanley, “Ethics, the Doctor and the Social Scientist”, 849.

³¹⁶ See H. A. Halpin, M. M. Morales-Suarez-Varela and J. M. Martin-Moreno, “Chronic Disease Prevention and the New Public Health”, *The New Public Health*, 32, no. 1 (2010): 121-125; B. Starfield, J. Hyde, J. Gervas and I. Heath, “The concept of prevention: a good idea gone astray?” *Journal of Epidemiological Community Health*, 62 (2008): 580-583.

³¹⁷ G.J. Millar, “Skip the Health Lesson, Teacher! A Commentary on Health Education in Canadian Elementary and Secondary Schools” *CMAJ*, 86 (1962): 647.

³¹⁸ Dorothy Porter, “How Did Social Medicine Evolve, and Where Is It Heading?”, *PLoS Medicine*, 3, no. 10 (2006): 1667-1672.

Social and Behavioural Medicine at the University of Saskatchewan, which was established in 1959-1960. Its first department head, Alexander Robertson, wrote several articles in the *CMAJ* in order to promote his department's vision of public health which he saw as different from preventive medicine: "I just happen to think that 'social' embraces the totality of what we are trying to achieve more successfully than 'preventive.'"³¹⁹ The Department combined the traditional tenets of public health, such as sanitation, with new epidemiological approaches to chronic illnesses based on morbidity and morality measures, health administration and social aspects of disease. He explains that the social aspects of disease is "where many would say that the art of medicine and the science of medicine overlap,"³²⁰ an area that is increasingly examined by the sociologist whose attention to "the study of social forces, social change and social groups... can help medicine unravel the eternally fascinating riddles of cause and effect."³²¹ Such elevation of the status of the sociologist into a scientist colleague in public health medicine was a way to bring social expertise into medicine's realm and to present medicine as a discipline and doctors as a profession as genuinely interested in society. Yet, the type of science of *the social* that was repeatedly invoked imagined social dimensions of health primarily in terms of the individual as an atomized subject—"the implications of the health state of an individual upon his social environment, and the role of his social environment in determining his state of health" and "man in his social state"³²²—a position that stands in contrast with a notion of *the social* in terms of medicine's role in democratic social reform, which would include access to health services and citizenship. For Robertson, the role of the sociologist as a colleague was to help medicine think differently about the domain of medicine in relation to social factors to help bridge the domain of medicine and the domain of *the social*, or to "play a part in reconciling the apparently divergent trends of modern medicine, the conflict between the scientist and the humanist in all of us", by exercising his or her ability to "use language intelligible to a layman to explain his[/her] concepts" and to "at least begin to apply

³¹⁹ Robertson, "The Place of Social Medicine", 724.

³²⁰ *Ibid.*, 725.

³²¹ Robertson, "A Commentary on Sociology", 703.

³²² Robertson, "The Place of Social Medicine", 724.

quantitative measurements to social phenomena.”³²³ The behaviourist view of *the social*, which could be quantified and understood using scientific methods, fell in line with the existing system of vision and division of the medical *habitus* that was primarily ruled by scientific capital. Hence, the adoption of behavioural models from the social sciences made sense at the level of the medical *habitus* during a time when doctors sought to become more socially attuned, and therefore more morally responsible toward the public, while at the same time maintain scientific standards.

At the same time that public health rose to the centre of attention for the medical profession in its goal to align its ongoing scientific objectives with the new concern to be more socially attuned and moral, general practice also emerged as a high priority for the profession. During the Saskatchewan affair, doctors claimed that the state’s intervention in health care threatened the sanctity of the doctor-patient relationship but the practice of medicine had been veering away from this model for some time. General practice and the family physician, the cornerstones of traditional medical practice, had been in a steady decline and fewer doctors chose to become family physicians as more and more extended their education in order to specialize or to conduct medical research.³²⁴ The critique of the medical profession as elitist highlighted a vast distance between the profession and the public, to which general practice was deemed an already existing solution. General practitioners emphasized their intimate involvement with patients at various stages in their lives and in affairs of their family as a way for the medical profession to be in touch with the public; despite the increasing complexities of medical treatments, they claimed people still “like to know their doctor” who “has always been, and will again be, a rock standing safe in the shifting sands of urban social change.”³²⁵ Indeed, it was often stated that while the medical profession had lost the public’s faith, the individual physician, particularly the family physician, still commanded a lot of respect and trust from his or her patients: “Let’s face the fact that in the eyes of our sickly patients we may be demigods; in the eyes of the collective public we seem to be a group of monopolistic

³²³ Robertson, “A Commentary on Sociology”, 704.

³²⁴ Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction, Second Edition* (Toronto: University of Toronto Press, 2010), 382-384.

³²⁵ W. Harding LeRiche, “The Family Physician: A vanishing Canadian?”, *CMAJ* 73 (1955): 572.

money-grubbers, bloated with self-importance, intolerant of intrusion in to our private domain and martyred in pseudo-sacrificial devotion to our indigent brethren.”³²⁶ While a specialist may have mastery over a highly technical aspect of medicine, the general practitioner claimed a better knowledge of the patient as a person by adopting a holistic approach to care, paying attention to “non-medical activities” as well as the patient’s social and economic environment.³²⁷ General practitioners overcame their lack of specialization by highlighting their rapport with patients in order to carve out a role for themselves as trusted mediators between highly specialized esoteric medical knowledge and patients, “who will guide them through the maze of medical technology, and who will provide genuine interest and friendship which means so much more than techniques.”³²⁸ General practitioners’ claim to their specialty took on a gendered discourse framing the existing trend toward clinical and esoteric medicine in masculine terms as “aggressive and scientific,”³²⁹ while their own practices were in contrast more feminine, enmeshed in the personal and domestic life of patients. General practice provided a way to think about establishing rapport with the public in terms of individualized relationships with patients which was in keeping with the profession’s position that health is an individual matter.

Despite their emphasis on the importance of emotional and social aspects of patient care, general practitioners still had to contend with the yardstick of science that dominated medicine. Hence, they avoided a nostalgic revival of the family doctor on “horse and buggy”³³⁰ of the nineteenth century, the golden age of the family doctor, and instead reinvented themselves in the age of specialization and scientific medicine: the College of General Practice was established in 1954 in order to organize and oversee a more comprehensive education and examination in family medicine as a specialty³³¹; general practitioners were encouraged to teach at medical schools in order to train more

³²⁶ F. Murray Fraser, “Let’s Face the Facts,” *CMAJ*, 85 (1961): 307

³²⁷ V.W.J. “The Family Doctor” *CMAJ*, 74 (1956): 479.

³²⁸ *Ibid.*

³²⁹ Max Alexandroff, “The Family Physician, 1955” *CMAJ* 72 (1955): 540.

³³⁰ Fraser, “Let’s Face the Facts”, 306.

³³¹ The College of Family Physicians, “College History”, para 1-3, <http://www.cfpc.ca/CollegeHistory/>

of their own³³²; general practitioners promoted their intimate knowledge of their patients as an ideal criteria for conducting research on diseases and illnesses that cannot be found or tracked well in hospitals, such as chronic diseases and illnesses related to age or heredity³³³; and the College developed fellowships on special medical topics, such as palliative care and geriatrics, in order to augment the scientific status of general practice through certification and continued education that emulated the specialization model.³³⁴ Along with organizational changes to elevate general practice as a specialty, there was a move to reinterpret and update the value of the doctor-patient encounter in the context of increasing incidents of psychiatric disorders. While some claimed that a continual emphasis on the doctor-patient relationship portrays the medical profession as archaic,³³⁵ others highlighted this relationship as “the art of medicine” or “bedside medicine”, which the profession should pay attention to given how “disease forms themselves have changed” from “gross organic lesions” of the early part of the twentieth century to “the psychoses” that in the mid-twentieth century “fill half the total number of hospital beds.”³³⁶ Thus, general practice teamed up with another lowly medical specialty—psychiatry—that was just gaining momentum at the time with developments in psychopharmaceuticals (such as tranquilizers)³³⁷, a trend toward more humane methods of psychotherapy³³⁸, and new categories of psychiatric conditions with the publication of the first edition of the Diagnostic and Statistical Manual of Mental Disorders in 1952.³³⁹ This new psychiatry which augmented both its moral standing with methods that aligned

³³² Robert F. Purtell, “General Practitioners’ Duty as Medical Teachers”, *CMAJ* 73 (1955): 750.

³³³ “General Practitioner Research”, Editorial, *CMAJ* 73(1955): 684-685.

³³⁴ “Committee on Fellowship”, Editorial, *CMAJ* 73 (1955): 232-233.

³³⁵ Fraser, “Let’s Face the Facts”, 306.

³³⁶ Marvin Wellman, “On the Practice of Medicine,” *CMAJ* 79 (1958): 189.

³³⁷ See Rober Whitaker, “Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America”, *Ethical Human Psychology and Psychiatry*, 7, no. 1 (2005): 23-35.

³³⁸ In the aftermath of the Second World War, there was a heightened demand for psychiatric treatment, which brought together veterans’ programs and mental health programs and propelled what had been predominately an academic discipline of psychology to embrace clinical psychiatry as a body of knowledge and practice as well as a professional concern. See Robin L. Cautin, “A Century of Psychotherapy, 1860-1960” in *History of Psychotherapy: Continuity and Change, Second Edition*, edited by John C. Norcross, Gary R. VandenBos, and Donald K. Freedheim (Washington DC: American Psychological Association, 2011).

³³⁹ See “DSM: History of the Manual”, American Psychiatric Association, para. 6.
<http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual>

with humanist ideals and its status as a scientific practice through expansions as a discipline provided scientific credibility to what general practitioners had been doing without thinking by virtue of being family physicians: listening to patients speak, providing them with assurance and noting the ways in which their social, emotional and financial lives affect their health, all of which the discourse of psychiatry rearticulated as “the therapeutic significance of the medical interview”³⁴⁰ and “helping people to solve the emotional and social problems created by crises at various periods of life”³⁴¹ as part of “the science of man as a thinking, dreaming, socializing and uniquely human being.”³⁴² Psychiatry, therefore, transformed what was considered to be the art of medicine into a viable therapeutic methodology, thereby augmenting the position and view-point of the general practitioner to the ranks of specialists and researchers. Psychiatry, too, gained status by linking itself with general practice which provided ideal clinical access to everyday patients for psychiatric conditions, or the social diseases of modern urban life, that were fast becoming the predominant health concern for general practice.³⁴³ Hence, general practice and psychiatry entered a mutually beneficial arrangement in which to reinforce one another’s scientificness. In the process of acquiring scientific status via disciplinary restructuring and re-articulation of its dispositions into psychiatric discourse, general practice embraced a particular notion of *the social*, that of a therapeutic encounter between an individual doctor and an individual patient or family.

Doctors took seriously the years of mounting criticisms that they were elitist professionals who were more concerned about their own political and economic powers and what was under the microscope than the plight of their patients or the public. They saw that their scientific standards overshadowed their moral obligations to the point that they could not sufficiently convince the public or themselves of their disinterestedness. Hence, the notion of *the social* began to emerge as a pressing issue that must be substantially embraced and dealt with through medical practices. Public health medicine

³⁴⁰ “The Therapeutic Value of Talk”, Editorial, *CMAJ* 77 (1957): 888.

³⁴¹ M. Tyndel, “The Role of the General Practitioner in Psychiatry” *CMAJ* 82 (1960): 324.

³⁴² Wellman, “On the Practice of Medicine”, 189.

³⁴³ Tyndel “Role of the General Practitioner”, 324.

and general practice, two disciplines facing rapid decline during the height of scientific medicine due to their scientific shortcomings, became ideal venues through which doctors as a group could regain their credibility as socially attuned and humane experts who are deserving of the public's trust. The developments in these two disciplines toward more behaviourist and psychiatric approaches presented methods and therapeutic categories that were homologous with the existing scientific standards in medicine. Hence, as professional medicine revived public health medicine and general practice for their close link to *the social*, these two disciplines shed some of their artfulness in order to gain credibility among other specialties and scientific medicine as a whole: public health medicine increasingly focused on individualized notions of social behaviour and general practice re-articulated the doctor-patient relationship in the psychiatric terms of psychotherapy.³⁴⁴ Overall, doctors' approaches to becoming more socially attuned as a way to regain their moral credibility resulted in the organization of the system of vision and division of the medical *habitus* to register *the social* in terms of individualized, behaviourist and psychiatric understandings.

Public/Media Relations as a Medical Strategy

The profession's unsuccessful struggles against the CCF government in Saskatchewan, the disappointing walk-out on July 1, 1962 and the growing concern among doctors that medicine must become more socially attuned all pointed to the pressures of forces from outside of the field of scientific medicine. Compelled to take seriously the mounting critique against their esotericism and view of what it means to fund health care in a disinterested manner, doctors as individuals and as a profession turned their gaze outward, which not only resulted in the resurgence of what were at the time lesser specialties of public health and general practice, but also the expansion of the field of medical practices to those concerns that were thought to be completely outside,

³⁴⁴ It would be difficult to entertain this analysis using a governmentality framework because the adoption of *the social* by doctors would be interpreted as the integration of the medical profession into the biopolitics of the state. However, by using a framework informed by Bourdieu allows an examination of how the pressures of public shaming and declining public trust in the medical profession created a bump in the road to rapid scientization and specialization and significantly reoriented the direction of medicine to the point of reviving what were seen as an outdated form of medicine, i.e. general practice.

and even antithetical to, disinterested medicine—public relations and a close engagement with the media. While the Canadian Medical Association provided public relations packages to doctors to persuade their patients and the public of their position in the political debate,³⁴⁵ the notion of public relations, a tactic associated with politics and the business world, was not an easy concept for doctors to readily accept as legitimately medical and disinterested. The integration of public relations into medicine required a considerable amount of symbolic work and struggle within the group itself: the issue of a more amicable relationship with the public, the state and the media had to be first established as a legitimately medical problem not just a political issue of the professional body, and public relations as a strategy had to be accepted as the appropriate solution to the problem, which then prompted it to be rearticulated and absorbed into the disinterested logic of medicine.

The *Canadian Medical Association Journal* published an American survey of public attitudes toward doctors which identified long waits and perceived inattentiveness by doctors and perceived unfairness in medical charges as the primary reasons for negative public opinion toward doctors.³⁴⁶ Around the same time, the Journal produced a series of editorial columns called “Public Relations Forum” from 1955 to 1956 which provided diverse ways in which doctors can improve their relations with patients and the public, ranging from how to train the receptionist at one’s private practice³⁴⁷ to how to talk to the press.³⁴⁸ The Canadian Medical Association highlighted the state of the doctor-public relationship as a pressing medical problem that must be addressed with better lines of communication with the public. The chairman of the CMA’s Committee on Public Relations defended his work by invoking the CMA’s original objectives in 1867, including the objective “[t]o direct and control public opinion in regard to the duties and responsibility of medical men,” and argued further that “all modern techniques and lines of communication must be used” in order to be faithful to this objective.³⁴⁹ He concluded

³⁴⁵ See L.W. Holmes, “A Code of Cooperation,” *CMAJ* 76 (1957): 891.

³⁴⁶ L.W. Holmes, “Public Attitudes Towards Doctors. V.” *CMAJ*, 76 (1957): 144-146.

³⁴⁷ L.W. Holmes, “Ambassadors of Goodwill” *CMAJ* 73 (1955): 683-684.

³⁴⁸ L.W. Holmes, “The Doctor Speaks” *CMAJ* 74 (1956): 396-397.

³⁴⁹ Gordon A. Sinclair, “Why Has the Canadian Medical Association a Public Relations Program” *CMAJ* 78 (1958): 359-360.

that doctors have “a collective responsibility to present the profession’s actions and views in a light which will enhance our reputation in the eyes of our fellow citizens.”³⁵⁰ The Association framed public relations as a remedy to the problem of public image of the medical profession which doctors as a group perceived to be caused by a misunderstanding by the public of the true intentions of the profession—that its opposition to the CCF government’s proposal for a publicly-funded health care is not based on a self-interested desire to protect their lucrative incomes but to ensure better quality of care for all: “For while the public would have supported us in resisting such restrictions of our liberty as would have brought about a deterioration of our service to them, they were entirely without sympathy with any effort on our part to resist a threat to our income.”³⁵¹ Public relations as a professional field emerged at the turn of the previous century as a strategy to harmonize the relationship between diverse fields such as government and politics, business and commerce and the democratic notion of a public with rights, including entitlements to transparent governance and business practices.³⁵² By the post-war era in which the CMA turned its attention to public relations, however, the practice was closely related to the memory of Nazi propaganda and to the business practices of advertising and marketing, all of which were associated with manipulation. Indeed, the chairman of the CMA’s Committee on Public Relations noted that “[i]t is quite apparent that there are some people who associate a medical public relations program with that of advertising or high-pressured publicity.”³⁵³ Hence, it was one thing to have doctors on board that the public image of medicine was a problem but quite another to convince them that public relations as a strategy was a legitimate solution. To turn to a business and political method of what was widely perceived as deception would be to confirm the public’s accusations that doctors are motivated by financial gains rather than by common good. The CMA and the *Canadian Medical Association Journal* invested a significant amount of discursive work to constitute public relations as a

³⁵⁰ Ibid., 360.

³⁵¹ H.B. Atlee, “CMA Public Relations and the Saskatchewan Affair”, Letters to the Journal, *CMAJ* 87 (1962): 878.

³⁵² For a history of public relations, see Robert L. Heath, Elizabeth L. Toth and Damion Waymer (eds), *Rhetorical and Critical Approaches to Public Relations Vol. 2* (New York: Routledge, 2009), particularly Chapter 5, “Perspectives on Public Relations History” by Ron Pearson.

³⁵³ Sinclair, “Why Has the Canadian Medical Association a Public Relations Program”, 359.

legitimate medical practice that is in line with the tenets of medical disinterestedness, work that deployed a strategy that is central to advertising and at times to public relations—euphemisms. Advertising is based on shaping the values and connotations associated with the product by reframing and recontextualizing it so that its original meaning morphs into something else that is appealing and novel and instills desire for consumption.³⁵⁴ Public relations directs this advertising strategy in order to associate particular—usually positive—meanings and values to a person or a group, which often requires euphemistic strategies that rhetorically re-frame what are normally perceived as negative traits into positive traits or re-articulate neutral qualities into more explicitly appealing ones.³⁵⁵ Finally, public relations strategy continuously projects this revised representation of the person or the group so that it becomes the new image of the person or the group. The CMA and the *CMAJ* sought to dissociate public relations from the world of politics, commerce and advertising as a strategy of manipulation and instead to convince doctors that public relations is a legitimate professional practice of medicine. The CMA and the *CMAJ* claimed that public relations is a means of creating a more effective line of communication with the public to “inform and persuade” with the intention of establishing “good public relationships—good will and harmony.”³⁵⁶ The chairman of the Committee of Public Relations differentiated between “good public relations” and “the promotional methods frequently used by those who oppose ethical medical practice” with whom doctors “are in competition with” but only vaguely defined the “good public relations” as the task “to interpret intelligently the viewpoint of orthodox medicine in Canada” which is based on “high standards” that are “directed and approved by doctors who are members of the Standing Committee on Public

³⁵⁴ For Saussurian semiotic approaches that examine this euphemistic strategy in advertising, see Robert Goldman, *Reading Ads Socially* (New York: Routledge, 1992); Judith Williamson, *Decoding Advertisements: Ideology and Meaning in Advertising* (New York: Mario Boyars Publishers, 1978); and Stuart Hall (ed.), *Representation: Cultural Representations and Signifying Practices* (Thousand Oaks, CA: Sage, 1997). See also Roland Barthes, “Rhetoric of the Image” in *The Visual Culture Reader*, Nicholas Mirzoeff (ed.), (New York: Routledge, 2002), 135-138.

³⁵⁵ For the relationship between advertising and public relations, see Robert Jackall and Janice Hirota, *Image Makers: Advertising, Public Relations and the Ethos of Advocacy* (University of Chicago Press, 2000).

³⁵⁶ L.W. Holmes, “The Five W’s of Medical Public Relations”, *CMAJ*, 73 (1955): 484.

Relations.”³⁵⁷ Another editorial on public relations compared this practice with public health strategy of preventive medicine:

[t]he practice of public relations, like that of medicine, should emphasize prevention, preserving the health of public attitude by precluding any sources of misunderstanding or conflict.³⁵⁸

The aim of such preventive approach was for the profession to “[reveal] itself as being interested in the welfare of the community and its citizens” and to “[tell] the public, within the bounds of good ethics, of course, about one’s community spirit.”³⁵⁹ In other words, the intention is not to deceive or to manipulate people into believing something that was false but better convey what was already an established truth—doctors’ honourable intentions. As the issue of payment was discussed more and more in relation to the health insurance debate, the euphemistic strategy of public relations also provided a way for doctors to navigate the uncomfortable and problematic situations of negotiating payment with patients by transforming what had once been seen as a necessary evil into a legitimate part of medical practice: “It is not too mercenary to help a patient budget for his medical care” because doctors can “smooth the way and relieve the patient’s uncertainty” by openly discussing the issue of payment.³⁶⁰ The strategy required that doctors come to see that their role includes an understanding of and a sensitivity to patients’ financial situations so that they are able to convince reluctant patients of both “the doctor’s moral right to charge a fee and consider the cost of medicine as a desirable ‘investment’”³⁶¹ as being connected and therefore equally reasonable. The efforts to transform public perception first required that doctors see that their practice as doctors includes the work of transforming the negative public opinion of the profession into a positive one, even if it means that doctors see this part of their practice as being not so different from those of public relations agents: “All the public relations programs in the world cannot remove the doctor’s responsibilities for paying attention to the

³⁵⁷ Sinclair, “Why Has the Canadian Medical Association a Public Relations Program”, 359.

³⁵⁸ L.W. Holmes, “Preventive PR” *CMAJ* 76 (1957): 229-230.

³⁵⁹ *Ibid.*, 230.

³⁶⁰ L.W. Holmes, “Doctors and Dollars” *CMAJ*, 73 (1955): 982.

³⁶¹ *Ibid.*

improvement of doctor-patient relationships”³⁶²; “It is in [the individual doctor’s] daily contact with people, in the office, in the club, on the golf course, in church, wherever it may be, that he must launch his attack against poor public relationships.”³⁶³

However, the scientific ideals still dominated medicine and the idea that doctors could be confused with a smooth-talking publicist, an advertising agent or even a well-meaning financial advisor was a lot to stomach; for doctors to be skilled in self-promotion and in shaping the perception of the public would require the dispositions and know-how associated with the economic and political world, which would in turn mean that they do not possess a disinterested *habitus*: “We also are not experts in speech making, or the art of public relations. Least of all are we experts in politics. A good doctor wants only to practice good medicine.”³⁶⁴ Also, there was a widespread understanding among doctors that individual doctors, particularly family physicians, were still held in high regard so that there was resistance to the proposition that the public image of the profession is a legitimately medical problem. Those who raised the alarm about public perception of the profession emphasized the responsibility of doctors toward the professional group to “enhance our reputation in the eyes of our fellow citizens”³⁶⁵ in order to secure their position of leadership in matters of health and illness. The growing unpopularity of the medical profession compelled many doctors to take a more cautious stance in the name of humility and to avoid taking such authoritative leadership roles for granted. Some doctors argued that “the reputation of the physician must be based on his integrity and knowledge and not on what the patient will say, or on the reaction of an public body.”³⁶⁶ Doctors must not be so conscious of the perception of the public in the first place because medical authority stems from wisdom and maturity of experts who remain distant from the lowly affairs of the public which does not understand what doctors do; doctors must simply demonstrate their honourable intentions toward the

³⁶² L.W. Holmes, “Public Attitudes Toward Doctors V.”, 145.

³⁶³ L.W. Holmes, “The Five W’s of Medical Public Relations”, 484.

³⁶⁴ “The Doctors’ Position – A presentation of the Saskatoon and District Medical Society Presented Over CFQC – TV – Friday June 1, 1962”, *Medicare: A People’s Issue - Saskatchewan Council for Archives and Archivists*. http://scaa.sk.ca/gallery/medicare/en_display.php?ref=en_doc-strike&max=113&dir=doctors-strike&img=99

³⁶⁵ Sinclair, “Why has the Canadian Medical Association a Public Relations Program?”, 360.

³⁶⁶ M. Etziony, “Medical Ethics—Faith, Fossil or Way of Life?” *CMAJ* 84 (1961): 1196-1198.

public by relying on the existing high standards of care—science will speak for itself because “[n]either the doctor’s work nor the doctor-patient relationship needs explaining. It cannot be explained. It is based on faith.”³⁶⁷ However, the disappointment in Saskatoon on July 1, 1962 produced a new attitude toward public relations among doctors that they had failed to win public support in their struggle against the provincial government in Saskatchewan due to an ineffective public relations strategy: “the public image, presence and voice, broadcast by the representatives of the medical organization of Saskatchewan was far weaker, more uncertain, clumsier and far less articulate than that of the confident, cocky and misleading representatives of the other side.”³⁶⁸ Those who took this position argued that, had doctors in the province and the nation as a whole taken their public image more seriously, they could have avoided being misunderstood by the public and the public being misled by the CCF government.³⁶⁹ Specifically, contributors to the *CMAJ* after the Saskatchewan affair claimed that “[f]reedom was the issue, not money”³⁷⁰ and further argued that “the public would have supported [the province’s doctors] in resisting such restrictions of [their] liberty”³⁷¹ because “most of the best types of men who would be motivated to enter a noble and free profession would no longer be so motivated if their future is to be servility in an undesirable form of civil service,”³⁷² a result that would ultimately harm the public. Although doctors accused the provincial government of conducting “very effective propaganda,”³⁷³ many admonished the CMA for “the appalling poor job of public relations”³⁷⁴ that was an “inept and confused picture”³⁷⁵ and relying on the scientific merits of medicine that was based in naïveté rather than maturity, in “false pride” rather than honour and in “false assumption that honesty and dedication to humanity will of necessity shine through and case a true image;

³⁶⁷ Baker, “Doctor-Patient Relationship or Doctor-Public Relationship”, 128.

³⁶⁸ Cappon, “CMA Public Relations and the Saskatchewan Affair”, 625.

³⁶⁹ Atlee, “CMA Public Relations and the Saskatchewan Affair”, 878.

³⁷⁰ Cappon, “CMA Public Relations and the Saskatchewan Affair”, 625.

³⁷¹ Atlee, “CMA Public Relations and the Saskatchewan Affair”, 878.

³⁷² Cappon, “CMA Public Relations and the Saskatchewan Affair”, 625.

³⁷³ A. D. Kelly, “The General Secretary Replies”, Letters to the Journal, *CMAJ* 87 (1962): 626-627.

³⁷⁴ Cappon, “CMA Public Relations and the Saskatchewan Affair”, 626.

³⁷⁵ Atlee, “CMA Public Relations and the Saskatchewan Affair”, 878.

and that nobody would cheat such a naively honest and devoted man as the doctor.”³⁷⁶ In so doing, they asserted, the profession had done a great disservice to the public by not protecting them from government propaganda.

The idea that public relations by the medical profession could be part of a service to the public to convey accurate information fell neatly into doctors’ concerns about the role of the media in public health education which they saw as pandering to the public’s demand for entertainment, namely shocking surgical procedures that rendered medicine into a spectacle, rather than what they perceived to be legitimate information on health. However, there were structural barriers for individual doctors to communicate directly with the public. The Code of Ethics of the CMA and the AMA explicitly forbade doctors to talk to the public on medical matters, except those in designated roles in executive positions on the CMA:

All opinions on medical subjects which are communicated to the laity by any medium, whether it be a public meeting, the lay press, radio or television should be presented as from some organized and recognized medical society or association and not from an individual physician.”³⁷⁷

This part of the Code was based on concerns at the turn of the previous century by the profession about individual doctors who advertised their private practices and personal concoctions to the public. While such practices were becoming antiquated due to increased technical advancements in the pharmaceutical industry and a much more pervasive embodiment of medical ethics by doctors, the section of the Code demonstrated a more general feeling of caution held by the profession with regard to any practice of self-promotion that is based on the logic of the economic field which would be read as

³⁷⁶ Cappon, “CMA Public Relations and the Saskatchewan Affair”, 626.

³⁷⁷ Canadian Medical Association, “Code of Ethics” 1945, 6.

unscientific and not disinterested.³⁷⁸ By framing the issue of communication with the public as a matter of health education and the dissemination of accurate scientific information, however, doctors could bypass the ethical constraints against speaking to the public, and in fact feel obligated to intervene in the affairs of popular media in the name of promoting scientific truth and providing public service. Indeed, one of the major criticisms against the CMA after the Saskatchewan affair was the Association's conservative position with regard to public relations which prevented individual doctors from engaging directly with the public thereby doing a great disservice of allowing the proliferation of what they claimed was misinformation on health insurance by the CCF government.³⁷⁹

In turning outward from their esoteric worlds of medicine, research and specializations to radio, television and the press, doctors came up against the field of journalism. William Osler, an influential Canadian doctor who revolutionized North American medical education in the early twentieth century, cautioned doctors against the "temptation to toy with the Delilah of the Press" which is "sure to play the harlot, and has left many a man shorn of his strength, namely the confidence of his professional brethren."³⁸⁰ The CMA's Code of Ethics of 1938 and 1945 also state:

Physicians should be extremely cautious in dealing with the Press. A physician should insist, wherever possible, on seeing a proof of what is to be printed under his name or on his authority.³⁸¹

³⁷⁸ The CMA's Code of Ethics of 1928 lumps together personal advertising and public relations: "It is derogatory to the dignity of the profession to resort to public advertisements, or private cards, or handbills inviting the attention of individuals affected by particular diseases, publicly offering advice and medicine to the poor gratis, or promising radical cures; to publish cases and operations in the daily prints, or suffer such publication to be made; to invite laymen to be present at operations, to boast of cures and remedies; to adduce certificates of skill and success, or to perform any other similar acts" (2-3). Ten years later, this section of the Code is revised and individual advertising is separated from "Communications to the Laity on Medical Subjects" (Code of Ethics, 1938, 6).

³⁷⁹ The CMA's Code of Ethics of 1945 contained decisions made by the British Medical Association that forbade Canadian doctors from "[discussing] in the lay press on disputed points of pathology or treatment" and from "taking charge of columns in which answers to correspondents on medical questions are printed" (6). These statements are absent in the 1956 version of the Code.

³⁸⁰ William Osler, "Internal Medicine as a Vocation," *Medical News*, New York, 71 (1897): 660.

³⁸¹ Canadian Medical Association, Code of Ethics, (1938), 6; (1945), 6.

Journalism at the turn of the previous century consisted mainly of penny press which was mostly concerned about advertising revenues and relied on sensationalism to sell papers; it was not until the 1920s with the emergence of public relations industries and government propaganda during World War I that the field as a whole began to take the issue of credibility and objectivity seriously, establishing journalism schools and codes of ethics in the name of public interest.³⁸² Despite these changes in journalism with respect to ethics and objectivity that appear to have come in line with those of medicine in the 1950s, there remained—and still remain—fundamental differences between the ways in which science and journalism handle the issue of scientific truth and objectivity. Patrick Champagne and Dominique Marchetti note that science prioritizes established ideas that are tested extensively to minimize their potential for error, while journalism embraces untested ideas and hypotheses as legitimately objective statements,³⁸³ an argument that was reflected in certain perspectives that appeared in the *CMAJ*: “The practice of medicine is thoughtful, careful and deliberate. It has to be. Newspaper work by the very sense of urgency inherent in it, [sic] is almost the opposite to this. It has to be.”³⁸⁴ The deep historical and epistemological differences between the two fields prompted the proposal that doctors must understand and learn how to navigate the differences in order to incorporate public relations through the press as part of a legitimate public health education strategy. One “Public Relations Forum” column on doctors and the press argued that the problem is not that journalists are not objective or not disinterested enough but that “[m]uch of the misunderstanding stems from the doctor’s lack of knowledge of how reporters work.”³⁸⁵ In a gesture that is embedded in public relations to establish a better relationship through communication and euphemisms, the editorial attempted to bridge the gap between the logic of journalistic field and that of the scientific field of medicine. Instead of shunning the press because of these differences, doctors must become the expert to whom the journalist turns when reporting on a medical

³⁸² Jeremy Iggers, “Contemporary Ethical Concepts in Historical Context”, in *Good News, Bad News: Journalism Ethics and the Public Interest* (Boulder, CO: Westview Press, 1999), 67

³⁸³ See Patrick Champagne and Dominique Marchetti, “The Contaminated Blood Scandal: Reframing Medical News”, in *Bourdieu and the Journalistic Field*, edited by Rodney Benson and Erik Neveu (Malden, MA: Polity Press, 2005), 117-118.

³⁸⁴ Baker, “Doctor-Patient Relationship or Doctor-Public Relationship”, 131.

³⁸⁵ L.W. Holmes, “The Doctor and the Press,” *CMAJ* 74 (1956), 224.

story. Hence, by augmenting the scientificness and disinterestedness of the field of journalism and the *habitus* of journalists, doctors sought to justify their dealings with the press as an act of collaboration in an effort to fulfill a public service of providing accurate health information in the most effective communicative means possible.

The events leading up to and after the doctors walk-out in Saskatchewan compelled the medical *habitus* to shift its perception of disinterested medical practice from a strictly scientific enterprise that must rely solely on the internal rules of rigour and ethics to one that must be socially engaged and explicitly interested in the public. The medical profession made sense of its failure to win the public to its side of the health insurance debate as a misunderstanding by the public of the profession's intentions, which prompted the group to—at first hesitantly—adopt hitherto new strategies of public relations and media relations as legitimate medical practice. The group absorbed these strategies which were borrowed from the world of politics and business with an entirely antithetical field logic to that of medicine, by framing public and media relations as a medical service that provides the public with education on matters of health and medicine, including health insurance.

Conclusion

The events of 1962 in Saskatchewan were not just a question of doctors' income, although money played a pivotal role in the question of health insurance in general. The disputes between the medical profession and the CCF government in Saskatchewan over a tax-funded, state-administered universal health insurance system was also a question of fundamental differences between the logic of the bureaucratic field of the state and the scientific logic of medicine, both of which conceptualized the public and its health in opposing ways, resulting in different understandings of what it means to act in the interest of public health in a disinterested manner. The medical profession was ultimately judged to be selfish, elitist and possibly unethical in its opposition to the Medical Care Act because it misrecognized the stakes involved in the struggle: the historical, political, social and cultural trend toward welfare governance meant that the public and the media

were much more in line with the position of the CCF government. The increasing popularity of the notion that the medical profession is elitist, while the individual family doctor is still respected, also prompted a reconceptualization of what is deemed an appropriate way for the profession to maintain its medical disinterestedness: public health and general practice, two lesser specialties which had been under threat of extinction due to increasing scientization and specialization of medicine, regained importance as ideal ways by which the group may re-establish rapport with the public. The notion that the medical profession must be socially attuned but at the same time maintain scientific standards, required that public health doctors and general practitioners deploy notions of the social and the scientific in strategic ways. The social in these practices became synonymous with individualized behaviour and psychiatric states, frames that aligned with the existing model of doctor-patient relationships and the profession's insistence in the political debates that health is an individual issue. As the medical *habitus* absorbed notions of the social into its systems of vision and division with regard to disinterestedness, strategies of public and media relations, which were associated with the worlds of politics and business, also became part of the group effort to build bridges with the public, the media and the government so as to prevent misunderstandings of the intentions of the profession. As the field of medicine increasingly opened its doors to the world outside of scientific medicine in the name of disinterestedness, the influence of external forces, such as politics, journalism and economics, would become increasingly problematic to the logic of disinterestedness as evidenced by the controversy over the dismissal of a very popular editor of the Canadian Medical Association Journal in 2006.

Chapter 5. Ethics and Objectivity in Medical Publishing

The notion of building bridges with the public and the media, which was conceived as the solution to the problem of deteriorating relationships with these groups during and after the Saskatchewan affair, opened the doors to other problems for professional medicine in more recent years, particularly in relation to the media. On February 20, 2006 the top editors of the *Canadian Medical Association Journal (CMAJ)* were fired, stirring a considerable amount of controversy in national and international medical circles. While this was not the first time that an editor of a medical journal had been fired in the history of Western medical publishing, not only was this the first time in the history of the *CMAJ* but the circumstances in which the dismissals took place made this a particularly heated topic. The editor-in-chief, John Hoey, and senior deputy editor, Anne Marie Todkill, had ushered the journal to significant international prestige over the previous decade; the dismissal followed recent high-profile firings at two prominent medical journals in 1999, the *Journal of American Medical Association (JAMA)*³⁸⁶ and *New England Journal of Medicine (NEJM)*³⁸⁷; and for the first time in the journal's history in December 2004 the management of the *CMAJ* was handed over to a private company, the Canadian Medical Association Holdings which also manages pensions for CMA members. The dismissal took place during a time of increasing corporatization of medical journals and a subsequent threat to editorial independence, one of the most cherished principles of not only medical publishing but also the intellectual work of science in general; indeed, the journal owners merely stated that the journal needed a

³⁸⁶ The senior editor of *JAMA*, George Lundberg, was fired for publishing an article on the perception of oral sex by American college students during the period of former President Bill Clinton's impeachment trials. See Janice Hopkins Tanne, "JAMA's editor fired over sex article", *British Medical Journal*, 318 (1999): 213.

³⁸⁷ Jerome Kassirer of *NEJM* disagreed with the journal publisher's new direction to publish other medical publications under the journal name. See Bruce Japsen, "New England Journal Of Medicine Fires Top Editor", *Chicago Tribune*, 27 July 1999. http://articles.chicagotribune.com/1999-07-27/business/9907270059_1_dr-jerome-kassirer-massachusetts-medical-society-consumer-newsletters

“fresh approach”³⁸⁸ to justify the dismissal and the act prompted a significant rally in support of the editors and claims that the CMA had violated editorial independence. Scientific journals and their circulation are integral part of the intellectual life of scientists in their pursuit of science for the sake of science but as a form of media such journals are also subject to the market logic of circulation figures and, quite often, advertising revenues in order to sustain them; the necessarily communal character of scientific work requires science to rely on infrastructure that is external to the ivory tower, making the ideal of a complete dissociation from other social worlds impossible. The debates surrounding the dismissal of the editors of the *CMAJ* and the fate of the journal brought this inherent contradiction within medical science into sharp relief.

While the notion that science is social, political and economic is not a new argument in the social studies of science, in the world of scientists and doctors, there still remains an effort to dissociate intellectual science from social, political and economic forces. At the heart of medical publishing is a belief that objectivity in medical research is both possible and desirable even while the criterion for good scientific research and publishing remains elusive, particularly where the contradictory logics of intellectual science and market forces constantly butt up against one another. Editorial autonomy figured centrally in the question of objectivity in the debates that followed the dismissals at the *CMAJ*. An editorial in the *Lancet* sharply denounced the firings as a “scandal” and the CMA’s actions “deeply troubling.”³⁸⁹ The breach in editorial autonomy was framed as the violation of fundamental values of medicine and medical professionalism which are “scientific objectivity, respect for patients, health promotion, altruism, truth-telling, leadership and benevolence.”³⁹⁰ These values were taken-for-granted as stable and transparent to everyone involved in medical journals: writers, editors, readers and publishers. Yet a Saskatchewan specialist stated that “[y]ou can either see medical journals as commercial or scientific enterprises... [b]ut perhaps not both,”³⁹¹ pointing to the contradictions in medical publishing where scientific objectivity may constantly

³⁸⁸ Bill Curry, “Interference alleged at medical journal,” *The Globe and Mail*, 22 February 2006: A14.

³⁸⁹ “Sacking of *CMAJ* editors is deeply troubling,” Editorial, *Lancet*, 367 (2006): 704.

³⁹⁰ Jerome P. Kassirer, Frank Davidoff, Kathryn O’Hara, and Donald A. Redelmeier, “Editorial autonomy of *CMAJ*” *CMAJ* 174 (2006): 945-950.

³⁹¹ Paul Webster, “Canadian researchers respond to *CMAJ* crisis,” *Lancet* 367 (2006): 1134.

require negotiation due to the ways in which it is corporately structured and financed. Others referred to the ways in which physicians' fees are allocated through the provincial governments in Canada so that "organized medicine is a political and social entity"³⁹² in a much broader sense. The dominant narrative surrounding the dismissal followed a particular discursive pattern: (1) identify the political and economic motivations of the journal owners; (2) separate them from the purer intentions of the journal editors which were to secure scientific objectivity and neutrality; and (3) suggest the ways in which the former attempted to taint and dominate the latter. While this methodology sheds light on the immediate and politically pressing aspects of the case, it cannot account for some interesting moves made by the parties involved as the event unfolded: both the journal owners and the dismissed editors appealed to the notion of scientific objectivity in order to justify their respective positions.

In this chapter, I read the position-taking by the two sides—the dismissed editors and their supporters versus the journal owners and their supporters—as a struggle over what it means to exercise objectivity in medical publishing in a disinterested manner, and by implication the social function of scientific objectivity in medical practice. I argue that the dismissal became an international controversy because the event raised potentially delegitimizing questions about medical publishing with its conflicting imperatives to identify and publicize pure science while maintaining business standards. I explore this tension at three different sites in the conflict: the debate about differing criterion for judging scientific research versus journalistic reporting, indeed whether the latter is legitimate content in medical journals; accusations of bias and immorality; and the different ways in which the journal owners and dismissed editors responded to the controversy in order to ensure future objectivity in Canadian medical publishing. In all these sites of struggle, scientific objectivity emerges as an elusive and undefined concept and its ambiguity and flexibility generate a multitude of positions with regard to a scientific issue, including those that are opposed to one another. All claims to disinterestedness are then assessed based on how well one can mobilize a particular articulation of scientific objectivity.

³⁹² Miriam Shuchman and Donald A. Redelmeier, "Politics and Independence – The Collapse of the *Canadian Medical Association Journal*," *New England Journal of Medicine* 354 (2006): 1339.

Scientific versus Journalistic Ethics

The dismissal took place shortly after a disagreement between the *CMAJ* owners and editors over an investigative news story that was published in the journal on December 6, 2005. The journal owners mobilized the standards of objectivity and ethics in the scientific field of medical research in order to withhold what they saw as a controversial story from reaching the printers while the journal editors upheld the equivalent standards in the journalistic field of investigative reporting in order to defend the story. The editorial writings in international medical journals pointed to the investigative news story incident as the cause of the dismissal but this dispute revealed more deep-seated contradictions between the rules of scientific research and those of journalism that simultaneously govern medical publishing. In particular the incident revealed medical publishing as a highly heteronomous space within medicine that is susceptible to the forces and rules in the fields of journalism and professional politics so that the goal to ensure objectivity in medical publishing became an object of struggle between representatives of these fields as well as those from medicine itself.

Two medical journalists at the *CMAJ*, Laura Eggerston and Barbara Sibbald, discovered that the Canadian Pharmacists Association (CPhA) was advising pharmacists to collect personal information from women seeking an over-the-counter emergency contraceptive commonly known as Plan B. The CPhA's survey stored details of menstrual cycle, methods of birth control, instances of unprotected sex and reasons for taking the drug along with prescription data, to which the journalists raised concerns about privacy and barriers to accessing the drug.³⁹³ As part of their investigation they had taken testimonials from thirteen women across Canada who purchased Plan B from local pharmacies, and the pharmacists who dispensed the drug were not told that their dispensing practices were under scrutiny. The CPhA got wind of the story from the federal Privacy Commissioner before the issue went to press and the CPhA's executive director confronted the CMA "whether it was true its reporters were conducting covert

³⁹³ Laura Eggerston and Barbara Sibbald, "Privacy issues raised over Plan B: women asked for names, addresses, sexual history," *CMAJ* 173 (2005): 1435-1436.

research, and whether the research was being carried out in an ethical manner.”³⁹⁴ The journal owners “agreed there was cause for concern”³⁹⁵ and asked the editors to pull the story on the grounds that it is scientific research and must follow the ethical requirements of biomedical research—that is, get informed consent from the pharmacists involved in the study. The journal owners argued that the story “could be confused with material in the journal’s research section, which is separate and must be reviewed by outside experts.”³⁹⁶ Similar to other medical journals such as the *Lancet*, the *CMAJ* prints peer-reviewed articles that follow ethical protocols of human research and also news material of interest to doctors such as editorials by the editorial board, opinion essays and letters to the editor by doctors across Canada, poetry, book reviews and obituaries. In order to publish the Plan B story the editors defined the article as legitimate and responsible journalism but not scientific research. This enabled them to get around the question of informed consent (a research concept, not a journalistic one) but without fully endorsing the values of journalism. At the pressure from the journal owners the story was published without the women’s testimonials which would have served as real-person citations valued in investigative reporting. In his editorial on January 3, 2006, Hoey documented the actions of the CMA as a “transgression”: “The CMA questioned the propriety of our investigation and the boundary between news reporting and scientific research. Our story was not scientific research, however, but legitimate journalism.”³⁹⁷ When the existing Journal Oversight Committee (JOC), which had been established in 2002 to ensure harmonious relations between the CMA and the editorial board, did not respond to the incident in a timely manner, Hoey appointed an ad hoc JOC to attend to the matter. This JOC echoed Hoey’s position that the original Plan B story “represented legitimate and ethically responsible journalism,”³⁹⁸ and argued that the information obtained through the covert method used “could not have been obtained by other means.”³⁹⁹ On the whole the journal owners upheld the ethical imperatives of biomedical research of human subjects

³⁹⁴ Anne McLroy, “How a battle for editorial independence came to cost so much,” *The Globe and Mail* April 1, 2006: A4.

³⁹⁵ *Ibid.*

³⁹⁶ Curry, “Interference alleged at medical journal”, A14.

³⁹⁷ “The editorial autonomy of *CMAJ*,” Editorial, *CMAJ* 174 (2006): 9.

³⁹⁸ Kassirer et al., “Editorial autonomy of *CMAJ*”, 945.

³⁹⁹ *Ibid.*

to argue against the original Plan B story while the journal editors turned to the ethics of responsible journalism in order to validate the story.

The arguments for and against the Plan B story by the journal editors and owners can be situated in the different ways in which biomedical research and journalism position covert research in their respective fields. Journalism has had a more comfortable relationship with the method because covert investigative reporting helped to blow the whistle on corruption among those in authority such as the Watergate scandal which in turn helped to augment the credibility of journalism as a profession that is responsible for the public's well-being.⁴⁰⁰ Such high profile investigative reports emerged from highly autonomous spaces within the field of journalism where journalists who partook in these reports could operate independently from the forces of economic and political fields so that can make explicit the ways in which economic and political forces enabled the doxic submission of the public that can lead to corruption. However, deception and dishonesty are not unilaterally endorsed in journalism as strategic or morally acceptable position-takings. Media philosopher, Matthew Kieran, notes that the responsibility to uncover truths that concern the public may require the journalist to engage in immoral activities such as deception but the ends of investigative journalism do not justify any means; rather "certain actions we normally think of as immoral can be, under certain strict conditions, morally justified,"⁴⁰¹ and it is the exact circumstances of these conditions that become the subject of debate within journalism. Those who supported the *CMAJ* editors including Canadian press journalists who wrote about the incident did not question whether Eggerston and Sibbald's choice of method was ethically legitimate; only the President of the Saskatchewan Medical Association contended that even within the ethical standards of journalism "the undercover method used cannot be justified" and "cannot reconcile that editorial freedom can legitimately be used to justify this type of

⁴⁰⁰ The newsmedia coverage of Watergate scandal in 1974 made the reporters, Carle Bernstein and Bob Woodward into heroes. Scholars in journalism studies point out that the Watergate reportage was highly sensationalized (James Aucoin, *The Evolution of American Investigative Journalism* (Columbia, MO: University of Missouri Press, 2005), 17-18; David L. Protess et al., *The Journalism of outrage : investigative reporting and agenda building in America* (New York: Guilford Press, 1991), 50-52), the reportage still remains a fixture in the popular image of journalism's virtues (see such films as *The Insider* about the tobacco industry and *Fair Game* about a journalist who writes about how the Bush administration misled the public to justify the invasion of Iraq).

⁴⁰¹ Matthew Kieran, *Media Ethics* (New York: Routledge, 1998), 159.

practice.”⁴⁰² The editors and their supporters instead highlighted the potential harm caused by the actions of the CPhA by invoking the journalistic notion of a public responsibility to seek and reveal truth in order to frame the two journalists as whistleblowers and their covert method as ethically justified. Yet by turning to the standards of ethics within the journalistic field—investigative reporting and public responsibility—the journal editors and their supporters also opened up the field of medicine to the effects of the journalistic field, potentially undermining the autonomy of medical science precisely at the location where scientificity of medicine is largely constituted—that is, medical journals which are the vehicle of research dissemination. This move is particularly charged given the historically uneasy relationship that medicine has had with journalism, as noted by William Osler in the early part of the twentieth century and the Saskatchewan medical profession during the health insurance debates. What appears different about the identification with journalistic visions by the *CMAJ* editors and their supporters is that they drew on the practices and ideals of a highly autonomous space within journalism and translated the cultural capital of “pure” journalism into viable forms of scientific capital in medicine; and to complete this conversion of capital across fields the editors aligned the disinterested *nomos* of autonomous journalism (public responsibility) with that of medicine (ethics).

Meanwhile, the journal owners drew on an entirely different notion of ethics—those of biomedical research—in order to ground their arguments against the Plan B story. Biomedicine’s position on covert research is less ambiguous: after the horrors of Nazi experimentations and other abuses of humans in research such as the Tuskegee syphilis study in 1932-1972 where African American men in Alabama were deceived into participating in a research study for decades without their knowledge, international and national ethical protocols for human research have greatly suppressed deception as a research method.⁴⁰³ These scandals in the early part of the twentieth century were severe blows to the reputation of science and its ability to justify its autonomy in terms of its

⁴⁰² Martin Vogel, “Sacking of CMAJ editors” *The Lancet* 367 (2006): 1486.

⁴⁰³ For a history of malpractices in medical research, see Andrew Goliszek, *In the Name of Science: A History of Secret Programs, Medical Research, and Human Experimentation* (New York: St. Martin’s Press, 2003).

altruistic commitment to progress, knowledge and common good. The Nuremburg Code of 1947 and the Declaration of Helsinki in 1964 outlined the ethical principles of research involving human subjects and these documents were efforts by biomedicine to re-gain its symbolic capital in the field of power as a truly disinterested enterprise. In doing so, biomedicine could better claim that it is still the legitimate space in which to produce the truth about the human body and that it is deserving of autonomy from other social forces including the law in order to accomplish this ideal. These documents were not in and of themselves legally binding but were general principles that were unevenly, if at all, integrated into laws across national and state borders, and the documents' protocols emphasize full disclosure and consent as the ultimate evidences of the ethical integrity of any research involving human subjects.⁴⁰⁴ However, the notion of consent assumes and requires a rational human subject who is capable of rational judgment which is complex and even impossible when the subjects are incapable of such judgment,⁴⁰⁵ most obviously in the cases of minors, physically unconscious individuals and individuals with severe mental disabilities. The work of biomedical science is driven by two equally pressing imperatives—a disinterested pursuit of knowledge for the sake of knowledge and a disinterested goal to do no harm. While generally the two imperatives coincide, they can come in conflict with one another in cases where the benefits may be substantial but consent may not be achieved or where a covert method is required for the study goals. Hence, the second *Tri-Council Policy Statement* which governs the ethical protocol for the major funding bodies in Canada allows deception and partial disclosure only in instances where such methods are necessary for viable research findings—often in psychological studies—where the study process does not put participants at risk of harm and only if the participants are informed of their participation in the study and are given

⁴⁰⁴ See Adriana Petryna, “Globalizing Human Subject Research” in *Global Pharmaceuticals*, Adriana Petryna, Andrew Lakoff and Arthur Kleinman (eds), (Durham: Duke University Press, 2006), 33-60.

⁴⁰⁵ Medical anthropologist Adriana Petryna has argued that medical ethics' overemphasis on consent of the individual obscures the complex contexts in which people decide to partake in biomedical research. Examining clinical trials by pharmaceutical and biotechnology firms in wealthier nations on off-shore sites in poorer and less stable nations, she finds that national and international ethics regulations and protocols fail and even perpetuate unethical practices under conditions of gross global inequalities because they are unable to account for the social, political and economic forces, such as poverty, lack of health care infrastructure, lack of protective legislations and monetary compensation that compel marginalized individuals across the globe to subject their bodies to biomedical research.

the opportunity to provide informed consent prior to the end of the research.⁴⁰⁶ Adriana Petryna argues that an emphasis on consent has reduced the issue of ethics in contemporary clinical research to a procedural matter of getting bureaucratic approval from a research ethics board and obtaining the signed document that guarantees consent so that the ideal of ethics is subject to variance across different bureaucratic spaces such as a research institution, a firm and regulatory bodies of different nation-states, each with its own set of struggles and field effects from different economic and political spaces.⁴⁰⁷ Hence, ethics is as much a strategy in a field of struggles as it is a question of ideals. In the case of the Plan B story the *CMAJ* owners found themselves in an awkward position in relation to the Canadian Pharmaceutical Association in the space of professional politics—the Association was upset by Eggerston and Sibbald’s implication that it engaged in unethical prescription practices which would seriously harm its reputation. Thus, the journal owners tried to block the story using a strategy within the field of medicine—ethics—and declared that the original story was unethical, not objective and unscientific, and yet they neglected to subject the surveys conducted by the Canadian Pharmacists Association to the same ethical standard, nor did they point out the ethics of collecting testimonials from the women in the original story without written consent.

The two conflicting positions on ethics by the journal editors and owners can also be situated in different understandings of objectivity in both journalism and science. Jeremy Iggers notes that in journalism there are two types of objectivity: one that is based in a realist position that measures objectivity based on the ability to represent a pre-existing reality as fact, and the other that is not necessarily based in a clear epistemological grounding and in which objectivity is measured by how well a journalist follows a set of accepted procedures.⁴⁰⁸ Lorraine Daston and Peter Galison also show that in Western science there has always been a tension between the realist notion of truth and an ongoing epistemological problem of how best to represent it, and the debates and

⁴⁰⁶ Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* 2010: 37-39.

⁴⁰⁷ Adriana Petryna, “Ethical Variability: Drug development and globalizing clinical trials,” *American Ethnologist*, 32 (2006): 183-197.

⁴⁰⁸ Iggers. *Good News, Bad News*, 92-93.

innovations in science are marked by changes in procedural criteria for establishing scientific objectivity. In general, the positions taken by the proponents of the debate about the Plan B story were divided along this line: the two journalists and editors of the *CMAJ* primarily took the position that their ethical obligation lay in their public responsibility to uncover the truth about the practices of the Canadian Pharmacists Association, whereas the journal owners framed objectivity as primarily procedural and ethics as a scientific responsibility to follow the procedures that are dictated by the field. These differing standards of objectivity were further complicated by the different procedures for ensuring objectivity in journalism and science: the former entertains hypotheses and untested ideas while the latter requires much more extensive testing but they also have competing systems of ethics. Despite their opposing standards the two co-exist in medical publishing and the Plan B incident drew the curtain away from a set of compromises and struggles for dominance between science and journalism in medical reporting. The journal owners claimed that the Plan B story had no place in the journal because it was illegitimate scientific research; they argued that the report itself was conducted as scientific research and therefore must meet the standards of peer-reviewed, ethical research on human subjects. The editors of the journal claimed that the Plan B story had a place in the journal because it was legitimate journalistic reporting; contrary to the claim made by the journal owners they argued that the report was not based on scientific research and therefore must meet the standards of journalistic reporting which the original story did. Both the journal owners and the editors grounded their respective arguments on notions of truthfulness and objectivity but drew on different standards: (medical) science and journalism. Yet neither claimed that the logic of one should be eliminated for the sake of the other. The journal owners never went as far as to claim that news reports should be eliminated from the contents of the journal altogether but in demanding that news meets the standards of scientific research they questioned the professional values of journalism and their appropriateness for medical reporting. Similarly, the editors and their supporters never went as far as to argue that the rules of journalism should override those of medical research. The ad hoc JOC argued that “although investigative reporting was not part of the original activities of the *CMAJ* (and does not figure prominently in the journal even now)... it is consistent with the journal’s

founding aim of providing a fresh and hence potentially corrective view,”⁴⁰⁹ a journalistic value that is based on a combination of the history of newspapers as the sensationalized penny press in the nineteenth century and as publically responsible profession in the twentieth century. Indeed, the JOC made a very clear distinction between journalism and science:

the report (both as it was intended to be published and as it eventually appeared) does not meet the definition of “research” as understood in medical science. It is not systematic, is not generalizable, and makes no pretense of statistical analysis. In no way does it fit into a “grey area.” It self-evidently fits within the norms of news investigation, not of scientific research, and its presentation within the news section of the journal makes its identity unambiguous.⁴¹⁰

The JOC claimed at once that investigative reporting aligned with the overall values of the *CMAJ* and that the Plan B report fit the norms of journalism not biomedical research. The appearance of these two contradictory statements suggests that despite a fundamental difference between medical science and journalism there still remains an impetus to position medical publishing unproblematically between these conflicting worlds, yet it is precisely the tension between them that spurred the debate surrounding the Plan B story.

The position of both the journal owners and the editors show that they were in fact in agreement that objectivity as a moral and technical value is central to medical science and medical publishing. Where they disagreed were the specific strategies by which one upholds this law within science. For the journal owners who occupy an administrative role this meant ensuring that the rules of science remained superior to those of journalism, even if it meant violating editorial autonomy. For the journal editors and their supporters, upholding objectivity meant a responsibility to uncover truth, even if it meant allowing the rules of journalism, an inferior science, to enter into medicine. In their own ways both the journal owners and editors took risks to exert their own interpretation of what it means to exercise objectivity.

⁴⁰⁹ Kassirer et al., “Editorial autonomy of *CMAJ*”, 946.

⁴¹⁰ *Ibid.*, 947.

Controversy and Failed Euphemisms

The disagreement about the Plan B story was one incident in the mounting tensions between the journal editors and owners: in 2001, Hoey ran an editorial that supported the use of medical marijuana⁴¹¹ which is contrary to the CMA's official position on the substance, and before their dismissal the editors ran an editorial that criticized the newly-appointed federal Minister of Health, Tony Clement, for his support of privatized medicine⁴¹² much to the embarrassment of the CMA. In these incidents, the editors sought to engage with what they saw as socially and politically pertinent issues for Canadian medicine while the journal owners wanted to maintain what they perceived to be a socially and politically neutral position with regard to controversial issues. Both sides struggled to expose the gaps in the other's euphemistic argument that they were acting with disinterestedness and also strove to respectively position themselves as the champion of objectivity. The struggle concerned the broader question of the specific ways in which objectivity may be rightly exercised in medical publishing, and objectivity operated as both a stake in the game and a manner of securing a more dominant position in the field.

While most of the disagreements between the journal editors and owners over editorial content took place behind the doors through departmental memos and phone conversations, the disputes over a 2002 editorial took place on the pages of the *CMAJ*: the editors highlighted a high profile case in which a man died of cardiac arrest in a Quebec emergency room largely due to understaffing which spurred the passing of a provincial bill that placed physicians under more demanding schedules and rigorous surveillance.⁴¹³ The editors argued that this political move by the provincial government resulted in a breach of trust between physicians and the government, and briefly noted that physicians too are obligated to their patients by bonds of trust but “[p]hysicians broke that trust by not staffing the ED of such an important regional hospital” in the first

⁴¹¹ “Marijuana: Federal Smoke Clears a Little” Editorial, *CMAJ* 164 (2001): 1397.

⁴¹² Wayne Kondro and Barbara Sibbald, “Tony Clement Appointed as Canada’s New Health Minister” *CMAJ* 174 (2006): 754.

⁴¹³ “Quebec’s Bill 114,” Editorial, *CMAJ* 167 (2002): 617.

place that resulted in the death of a patient.⁴¹⁴ The CMA's president at the time, Dana Hanson, argued that the editorial's claim that "physicians have betrayed the trust" is unsubstantiated and "amounts to an unwarranted attack on the whole profession"; she concluded that the editorial is "seriously flawed" and "repugnant" and that "our colleagues in Quebec deserve a retraction."⁴¹⁵ The entire editorial board responded to Hanson's letter under the banner of editorial independence calling it a sign of "clear and present danger" for "the right to articulate such opinions without concern for retribution by an organization or corporation that holds ownership or operating responsibility for the journal."⁴¹⁶ In the next issue of the journal Hanson withdrew her demand for the retraction of the editorial. In this conflict the editorial board and Hanson engaged in an editorial banter in which each sought to claim a disinterested position by demonstrating flaws in the other's euphemistic claims. For instance, Hanson argued for the protection of professional colleagues from undue criticism which served as an acceptable euphemism within medical disinterestedness for avoiding political conflict among professional constituents. The editorial board euphemized their criticisms against the Quebec emergency doctors as claims of a neutral and objective observer. Both sides drew on existing possibilities within the discursive field to accuse the other of violating medical disinterestedness by pointing to the ways in which the other's euphemistic strategies are unreliable and untenable.

The rhetorical moves made by each party during the incident of Quebec Bill 114 can also be seen as strategies to write the rules of objectivity in a manner that benefits them; by accusing the other of going against objectivity, each side tried to position itself as morally and scientifically superior in order to steer the journal. Both the Quebec editorial and the Plan B story placed the CMA in uncomfortable situations where it had to deal with retaliations from powerful professional and political groups such as the Quebec Medical Association, the federal government and the Canadian Pharmacists Association. The journal owners strove to portray the editors as biased in order to more generally claim that opinions about controversial issues do not have a rightful place in medical

⁴¹⁴ Ibid.

⁴¹⁵ Dana Hanson, "Questions of trust," *CMAJ* 167 (2002): 986.

⁴¹⁶ *CMAJ* Editorial Board, "A letter from *CMAJ*'s editorial board to the CMA," *CMAJ* 167 (2002): 1230.

publishing; for example, in her letter the CMA president used words such as “betrayed the trust” (which was a misreading of the word “broken” in the original editorial), “unwarranted attack” and “repugnant” in order to assess the opinion of the editors as extreme, unsubstantiated and base—that is, not objective. Meanwhile, the editors’ distrust toward the journal owners were mounting: when the management of the *CMAJ* became privatized there were concerns that the journal contents could be compromised by external pressures such as the pharmaceutical industry and other major advertisers in the journal.⁴¹⁷ A March 2006 editorial in the *CMAJ* stated that the “integrity of the knowledge is being corroded by commercial interests” in Canadian medicine,⁴¹⁸ alerting to the perceived threat of market forces to the science of medicine. The firings at the *JAMA* and the *NEJM* also placed the *CMAJ* editors on high alert. Hence, the editors emphasized editorial autonomy as the site at which objectivity must be defended and their supporters often turned to historicized narratives that medical journals have always had “an important watchdog function by challenging the forces that undermine the values of medicine.”⁴¹⁹

The positions adopted by the journal owners and the editors with respect to marijuana, the Quebec Bill 114, the Plan B story and the federal Health Minister were in keeping with the tenets of medical disinterestedness at different moments in the history of professional medicine in Canada. The journal owners’ insistence on maintaining harmonious relations with other groups is in keeping with the CMA President’s goal in 1963 to build bridges with the public, the elected governments and the media⁴²⁰ (i.e. worlds outside of the intellectual field of medicine) as a way to effectively convey the disinterested intensions of doctors. The owners thus mobilized the professional ethic of public relations which in the aftermath of the Saskatchewan affair had been somewhat reluctantly integrated into medical disinterestedness. Meanwhile, the journal editors drew on the nineteenth century’s legacy of medical journals as forums for disputes between medical men over questions of what constitutes a learned profession in the nineteenth

⁴¹⁷ McIlroy, “How a battle for editorial independence came to cost so much”, A4.

⁴¹⁸ “Is medicine still a profession?”, Editorial, *CMAJ* 174 (2006): 743.

⁴¹⁹ “Sacking of *CMAJ* editors is deeply troubling,” Editorial, *Lancet*, 367 (2006): 704.

⁴²⁰ G.W. Halpenny, “We Must Build Bridges” *CMAJ* 87 (1962), 183-186.

century, including socially charged issues such as French-British relations. The editors and their supporters especially deferred to Thomas Wakley, the controversial founder of the *Lancet* who took on a decidedly heterodox position by highlighting malpractices at a time when medical men were trying to forge a brotherhood and disseminating scientific knowledge to less privileged rural medical men much to the dismay of his more conservative orthodox peers.⁴²¹ Thus, the editors and their supporters drew on the ethic of heterodox medical men of the nineteenth century who upheld the democratic ideals of science in order to instigate medical and social reform.

Arguments for objectivity on both sides of the disputes at once mobilized different but equally accepted versions of medical disinterestedness in order to justify their positions but there were also holes in their respective arguments. While the journal owners insisted that controversial social and political issues do not have a legitimate place in medical publishing, the early *Lancet* contained very little science and was in fact a vehicle to raise controversy and to entertain physicians and the public (the early *BMJ* was also more interested in promoting the profession than in disseminating scientific research).⁴²² Indeed, nineteenth century Canadian medical journals were forums for heated socio-political battles between medical men and the *CMAJ* of the 1950s-1960s contained editorials and essays on medical reform that often delved into competing political philosophies. Meanwhile, the journal editors upheld editorial independence as a way to protect the intellectual and democratic values of science but Richard Smith, a former editor-in-chief for the *BMJ*, cautions that editorial decisions often receive little monitoring and that “little progress had been made in a decade to develop ways to respond to editorial misconduct”, pointing to “a complacent culture.”⁴²³ He argues that while journal owners have the legal right to interfere in cases of editorial misconduct there is no clear-cut line between misconduct and legitimate conduct. In fact he claims that

⁴²¹ Richard Smith, *Trouble with Medical Journals*, (London: The Royal Society of Medicine Press, 2006), 33-34.

⁴²² *Ibid.*, 33-36.

⁴²³ *Ibid.*, 140.

[e]ditors are expected to discriminate, but they should discriminate on grounds of evidence, importance, relevance, quality and clarity rather than on personal foibles. But it is also widely believed to be the job of the editor to give a publication a ‘personality’—and that’s likely to be related to his or her personality. So some personal selection seems desirable.⁴²⁴

The notion of “personality,” which Smith places in air-quotations, contrasts with the subject- and personality-free notions of “evidence, importance, relevance, quality and clarity,” demonstrating that there is a tension between the standards of objectivity and the expectations of artistry in editorialship. Smiths’ description of editors thus suggests that medical publishing is messy and amorphous and cannot be guided by the objectivity of scientific or journalistic rules or by the subjectivity of the editor alone. Instead, the overall trustworthiness of a medical journal is made possible by the figure of the editor who embodies the scientific dispositions of the medical *habitus* but who can still exercise creativity and innovation within the range of what is possible and thinkable in medical publishing. Smith’s stance on the scientific and disinterested role of the editor is also reflected in his conclusion that “[w]e have no good data, only stories, but I suspect that cases of editors performing poorly far outnumber cases of frank misconduct,”⁴²⁵ highlighting not only the difficulty in distinguishing explicit and intentional (mis)conduct from unintentional and well-intended (mis)conduct but also the inherent ambiguity and flexibility in the criteria for scientific objectivity.

Ultimately, the owners and the editors equally strove to defend and maintain their own version of objectivity to be taken as the dominant norm in the journal: the former drew on the values of editorial independence while the latter advocated that engaging in direct social and political debates is not the proper realm of medical publishing. The rhetorical strategies of both sides took on a highly moralized tinge, suggesting that questions of good science are embedded in a social struggle over the power to define what objectivity means (and what it does not mean). Yet objectivity itself remained ambiguous, undetermined and used to support two entirely opposing positions—no one really defined what objectivity was although everyone made a case for it.

⁴²⁴ Ibid., 144.

⁴²⁵ Ibid., 145.

Separation of Science and Business

The result of the disputes between the journal editors and owners were felt across Canadian medicine: sixteen out of eighteen other members of the editorial board resigned to express solidarity with John Hoey and the interim senior editor, Stephen Choi, resigned from the position one week after his appointment.⁴²⁶ While the subsequent interim editor of the journal, Noni MacDonald, claimed that the controversies were blown out of proportion,⁴²⁷ there was mounting negative publicity against the CMA: the Canadian press such as the *Globe and Mail* and the *CBC* consistently reported on the events and potential contributors withheld submissions to the journal, claiming that they are unable to trust the journal's integrity—"I feel no compelling reason to do *pro bono* research for a CMA mouthpiece"⁴²⁸—or that they would rather submit their article to a more stable journal.⁴²⁹ There was a very real fear that the reputation of the journal was on the line which would greatly threaten the legitimacy of the CMA itself and the reputation of Canadian medicine in general. The incident made uncomfortably and even dangerously explicit what had been an implicit and unspoken reality of medical publishing—that the business of publishing coexist with the intellectual work of science. After the dismissal the owners of the *CMAJ* and the dismissed editors came up with different solutions to the problem of the tainted image of Canadian medical publishing: the CMA established an external review panel to investigate the governance of the *CMAJ* and the dismissed editors founded a new open-source medical journal. Both moves represented strategies that reflected their respective positions on how best to protect and to enact objectivity in medical publishing. Yet both relied on a relatively vague criteria of trust and good faith in the editorial and ownership structures as a way to ensure that the business of medical publishing remains separate from the intellectual work of science.

⁴²⁶ Alan Brookstone, "Crisis at the *CMAJ*", *British Columbia Medical Journal* 48, no. 3 (2006): 109.

⁴²⁷ Noni MacDonald is cited as stating that "the controversy has been fuelled by "explosive anger" and that the *CMAJ* was "still getting very high quality stuff coming in" (Paul Webster, "Canadian Researchers Respond to *CMAJ* Crisis", *Lancet* 367, no. 9517 (2006): 1134.

⁴²⁸ Webster, "Canadian Researchers Respond to *CMAJ* Crisis", 1133.

⁴²⁹ David Spurgeon, "Authors Threaten to Withhold Articles from *CMAJ*", *British Medical Journal* 332, no. 7545 (2006): 812.

The CMA appointed a Governance Review Panel which in July 2006 made a set of recommendations: (1) to return the ownership of the journal to the CMA board of directors and not under the management of CMA Holdings which is a private corporation; (2) to make explicit the role and composition of the Journal Oversight Committee (JOC) so that each member serves for a fixed term (a maximum of three years), that members be filled by the CMA board from a shortlist of candidates provided by the existing JOC, and that the JOC includes a freelance journalist; (3) to mandate that the JOC responds within forty-eight to seventy-two hours of a complaint and is granted the full authority to arbitrate in cases of editorial conflict; (4) to cap the maximum term of the editor-in-chief at five years (Hoey served ten years before he was dismissed); and (5) to divide the duties of the editor-in-chief into two separate streams—management of journal content through the JOC and of journal business through the CMA board in order to ensure editorial independence and organizational transparency.⁴³⁰ The Panel’s recommendations, which the CMA adopted, generally envisioned an organizational restructuring of the conditions of journal ownership, of editorship and of the interactions between the two streams. What was clearly absent in the Panel’s report were explicit rules to “‘Publish this, but not that’”⁴³¹; instead, it stressed that the owners and editors must be able “to work together in a spirit of mutual trust and collaboration,” claiming that “trust and good faith cannot be mandated,”⁴³² i.e. written as rules. The implication was that it is impossible to impose explicit rules to govern the relationship between the editorial board and the CMA. In fact, rules are not truly desirable because they would be antithetical to the democratic ideals of scientific work and the disinterested ideal of scientific knowledge as a natural and cumulative progression. Rules may also introduce forces that are external to the logic of the scientific field such as political pressures and conflicts.

Yet restructuring the conditions under which the intellectual work of scientific medicine may be conducted in a disinterested manner was not entirely derived from a

⁴³⁰ Amir Attaran. “Finding true north for the *Canadian Medical Association Journal*” *The Lancet* 368 (2006): 1309-1311.

⁴³¹ *Ibid.*, 1310.

⁴³² Robert Steinbrook, “Turning the Page at the *CMAJ*,” *New England Journal of Medicine* 355 (2006): 547.

purely intellectual goal to ensure objectivity and neutrality. It was a strategic move to salvage Canadian publishing from a crisis of faith by those who are invested in the journal as an objective enterprise—contributors, researchers, reviewers, readers as well as the public. Amir Attaran, a professor of law and population health who served on the Panel, claimed that “[t]hese and other recommendations by the panel will help to avoid the ultimate criticism: that the *CMAJ* is only a house organ for the CMA.”⁴³³ His specific reference to “the need to avoid criticism” rather than to proactively ensure objectivity and neutrality is evocative of Gaye Tuchman’s study of journalistic objectivity as a ritualized strategy or “tactics used offensively to anticipate attack or defensively deflect criticism”⁴³⁴ in the struggle to claim truthfulness. The dismissal of the editors placed the administrative aspects of the intellectual work of medical science under the spotlight, resulting in an uncomfortable and problematic situation for Canadian medical publishing where its scientificness and disinterestedness was put into question. To remedy the situation the best that the Panel could do was to cordon off intellectual science from the business of medical journals, symbolized by its recommendation to include a more prominent disclaimer that the editorial contents do not necessarily reflect the CMA’s views and policies.⁴³⁵ Neither the Panel nor the CMA went as far as to completely eliminate business aspects of the journal, nor did they claim to do so. However, by increasing the distance between the intellectual work of science (encapsulated by editorial independence) and the administrative work of the scientific institution (represented by the CMA board that oversees the business side of publishing) as much as possible, the journal owners could claim that editorial autonomy remains unhindered by economic and political forces thereby ensuring the journal’s reputation and the CMA’s own international professional standing as an objective group. The business side of medical publishing returned to being an acceptable compromise and a necessary evil in the production of scientific medicine—it became an implicit and unspoken reality that business and science co-exist in medical publishing. In fact, the incident was rendered

⁴³³ Attaran, “Finding True North” 1310.

⁴³⁴ Gaye Tuchman, “Objectivity as Strategic Ritual: An examination of newsmen’s notions of objectivity,” *American Journal of Sociology* 77 (1972): 661.

⁴³⁵ Noni MacDonald et al., “Editorial Independence for *CMAJ*: Signposts along the road,” *CMAJ* 175 (2006): 453.

into a temporary problem that was ultimately resolved: “Already, *CMAJ*’s new governance structure is being recognized by other associations as a model for journal publishing, a strong signal of the importance and visionary nature of the Governance Review Panel’s work.”⁴³⁶ What had been a controversy that shook the very foundations of intellectual medicine in Canada became absorbed into the continuity of medical history and progress. It was deemed that a mere structural separation of the administrative side and the intellectual work of medical publishing was sufficient in order to legitimately present medical research in a disinterested and objective manner.

While the CMA struggled to improve the organizational structure of the *CMAJ*, Hoey, Todkill and their colleagues broke away from the journal altogether and founded an open-access journal, *Open Medicine*, with unrestricted access under the Creative Commons license.⁴³⁷ The ownership of medical knowledge and editorial independence became the primary lenses through which the editors framed their rationale for founding *Open Medicine*. The editors emphasized that “medical knowledge should be public and free from undeclared influence” and that the contents of the journal “will be ‘owned’ by all who read and contribute to it.”⁴³⁸ These rhetorical and organizational moves were based on debates within the *CMAJ* and among international medical journals that had developed over the years, namely that medical associations do not own journals but are custodians of them and cannot interfere with intellectual work:

Any medical journal belongs, intellectually and morally, to its contributors, editors, editorial boards and readers—a sort of constituent assembly. It also belongs to the world: the dissemination of medical science is, or should be, ultimately a humanitarian project, and not merely the special preserve of professional associations.⁴³⁹

⁴³⁶ Ibid.

⁴³⁷ Creative Commons is a non-profit organization that provides legal infrastructure for allowing authors of various intellectual and cultural products to share their work with others and still retain credit for the initial authorship. According to the Creative Commons it is a new way of thinking about the protection of intellectual property in more flexible terms that are still within the legal framework of copyright. See <http://www.CreativeCommons.org/About>

⁴³⁸ James Maskalyk, “Why Open Medicine?” *Open Medicine* 1 (2007): E1.

⁴³⁹ John Hoey et al., “Science, Sex and Semantics: The firing of George Lundberg,” *CMAJ*, 160 (1999): 508.

This vision draws on the Enlightenment ideals of scientificity—progress, humanism, communalism and equality—that composed the rationale for Victorian scientificity that had greatly influenced Canadian medical men’s struggle to restrict or access membership into the profession. Here, these ideals are reimagined to outline the conditions under which knowledge production and dissemination may be deemed scientific. While the CMA sought to regain the faith of the *CMAJ*’s readership and contributors by structurally distancing the business from the intellectual work of science, the new editors of *Open Medicine* altogether did away with the business aspects of publishing that runs so contrary to the disinterested logic of intellectual science. Their position was that the “noneconomic benefits” would offset the financial losses (revenue from print subscriptions and advertising) by allowing a “wider dissemination of scholarly and scientific content”⁴⁴⁰ which is the ultimate goal of a truly disinterested intellectual enterprise. The disinterested logic was extended to instances of editorial misconduct which is to be assessed as a violation of intellectual standards rather than as political or financial transgression so that the misconduct may be assessed within the scientific community of editors, writers and readers.

However, there are problems deep within the editorial process that have little to do with journal ownership. Richard Smith points out that there is a serious gap in knowledge and training when editors first come on board that results in inconsistencies: “most editors of the world’s 10,000 or so biomedical journals have received no training” and “many editors work largely alone” at the same time that “editing... is becoming steadily more complex.”⁴⁴¹ While some editorial training has become available, particularly through the World Association of Medical Editors, it is extremely limited and “most editors still learn on the job.”⁴⁴² The Committee on Publication Ethics and the International Medical Scientific Press Council were established to monitor editorial accountability but both are based on complaints with lots of procedural problems and there are no disciplinary measures in place other than removal from the groups.⁴⁴³ The

⁴⁴⁰ “Open Access in Medical Publishing: Trends and countertrends” Editorial, *CMAJ* 172 (2005): 149.

⁴⁴¹ Smith, *Trouble with Medical Journals*, 151.

⁴⁴² Ibid.

⁴⁴³ Ibid.

editorial policies of *Open Medicine* do not directly address these issues, nor do they lay out rigid rules of conduct, but instead rely on the skills, commitment and good faith of a volunteer-based board who will “support the Editor-in-Chief(s) to maintain Journal principles underlying the editorial integrity and independence of the Journal” which are “editorial independence, Journal advertising policies and the open access platform.”⁴⁴⁴ The accountability of the editor-in-chief is to be ensured by an annual meeting to “review a report on the performance of the Editor-in-Chief from the Chair of the Board of Directors.”⁴⁴⁵ The position of *Open Medicine* demonstrates an appeal to the rationalism of the group and an emphasis on trust and good faith in the individual members of the board in order to establish the scientificness and disinterestedness of the journal’s editorialship. The symbolic relations of a community of scientific individuals refer to what Daston and Galison’s describe as trained judgment which is the form that objectivity has taken in the twentieth century: where in the nineteenth century it became impossible to defer to an external reality unhindered by human subjectivity as a way to claim an objective scientific observation, in the twentieth century the notion of a scientific subjectivity that is inclined to suppress itself through proper training allowed Western science to by-pass the problem of the subjectivity of the observer. In other words a fully inculcated scientific *habitus* resolved the issue of maintaining a standard of objectivity across scientific practices. Similarly, the terms of reference of *Open Medicine* relies on an honour system in which the scientific aptitude of individual editor may be ensured through the structural processes of medical education, research and board selection so that trust and good faith, not explicit and rigid rules of conduct, may govern the editorial board.

Thus, the two opposing sides of the controversy, the journal owners and the dismissed editors, both relied on a loosely defined honour code to rectify what was perceived as a broken system and to emerge from the highly publicized crisis with their scientific reputation intact. While the two groups disagreed about the role and mandate of the medical journal to the point of severing ties, they in fact equally relied on modifying

⁴⁴⁴ “Editorial Policies”. *Open Medicine: A peer-reviewed, independent, open-access journal*.
<http://www.openmedicine.ca/about/editorialPolicies>

⁴⁴⁵ Ibid.

organizational processes to mend and restructure relationships between the editors-in-chief, the editorial board, the board of directors and the readership rather than to erect a code of rules that explicitly outline what can be done and what cannot be done. The separation of the administrative aspects of science and intellectual work opened up different enunciative positions from which to claim scientific disinterestedness as objectivity and scientificity—through structural and tentative division between the editorial board and the business of a journal or through a complete abandonment of an explicitly business model of journal management that nevertheless relies on a pool of candidates who are not necessarily trained in editorialship. In both instances disinterestedness operates as procedural objectivity, a defensive mechanism to deflect criticism and to keep misconduct at bay rather than as an explicit rule that precedes every act.

Conclusion

The dismissal of the senior editors of the *CMAJ* and the events surrounding it demonstrate that the event was about more than just the violation of editorial autonomy. The conflict between the journal editors and the journal owners over the Plan B story that spurred the dismissal demonstrates a collision between two different and yet equally credible standards with respect to ethics in medical research and in journalism. Because the field of medicine relies upon the structures of the field of journalism—for publishing and for argumentative styles in medical reporting—it was also possible to make ethical claims that may be acceptable in journalism but not in medicine. The journal editors and the owners struggled to dismantle the other's claim to disinterestedness by revealing the euphemistic strategy the other used by claiming that the strategy reveals an ulterior non-disinterested motivation. The editors' euphemistic claim to editorial freedom as a way to criticize other doctors in the field proved to be a much more successful strategy during a climate in which the issue was becoming increasingly related to the loss of scientific credibility in medical publishing. Hence, the circumstances surrounding the dismissal demonstrates the specific ways in which it was possible to accuse the journal owners of violating editorial autonomy as a transgression of medical disinterestedness. Finally,

both the dismissed editors and the owners of the *CMAJ* took up surprisingly similar strategies in order to ensure editorial autonomy and scientific objectivity in their respective journals—by structurally separating the science from the business of medical publishing and by choosing an editorial board based on the moral credibility of its individual members.

Chapter 6. Conclusion: Medical Disinterestedness

Medical disinterestedness—as a way to understand the relationship between the moral and scientific imperatives in medicine in terms of a unique system of rewards, constraints and possibilities—provides an alternative to existing approaches to the study of doctors and medical professions that are either completely cynical of doctors’ claim to moral integrity or that take at entirely face-value the medical profession’s claims to altruism. Analyzing writings by and for doctors that appear in prominent medical journals in Canada allowed me to examine the specific discursive strategies that doctors used and were compelled to use—with varying degrees of success—in order to maintain their claims to scientific and moral integrity during moments when these claims were put into question. Locating medical disinterestedness in a historical framework of Foucaultian archaeology also helps to go beyond subjects contained within the domain of bioethics, such as assisted suicide and reproductive technologies, and instead to include historical events that highlight different and shifting standards of what it means to be a virtuous and scientific doctor and what constitutes a morally and scientifically legitimate medical profession. This starting point to the inquiry allowed me to examine together such vastly different historical moment as medical men’s struggle in the nineteenth century to define the limits of the medical profession and to define their ethical norms, the Saskatchewan’s medical profession’s unwillingness to support the tax-funded state-administered health insurance system in the 1950s-1960s, and the controversial firing of the senior editors of the *CMAJ* in 2006 by the publishing company. Taking medical disinterestedness as an object of analysis, instead of using established standards in bioethics or in other contemporary measures of morality and scientificness, allowed me to work with the understanding that standards of morality and scientificness in medicine are in flux, amorphous and often indistinct. Although medical disinterestedness underwrites the ethos of doctors—from the way they are expected to relate to one another to they way they are expected to understand their obligations toward their patients and the

public—it remains a moving target throughout its history, particularly in moments where its specific conditions, contents and contours are put into question and then debated.

The analysis of the three historical moments and of the editorial writings that appear in prominent medical journals in Canada during these moments demonstrates that consolidating and maintaining medical disinterestedness is neither easy nor consistent. Rather than working from fixed and absolute notions of morality and science, doctors turned to different ways of legitimizing their moral and scientific integrity depending on the kinds of pressures that they faced, whether it was to present doctors as a unified group of scientific gentlemen, to deflect accusations of elitism and self-interest, or to respond to the potential loss of the faith among doctors and clinicians in objective medical journals. The standards of what is moral and what is scientific were on shifting sands and the standards of the previous era often had to be revisited, reworked or reimagined altogether in order to respond to the immediate threats to the ideal and belief in medical disinterestedness. In these processes, doctors as a group at times had to embrace new ways of being doctors, sometimes easily and readily—as in the case of taking up public health as an object of medical knowledge in the late nineteenth century—and at other times with great reluctance and without a neat closure—as in the case of adopting public and media relations. Often, these new strategies that doctors developed in order to respond to the threats to its disinterested ideals lay the groundwork for conflicts and tensions in a future era: the public, which doctors took up as the object of their knowledge and which helped them to elevate their status in the nineteenth century, turned around and accused them of elitism and self-interest in the mid-twentieth century; participation in the media, which in the mid-twentieth century served as a way for doctors to present themselves as socially engaged, opened medicine up to the forces of media industries and journalistic standards. Hence, medical disinterestedness as *nomos* is highly generative in the sense that it produces new objects of medical knowledge and practices (e.g. public health), new practices (e.g. public and media relations) and new epistemic positions (e.g. objectivity that could be sufficiently independent from market forces and politics), at the same time that it produces new conditions for conflict, struggles and uncertainty. At the same time, however, the *nomos* of medical disinterestedness is durable and has a high degree of elasticity in the sense that it allows

the possibility of making diverse moral and scientific claims that are specific to the emergent concerns and tensions. In this sense, the *nomos* of medical disinterestedness—and perhaps *nomos* in general—is much like bureaucratic order and bureaucratic rules that Bourdieu refers to in *The Social Structures of the Economy*. In this text, he refers to the ways in which civil servants are constrained by the rules of the firm, such as laws, policies, chain of commands, etc., but also the ways in which the same rules offer a “scope of interpretation” of such rules.⁴⁴⁶ Hence, a significant part of the (bureaucratic) struggle is to claim one’s (or one’s groups’) interpretation of the rules—which corresponds to one’s and one’s group’s positioning in the field—namely the range of what is permissible and what is not, in ways that suit one’s and one’s group’s position-takings. While Bourdieu does not use the term *nomos* in this discussion, the link between the bureaucratic rule and *nomos* are not only clear and he also provides an empirical illustration of how *nomos* works within a field. When brought to the examples I have outlined in my historical analysis, it goes to show that, even in moments of crises where the scientific and moral legitimacy of doctors and of the medical profession are put in jeopardy, doctors and the medical profession struggle to interpret the rules of disinterestedness—such as gentlemanliness and rationality, public responsibility and objectivity—in order to re-establish their position as scientific and moral experts. Hence, medical disinterestedness, as an implicit and all-encompassing law and as a rule that necessarily invites interpretation, is able to adapt and to allow the medical *habitus* and the structural forces in the field of medicine to persist, albeit in slightly modified forms.

The three historical moments that I have chosen are by no means an exhaustive catalogue of the events in which medical disinterestedness came under threat in Canada. The framework that I have synthesized using Bourdieu’s concept and Foucault’s archaeological approach allows the examination of additional cases that may pertain to this type of historical telling, such as the moment preceding the professionalization of doctors when they operated in guilds and apprenticeships, doctors’ relationship to and responses to patient-advocacy movements and recent controversies about the uncomfortably close relationship between medicine and pharmaceutical industries, to

⁴⁴⁶ Bourdieu, *The Social Structures of the Economy*, 130-131.

name just a few examples. There is also the issue of the relationship between doctors and other health professions, such as nursing and pharmacy, which in the era of organized care and team-based medicine presents new pressures and possibilities as different moral and scientific standards may collide across professional boundaries. Each era and area of inquiry presents a unique set of concerns and tensions that challenge the ideal of medical disinterestedness, prompting different types of responses and strategies.

The study also raises the question of whether or not medicine constitutes its own unique field or if it is a subset of another field, i.e. the scientific field or the bureaucratic field of the state. In other words, are doctors more akin to academic scientists who also have administrative concerns or are they bureaucrats who command a high degree of technical knowledge and credibility? When thought of as a scientific field, doctors operate on the atemporal intellectual capital of biomedical science but also on the temporal bureaucratic capital in the form of hospital administration, health insurance, pensions, public relations and political lobbying. If considered in terms of a bureaucratic field, doctors would be holders of technical capital—i.e. expertise in medicine and medical care—in the state apparatus. I am inclined to conclude that medicine oscillates between the logic of these two fields and a significant part of the struggle of doctors as a group is the question of whether medicine is located in one or the other. For instance, in the 1950s-1960s, the elected government in Saskatchewan tried to pull medicine and health care into the bureaucratic space of the state, while the medical profession in the province resisted the move in order to maintain medicine's autonomy as an independent scientific enterprise, not merely a technical arm of the state. Meanwhile, medical men in the late nineteenth century aligned themselves with the state through public health as a way to establish themselves as legitimate experts in all matters of health during a historical moment in which they faced significant competition from alternative practitioners as well as suspicion from the elected government. A Bourdieuan analysis of medicine, therefore, would be most fruitful if it were mindful of this oscillation as a feature of professional medicine, instead of trying to fix medicine as one type of field or another. Such an analytic stance is truly in keeping with Bourdieu's vision of a field as a field of struggles, including the struggle to define the field in the first place. Such a stance also helps us to analyze what happens within the realm of what is considered to be

medical in ways that are attentive to the specific scientific, moral, cultural, social, political and economic struggles as they unfold, rather than beginning the analysis with a set of assumptions about doctors as a group and medicine as a practice. Such an analytic position will also be indispensable for examining the relationship that doctors as a group, or medical professions, have with the pharmaceutical industry, the biotechnology industry, the insurance industry and other health professions, such as nursing and pharmacy.

References

- Alexandroff, Max. "The Family Physician, 1955." *CMAJ* 72 (1955): 540.
- American Psychiatric Association. *DSM: History of the Manual*. n.d.
<http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual>.
- Armstrong, David. "Embodiment and ethics: constructing medicine's two bodies." *Sociology of Health and Illness* 28, no. 6 (2006): 866-881.
- Armstrong, David, and Jane Ogden. "The role of etiquette and experimentation in explaining how doctors change behavior: a qualitative study." *Sociology of Health and Illness* 28, no. 7 (2006): 951-968.
- Atlee, H. B. "CMA Public Relations and the Saskatchewan Affair." *CMAJ* 87 (1962): 878.
- Attaran, Amir. "Finding true north for the Canadian Medical Association Journal." *Lancet* 368 (2006): 1309-1311.
- Aucoin, James. *The Evolution of American Investigative Journalism*. Columbia, MO: University of Missouri Press, 2005.
- Badgley, Robin F., and Samuel Wolfe. *Doctors' Strike: Medical Care and Conflict In Saskatchewan*. New York: Atherton Press, 1967.
- Badgley, Robin F., and Samuel Wolfe. "The Doctors' Right to Strike." In *Ethical Issues in Medicine: The Role of the Physician in Today's Society*, edited by E. Fuller Torrey, 301-321. Boston: Little, Brown & Co., 1968.

- Baehre, Rainer. "The Medical Profession in Upper Canada Reconsidered: Politics, Medical Reform, and Law in a Colonial Society." *Canadian Bulletin of Medical History/Bulletin canadien d'histoire de la médecine* 12 (1995): 101-124.
- Baker, Harry. "Doctor-Patient Relationship or Doctor Public Relationship." *CMAJ* 78 (1958): 129.
- Balsamo, Anne. *Technologies of the Gendered Body: Reading Cyborg Women*. Durham: Duke University Press, 1996.
- Barthes, Roland. "Rhetoric of the Image." In *The Visual Culture Reader*, edited by Nicholas Mirzoeff, 135-138. New York: Routledge, 2002.
- Becker, Howard S., Blanche Geer, Everett C. Hughes, and Anselm L. Strauss. *Boys in White: Student Culture in Medical School*. Transaction Publishers, 1976.
- Bederman, Gail. *Manliness and Civilization: A cultural history of gender and race in the United States, 1880-1917*. Chicago: University of Chicago Press, 1995.
- Benson, Rodney, and Erik Neveu, . *Bourdieu and the Journalistic Field*. Cambridge: Polity, 2005.
- Bernier, Jacques. "Le corps médical québécois à la fin du XVIIIe siècle." Edited by Charles G. Roland. *Health, disease and medicine: essays in Canadian history : proceedings of the First Hannah Conference on the History of Medicine, McMaster University, June 3-5, 1982*. Hannah Institute for the History of Medicine, 1984. 36-64.
- Biagioli, Mario. *Galileo, Courtier: The Practice of Science in the Culture of Absolutism*. Chicago: The University of Chicago Press, 1993.
- Bilson, Geoffrey. *A Darkened House*. University of Toronto Press, 1980.

- Bilson, Geoffrey. "Canadian Doctors and the Cholera." In *Medicine in Canadian Society: Historical Perspectives*, edited by S. E. D. Shortt, 115-136. Montréal: McGill-Queen's University Press, 1981.
- Bonner, Thomas N. *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States, 1750-1945*. Cary, NC: Oxford University Press, 1996.
- Bourdieu, Pierre. *Distinction: A Social Critique of the Judgement of Taste*. Translated by Richard Nice. Cambridge MA: Harvard University Press, 1984.
- . "On the Family as a Realized Category." *Theory, Culture and Society* 13, no. 3 (1996): 19-26.
- . *Outline of a Theory of Practice*. Translated by Richard Nice. Cambridge: Cambridge University Press, 1977.
- . *Practical Reason*. Stanford: Stanford University Press, 1998.
- . *Science of Science and Reflexivity*. Translated by Richard Nice. Chicago: University of Chicago Press, 2004.
- . "Social Space and Symbolic Power." *Sociological Theory* 7, no. 1 (Spring 1989): 14-25.
- . *The Field of Cultural Production*. Edited by Randal Johnson. Columbia University Press, 1993.
- . "The Political Field, the Social Science Field, and the Journalistic Field." In *Bourdieu and the Journalistic Field*, edited by Rodney Benson and Erik Neveu, 29-47. Cambridge: Polity, 2005.
- . "The Production of Belief: Contribution to an Economy of Symbolic Goods." *Media, Culture and Society* 2 (1980): 261-293.

- . *The Social Structures of the Economy*. Translated by Chris Turner. Cambridge: Polity, 2005.
- Bourdieu, Pierre. "The Specificity of the Scientific Field and the Social Conditions of the Progress of Reason." In *The Science Studies Reader*, edited by Mario Biagioli, 31-50. New York: Routledge, 1999.
- Bowker, Geoffrey, and Leigh Starr. *Sorting Things Out: Classification and its Consequences*. Cambridge: MIT Press, 1999.
- Britten, Nicky. "Prescribing and the defence of clinical autonomy." *Sociology of Health and Illness* 23, no. 4 (2001): 478-496.
- Brookstone, Alan. "Crisis at the CMAJ." *British Columbia Medical Journal* 48, no. 3 (2006): 109.
- Callawaert, Staf. "Bourdieu, Critic of Foucault: The Case of Empirical Social Science against Double-Game Philosophy." *Theory, Culture & Society* 23 (2006): 73-98.
- Callon, Michel. "Four Models for the Dynamics of Science." In *Handbook of Science and Technology Studies*, edited by Sheila Jasanoff, Gerald E. Markle, James C. Petersen and Trevor Pinch. Thousand Oaks: Sage, 1995.
- Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. 2010.
- Canadian Medical Association. *Code of Ethics of the Canadian Medical Association*. 1938.
- . *Code of Ethics of the Canadian Medical Association*. 1948.
- . *Code of Ethics of the Canadian Medical Association*. 1956.
- . *Code of Ethics of the Canadian Medical Association*. 1928.

- . "Code of Ethics." *Canadian Medical Association*. March 2012.
<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf> (accessed February 18, 2012).
- Canadian Medical Association. *Code of Ethics of the Canadian Medical Association*. 1846.
- Canniff, William. *The Medical Profession in Upper Canada 1783 - 1850: An Historical Narrative with Original Documents relating to the Profession, including Some Brief Biographies*. Toronto: William Briggs, 1894.
- Cappon, Daniel. "CMA Public Relations and the Saskatchewan Affair." *CMAJ* 87 (1962): 625-626.
- Cartwright, Lisa. *Screening the Body: Tracing Medicine's Visual Culture*. Minneapolis: University of Minnesota Press, 1995.
- Cautin, Robert L. "A Century of Psychotherapy, 1860-1960." In *History of Psychotherapy: Continuity and Change, Second Edition*, edited by John C. Norcross, Gary R. VandenBos and Donald K. Freedheim, 3-38. Washington, DC: American Psychological Association, 2011.
- Champagne, Patrick, and Dominique Marchetti. "The Contaminated Blood Scandal: Reframing Medical News." In *Bourdieu and the Journalistic Field*, edited by Rodney Benson and Erik Neveu, 113-134. Malden, MA: Polity Press, 2005.
- Clarke, Adele, and Virginia Olsen. *Revisioning Women, Health and Healing: Feminist, Cultural and Technoscience Perspectives*. New York: Routledge, 1999.
- CMAJ Editorial Board. "A Letter from CMAJ's Editorial Board to the CMA." *CMAJ* 167 (2003): 1230.
- Coburn, David. "Canadian Medicine: Dominance or Proletarianization?" *The Milbank Quarterly* 66, no. Suppl. 2 (1988): 92-116.

- Coburn, David. "Medical Dominance Then and Now: Critical Reflections." *Health Sociology Review* 15 (2006): 432.
- Coburn, David. "State authority, medical dominance, and trends in the regulation of the health professions: The Ontario case." *Social Science & Medicine* 37, no. 2 (July 1993): 129-138.
- Coburn, David, George M. Torrance, and Joseph M Kaufert. "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine?" *International Journal of Health Services* 13, no. 3 (1983): 407-432.
- Committee on Conflict of Interest in Medical Research, Education, and Practice; Institute of Medicine. *Conflict of Interest in Medical Research, Education, and Practice*. Edited by Bernard Lo and Marilyn J. Field. Washington DC: National Academies Press, 2009.
- "Committee on Fellowship." *CMAJ* 73 (1955): 232-233.
- "Counter-petition to the Governor General." *British American Journal of Medical and Physical Science* 3 (1848): 246.
- Creative Commons. *About - Creative Commons*. n.d. <http://creativecommons.org/about>.
- Cruse, Julius M. "History of Medicine: The Metamorphosis of Scientific Medicine in the Ever-Present Past." *The American Journal of the Medical Sciences* 318 (1999): 171-180.
- Curry, Bill. "Interference Alleged at Medical Journal." *Globe and Mail*, February 22, 2006: A14.
- Daston, Lorraine, and Peter Galison. *Objectivity*. MIT Press, 2010.
- "Debate on the Thompsonian Bill." *British American Journal of Medical and Physical Science*, 1849: 26.
- Dickens, Charles. *Bleak House*. 1852.

- Duffin, Jacalyn. *History of Medicine: A Scandalously Short Introduction, Second Edition*. Toronto: University of Toronto Press, 2010.
- Duster, Troy. *Backdoor to Eugenics*. New York: Routledge, 2003.
- "Editorial Policies." *Open Medicine: A peer-reviewed, independent, open-access journal*. n.d. <http://www.openmedicine.ca/about/editorialPolicies>.
- Edwards, Bob, and Micheal W. Foley. "Civil Society and Social Capital Beyond Putnam." *American Behavioral Scientist* 42, no. 1 (1998): 12.
- Eggerston, Laura, and Barbara Sibbald. "Privacy issues raised over Plan B: women asked for names, address, sexual history." *CMAJ* 173 (2005): 1435-1436.
- Elliot, G. R. F. "Teaching of Preventative Medicine in Canada." *CMAJ* 74 (1956): 457.
- Etzioni, M. "Medical Ethics—Faith, Fossil or Way of Life?" *CMAJ* 84 (1961): 1196-1198.
- Foucault, Michel. "The Crisis of Medicine or the Crisis of Antimedicine?" *Foucault Studies* 1 (2004): 5-19.
- . *Madness and Civilization: A History of Insanity in the Age of Reason*. Translated by Richard Howard. New York: Vintage, 1988.
- . *Security, Territory, Population: Lectures at the Collège de France, 1977-1978*. Edited by Michel Senellart. Translated by Graham Burchell. New York: Palgrave, 2007.
- . *The Archaeology of Knowledge & The Discourse on Language*. Translated by A. M. Sheridan Smith. New York: Pantheon Books, 1972.
- . *The Birth of Biopolitics: Lectures at the Collège de France 1978-1979*. Edited by Michel Senellart. Translated by Graham Burchell. New York: Palgrave Macmillan, 2008.

- . *The Birth of the Clinic: An Archeology of Medical Perception*. Translated by A. M. Sheridan. London: Routledge, 2003.
- . *The History of Sexuality Volume 1: An Introduction*. Translated by Robert Hurley. New York: Vintage Books, 1990.
- Fowler, Bridget. *Pierre Bourdieu and Cultural Theory: Critical Investigations*. London: Sage, 1997.
- Fraser, F. Murray. "Let's Face the Facts." *CMAJ* 73 (1955): 306-307.
- Fraser, Susan, and Kylie Valentine. *Substance and Substitution: Methadone Subjects in Liberal Societies*. New York, Basingstoke: Palgrave Macmillan, 2008.
- Fraser, W. "Queries in Medical Ethics." *British American Journal of Medical and Physical Science* 5, no. 6 (1849): 152-156.
- Friedson, Eliot. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago: University of Chicago Press, 1970.
- Gelfand, Toby. "Who Practised Medicine in New France?: A Collective Portrait." Edited by Charles G. Roland. *Health, disease and medicine: essays in Canadian history : proceedings of the First Hannah Conference on the History of Medicine, McMaster University, June 3-5, 1982*. Hannah Institute for the History of Medicine, 1984. 16-35.
- "General Practice: General Practitioner Research." *CMAJ* 73 (1955): 684-685.
- Geyman, John. *The Corrosion of Medicine: Can the Profession Reclaim its Moral Legacy?* Monroe, ME: Common Courage Press, 2008.
- Gidney, R. D., and W. P. J. Miller. "The Origins of Organized Medicine in Ontario, 1850-1869." Edited by Charles G. Roland. *Health, disease and medicine: essays in Canadian history : proceedings of the First Hannah Conference on the History of*

- Medicine, McMaster University, June 3-5, 1982.* Hannah Institute for the History of Medicine, 1984. 65-95.
- Gilman, Sander L. "AIDS and Syphilis: The Iconography of Disease." *October* 43, AIDS: Cultural Analysis/Cultural Activism (Winter 1987): 87-107.
- Globe and Mail.* "Doctors Outside the Law." July 4, 1962: 6.
- Globe and Mail.* "Group Warns MDs to Yield by Friday." July 5, 1962: 1.
- Globe and Mail.* "The Democratic Way." July 7, 1962: 6.
- Globe and Mail.* "UK Medical Journal Oppose MD's Strike." July 13, 1962: 8.
- Godfrey, Charles M. *Medicine for Ontario: A History.* Mika Publishing Company, 1979.
- Godfrey, G. R. "The Hannah Institute: promoting Canadian history of Medicine." *CMAJ*, 1983: 1325-1328.
- Goldman, Robert. *Reading Ads Socially.* New York: Routledge, 1992.
- Goliszek, Andrew. *In the Name of Science: A History of Secret Programs, Medical Research, and Human Experimentation.* New York: St. Martin's Press, 2003.
- Grover, Jan Zita. "AIDS: keywords." In *AIDS: Cultural Analysis, Cultural Activism*, edited by Douglas Crimp, 17-30. Cambridge: MIT Press, 1988.
- Hacking, Ian. *The Social Construction of What?* Cambridge, MA, London: Harvard University Press, 1999.
- Hall, Stuart, ed. *Representation: Cultural Representations and Signifying Practices.* Thousand Oaks, CA: Sage, 1997.
- Halpenny, G. W. "We Must Build Bridges." *CMAJ* 87 (1962): 183-186.

- Halpin, H. A., M. M. Morales-Suarez-Varela, and J. M. Martin-Moreno. "Chronic Disease Prevention and the New Public Health." *The New Public Health* 32, no. 1 (2010): 120-154.
- Hammonds, Evelyn. "Towards a Genealogy of Black Female Sexuality: The Problematic Silence." In *Feminist Theory and the Body: A Reader*, edited by Janet Price and Margaret Shildrick, 245-259. New York: Routledge, 1997.
- Hammonds, Evelyn. "New Technologies of Race." In *Processed Lives: Gender and Technology in Everyday Life*, edited by Jennifer Terry and Melodie Calvert, 108-121. New York: Routledge, 1997.
- Hamowy, Ronald. *Canadian Medicine: A study in restricted entry*. The Fraser Institute, 1984.
- Hanley, F. W. "Ethics, the Doctor and the Social Scientist." *CMAJ* 73 (1955): 849.
- Hanson, Dana. "Questions of Trust." *CMAJ* 167 (2002): 986.
- Harrison, C. P. "Fluoridation." *CMAJ* 81 (1959): 128.
- "Health Education of the public in Canada." *CMAJ* 85 (1961): 1008.
- Heath, Robert L., Elizabeth L Toth, and Damion Waymer, . *Rhetorical and Critical Approaches to Public Relations Vol. 2*. New York: Routledge, 2009.
- Higgins, G. K. "Universal Health Insurance: A Problem of Minority Rights." *CMAJ* 87 (1962): 1383.
- Hightower, Renady. "Ethnography of the habitus of the emergency physician." PhD Dissertation, Wayne State University, 2010.
- Hodges, Francis T. "Public Relations Forum: Medicine's Seven Deadly Sins." *CMAJ* 76 (1957): 660.

- Hoey, John, et al. "Science, Sex and Semantics: The firing of George Lundberg." *CMAJ* 160 (1999): 508.
- Hollobon, Joan. "A Prairie Doctor and His Conscience." *Globe and Mail*, July 4, 1962: 7.
- Holmes, L. W. "A Code of Cooperation." *CMAJ* 76 (1957): 891.
- Holmes, L. W. "Ambassadors of Goodwill." *CMAJ* 73 (1955): 683-684.
- Holmes, L. W. "Doctors and Dollars." *CMAJ* 73 (1955): 982.
- Holmes, L. W. "Preventative PR." *CMAJ* 76 (1957): 229.
- Holmes, L. W. "Public Attitudes Towards Doctors. V." *CMAJ* 76 (1957): 144-146.
- Holmes, L. W. "The Doctor and the Press." *CMAJ* 74 (1956): 224.
- Holmes, L. W. "The Doctor Speaks." *CMAJ* 74 (1956): 396-394.
- Holmes, L. W. "The Five W's of Medical Public Relations." *CMAJ* 73 (1955): 484-485.
- Houston, C. Stuart. "Saskatchewan's municipal doctors a forerunner of the medicare system that developed 50 years later." *CMAJ* 151 (1995): 1643.
- Howell, Colin D. "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Medical Professionalism." Edited by Charles G. Roland. *Health, disease and medicine: essays in Canadian history : proceedings of the First Hannah Conference on the History of Medicine, McMaster University, June 3-5, 1982*. Hannah Institute for the History of Medicine, 1984. 105-122.
- Iggers, Jeremy. "Contemporary Ethical Concepts in Historical Context." In *Good News, Bad News: Journalism Ethics and the Public Interest*, 57-73. Boulder, CO: Westview Press, 1999.
- "Is Medicine Still A Profession?" *CMAJ* 174 (2006): 743.

- J., V. W. "General Practice: The Family Doctor." *CMAJ* 74 (1956): 479-480.
- Jackall, Robert, and Janice Hirota. *Image Makers: Advertising, Public Relations and the Ethos of Advocacy*. University of Chicago Press, 2000.
- Japsen, Bruce. "New England Journal of Medicine Fires Top Editor." *Chicago Tribune*, July 27, 1999.
- Jecker, Nancy S., Albert R. Jonsen, and Robert A. Pearlman. *Bioethics: An Introduction to the History, Methods, and Practice 2nd Edition*. Toronto: Jones and Bartlett Publishers, 2007.
- Johnson, George. "Can Science Prove the Existence of God?" *The New York Times*, November 11, 2003.
- Jonsen, Albert R. "'A History of Bioethics as Discipline and Discourse'." In *Bioethics: An Introduction to the History, Methods and Practice*, edited by Nancy S. Jecker, Albert R. Jonsen and Robert A. Pearlman, 3-16. Sudbury: Jones And Bartlett, 2007.
- Kassirer, Jerome P., Frank Davidoff, Kathryn O'Hara, and Donald A. Redelmeier. "Editorial autonomy of *CMAJ*." *CMAJ* 174 (2006): 945-950.
- Keen, Eddie. "My Patients Come First, Says One Non-Striker." *The Vancouver Province*, July 3, 1962: 2.
- Kelly, A. B. "The Saskatchewan Situation: One Man's View." *CMAJ* 87 (1962): 1114.
- Kelly, A. D. "The General Secretary Replies." *CMAJ* 87 (1962): 626-627.
- Kelly, A. D. "The Saskatchewan Situation: One Man's View." *CMAJ* 87 (1962): 1113.
- Keränen, Lisa. *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research*. Tuscaloosa: The University of Alabama Press, 2010.
- Kieran, Matthew. *Media Ethics*. New York: Routledge, 1998.

- Kim, Kyung-Man. "What would a Bourdieuan sociology of scientific truth look like?" *Social Science Information* 48, no. 1 (March 2009): 57-79.
- King, Samantha. *Pink Ribbon, Inc.: Breast Cancer and the Politics of Philanthropy*. Minneapolis : University of Minnesota Press, 2006.
- Knorr-Cetina, K. D. "New Developments in Science Studies: The Ethnographic Challenge." *The Canadian Journal of Sociology* 8, no. 2 (1983): 153-177.
- Kondro, Wayne, and Barbara Sibbald. "Tony Clement Appointed as Canada's New Health Minister." *CMAJ* 174 (2006): 754.
- Koyl, L. F. "Have We Missed the Boat?" *CMAJ* 74 (1956): 300.
- Latour, Bruno. *Pasteurization of France*. Translated by Alan Sheridan and John Law. Cambridge: Harvard University Press, 1988.
- Leblond, Sylvio. "La Médecine dans la province de Québec avant 1841." *Les Cahiers des dix* 35 (1970): 65-95.
- LeRiche, W. Harding. "The Family Physician: A Vanishing Canadian?" *CMAJ* 73 (1955): 572.
- Lovell, Terry. "Bourdieu, Class and Gender: The Return of the Living Dead?" *The Sociological Review* 52 (2004): 35-56.
- Luke, Haida. *Medical Education and Sociology of Medical Habitus: "It's Not About the Stethoscope!"*. Kluwer Academic Publishers, 2003.
- MacDermot, H.E. *History of the Canadian Medical Association 1867 - 1921*. Canadian Medical Association, 1935.
- MacDonald, Noni, et al. "Editorial Independence for CMAJ: Signposts along the road." *CMAJ* 175 (2006): 453.

- Malik, Kenan. *The Meaning of Race: Race, History, and Culture in Western Society*. New York: New York University Press, 1996.
- Marchildon, Gregory P., and Klaartje Schirjvers. "Physician Resistance and the Forging of Public Healthcare: A Comparative Analysis of the Doctors' Strikes in Canada and Belgium in the 1960s." *Medical History* 55 (2011): 219.
- "Marijuana: Federal Smoke Clears a Little." *CMAJ* 164 (2001): 1397.
- Maskalyk, James. "Why Open Medicine?" *Open Medicine* 1 (2007): E1.
- McGoey, Linsey. "Pharmaceutical Controversies and The Performative Value of Uncertainty." *Science as Culture* 18 (2009): 151-164.
- McIlroy, Anne. "How a Battle for Editorial Independence Came to Cost So Much." *Globe and Mail*, April 1, 2006: A4.
- McKinlay, John, and Joan Arches. "Towards the Proletarianization of Physicians." *International Journal of Health Services* 15 (1985): 161-195.
- McTavish, Lianne. *Childbirth and the Display of Authority in Early Modern France*. Ashgate, 2005.
- MD Physician Services. *Who We Are | MD Physician Services*. n.d. <https://mdm.ca/about-md/who-we-are/index.asp> (accessed December 12, 2012).
- Médecins Sans Frontières/Doctors Without Borders. *History & Principals - Doctors Without Borders*. n.d. <http://www.doctorswithoutborders.org/aboutus/> (accessed December 21, 2012).
- "Medicine and Morals." *CMAJ* 81 (1959): 744.
- Mialet, Hélène. "The 'Righteous Wrath' of Pierre Bourdieu." *Social Studies of Science* 33, no. 4 (2003): 613-621.
- Millar, G. J. "Skip the Health Lesson, Teacher!" *CMAJ* 86 (1962): 647.

- Mitchinson, Wendy. "Canadian Medical History: Diagnosis and Prognosis." *Acadiensis* 12 (1982): 125-135.
- Mol, Annmarie. *The Logic of Care: Health Care and the Problem of Choice*. Abingdon, Oxon, New York: Routledge, 2008.
- Montgomery, Kathryn. *How Doctors Think: Clinical Judgement and the Practice of Medicine*. Oxford University Press USA, 2006.
- Myles, John. *Bourdieu, Language and the Media*. New York: Palgrave Macmillan, 2010.
- Navarro, Vicente. *Medicine Under Capitalism*. Prodist, 1976.
- Navarro, Vicente. "Professional Dominance or Proletarianization?: Neither." *The Milbank Quarterly* 66 (Suppl. 2) (1988): 57-75.
- Naylor, C. David. *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911-1966*. Montréal & Kingston: McGill-Queen's University Press, 1986.
- Neatby, Hilda. "The Medical Profession in the North-West Territories." In *Medicine in Canadian Society: Historical Perspectives*, edited by S. E. D. Shortt, 165-188. Montréal: McGill-Queen's University Press, 1981.
- Nettleton, Sarah, Roger Burrows, and Ian Watt. "Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge." *Sociology of Health & Illness* 30, no. 3 (April 2008): 333-348.
- Nye, Robert. "Medicine and Science as Masculine 'Fields of Honor'." *Osiris* 12 (1997): 60-79.
- "Open Access in Medical Publishing: Trends and countertrends." *CMAJ* 172 (2005): 149.
- Osborne, Thomas. "Medicine and epistemology: Michel Foucault and the liberality of clinical reason." *History of the Human Sciences* 5, no. 2 (1992): 63-93.

- Osler, William. "Internal Medicine as a Vocation." *Medical News* 71 (1897): 660.
- Ostherr, Kirsten. *Cinematic Prophylaxis*. Durham: Duke, 2005.
- Pasternak, Boris. *Doctor Zhivago*. 1957.
- Patton, Cindy. "Introduction: Foucault after Neoliberalism; or, The Clinic Here and Now." In *Rebirth of the Clinic: Places and Agents in Contemporary Health Care*, edited by Cindy Patton, ix - xx. Minneapolis: University of Minnesota Press, 2010.
- . *Inventing AIDS*. New York: Routledge, 1990.
- . *Sex and Germs: The Politics of AIDS*. Boston: South End Press, 1985.
- Patton, Cindy, and John Liesch. "In Your Face." In *Cosmetic Surgery: A Feminist Primer*, edited by Cressida J. Hayes and Meredith Jones, 209-224. Farnham, England; Burlington, VT: Ashgate, 2009.
- Percival, Thomas. *Medical Ethics: Or, a Code of Institutes and Precepts, adapted to the Professional Conduct of Physicians and Surgeons*. Manchester: S. Russell, 1803.
- Petryna, Adriana. "Ethical Variability: Drug Development and Globalizing Clinical Trials." *American Ethnologist* 32 (2006): 183-197.
- Petryna, Adriana. "Globalizing Human Subject Research." In *Global Pharmaceuticals*, edited by Adriana Petryna, Andrew Lakoff and Arthur Kleinman, 33-60. Durham: Duke University Press, 2006.
- Porter, Dorothy. "How Did Social Medicine Evolve and Where Is It Heading?" *PLoS Medicine* 3, no. 10 (2006): 1667-1672.
- "Professional Etiquette." *British American Journal of Medical and Physical Science* 1, no. 11 (1846): 306-307.

- Protest, David L., et al. *The Journalism of Outrage: Investigative Reporting and Agenda Building in America*. New York: Guilford Press, 1991.
- Purtell, Robert F. "General Practice: General Practitioners' Duty as Medical Teachers." *CMAJ* 73 (1955): 750.
- "Québec's Bill 114." *CMAJ* 167 (2002): 986.
- Rabson, L. R. "The People's Health—Whose Responsibility?" *CMAJ* 88 (1963): 198.
- Reid, J. W. "Acceptance of Payments from a Third Party." *CMAJ* 88 (1962): 819.
- Robertson, Alexander. "A Commentary on Sociology in the Medical School." *CMAJ* 84 (1961): 704.
- Robertson, Alexander. "The Place of Social Medicine." *CMAJ* 82 (1960): 724.
- Rose, Nikolas S. *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press, 2007.
- Ruhl, P. Lealle. "Liberal Governance and Prenatal Care." *Economy and Society* 28 (1999): 95-117.
- "Sacking of CMAJ editors is deeply troubling." *Lancet* 367 (2006): 704.
- "Schoolmasters to the Nation." *CMAJ* 74 (1962): 1030.
- Shah, Nyan. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown*. University of California Press, 2009.
- Shapin, Steven. *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*. Princeton: Princeton University Press, 1985.
- . *The Scientific Life: A Moral History of a Late Modern Vocation*. Chicago: The University of Chicago Press, 2008.

- Shortt, S. E. D. "Antiquarians and Amateurs: Reflections on the Writing of Medical History." In *Medicine in Canadian Society. Historical Perspectives*, edited by SED Shortt, 1-18. McGill-Queen's University Press, 1981.
- . "'Before the Age of Miracles': The Rise, Fall and Rebirth of General Practice in Canada, 1890-1940." Edited by Charles G. Roland. *Health, disease and medicine: essays in Canadian history : proceedings of the First Hannah Conference on the History of Medicine, McMaster University, June 3-5, 1982*. Hannah Institute for the History of Medicine, 1984. 123-152.
- Shortt, S. E. D. "Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century." *Medical History* 27 (1983): 51-68.
- Shuchman, Miriam, and Donald A. Redelmeier. "Politics and Independence – The Collapse of the Canadian Medical Association Journal." *New England Journal of Medicine* 354 (2006): 1339.
- Sinclair, Gordon A. "Why Has the Canadian Medical Association a Public Relations Program?" *CMAJ* 78 (1958): 359-360.
- Sismondo, Sergio. *An Introduction to Science and Technology Studies*. Malden: Blackwell, 2004.
- Smith, Richard. *Trouble with Medical Journals*. London: The Royal Society of Medicine Press, 2006.
- Sohl, P., and H. A. Bassford. "Codes of Medical Ethics: Traditional Foundations and Contemporary Practice." *Social Science of Medicine* 22 (1986): 1175-1179.
- Sontag, Susan. *AIDS and its Metaphors*. New York: Farrar, Straus, Giroux, 1989.
- Sparks, Tabitha. *The Doctor in the Victorian Novel*. Burlington, VT: Ashgate, 2009.

- Spurgeon, David. "Authors Threaten to Withhold Articles from the CMAJ." *British Medical Journal* 332, no. 7545 (2006): 812.
- Starfield, B., J Hyde, J Gervas, and I. Heath. "The Concept of Prevention: A Good Idea Gone Astray?" *Journal of Epidemiological Community Health* 62 (2008): 580-583.
- Starr, Paul. *The Social Transformation of American Medicine*. Basic Books, 1983.
- Steinbrook, Robert. "Turning the Page at the CMAJ." *New England Journal of Medicine* 355 (2006): 547.
- Stone, Deborah A. "The Doctor as Businessman: The Changing Politics of a Cultural Icon." *Journal of Health Politics, Policy and Law* 22, no. 2 (April 1997): 533-556.
- Strong-Boag, Veronica. "Canada's Women Doctors: Feminism Constrained." In *Medicine in Canadian Society: Historical Perspectives*, edited by S. E. D. Shortt, 207-236. Montréal: McGill-Queen's University Press, 1981.
- Sturken, Marita, and Lisa Cartwright. "Scientific Looking and Looking at Science." In *Practices of Looking: An introduction to visual culture*, 279-314. New York: Oxford University Press, 2001.
- Tanne, Janice Hopkins. "JAMA's editor fired over sex article." *British Medical Journal* (318), 1999: 213.
- Taylor, Malcolm G. *Health Insurance and Canadian Public Policy*. Montréal & Kingston: McGill-Queen's University Press, 2009.
- "The Central Board of Health." *British American Journal of Medical and Physical Science* 5 (1849): 75.
- The College of Family Physicians. *College History*. n.d.
<http://www.cfpc.ca/CollegeHistory/>.

- "The Doctors' Position - A Presentation of the Saskatoon and District Medical Society presented over CFQC - TV Friday June 1, 1962." *Medicare: A People's Issue - Saskatchewan Council for Archives and Archivists*. n.d.
http://scaa.sk.ca/gallery/medicare/en_display.php?ref=en_doc-strike&max=113&dir=doctors-strike&img=99.
- "The Doings of the 'Repeal Association'." *British American Journal of Medical and Physical Science* 3 (1848): 277.
- "The Duties of the Government of Our Profession." *Dominion Medical Journal* 1 (1868): 49.
- "The Editorial Autonomy of CMAJ." *CMAJ* 174 (2006): 9.
- "The Hammer and the Heritage." *CMAJ* 87 (1962): 303.
- "The Homeopaths and Eclectics." *British American Journal of Medical and Physical Science* 2 (1869): 27.
- "The Homeopaths and Eclectics." *British American Journal of Medical and Physical Science* 1 (1868): 230.
- "The Medical Bill and the School of Medicine of Montréal." *British American Journal of Medical and Physical Science* 2 (1846): 21.
- "The Ministry and the Board of Health." *British American Journal of Medical and Physical Science* 5 (1850): 303.
- The Province*. "Crowd Size in Dispute." July 12, 1962: 1.
- "The Public Health." *British American Journal of Medical and Physical Science* 5 (1849): 52.
- "The Social Scientist and the Hospital." *CMAJ* 72 (1955): 857.
- "The Therapeutic Value of Talk." *CMAJ* 77 (1957): 888.

- Thompson, Stephen L., and J. Warren Salmon. "Strikes by Physicians: A Historical Perspective Toward an Ethical Evaluation." *International Journal of Health Services* 36, no. 2 (2006): 331-354.
- "Thompsonian Petitions to the Legislative Assembly." *British American Journal of Medical and Physical Science*, 1847: 80.
- Thorne, Sally E., Susan R. Harris, Karen Mahoney, Andrea Con, and Liza McGuinness. "The Context of Health Care Communication in Chronic Illness." *Patient Education and Counseling* 54 (2004): 299-306.
- Tollefson, E. A. *Bitter Medicine: The Saskatchewan Medicare Feud*. Saskatoon, SK: Modern Press, 1964.
- Torrance, George M. "Socio-Historical Overview." In *Health and Canadian Society: Sociological Perspectives*, edited by David Coburn, Carl D'Arcy and George M. Torrance, 12. Fitzhenry & Whiteside, 1987.
- Treichler, Paula, Lisa Cartwright, and Constance Penley. *The Visible Woman: Imaging Technologies, Gender and Science*. New York: New York University Press, 1998.
- Treichler, Paula A. *How to Have a Theory in an Epidemic: Cultural Chronicles of AIDS*. Durham: Duke University Press, 1999.
- Tuchman, Gaye. "Objectivity as Strategic Ritual: An examination of newsmen's notions of objectivity." *American Journal of Sociology* 77 (1972): 661.
- Tunis, Barbara. "Medical Education and Medical Licensing in Lower Canada: Demographic Factors, Conflict and Social Change." *Histoire sociale/Social History* 27 (May 1981): 67-91.
- Tunis, Barbara R. "Medical Licencing in Lower Canada: The Disputes Over Canada's First Medical Degree." In *Medicine in Canadian Society: Historical Perspectives*, edited by S. E. D. Shortt, 137-164. Montréal: McGill-Queen's University Press, 1981.

- Tyndel, M. "The Role of the General Practitioner in Psychiatry." *CMAJ* 82 (1960): 324.
- Underhill, Paul. "Alternative Views of Science in Intra-Professional Conflict: General Practitioners and the Medical and Surgical Elite." *Journal of Historical Sociology* 5, no. 3 (1992): 322-350.
- "Unjust Laws Exist." *CMAJ* 87 (1962): 190.
- Vogel, Martin. "Sacking of CMAJ Editors." *Lancet* 367 (2006): 1486.
- Wacquant, Loïc J. D. *An Invitation to Reflexive Sociology*. Chicago: The University of Chicago Press, 1992.
- Webster, Paul. "Canadian researchers repond to CMAJ Crisis." *Lancet* 367 (2006): 1134.
- Webster, Paul. "Canadian Researchers Respond to CMAJ Crisis." *Lancet* 367, no. 9517 (2006): 1133-1134.
- Weininger, Elliot B., and Annette Lareau. "Translating Bourdieu into the American Context: The Question of Social Class and Family-School Relations." *Poetics* 31, no. 5-6 (2003): 375-402.
- Weir, Lorna. *Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subject*. London: Routledge, 2006.
- Wellman, Marvin. "On the Practice of Medicine." *CMAJ* 79 (1958): 189.
- Wendell, Susan. *Rejected Body: Feminist Philosophical Reflections on Disability*. New York: Routledge, 1996.
- West, Candace. "When the Doctor is a "Lady": Power, Status and Gender in Physician-Patient Encounters." *Symbolic Interaction* 7, no. 1 (Spring 1984): 87-106.
- Whitaker, Robert. "Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America." *Ethical Human Psychology and Psychiatry* 7, no. 1 (2005): 23-35.

William, A. Paul, Eugene Vayda, Mary L. Cohen, Christel A. Woodward, and Barbara M. Ferrier. "Medicine and the Canadian State: From the Politics of Conflict to the Politics of Accommodation?" *Journal of Health and Social Behavior* 36, no. 4 (1995): 303-321.

Williams, Simon J. "Theorising Class, Health and Lifestyles: Can Bourdieu Help Us?" *Sociology of Health and Illness* 17, no. 5 (1995): 577-604.

Williamson, Judith. *Decoding Advertisements: Ideology and Meaning in Advertising*. New York: Mario Boyars Publishers, 1978.

Willis, Evan. "Introduction: Taking Stock of Medical Dominance." *Health Sociological Review* 15 (2006): 421.

—. *Medical Dominance: The Division of Labour in Australian Health Care*. Allen & Unwin, 1983.