THE DISCIPLINE OF DOCTORS IN MANITOBA

BY

EDMUND G. A. SCHOLLENBERG

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Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF LAWS

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- Clergy 0319
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Theology 0469

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- Archaeology 0324
- Cultural 0326
- Physical 0327

Business Administration
- General 0310
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- Banking 0770
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Economics
- General 0501
- Agricultural 0503
- Commerce-Business 0505
- Finance 0508
- History 0509
- Labor 0510
- Theory 0511

Folklore 0358
Geography 0366
Gerontology 0351
History
- General 0578
- Ancient 0579
- Medieval 0581
- Modern 0582
- Black 0328
- African 0331
- Asia, Australia and Oceania 0332
- Canadian 0334
- European 0335
- Latin American 0336
- Middle Eastern 0333
- United States 0337

History of Science 0585
Law 0398
Political Science
- General 0615
- International Law and Relations 0616
- Public Administration 0617

Recreation 0814
Social Work 0452
Sociology
- General 0626
- Criminology and Penology ... 0627
- Demography 0938
- Ethnic and Racial Studies 0631
- Individual and Family Studies 0628
- Industrial and Labor Relations 0629
- Public and Social Welfare 0630
- Social Structure and Development 0700
- Theory and Methods 0344

Transportation 0709
Urban and Regional Planning 0999
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- Animal Pathology 0476
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- Forestry and Wildlife 0478
- Plant Culture 0479
- Plant Pathology 0480
- Plant Physiology 0817
- Range Management 0777
- Wood Technology 0746

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- General 0306
- Anatomy 0287
- Biostatistics 0308
- Botany 0309
- Cell 0379
- Ecology 0329
- Entomology 0353
- Genetics 0369
- Limnology 0793
- Microbiology 0410
- Molecular 0307
- Neuroscience 0317
- Oceanography 0416
- Physiology 0433
- Radiation 0821
- Veterinary Science 0778
- Zoology 0472

Biophysics
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- Medical 0760

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Geochemistry 0996
Geodesy 0370
Geology 0372
Geophysics 0373
Hydrology 0388
Mineralogy 0411
Paleobotany 0345
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Paleontology 0418
Paleozoology 0985
Palynology 0427
Physical Geography 0368
Physical Oceanography 0415

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Environmental Sciences 0768
Health Sciences
- General 0566
- Audiology 0300
- Chemotherapy 0992
- Dentistry 0567
- Education 0350
- Hospital Management 0769
- Human Development 0758
- Immunology 0982
- Medicine and Surgery 0564
- Mental Health 0347
- Nursing 0569
- Nutrition 0570
- Obstetrics and Gynecology .. 0380
- Occupational Health and Therapy 0354
- Ophthalmology 0381
- Pathology 0571
- Pharmacology 0419
- Pharmacy 0572
- Physical Therapy 0382
- Public Health 0573
- Radiology 0574
- Recreation 0575
- Speech Pathology 0460
- Toxicology 0383

Home Economics 0386

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Chemistry
- General 0485
- Agricultural 0749
- Analytical 0486
- Biochemistry 0487
- Inorganic 0488
- Nuclear 0738
- Organic 0490
- Pharmaceutical 0491
- Physical 0494
- Polymer 0495
- Radiation 0754

Mathematics 0405
Physics
- General 0605
- Acoustics 0986
- Astronomy and Astrophysics 0606
- Atmospheric Science 0608
- Atomic 0748
- Electronics and Electricity 0607
- Elementary Particles and High Energy 0798
- Fluid and Plasma 0759
- Molecular 0609
- Nuclear 0610
- Optics 0752
- Radiation 0756
- Solid State 0611

Statistics 0463

Applied Sciences
Applied Mechanics 0346
Computer Science 0984
Engineering
- General 0537
- Aerospace 0538
- Agricultural 0539
- Automotive 0540
- Biomedical 0541
- Chemical 0542
- Civil 0543
- Electronics and Electrical 0544
- Heat and Thermodynamics ... 0348
- Hydraulic 0545
- Industrial 0546
- Marine 0547
- Materials Science 0794
- Mechanical 0548
- Metallurgy 0743
- Mining 0551
- Nuclear 0552
- Packaging 0549
- Petroleum 0765
- Sanitary and Municipal 0554
- System Science 0790

Geotechnology 0428
Operations Research 0796
Plastics Technology 0795
Textile Technology 0994

PSYCHOLOGY
General 0621
Behavioral 0384
Clinical 0622
Developmental 0620
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Enseignement primaire. 0524
Enseignement professionnel 0747
Enseignement religieux 0527
Enseignement secondaire 0533
Enseignement spécial 0529
Enseignement supérieur 0745
Évaluation 0288
Finances 0277
Formation des enseignants 0530
Histoire de l'éducation 0520
Langues et littérature 0279
Lecture 0535
Mathématiques 0280
Musique 0522
Orientation et consultation 0519
Philosophie de l'éducation 0998
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Théologie 0469

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- Culturelle 0326
- Physique 0327

Droit 0398
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- Commerce-Affaires 0505
- Économie agricole 0503
- Économie du travail 0510
- Finances 0508
- Histoire 0509
- Théorie 0511

Études américaines 0323
Études canadiennes 0385
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Folklore 0358
Géographie 0366
Gérontologie 0351
Gestion des affaires
- Généralités 0310
- Administration 0454
- Banques 0770
- Comptabilité 0272
- Marketing 0338

Histoire
- Histoire générale 0578
- Ancienne 0579
- Médiévale 0581
- Moderne 0582
- Histoire des noirs 0328
- Africaine 0331
- Canadienne 0334
- États-Unis 0337
- Européenne 0335
- Moyen-orientale 0333
- Latino-américaine 0336
- Asie, Australie et Océanie 0332

Histoire des sciences 0585
Loisirs 0814
Planification urbaine et régionale 0999
Science politique
- Généralités 0615
- Administration publique 0617
- Droit et relations internationales 0616

Sociologie
- Généralités 0626
- Aide et bien-âtre social 0630
- Criminologie et établissements pénitentiaires 0627
- Démographie 0938
- Études de l' individu et de la famille 0628
- Études des relations interethniques et des relations raciales 0631
- Structure et développement social 0700
- Théorie et méthodes. 0344
- Travail et relations industrielles 0629

Transports 0709
Travail social 0452

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- Généralités 0473
- Agronomie. 0285
- Alimentation et technologie alimentaire 0359
- Culture 0479
- Élevage et alimentation 0475
- Exploitation des pâturages 0777
- Pathologie animale 0476
- Pathologie végétale 0480
- Physiologie végétale 0817
- Sylviculture et faune 0478
- Technologie du bois 0746

Biologie
- Généralités 0306
- Anatomie 0287
- Biologie (Statistiques) 0308
- Biologie moléculaire 0307
- Botanique 0309
- Cellule 0379
- Écologie 0329
- Entomologie 0353
- Génétique 0369
- Limnologie 0793
- Microbiologie 0410
- Neurologie 0317
- Océanographie 0416
- Physiologie 0433
- Radiation 0821
- Science vétérinaire 0778
- Zoologie 0472

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- Généralités 0786
- Medicale 0760

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Biogéochimie 0425
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Géographie physique 0368
Géologie 0372
Géophysique 0373
Hydrologie 0388
Minéralogie 0411
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Paléobotanique 0345
Paléoécologie 0426
Paléontologie 0418
Paléozoologie 0985
Palynologie 0427

SCIENCES DE LA SANTÉ ET DE L'ENVIRONNEMENT
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Sciences de l'environnement 0768
Sciences de la santé
- Généralités 0566
- Administration des hôpitaux 0769
- Alimentation et nutrition 0570
- Audiologie 0300
- Chimiothérapie 0992
- Dentisterie 0567
- Développement humain 0758
- Enseignement 0350
- Immunologie 0982
- Loisirs 0575
- Médecine du travail et thérapie 0354
- Médecine et chirurgie 0564
- Obstétrique et gynécologie 0380
- Ophtalmologie 0381
- Orthophonie 0460
- Pathologie 0571
- Pharmacie 0572
- Pharmacologie 0419
- Physiothérapie 0382
- Radiologie 0574
- Santé mentale 0347
- Santé publique 0573
- Soins infirmiers 0569
- Toxicologie 0383

SCIENCES PHYSIQUES
Sciences Pures
Chimie
- Généralités 0485
- Biochimie 487
- Chimie agricole 0749
- Chimie analytique 0486
- Chimie minérale 0488
- Chimie nucléaire 0738
- Chimie organique 0490
- Chimie pharmaceutique 0491
- Physique 0494
- PolymÇres 0495
- Radiation 0754

Mathématiques 0405
Physique
- Généralités 0605
- Acoustique 0986
- Astronomie et astrophysique 0606
- Électronique et électricité 0607
- Fluides et plasma 0759
- Météorologie 0608
- Optique 0752
- Particules (Physique nucléaire) 0798
- Physique atomique 0748
- Physique de l'état solide 0611
- Physique moléculaire 0609
- Physique nucléaire 0610
- Radiation 0756

Statistiques 0463

Sciences Appliqués Et Technologie
Informatique 0984
Ingénierie
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- Agricole 0539
- Automobile 0540
- Biomédicale 0541
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- Conditionnement (Emballage) 0549
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- Génie chimique 0542
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- Génie électronique et électrique 0544
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- Génie mécanique 0548
- Génie nucléaire 0552
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Textiles et tissus (Technologie) 0794

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Personnalité 0625
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CONTENTS

ABSTRACT

The medical profession has acquired a high level of autonomy. The history of this acquisition in England, Canada, and the United States suggests that different paths will lead to similar results. This challenges attempts at a single theory of professional development. Against this background the history of medical licensure in Manitoba is traced. After noting the important non-disciplinary issues of the past, a detailed archival record of disciplinary proceedings in Manitoba over a century is presented. The priorities in this area have shifted in focus from largely intraprofessional concerns to those more responsive to patients. Limited data available from elsewhere suggests this material is fairly representative of the profession at large. Several other countries are also noted to have similar degrees of medical autonomy. Whether this autonomy preceded or flowed from the socioeconomic status of physicians is unclear. Arguably, status, income, and autonomy are concordant in professional development, at least with regard to the medical profession. Finally, some recent trends in disciplinary issues and the prospect for further evolution are discussed.

I. INTRODUCTION

The province of Manitoba was only a few months old when its political leaders granted the physicians of the province the right to regulate their profession. This paper is an attempt to extract, from primary sources, the story of the acquisition and application of that power.

Such a chronology might have some interest of itself, but clearly some attempt must be made to place this anecdotal research in context. To that end reference can be made to made to a small amount of roughly comparable material on professional discipline, to various histories of Canadian medicine, and, to an admittedly limited extent, to various commentators on professionalism in general. Whether conclusions may flow obviously depends on the comparability of the analysis.

It might, at this point, be useful to note the following definitions or descriptions of "profession":

> A vocation in which the professed knowledge of some branch of learning is used in its application to the affairs of others, or in the practice of an art based upon it.[1]

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1 *Oxford Shorter Dictionary*, as discussed in Everett C. Hughes, "Professions" in *The Professions in America* (ed. Kenneth S. Lynn), 1965.
Hughes also defines *professionalization* as "the collective effort of an organized occupation to improve its place and increase its power in relation to others", in Everett C. Hughes, "The Social

1) a shared sense of identity
2) the fact that few leave after initial entrance
3) shared values
4) a shared definition of how one acts to members and non-members
5) a common language
6) the power over individual members
7) a distinct way of socializing new generations[2]

> . . . a systematic body of highly developed technical knowledge; a strong norm of autonomy that emphasizes self-regulation; a norm of altruism that submerges self-interest and emphasizes service; the need for extensive authority over clients; a distinct occupational culture; and, finally, recognition of professional status by social, political, and economic elites.[3]

While these views emphasize the functional elements of a profession, others have tended to look at how a profession develops, that is, the process of professionalization:

1) A professional association must be established.
2) There must be a change of name which dissociates the occupation from its previous non-professional status and provides it with a title which is its exclusive domain.
3) There is the development and adoption of a code of ethics.

Significance of Professionalization" in *Professionalization* (eds. Howard M. Vollmer and D. L. Mills), 1966

2 William J. Goode, "Community within a Community: The Professions" (1957), 22 Am. Soc. Rev. 194 William J. Goode, "Encroachment, Charlatatanism, and the Emerging Profession: Psychology, Sociology and Medicine" (1960), 25 Am. Soc. Rev. 902; But see Julius A. Roth, "Professionalism: The Sociologist's Decoy" (1974), 1 *Sociology of Work and Occupations* 6

3 Marilynn Rosenthal, *Dealing with medical malpractice: The British and Swedish experience*, 1988, at 39. See also Everett C. Hughes, *Men and their Work*, 1958; Ernest Greenwood, "Attributes of a Profession" (1957), 2 *Social Work* 45

4) there is political agitation to gain popular and legal support and the setting up of a mechanism controlled by the profession to train new members.[4]

By the time physicians in Manitoba were given the right to govern themselves they were, for most purposes, clearly a profession. They would already have met most of the definitional demands above. Thus we can look at the acquisition of autonomy, especially compared to elsewhere, at the use made of this power, at how autonomy was maintained, and at how the profession reacted to threats and strains.

From those reference points, the first focus will be the acquisition of self regulation. Physicians themselves have always felt they alone had the competence to regulate their own. Put another way, they earned this right by demonstrating their rigorous training and high moral commitment to public service. This was evidence, they would claim, that their profession could police itself without significant supervision by society. This, to take one view, is what being a professional was all about.[5]

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4 Theodore Caplow, *The Sociology of Work*, 1954, at 139
5 Talcott Parsons, "Professions" (1968), 12 Int. Encyc. Social Sciences 536

This argument that they could be trusted was also reinforced by another aspect of professional development. Professionals, and perhaps physicians in particular, are in a tremendous position to take advantage of their clients. The fact that they "normally" do not is further evidence, they would claim, of their high purposes. In short, they can be "trusted", both as individual practitioners and collectively.[6] Argued another way though, it might seem that these rebuked opportunities for exploitation do not of themselves imply so much as does the social prestige which might follow from this altruistic denial of normal human impulses.[7]

Along the same lines is the argument, also self-evident to physicians, that they are performing a valuable service to society. This value would be appreciated by all and, as a consequence, the profession would not suffer any political interference in its affairs.[8] Thus it would seem incidental that other rewards, such as income and status, would follow.

Others would dispute this sequence. Carr-Saunders, and later Larson, would assert that remuneration and

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6 Goode, *supra* n. 2, at 196
7 Bernard Blishen, *Doctors & Doctrines* , 1969, at 16
8 Donald J. Treiman, *Occupational Prestige in Comparative Perspective* , 1977

status precede the recognition of the profession as worthy of autonomy. Self-regulation would be another reward for achieving the appropriate social status.[9]

There is reason for a note of caution at this point. Many of these views, Freidson argues, have arisen without great concern for the evidence:

> On the whole, I think it fair to say that all the theories I have discussed are too grand and sweeping to have much more than rhetorical and possibly political value. They are casual about providing the evidence to support their validity, and as often as not when they do provide evidence it is of dubious relevance to the analytic implications of their concepts.[10]

In considering the evidence for the story in Manitoba there may be very little to go on. Perhaps it is like looking at the history of the metric system by starting with its "adoption" in Canada. A longer view is necessary. To that end the family tree of self-regulation must be explored. If this descent from the jungle followed similar routes in other jurisdictions then one's skepticism about a "unified" theory of such development might be quieted. Alternatively if similar results seem

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9 A. M. Carr-Saunders and P.A. Wilson, *The Professions*, 1964, at 298
Magali S. Larson, *The Rise of Professionalism: A Sociological Analysis*, 1977

10 Eliot Freidson, "The Reorganization of the Medical Profession" (1985), 42 Med. Care Rev. 11, at 22

to arise no matter what the chronology, one will be tempted to look further.

Unfortunately, even for comparative purposes, the record for Manitoba on this issue is limited. There are no surviving records at all of the debate, if there was one, over the first *Medical Act*. Still, though, as the profession in Manitoba, with the aid of its political friends, subsequently solidified its autonomy, the record improves and provides some insights, if not conclusions.

It is on the second aspect of this review, the exercise and application of medical autonomy in Manitoba, that the record also improves. The minute books of the College of Physicians and Surgeons of Manitoba, and correspondence to and from the College, provide a great deal of information on what is the most important aspect from this paper's point of view. For instance, although this may be an artifact of viewing information from a single source, there is revealed a fair unity of purpose. In other words there is tentative confirmation of Goode's views on the importance of the professional "community":

> The larger society obtains indirect control of professions by permitting direct social control by the professional community itself. The profession avoids lay control by maintaining its own strong control over itself. Failure to discipline would

> mean both loss of prestige in the society, and loss of professional autonomy.[11]

This can be taken a step further when one considers two approaches to control of the profession, cooptative control and disciplinary control, to stretch the terminology used by the Ehrenreichs.[12] Avoidance of disciplinary control for aberrant behavior would ensure to the profession, the loyalty of its members. It is this aspect of discipline that the archival record from Manitoba is most complete. From that then one could be led to seek evidence of the degree of control alleged by Blishen:

> It is evident that this type of [discipline] committee exercises a great deal of control over professional conduct.[13]

Even if such control is not apparent then one should at least be able to make note of the norms which the profession imposed and compare that to those they professed. Which leads to the next question, the value and utility of the ethical codes which are used by

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11 Goode, *supra* n. 2, at 198

12 Barbara and John Ehrenreich, "Medicine and Social Control", in *The Cultural Crisis of Modern Medicine*, (ed. John Ehrenreich), 1978, at 48-49. While the terms "disciplinary" and "cooptative" control are used there to refer to control of patients and their situations by physicians, the principles can also be applied to the control of physicians by their peers through a licensing authority.

13 Bernard Blishen, *Doctors in Canada* 1991, at 119

professions to guide, at least ostensibly, their behavior. Blishen describes them as "powerful weapons".[14] If this was the case one would expect, but one will not find, repeated references to its Code of Ethics by the College in Manitoba throughout the years.

Codes, of course, may have a baser role. In what is in essence a public relations exercise, they may be used to demonstrate to the public the high standards which the profession imposes on its members. They become an important part of what is another part of the story, the maintenance and solidification of autonomy.

For this effort to be successful, the values proclaimed must be linked to those of society at large.[15] The public must be convinced that it is for the larger good, and not self-interest, that the profession imposes such rules on its members. Hence, for example, it is not to stifle competition, but to prevent confusion, that advertising is limited. In any case, one thus expects references to these pronouncements when the profession asserted its right to autonomy.

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14 *Ibid*. at 118; Larson, *supra* n. 9; John Kultgen, "The Ideological Use of Professional Codes" in *Ethical Issues in Professional Life* (ed. Joan C. Callahan), 1988

15 Vernon K. Dibble, "Occupation and Ideologies" (1962), 67 Am. J. Sociology 229

Along the same lines, it must be shown, in order to maintain control, that the profession, and the Manitoba College in particular, was effective in controlling its members for the public good.[16] Countering this need was the strong urge to keep its functions as private as possible.

The other aspect of the developmental history of the disciplinary power was how it actually was used. After being thus enabled by legislation physicians could simply have ignored the power, or used it against only the most egregious behavior, or mercilessly applied it against all manner of sin, large or small. Furthermore, even without legislative changes the approach to discipline may have evolved. Hence the need for a closer look, literally case by case, at how physicians have been disciplined in Manitoba. After all, membership in a professional group is clearly valued. So much so that even voluntary exits are uncommon. Since the penalty would be seen as so severe it might have created some reluctance to prosecute misconduct by a colleague. Or perhaps this might lead to some selectivity in prosecution, ignoring transgressions in some and punishing them in others. Perhaps then it

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16 Eliot Freidson, *Doctoring Together: A Study of Professional Social Control*, 1975

would be the actor not the act which would attract attention and possible sanction.

Finally there is the question of change. For example, one would expect, according to Bucher and Strauss, a gradual decrease in the unity of purpose of the profession.[17] One should see evidence that, rather than being unified, physicians were pursuing the interests of their own constituency. There were many self-interested segments each with their own agenda. Over time such factors as specialization would supposedly create the equivalent of a "party system" within such bodies as the College.

There are other forces for change. The profession will gradually lose some measure of control both to better informed consumers and to the state as insurer. At some point the response to this "communal control"[18] will be reflected in the College's records. There should arguably soon be evidence of some strain within the profession in response to these forces.

Before going any further several limitations in this review must be noted. While the internal documents were

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17 Rue Bucher and Anselm Strauss, "Professions in Process" (1961), 66 Am. J. Sociology 325

18 Blishen, *supra* n. 13, at 145

available for review, it was not always possible to get a broader view of the external forces at work at a point in time. Outside of some political and editorial opinions there is really not much more than guesses regarding the larger social context in which Manitoba physicians were functioning. Thus one must be careful not to overstate the observations. Of course, if one is aware of other events that are *not* reflected in College proceedings, that omission may speak of itself.[19]

Hence there are two major sections to this effort, a *macro* look at the history of medical legislation and a *micro* look at the discipline of physicians in Manitoba. At that point it will be useful to consider again the broader picture with a look at licensing and discipline elsewhere in Canada and beyond.

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19 For example, there is no reference whatsoever to the Flexner Report, Abraham Flexner, *Medical Education in the United States and Canada*, 1910. Yet this report is often asserted to be the turning point of professionalization for North American medicine. See Blishen I, *supra* n. 7; David Coburn *et al*, "Medical Dominance in Canada in Historical Perspective: The Rise and Fall of Medicine" (1983), 13 Int. J. Health Services 407. *Quare*, whether its impact in Canada is overrated.
See also the similar absence of comment on the Saskatchewan doctors' strike, *infra*.

II. DEVELOPMENT OF MEDICAL SELF-REGULATION

Introduction

The first *Medical Act* for Manitoba passed rather easily.[20] As will be noted later, there may have been some uniquely Manitoban reasons for this ease of passage. On the other hand, perhaps any potential controversy had already played itself out elsewhere. The "battles" may have already been fought. After all, other provinces had gone this route, sometimes many years before. To assess this more fully it might be useful to review earlier attempts at medical licensure legislation.

The detail here may be excessive. Nevertheless, the ebb and flow of events are interesting of themselves. More importantly the rough road, which in some cases was more of a maze, that proponents of medical autonomy had to take may cause us to hesitate before accepting any glib assertions on the development of medical hegemony. Facts may get in the way. If there appear to be significant differences in the development of autonomy, how can critics assert that professionalization followed a particular path?

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20 *An Act Relating to Medical Practitioners in the Province*, S.M 1871, c. 26

In any case, what follows will be an attempt, and not an exhaustive one, to highlight the differences in the routes the medical profession had to take in other jurisdictions to reach its goal. Of course, it may be harder to say whether the process in Manitoba was in any way so influenced.

Licensure in England

The development of medical licensure in England is illustrative even if it does not represent the earliest attempts at control.[21] A review here yields the first examples of how the scheme of regulation, and the profession as a whole, were shaped by struggles for power, almost internecine fighting, and many alliances made and broken.

The reason for looking at this go beyond simple comparative purposes. Contemporary Canadian physicians have, based on the "authorized" histories of the English Colleges, tended to glorify them. The roots of self-

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21 For example in Persia, China, and Normandy, all in about the eleventh century. See David J. Fine and Eve R. Meyer, "Quality Assurance in Historical Perspective" (1983), 28 *Hospital & Health Services Administration* 94. Actually there was a fairly open market for medical care in ancient Greece and Rome, but even by the fourth century restrictive rules had been adopted in other societies: Darren Amundsen, "Visigothic Medical Legislation" (1971), 45 Bull. Hist. Med 553

regulation can be traced back to the first College of Physicians. In fact, the regulatory authority in seven provinces still glorifies the term "College", notwithstanding its ability to confuse the public. The fact that contemporary practitioners would have little in common with the true "physicians" of the past is still unknown. The mythology of these past events largely influences contemporary attitudes. Rather than a murky past, one will hear claims that these events represent a glorious history to be looked back on with admiration.

A pivotal factor in the history of medicine in England was its longstanding division into three branches: the physicians, the surgeons, and the apothecaries. The physicians, somewhat analogous to today's internists, were part of and only practiced among the elite of London society. The surgeons originally arose as rather specialized barbers and ordinarily limited themselves to cutting and lancing. In the beginning, the apothecaries were merely part of the Grocers' Guild. They eventually became more than pharmacists, often diagnosing and advising in addition to dispensing. They thus could be likened to today's general practitioner. Add to this the innumerable numbers of practitioners, especially outside of London, who defied

precise definition and it is not surprising that order of any kind took so long to be achieved.[22]

Distinctions eventually began to blur between the surgeons and the apothecaries but not for the physicians. They continued to study the classics of both literature and medicine, as the source of *all* required knowledge, and confined their ministrations to the London nobility. Yet they succeeded in obtaining passage of an *Act* in 1512 which required the licensure of all London physicians by the Bishop of London unless they were graduates of Oxford or Cambridge.[23] However, the physicians overreached. Two additional provisions, added before final passage, ensured the *Act*'s ineffectiveness. Firstly, the *Act* was now to cover all of England with any local bishop able to grant a licence. Secondly, the *Act* was extended to include surgeons, authority over whom was vested in the Barbers' Guild. The King confirmed this formally on the

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22 See generally R.S. Roberts, "The Personnel and Practice of Medicine in Tudor and Stuart England: Part I. The Provinces" (1962), 6 Med. Hist. 363; R. Vashon Rogers, *The Law and Medical Men*, 1884; R. S. Roberts, "Medical Education and the Medical Corporations" in *The Evolution of Medical Education in Britain* (ed. F.N.L. Poynter), 1966

23 The requirement to have attended Oxford or Cambridge had nothing to do with adequacy of medical training as neither taught medicine at that time. *An Act for the appointing of Physicians and Surgeons*, 3 Hen. 8, c. 11 (1512). The power of the clergy to grant medical licences, the so-called "Lambeth M.D.'s", persisted into the last century.

same day the Act was proclaimed. Thus the requirement for licensing surgeons or rural practitioners was largely ignored.[24] Medical practice remained essentially unrestricted.

Thus, what arose from the 1512 *Act* was not what the London physicians had sought, a monopoly for a select group of practitioners. If the *Act* had any significance it was as the first real legislative distinction between medicine and surgery, at least in terms of defining them as separate callings. More importantly, there arose a clear signal that it was easier to legislate these sorts of restrictions than to enforce them. The physicians were not deterred:

> The intricate process by which London's physicians managed to elevate their tribe above all other healers is not easily explicable, but it had something to do with claims of higher education and competence. Physicians were gentlemen; surgeons and apothecaries were unlettered craftsmen, not admissible to the ranks of the gentry. For all that, it probably made little difference to the patient except for the fee he was required to pay. The medieval physician's knowledge of Galen was, in effect, hardly more valid than the apothecary's knowledge of herbs.[25]

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24 Roberts, R.S., "The Personnel and Practice of Medicine in Tudor and Stuart England: Part II. London" (1964), 8 Med. Hist. 217, at 220

25 Carleton B. Chapman, *Physicians, Law, and Ethics*, 1984, at 61

It was also during this period that one of the King's own physicians, Thomas Linacre, persuaded him to grant a charter to the College of Physicians in 1518.[26] Linacre and five others were to form a College which was to have control over the practise of "physick" for the city of London. This charter was confirmed by legislation in 1523[27] which extended the mandate to the entire country.

One could make a modest public health argument for the development such a College.[28] London had been troubled by repeated epidemics, including the plague. Arguably the King could take counsel from a learned body on the management of such issues. Still, though, it cannot be denied that this was really a question of power and income. There were only a dozen physicians in all of London at the time. The population of 60,000 clearly could not rely on them for health care. They would have to turn to surgeons, apothecaries, and others for treatment.[29]

The physicians persisted, if not by eliminating the competition then by at least attempting to control it. In

26 Originally called the Commonality and Fellowship of the Faculty of Physick. *Ibid.*, at 62
27 14 & 15 Hen. 8, c. 5 (1523)
28 Roberts II, *supra* n. 24, at 222
29 *Ibid.*

so doing new alliances were made. In 1540 an *Act*[30] was passed allowing physicians to do surgery. The *Act* also allowed them some measure of control over the apothecaries. At the same time control over surgery in general was vested in the combined Company of Barber-Surgeons[31]. The *Act* specifically precluded "pure" barbers from doing surgery now.

The College of Physicians and the Company of Barber-Surgeons thus had the power, if they combined forces, to prosecute and possibly eliminate practice by apothecaries and those otherwise not licensed by the major players. They became carried away. Parliamentarians, among others, did not look favorably on their aggressive attempts at prosecution. As a result Parliament passed what became known as the *Quack's Charter* in 1542.[32] The *Act* precluded

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30 32 Hen. 8, c. 40 (1540)

31 32 Hen. 8, c. 42 (1540) created the "Masters or Governors of the Mystery and Commonality of Barbers and Surgeons of London". The groups were not separated again until 1745. *An Act for making the Surgeons of London and the Barbers of London two separate and distinct corporations*. 18 Geo. 2, c. 15 (1745)

32 *A Bill that Persons, being no common Surgeons, may minister Medicines, notwithstanding the Statute*, 34 & 35 Hen. 8. c. 8 (1542). The preamble stated that since passage of the 1511 act, the "Company and Fellowship of Surgeons of London . . . have sued, troubled, and vexed divers honest persons". The physicians thus could blame the surgeons for ruining a good thing. For a generally sympathetic approach to their concerns see their authorized history:

prosecution for illegal practice by those with knowledge of herbs and certain common complaints. Clearly those outside of the privileged circle of London society were to be allowed to obtain care from any who would provide it. When the College of Physicians attempted to rely on the earlier acts in their prosecutions it was clear that the 1542 act had effectively repealed the penal provisions of 1512 and 1523.

At this point, personalities as much as legislation determined events. After 1555 John Caius took over the presidency of the College. He set it on a course which persisted for some time. Among his "priorities" were designing regalia for the College, insisting he be addressed as "His Excellency", and, more importantly, attempting to define an "ethical" standard for College members.[33] This standard was set out in a series of statutes kept secret from even the membership.[34] It is clear, though, that patients' concerns had the lowest priority. Offences mainly entailed such sins as showing disrespect for other physicians and disagreeing with the masters, particularly Galen. At the same time a form of Hippocratic Oath began to appear. Its authenticity aside,

George Clark, *A History of the Royal College of Physicians of London* (3 vols.), 1964

33 *Ibid.*

34 Clark actually reproduces them but in Latin, *Ibid.*

it was an attempt to create an ethical, if somewhat mystical, bond to the moral authority of the ancients.[35]

By the seventeenth century while new battles were to be joined, it is worth noting that despite what had gone on already the delivery of medical care had changed little:

> A survey of English medicine in 1600 would reveal a very large body of town and country people who treated their neighbours with locally grown herbs; a somewhat smaller group of surgeons and apothecaries who at times had episcopal licenses to practice physic, but, even when they did not, prescribed for the middling classes of artisans and yeomen; a smaller group of graduate physicians resident in the provinces, who usually had episcopal licenses or were extra-licentiates of the Royal College; and a very small but well-organized group of consultant physicians resident in London and distinguished by their medical education, elaborate dress, and courtly manners.[36]

Alliances shifted again before long. Rather than lose any further power to Barber-Surgeons as a group, the physicians began to grant licenses in medicine to surgeons in 1627. If they as a body allowed surgeons to practice this way, it would supposedly be less likely that the surgeons as a group would seek to usurp this control on their own. That flank thus protected for a while, the College of Physicians next turned its

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35 Chapman, *supra* n. 25, at 65-66
36 Joseph F. Kett, *The Formation of the American Medical Profession*, 1968 at 4

attention to the apothecaries. As the latter's therapeutic armamentarium increased so did the expectation by the public that they would dispense medication and advice directly. In 1617 the apothecaries separated from the Grocers' Guild. This separation from the grocers was engineered with the help of the physicians who backed the apothecaries in exchange for the latter agreeing not to dispense for surgeons or unlicensed practitioners. The physicians' motives seemed clear.

However the apothecaries quickly saw the rub in this scheme. They realized that 40 physicians could not possibly cater to a population of now 300,000. If they only filled prescriptions from physicians, as opposed to prescribing themselves, they would not do much business. Furthermore, denying their services to non-physicians would only encourage the latter to do their own dispensing. Finally, the apothecaries had been doing quite fine in competition with the physicians. They would be disinclined to forsake their growing popularity with the public for the aloofness[37] the physicians sought to cultivate:

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37 A medical critic in 1683 called the College a "conclave", run by "pope or patriarch" and "cardinals" and with a fanatic devotion to their "faith". Gideon Harvey, 1683, quoted in R.E. Wright-

> The London public had become dependent on the apothecary for the simple reason that his services were relatively cheap and efficient, and he could be relied on to prescribe, dispense and even dress wounds and do bleeding without calling in physicians and surgeons. He could be consulted in his shop, and the required medicine would be handed over the counter there and then or delivered by the apprentice. If the patient needed attention in the home the apothecary was always prepared to visit and give advice, and for this service there would be no special fee, although of course the prices of the medicines would have to cover his extra expenses.[38]

In 1815 apothecaries gained another victory by legislation[39]. Now all who dispensed would require a license from the Society of Apothecaries. Six thousand licenses were granted within the first twenty years, with the majority going to those already licensed as surgeons.[40] Thus the most common type of practitioner became the apothecary-surgeon, licensed by both authorities. Their difficulty was that power in the licensing bodies was left to those in exclusive practice, that is, those only licensed as apothecaries *or* as

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St. Clair, "Citadel of the Physicians" (1966), 65 N. Z. Med. J. 586.

38 Roberts II, *supra* n. 24, at 229. See also Richard H. Shryock, "Public Relations of the Medical Profession in Great Britain and The United States: 1600-1870" (1930), 2 Ann. Med. Hist. 308, at 310

39 *An Act for better regulating the Practice of Apothecaries throughout England and Wales*, 55 Geo. 3, c. 194 (1815)

40 Only the governors of the Society, the "Freemen", were prohibited from any other license or practice. Peterson, M. Jeanne, *The Medical Profession in Mid-Victorian London*, 1978 at 17, 22

surgeons. Thus those with qualifications in two bodies had influence over neither.

What followed was a period of significant debate in medical and political circles. There were at least seventeen proposals placed before Parliament.[41] Those politicians who took a *laissez-faire* approach to government regulation sought to limit any restrictions on practice. Patients should be free to see whom they wish, and anyone who could attract such patients, regardless of training, should be allowed to do so. There were also conflicts within the already licensed profession. Obviously, unrestricted practice by any and all would have the most negative effect on the general practitioners. In contrast, the elite Colleges had less to lose and seemed more concerned with maintaining their existing level of control. The eventual result, the *Medical Act* of 1858[42], was a compromise which proved a disappointment to those who had been calling loudest for reform.

Still, by any criteria *The Medical Act* of 1858 was significant, either because it unified the licensure of

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41 David L. Cowan, "Liberty, Laissez-Faire and Licensure in Nineteenth Century Britain" (1969), 43 Bull. Hist. Med. 30

42 *The Medical Act*, 21 & 22 Vic. c. 90 (1858)

all medical practitioners under one body, the General Medical Council[43], or because the Act managed to preserve the influence and authority of the *nineteen* former licensing bodies previously recognized to govern various branches of medical practice in various parts of the United Kingdom.[44]

This General Medical Council was to prepare a register of all medical practitioners. Such a register was not to distinguish between different forms of license. That was as radical as the *Act* got. The membership on the council was limited to the medical corporations, the universities, and a few Crown appointees. There was no one representing general practice. And the elite Colleges lost none of their power to set standards, qualify candidates, or bestow fellowships. As a final insult to the general practitioners, the only consequence of unlicensed practice was the preclusion from government employment. Still the *Act* is seen by some as the beginning of some important changes in the status quo:

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43 More formally called the "General Council of Medical Education and Registration of the United Kingdom"

44 In addition to the Universities, there were societies or colleges licensing physicians, surgeons, and apothecaries in London, Edinburgh, Glasgow, and Dublin. See Peterson, *supra* n. 40, at 289.

> It required many centuries for Britain's politicians and legislators to comprehend that the medical profession, if rendered autonomous by law, would turn its attention primarily to the maintenance of monopoly, financial privilege, and special social status. First the jurists, then the legislators, perceived that the profession's own regulations were not directly concerned with protecting the patient from injury or compensating him after the fact of injury. The courts, and later the legislature felt necessary to move into the breach..[45]

At this point several observations might be made. First, even as of a century ago, it seems not particularly helpful to speak of English medicine as *a* profession in the singular. Some sense of unity, or at least common identity, seems to have only arisen when each group's courses began to intersect, as it became obvious they were more or less providing the same service, medical care. Before that they were as competitive as medical practitioners might be with chiropractors today.

Secondly, while providing a valued service might help to gain some respect and autonomy, it seems none of these groups were providing a service not otherwise obtainable, if not from each other then from unlicensed practitioners. That, and their jurisdictional rivalries, precluded any form of monopoly developing until they collectively had something to offer that the untrained

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45 Chapman, *supra* n. 25, at 72-73

practitioners did not. Even at that point, which might have coincided with the *Act* of 1858, the absence of any real penalty provisions meant this ostensible "monopoly" was unenforceable.

In the end these disparate organizations more or less achieved the prize of autonomy. In some ways this is surprising given the history up until 1858. These bodies put so much effort into competition that it seems hard to imagine how effective control over members could be exercised. Of interest as well is the different paths taken to reach about the same point. From the outset the College of Physicians was the archetype of a professional organization. They had a sense of identity, shared values, and asserted internal controls. Yet their numbers were small. Despite their political connections they had little influence over the delivery of health care. They sought power but were limited in their ability to assert it. The Quack's Charter of 1542 and subsequent unsuccessful battles with the apothecaries demonstrate their limitations. They were never able to assert a monopoly. Yet in the end they succeeded.

The apothecaries also succeeded. They began without the professional trappings of the physicians. For some time it is hard to see them as a profession at all. They

did, though, offer a service which evidently had some value. Which suggests somewhat incongruous lessons. Autonomy, it seems, came to the physicians because they persisted in asserting it. It came to the apothecaries because, they would argue, they earned it. Perhaps there were contemporary political forces which allowed both approaches to succeed. In other words, it was not so much what each group sought as what they were given. Perhaps, also, the distinctions between the factions began to blur as time passed, at least in the public's view. All these practitioners began to be seen as an aggregate, and not of three different stripes.

Medical Licensure in the New World

Whether one looks at the colonies that eventually became Canada or the United States, the end result of the evolution of medical licensing is remarkably similar. Still, while avoiding some of the tensions that permeated the scene in the mother country, other schisms were evident as events unfolded on this side of the Atlantic. By looking at these tensions, and the effects they did or did not have, perhaps some underlying processes may be evident.

The first thing to note about whether or not the English approach to licensure was adopted in the colonies

was the lack of class distinctions that were so much a part of English medicine. This is first due to the fact that few physicians, or even "pure" surgeons, came to the New World. Most immigrant practitioners would best be described as apothecary-surgeons. Secondly, most immigration came from rural Britain where regulation of practice was weakly enforced. Finally, once here, practitioners of whatever stripe tended to be labelled as simply "doctor", thus ensuring an egalitarianism still absent in Britain today.

Quebec

The first attempt at licensure after the British conquest was the *Ordinance* of 1788.[46] This remained in effect for some time but here were however persistent tensions between sectors of the profession that perhaps influenced the pace at which self-regulating autonomy was gained. For instance, the anglophone physicians of the

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46 *An Act or Ordinance to prevent persons practising Physic and Surgery within the Province of Quebec, or Midwifery in the Towns of Quebec and Montreal, without Licence,* S.Q. 1778, c. 8. Even prior to the British conquest in 1759 there had been an attempt at restrictive licensure in Quebec. The Intendant Bigot had passed an ordinance in 1750 limiting licensure to those already in the colony or who had taken an exam before a panel of physicians designated by the Governor. See generally J.J. Heagerty, *Four Centuries of Medical History in Canada*, 1928; Maude E. Abbott, *History of Medicine in the Province of Quebec*, 1931

Montreal General Hospital began the first medical school, in the form of the Montreal Medical Institute. To effect complete control, they successfully petitioned the Governor to have themselves appointed as the medical examining board for Montreal. Since their medical school could not yet grant degrees, their students would have to sit an exam. These candidates would seem to have had their chances of success enhanced with their own teachers doing the examining. It looked as if those running the school could thus make certain that their own graduates received licenses notwithstanding the lack of a proper degree. Supposedly they might be less sympathetic to candidates who did not attend their school. Almost complete control over professional education and licensure was vested in the same group of English-speaking physicians.[47]

Unfortunately events overtook this cadre. In 1831 a new *Act* was passed.[48] Exemptions from examination were

47 Ronald Hamowy, *Canadian Medicine, A Study in Restricted Entry*, 1984, at 30-31. Extensive reliance will placed on this source in the subsequent discussion. Much of the primary material cited is simply not otherwise available. More importantly, although there are many books on Canadian medical history almost no other provides any kind of legal or political context. Such a context can be referred to without necessarily considering his major focus which is basically a critique of the Canadian medical monopoly.

48 S.L.C. 1831, c. 27

allowed for female midwives, those already licensed, and those with degrees that met certain standards. More significantly, examining boards were no longer appointed but elected by members of the profession. At the first such election none of the previous board were chosen by their colleagues.

Not surprisingly conflict was inevitable. The Montreal Medical Institute became part of McGill College and thus gained the right to grant degrees in 1832. The first such degree was presented in 1833.[49] The graduate, William Logie, had to present his credentials to a board now unsympathetic to his teachers and their school. The Board rejected his degree on the grounds that the *Act* required five years of training at the same institution. He, of course had done just that, except that in his final year the name of the school had been changed from the Montreal Medical Institute to the Medical Faculty of McGill College. He had to go to court to force the board to grant him a license.[50] The event is illustrative of

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49 Barbara Tunis, "Medical Licensing in Lower Canada: The Dispute over Canada's First Medical Degree", in *Medicine in Canadian Society, Historical Perspectives* (ed. S.E.D. Shortt), 1981

50 Although he apparently never practiced in Quebec but moved to the U.S. *Ibid*.

the power struggles which were often a part of the history of medical licensing in Quebec.[51]

By 1847 a College of Physicians and Surgeons was formed in Lower Canada.[52] Although not yet creating a single examining board, the College could regulate the admission to and curricula of the medical schools. Still large numbers apparently practiced unlicensed.[53] A medical editorial of the time asked the profession to "circle the wagons":

> Let the past be now forgotten, and let each member of the profession strive his utmost to enhance the general prosperity, by sustaining the Law in its operation. Where the Act is defective, let a united appeal to the Legislature be made for its amendment; but let there be no longer discord, where unanimity should alone prevail. . . Let there be no longer discordant principles, when one object alone is sought to be attained; but let all strive, prompted by oneness of sentiment and feeling, to ensure for the incorporated profession that respect from the public which the provisions of the Act of Incorporation are intended to secure for it, and which it must and should command.[54]

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51 There was further conflict when the Medical Board initially refused to recognize the degrees granted by the first French medical school. Sylvio Leblond, "La Medecine dans la province de Quebec avant 1847" (1970), 35 *Cahiers des Dix* 69

52 *An Act to incorporate the Members of the Medical Profession in Lower Canada, and to regulate the Study and Practice of Physic and Surgey therein,* S.Pr.C. 1847, c. 26

53 Hamowy, *supra* n. 47, at 53

54 *British American Medical Journal*, 1848, quoted in Abbott at 72. Despite these pleas opposition, usually from the younger francophone physicians was organized into a "Repeal Association", *Ibid.*

Thus the development of professional autonomy in Quebec would mimic some elements of the story in England. While the profession was not formally divided in the same way, there were elements and factions which sought to assert control, even despite the fact that so much care was being provided by unlicensed practitioners.

Yet, in some ways, and despite these tensions, the profession in Quebec may have, in the long run, been more successful than elsewhere in establishing control over medical practice and the profession. Consider the proposals for a new *Act* in 1875. One would have required each and every candidate to sit an exam. The eventual *Act* in 1876[55] did not go that far but did provide an exemption from examination only for Quebec graduates, easily the most insular legislation of the day. In the end then autonomy arises despite the internal squabbling within the Quebec profession. Evidently the profession as such need not necessarily present a united front in order to achieve self-regulation.

Ontario

The development of licensure may be characterized as a class conflict in England, and in part an ethnic

55 *An act to amend and consolidate the acts relating to the profession of medicine in the province of Quebec*, S.Q. 1876, c. 26

conflict in Quebec. It is a bit harder to characterize the genesis of medical licensure laws in Ontario. In some ways it would seem that where conflict was possible it occurred. That seemed true whether the conflict was between urban and rural, licensing bodies and universities, orthodox and heterodox practitioners, and even between the colony and Britain.

When Upper Canada became a separate jurisdiction from Quebec in 1791, it first inherited the recent *Medical Ordinance*[56] passed in 1788. Considerably more frontier-like than Lower Canada, it was nevertheless quickly proposed that some form of restrictive medical license be created. However when the matter was put before a legislative committee, it took only one evening to conclude that "in view of the infant state of the province there should be no attempt to restrict the practice of medicine."[57]

Nonetheless such a measure was introduced in 1794 and again in 1795, when it finally passed.[58] The *Act*

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56 *An Act or Ordinance to prevent persons practising Physic and Surgery within the Province of Quebec, or Midwifery in the Towns of Quebec and Montreal, without Licence*, S.Q. 1788, c. 8

57 Elizabeth MacNab, *A Legal History of the Health Professions in Ontario*, 1970, at 4

58 *An Act to regulate the practice of physic and surgery*, S.U.C. 1795, c. 1

prohibited unlicensed medical practice except by those who graduated from an Empire university, those in the military, and those in practice as of 1791. Unlike later versions female midwives were not also exempt.

The 1795 *Act* was unacceptable either because it was unenforceable or, if it had been enforced, it would have been unfair to those physicians providing a service in outlying areas. At any rate it was repealed in 1806.[59] Legally this left the 1788 *Ordinance* in force but, in fact, the situation was treated as unregulated. The medical landscape had not really changed since 1795, the difficulties were still operative, but proposals to reinstitute regulation continued. There is evidence of editorial support:

> It is an incontestable fact that we are all created patients, but few of us are born physicians, and that education and studious practice, as well as a just judgment of diagnostics and the efficient operative qualities of prescriptions, form the necessary parts of fortunate and conspicuous practitioners.[60]

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59 S.U.C. 1806, c. 2

60 *York Gazette*, October 8, 1808, quoted in H.B. Anderson, "Medical Licensure and Medical Boards in Upper Canada" (1928), 18 Can. Med. Assoc. J. 209, at 210. The first attempt at reregulation was in 1808. MacNab, *supra* n. 57, at 5

After several earlier attempts,[61] the *Act* of 1827 was passed.[62] Controversy arose during the tenure of this *Act*. It was the Medical Board and its conduct which attracted calls for reform. The Board itself seemed to continue as before, passing just over half of those who presented applications. But some physicians expressed resentment. At a medical meeting called to air complaints, the following resolution was passed:

> *Resolved*, That it is contrary to the practice in other countries and manifestly inexpedient, that *two* or *three* medical practitioners holding their inquisition in utter darkness should have from year to year the power of pronouncing *without appeal*, on the professional merit of *their own* pupils, or those of others with whom they may possibly be at variance.[63] (original emphasis)

Perhaps most interesting though is an exchange of letters between several physicians and the president of the Board in 1832. The physicians proposed the creation of a College which could, like the Law Society, discipline members for "unworthy" conduct. Board president Dr. Christopher Widmer rejected the idea:

> If it be true in the second place, that any regular licentiate descend to unworthy professional

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61 *An act to license practitioners in physic and surgery throughout this province*, S.U.C. 1815, c. 5, am. S.U.C. 1818, c. 13, am. S.U.C. 1819, c. 2.

62 *An act to amend the laws regulating the practice of physic, surgery, and midwifery, in this province*, S.U.C. 1827. c. 3

63 *Patriot*, January, 1836, quoted in William Canniff, *The Medical Profession in Upper Canada, 1783-1850*, 1894.

> practices not within the redress of the laws of the land, the evil must be left, as in other countries, to the corrective influence of public opinion.[64]

Although the idea of a College was eventually adopted it is striking that one of the more influential medical authorities of the day should state such opposition. At least on the individual level this may belie the image of a medical oligarchy resolutely driving for greater power and control.

At any rate, perhaps because of an increasing number of "unorthodox" practitioners, the Medical Board soon petitioned the government for increased powers. Again they seemed to have had at least some support in the press:

> Quacks are an intolerable nuisance in any and every country, but especially in this, where empiricism and radicalism go hand in hand. It is a monstrous grievance that our Government should allow the Province to swarm, as it does, with these pestilent vagabonds, every one of whom is a Yankee loafer, and makes his occupation a cloak for inculcating Jacobinical principles. All know how numerous have been the self-styled "doctors" implicated in the rebellion, but perhaps all may not know that they were almost one and all Yankee Quacks. We are truly glad to see that the medical board are active in setting about means to annihilate the dirty birds, nest and all, we trust the Legislature will second their efforts.[65]

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64 *Ibid*. at 67

65 *Patriot*, October 12, 1838, quoted in Canniff, *supra* n. 63, at 111. The comments also suggest politics were as much a concern as the public health.

Thus followed the brief existence of the College of Physicians and Surgeons of Upper Canada.[66] Trouble began quickly. The College evidently thought it had power it did not really have. There was no statutory authority to discipline as yet, and an attempt to do so was simply ignored by the alleged wrong-doer.[67]

However, the College's truly fatal error was an attempt to restrict the license, to only surgery, of an applicant who was already a Licentiate of the Royal College of Surgeons of London.[68] This attracted the attention of the Surgeons in London who asked the Colonial Office to disallow the *Act*. Their argument was that any restriction on the rights of their licentiates in the colonies would violate the Imperial *Act* granting their Charter.[69] The Colonial Office agreed and the *Act* was disallowed.[70] Looking back this might be seen as an important setback for the tide of monopolization by the profession.[71] Nevertheless there are a number of odd aspects to the event. Firstly, the 1839 *Act* did not seem

66 *An Act to Incorporate certain persons under the style and title of the College of Physicians and Surgeons of Upper Canada*. S.U.C. 1839, c. 38
67 Charles M. Godfrey, *Medicine for Ontario*, 1979, at 223
68 Canniff, *supra* n. 63, at 151
69 *An Act for making the Surgeons of London and the Barbers of London two separate and distinct corporations, 1745*, 18 Geo. 2, c.15 (Imp.)
70 *Upper Canada Gazette*, January 7, 1841
71 Hamowy, *supra* n. 47, at 39

any more restrictive than prior *Acts* which were not disallowed.[72] Secondly, even in England, Royal College Licentiates could not practice more than surgery without approval of the appropriate college. Thirdly, similar *Acts* elsewhere had not been disallowed.[73] Finally, there seemed to be no clear benefit to mandating a return to the 1827 *Act* even for licentiates from London.

The public record is particularly confusing. The Colonial Office had ostensibly criticized the *Act* for among other things "a tendency to establish a monopoly".[74] The College responded that since many applicants were granted licenses without discretion, such a monopoly would in fact be impossible.[75] It may be that it was the very concept of a colonial "College" which attracted attention. We do know that even their legal friends in Upper Canada were against the idea of such a

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72 This act and a British Columbia ordinance of 1867 were the only medical acts disallowed by London even though they had the authority to do so until 1931. *Ibid.* at 40. For later cases involving Imperial paramountcy see *Regina v. College of Physicians and Surgeons of Ontario* (1879), 44 U.C.Q.B. 564; *Metherell v. The Medical Council of British Columbia* (1892), 2 B.C.R. 186

73 *Medical Act, 1862,* (Queensland), Hamowy, *supra* n. 47, at 317

74 Hamowy, *supra* n. 47, at 39

75 *Ibid.*

College, even though the lawyers themselves had already achieved the same aims in their own Law Society.[76]

Another significant development was the opening of medical schools in what was Upper Canada. The battle for control of curricula between the rapidly proliferating schools and the Medical Board was soon joined. The Board obviously hoped its mandate included such control because the legislation clearly gave local graduates the right to a license without further examination. To ensure their power, the Board pressed, in 1844, for a bill that would guarantee their control over curricula and admissions at the medical schools. Their efforts were strongly opposed by the schools themselves. The physicians of the medical schools may have claimed to be promoting their educational and intellectual autonomy but many were also protecting what was often a personal investment in these institutions.

The other nidus for controversy was the rigor of the course of studies offered. At King's College (later University of Toronto) medical studies included three years of lectures plus at least two other years of training. At the same time, American schools usually required less than three years in total, often without

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[76] *Ibid.* at 315

any mandated practical apprenticeship. It was possible to complete some courses in a year.[77] Critics describe the Canadian requirements as "totally incongruous" with those in the States and simply as further evidence of the barriers that established practitioners put up to deny entry into the profession.[78] In contrast American analysts of medical education at that time saw the lax standards of many of their schools as evidence of grossly inadequate training.[79] Nevertheless it is claimed that the curriculum at King's College was such an impediment that only nineteen graduated between 1844 and 1849. Whether that is a high or low number depends on what resources were actually available and it belies the fact that the majority of the students trained took classes occasionally and took the Board exam without bothering to graduate.[80]

The next significant development was the *Medical Act* of 1865.[81] This *Act* went some way to recreating a College. Practicing physicians now elected members to a

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77 *Ibid.* at 42
78 *Ibid.* at 43
79 An attitude confirmed by Flexner's review of medical education in 1910. Abraham Flexner, *Medical Education in the United States and Canada*, 1910
80 Godfrey, *supra* n. 67, at 55
81 *An Act to regulate the Qualifications of Practitioners in Medicine and Surgery in Upper Canada*, S.O. 1865, c. 34

"General Council of Medical Education and Registration of Upper Canada". This Council was to set standards for the medical schools admission and curricula. Among other things the Council was to ensure no "particular theory of practice" was being inculcated by a school.[82] At any rate the *Act* seems to represent a compromise in what had become a power struggle between the Board and the universities.

Of greater interest are the changes in the penalty section. While licensed practitioners were given the exclusive authority to sign certificates and sue for fees, it was now only the willful attempt to deceive the public regarding one's registration status that would attract a penalty for illegal practice.[83] The ability to prosecute for unlicensed practice had clearly been attenuated. There seemed a clear acknowledgement that a great deal of "health care" was sought and accepted from nonmedical practitioners. Indeed one estimate suggests that even by the time of Confederation, only one third of those offering their services were registered.[84]

The profession also turned inward to consider discipline of those already licensed. As early as 1868

82 S. 20
83 S. 31
84 Godfrey, *supra* n. 67, at 83

the "Medical Alumni Association of Victoria College" sought to discipline, obviously without effect, several physicians for such deeds as proclaiming useless cures, advertising, and being associated with an eclectic practitioner.[85] By 1886 the Ontario College sought amendments to allow erasure for "infamous or disgraceful conduct in a professional respect".[86] This phrase eventually appeared in the 1887 amendments.[87]

Before turning to the application of these provisions, it might be worth keeping in mind the context of any such attempts at discipline. The College was not without opposition. For instance, the tensions with the medical schools continued. In an 1889 speech one professor proclaimed:

> [The boards] have in some provinces assumed the role of educators, and dictate to teachers what they must teach and to learners what they must learn. They have injured the profession they were intended to protect, and they have hampered and impeded the progress of the medical schools. . . . In particular, the College of Physicians and Surgeons of Ontario imposes upon our students certain very vexatious regulations, and exacts of them pecuniary taxes, wholly out of proportion to the benefits they

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85 Godfrey, *supra* n. 67, at 191
86 MacNab, *supra* n. 57, at 20
87 *An Act to Amend the Ontario Medical Act*, S.O. 1887, c. 24. Erasure was not to be imposed for adopting any particular theory of practice, because of political crimes out of "Her Majesty's dominions", or if the College feels the offence is trivial or the circumstances do not warrant erasure. S. 3

> may ever expect to derive from becoming licentiates.[88]

At any rate, even up to this point, doctors in Ontario were yet to really function as a profession. Of course there were attempts at asserting some control, but the repeated early failures at either establishing statutory control or maintaining it reinforce the notion that external conditions have to be right, both practically and politically, for any licensing scheme to succeed. No matter what the practitioners of the day asserted, there were simply not enough of them to cover the expanse of the province. Even if they could, there were again too many factions and rivalries to produce an effective monopoly. Nor could this occur as long as the legislation only gave the Medical Board nominal control over most applicants. It also seems true that most practitioners probably did not want the kind of control that some were advocating. This affected the influence the Board could have over those already registered as attested to by the large numbers who evidently refused to maintain their licenses from year to year.

In Ontario then, in some contrast to England and Quebec, factional fighting may have actually delayed the

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88 Professor R.L. MacDonnell, 1889, quoted in Hamowy, *supra* n. 47, at 176

acquisition of real autonomy. Clearly there were elements both within and without which did not think it a good thing for the profession to control itself this way. Yet in the end more or less the same result was achieved.

Perhaps if there is a key difference between the development of licensure laws in Canada and Britain it is the pragmatism which the profession needed to display here. Even where prosecution of the unlicensed was possible, it had to be done selectively to prevent an untoward backlash. Licensing authorities who took the role too seriously risked being ignored, being overruled, or even losing their mandate.[89]

Evidently though some measure of control was gained. It is still arguable as to what factors led to the increase in public stature which allowed this. One element, physicians would argue, is the increased standing of the individual practitioner. By the end of the last century there certainly had been some scientific

89 In 1907 the Nova Scotia Medical Board erased the name of Ira E. Dyas for presenting false credentials to obtain a license. The citizens of Amherst petitioned the government on his behalf. The Attorney-General introduced a bill to overrule the Board. This was eventually withdrawn and the erasure was upheld in court. *Re Ira Everett Dyas* (1908), 5 E.L.R. 545 (N.S.S.C.). See Colin D. Howell, "Reform and the Monopolistic Impulse: The Professionalization of Medicine in the Maritimes" (1981), 9 *Acadiensis* 3, at 17

advances which increased the efficacy, and hence the value, of medical care. Whether physicians took advantage of them is another matter. What is known is that the public image of the medical profession began to improve. One suggestion is that perhaps this had more to do with a more visible assertion of scientific power than might involve the individual patient. Thus, for example, physicians began to proclaim their authority, in the scientific sense, in matters ranging from public health to criminal behavior.[90] That is, almost any social ill might be treated as a medical problem for which, eventually, a "cure" might be found. Nevertheless, whether it was the new century or the rush of technological marvels at that time, a scientific model for a problem must have had some contemporary appeal. Promulgating such views, it could be argued, at least provided the profession with some good public relations.

American Medical Licensing

Only the briefest of comments need be made on the development of licensing legislation in the United States. There is clearly enough material to fill several tomes.[91] The point need only be made that there seems to

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90 *Ibid.*

91 See generally Richard H. Shryock, *Medicine and Society in America, 1660-1860*, 1960; Joseph F. Kett, *The*

be significant differences in this history compared to that already discussed.

The starting points, though, are quite similar with most immigrant practitioners being surgeon-apothecaries, usually from rural England.

With this migration occurred an important semantic event similar to what occurred in Canada. All of these practitioners, almost none of whom were physicians in the English sense, began to be called "physicians" and to take the title "doctor".[92] To this day English surgeons may still be referred to as "mister" but from the outset there was to be no such distinction in America:

> Where America differed from most European countries was the democratic assumption that allowed every would-be practitioner to call himself "doctor." Americans created a linguistic fiction of medical equality - even if there was no practical equality in terms of practice, education, and access to institutional status.[93]

Early colonial "licensing" laws were quite different from early English attempts to restrict practice. American colonies first began to confer licenses that

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Formation of the American Medical Profession : The Role of Institutions, 1780-1860, 1968

92 Kett, *Ibid.* at 6, Shryock, *Ibid.*, at 10

93 Charles E. Rosenberg, "Doctors and Credentials - The Roots of Uncertainty" (1984), 6 *Transactions & Studies of the College of Physicians of Philadelphia* 295, at 297

were really only honorary titles. Various individuals, beginning in the 1650's, were legislatively licensed in the sense that they were acknowledged to have demonstrated some skill, whether or not they had any training.[94] There was no attempt to restrict the activities of any others.

By the start of the Revolution it was estimated that only 400 out of 3500 practitioners in the American colonies had any formal training.[95] Nevertheless, thus began a period characterized by increasing attempts to legislate or otherwise limit licensure.

The ebb and flow of statutory provisions that characterized the first half of the last century in many American states was also influenced by many battles within the medical profession itself. All of the states had made a degree an automatic guarantee of a license. Not surprisingly, medical school became attractive as the method of choice for entering the profession. Medical schools began to compete for students. Schools were being opened yearly with at least thirty in business by 1839. Nor were these modest operations. Some had enrollments of over four hundred while schools at Yale and Harvard had

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94 Kett, *supra* n. 91, at 7
95 Shryock, *supra* n. 91, at 9

45 and 75 students respectively. Legislation generally encouraged the degree as the route to licensure and there were many in line to offer this service. Some schools unapologetically offered no instruction, saying they were thus saving the students money. They argued that schools that forced students to attend classes were doing so strictly for monetary gain:

> Now no board of professors or examiners have an equitable right to make more than one demand, and that is 'is the applicant qualified?' The requirement of a specified term, or time of study, is from purely mercenary considerations. If an applicant is born with the knowledge it is no person's business.[96]

It must also be remembered that any efforts at licensure centered ultimately over the only sanction that applied to unlicensed practice, the inability to sue for fees:

> The practical operation of these laws was rather favorable to the class of irregular practitioners. The penalty they imposed was never regarded [*sic*], the disability of collecting debts afforded a pretext for demanding payment in advance, and gave to their demands the character of debts of honor.[97]

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96 John C. Bennett, 1845, quoted in Frederick C. Waite, "The First Medical Diploma Mill in the United States" (1946), 20 Bull. Hist Med. 495, at 501. It might also be worth noting the lack of hospital involvement in American training compared to Britain. Shyrock, *supra* n. 91, at 142.

97 *Ibid*. at 21, quoting from "Report of a committee of the Albany Medical Society", 1844

In the context of these turf wars, another element was added: the Thomsonians.[98] This group, founded by a New Hampshire farmer, promulgated a limited herbal approach to therapeutics. They became a popular alternative to bloodletting and purgatives. In Canada they sought recognition in existing licensing legislation. Their American counterparts thought it better to "lick 'em" rather than "joining 'em". Their efforts contributed, in the 1840's, to almost every state abandoning any restrictions on medical practice. Those who sought to remove restrictions could rely on the persuasive argument that it was antilibertarian to intrude on individual rights this way:

> A people accustomed to govern themselves, and boasting of their intelligence, are impatient of restraint. They want no protection but freedom of inquiry and freedom of action.[99]

By the time of the Civil War licensing laws were either repealed in most states or simply ignored. If an individual sought a medical career, a degree was easily obtained and a license, such as it was, would follow. If

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98 *Ibid.* at 20-21

99 A New York State Senator who introduced the repeal bill in 1844. Quoted in Richard H. Shryock, "Public Relations of the Medical Profession in Great Britain and the United States: 1600-1870" (1930), 2 Ann. Med. Hist. 308, at 322. Shryock goes on to comment: "Thus did the democratic American of the forties declare his inalienable rights to life, liberty and quackery." at 323

an individual was not interested in a degree he could practice without one and suffer no real inconvenience.

Yet within twenty years laws restricting licensure became again the rule. Several factors allowed this resurrection. By this point the "irregular" sects were waning in popularity. In addition, the continued proliferation of licentiates based solely on a degree was beginning to cause concern. [100] It became necessary, it was argued, to establish some mechanism to assess the schools that were producing these graduates. Boards were established to screen schools by screening their applicants.

In other words the second half of the last century is characterized by a shift from an almost complete lack of regulation to the first signs of the framework of modern state licensing laws. Several factors were common:

> The [statutory history] reveals that there were four major avenues of reform for physician licensure: state boards were established to administer licensure, licensed practitioners were required to register with the state, license applicants were required to pass an examination even if possessing a medical diploma, and escalating requirements for curriculum length and content were imposed on the medical schools from which license applicants might come.[101]

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100 Samuel L. Baker, "Physician Licensure Laws in the United States: 1865-1915" (1984), 39 J. Hist. Med. 173, at 177

101 *Ibid.*, at 174

At any rate, events of this century, including the Flexner report on medical education and the emergence of the American Medical Association, probably had the most to do with shaping American medicine into the paradigm of professionalism that it remains. Nevertheless, even if this history is truncated at about 1900, there are parallels with the scheme that had developed in Canada. Still, at no time was the scene here as unregulated as it had been in the United States at mid-century.

Perhaps then it is necessary to confront the same factors noted earlier: provision of a valued service, increased respect for individual practitioners, increased prominence of medical opinion, an aura of scientific certainty. On the other hand, perhaps physicians climbed the social ladder because of their economic, as opposed to their scientific success. As incomes rose so, supposedly, would influence, particularly with their political cohorts.

Without more evidence of the political context of these events any conclusions would only be conjecture. There remain only some isolated clues that suggest many factors were at work. For instance, several times in the Ontario legislature reform was blocked by committees consisting only of physicians. On the other hand, as of

1832 the president of the Ontario Board was on record as opposing giving the Board a disciplinary function. There really did not seem, in any of these jurisdictions, an agenda or master plan which was being followed by the medical forces. While some in authority may have sought increased powers, there is evidence from the controversies in Ontario and the United States that not all practitioners supported their leaders. It seems some wanted to be let alone. Autonomy was to be a personal, not a collective, goal. Thus it is with those themes in mind that attention may now be turned to the acquisition of autonomy in Manitoba.

III. MEDICAL LICENSURE IN MANITOBA

It is in this historical context that we find the first session of the Manitoba legislature creating the "Provincial Medical Board of Manitoba".[102] The Board's only role initially was to assess training and even that function was limited to accepting those with university medical degrees and examining those without one. No disciplinary function was envisioned. Still the qualifications to become a student (in an as yet nonexistent medical school) were to include "good moral character", as well as some academic requirements.[103] More importantly only those registered with the Board were to practice medicine. As already stated, a monopoly on medical care was to be thus created.

From the perspective of the discussion in Part II it can be seen that this is a fairly modest beginning. Perhaps this relates to the point in time at which these early events took place. For example, Quebec was still functioning under its 1847 *Act* and would not undertake significant reform until 1876. At the same time it had only been two years since Ontario had reformed its

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102 *An Act Relating to Medical Practitioners in the Province*, S.M 1871, c. 26

103 S. 11

College. Finally, at the extreme, the American scene had just begun to come under some order.

At any rate, from this first effort further changes were made in 1877 when the Board became the College of Physicians and Surgeons of Manitoba.[104] Qualifications to practice were not changed but the practitioner, if registered, was allowed to sue for unpaid fees. (In the past fees were considered honoraria.) Furthermore fines for unlicensed practice were in part to go to the College.

The first power to revoke a license or restrict entry on non-academic grounds was granted in 1886.[105] Registration could be refused for a convicted felon and was to be revoked in the case of any practitioner convicted of a felony or a misdemeanor.[106] Finally registration could also be revoked for "infamous or unprofessional conduct in any respect". The important point here is that within sixteen years of the formation of the province Manitoba physicians had, in theory, acquired complete autonomy over who could or could not practice medicine.

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104 *An Act respecting the Medical Profession*, S.M. 1877, c. 13
105 *Manitoba Medical Act*, S.M. 1886, c. 31
106 S. 19

To put this story in the context of some of the approaches mentioned in the Introduction presents some difficulties. There are no surviving records of these very early political debates. Hence, it is unclear what factors resulted in the acquisition of autonomy by physicians in Manitoba. It is not known whether the usual arguments about professional training and commitment were advanced.[107] Perhaps the "trust"[108] argument was raised although we can not even be sure that the profession's reputation would have been what they claimed it was.

A more complete approach than this one would look at the socio-economic status of doctors at the relevant times. Did high remuneration lead to high status and that lead to the political recognition necessary for granting autonomy? The evidence on this point is beyond the scope of this review. Some physicians were certainly moving in the higher echelons of Manitoba society. It is just not that clear that as a group they were seen as that successful. Perhaps it only matters that some, the ones that the politicians knew, had achieved such a measure of status.

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107 Talcott Parsons, "Professions" (1968), 12 Int. Encyc. Social Sciences 536

108 William J. Goode, "Community within a Community: The Professions" (1957), 22 Am. Soc. Rev. 194

In any case the general format of the College of Physicians and Surgeons was established. Its "parliament" was a Council mostly elected by its members but with representation from the medical school. Eventually an Executive Committee evolved which had full authority delegated from the Council.

In 1888 several interesting changes were made to the 1886 *Act* which both increased and decreased the power of the College.[109] On the one hand the types of offenses which could disqualify individuals from registration were extended to include misdemeanors as well as felonies.[110] On the other hand, the College now had the discretion to disregard prior convictions because of the "trivial nature of the offence or from the circumstances".[111] In addition there was to be no erasure for "a political offence out of Her Majesty's dominions".[112] There was an additional provision precluding the College from erasing individuals for "adopting or refraining from adopting the practice of any particular theory of medicine."[113] This

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109 S.M. 1888, c. 36
110 S. 10. Previously conviction on a misdemeanor was grounds for erasure but not for initially refusing registration.
111 S. 11
112 S. 11
113 S. 11

concession to heterodoxy continued with the provision for homeopathic practitioners on the board of the College.[114]

The power of the College to discipline was significantly increased in 1920.[115] Registration could be refused or withdrawn for any offence under a provincial statute, not only for felonies and misdemeanors as before.[116] More importantly the grounds for discipline were redefined:

> . . . or of professional incompetence, negligence, or misconduct so gross as to disqualify such person, in the opinion of the council, from practising medicine, surgery or mid-wifery.[117]

The College was also granted the power to subpoena witnesses and documents.[118] No significant debate was recorded on any of these amendments.

The next gain by the College was the right to assess costs in a disciplinary hearing. Although there is no record of any opposition, it did take six months to achieve passage after the bill was hoisted when first introduced.[119]

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114 S. 1

115 *An Act to amend "The Medical Act"*, S.M. 1920, c. 74. See discussion, *infra*, regarding offences under the *Temperence Act* .

116 S. 3

117 S. 3

118 S. 7

119 *An Act to amend "The Medical Act"*, S.M. 1923, c. 31. Rather than attempting to defeat a bill outright, a

It might be useful at this point to reconsider how easily much of this legislation was passed, particularly at the outset. As suggested earlier perhaps any potential controversy here had already been spent elsewhere. That is, many of the battles may have already been fought. Still, there may be some local factors worth noting.

Firstly it is clear the medical community had little influence on the basis of numbers. The first register of the College lists only forty-nine practitioners up until 1883.[120] Nonetheless some of these had achieved influence that had little to do with medicine. That is, they became prominent for other reasons.

For instance, several physicians, being among the non-Metis population opposed to Louis Riel in 1869, gained notoriety for their efforts to thwart the rebellion. Four were among a group who tried to prevent Riel from seizing a warehouse. All were eventually captured and imprisoned. One, John Christian Schultz, managed to escape via an improvised rope and eventually arrived in Toronto where he sought intervention by the federal government. As with "war heroes" everywhere,

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legislative opponent would often move to table it for six months, a "six month hoist".

120 Ross Mitchell, *Medicine in Manitoba, The Story of its Beginnings*, 1954, at 57

Schultz and others quickly rose to prominence in the post-rebellion era. He was elected to Parliament and later appointed to the Senate. In 1888 he became Lieutenant-Governor of Manitoba.

Among those defending the warehouse with Schultz was John Harrison O'Donnell who went on to be first speaker of the Legislative Council, a short lived provincial version of the Senate. The first Speaker of the Legislative Assembly was also a physician, Curtis James Bird. It was these same Doctors O'Donnell, Bird, and Schultz who were also designated as the executive of the first Medical Board.[121] Another physician, D.H. Harrison, was even briefly premier in 1887.

Thus, perhaps more so than today, physicians were active in the real politic of the province. There were always three or four sitting as Members of the Legislative Assembly through to the 1950's.[122] It is difficult to do anything more than obtain hints of the influence of these medical politicians. As shown earlier, three of them had a role in both early government *and* early medical regulation. It would be interesting to show, for example, that they, as physicians, had clearly

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121 *Ibid*. at 48. S.M. 1871, c. 26, s. 4
122 Mitchell, *supra* n. 120, at 110

influenced the structure of the early legislation. Unfortunately there is no "smoking gun" evidence that they did so, either in the sessional records of the Legislature or in what private letters have been preserved.[123] Nevertheless, it cannot be denied that these men were prominent. It would be hard to conceive how such legislation would be passed without their approval.

It is also likely that the influence could have been less direct. As members of the early social and political elite of the province, it seems likely that they would have allies or at least like-thinking people within their social circles. For instance, the legal profession has always been well represented in the political forum. Those individuals would tend to be *ad idem* with their professional colleagues on the wisdom of self-regulation and discipline by professions.

It is worth noting the specific role of the medical politicians in the Legislature. Although in these cases it is possible to document specific comments on specific bills, it is less possible to be certain of the effect such intervention had. Nevertheless, their opinions were

123 Many of the public and private letters of John Christian Schultz are in the Provincial Archives, but a search of these was unfruitful.

clearly recorded. For instance, it is interesting that when amendments to *The Medical Act* were debated in 1903 the recorded opinions are exclusively those of the medical members. The bill recognized the federally created Medical Council of Canada[124]:

> Dr. Grain desired to place himself on the record in this matter. He had discussed the bill with several doctors, and the feeling in its favour was general.[125]

As will be shown again later, these medical politicians seemed to see themselves as speaking as much for their professional brethren as for their constituents.

Pursuit of Unlicensed Practitioners

Since most of this analysis focuses on the disciplinary functions of the College it should be remembered that, until recently, this was but a small part of the College's role. To put the disciplinary aspects in context, some of the College's other concerns might be briefly mentioned. Clearly the early years of

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124 S.M. 1903, c. 38

125 *Morning Telegram*, February 25, 1903. There were no official "Hansards" until 1958. From about 1885 until then, the only record of Legislative debates was that reported in the daily newspapers. These have been preserved in "Scrapbooks" at the Legislative Reading Room. The date of debate on a particular bill can be obtained from the *Journals* of the Legislature.

the College record little disciplinary activity. If anything this period is characterized by several obsessions. Chief among these was the prosecution of unlicensed practitioners. In fact this effort seemed almost all-consuming in the twenty years after the 1886 *Act*. Members of the College found several reasons to get animated over the issue. In some cases those practicing without a license were in fact medically trained and were only trying to avoid the steep entrance fee. Those who had paid would no doubt resent anyone else avoiding the charge. In other cases, as will be noted, the unlicensed were itinerant practitioners touting novel, but often questionable, therapies. Regular physicians saw them as modern day snake oil salesmen, taking advantage of desperate members of the public. Finally there were others, generally without formal training, who practiced various healing arts within their own ethnic communities. These were not seen so much as a threat to their patients as to the economic health of the local licensed practitioner.

No effort was spared to put down unlicensed practice. Rural practitioners regularly "reported" every

incident they heard of.[126] The College also relied on detective agencies to gather evidence. However, the College's efforts were not without difficulties. A private detective reported his failure to get evidence that an unlicensed practitioner was actually prescribing medication:

> The other patient I sent to get treated for lung disease. He also failed to get any prescription and after two trials I withdrew him also.[127]
>
> I went even so far as to place a spotter in a certain residence in the city where "Bergman" was treating a patient.[128]

This raised one of the difficulties particularly with "alternative" therapies. What constituted medical practice? Consider the question of electricity. All manner of diseases, promoters would claim, could be cured by an electric current. In fact, there was no evidence then, nor is there now, that such an approach had any effect on most conditions. Electrical "therapists" would, however, promise to cure illness. The College saw this as practicing medicine. However, as the College's lawyer

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126 For example, Letter, W.J. Roche to CPSM, 26 April, 1887. From the Provincial Archives of Manitoba. See Part IV, *infra*.

127 Letter, McKenzie's Detective Agency to CPSM, 5 March, 1895

128 Letter, McKenzie's Detective Agency to CPSM, 10 October, 1895

contended, if treatment with electricity was "medical practice", why was it not taught in medical schools:

> It would nevertheless be impossible to procure a conviction until at least the medical Schools have as a whole taken up electricity as part of their course, and have qualified their graduates as Electricians to the necessary extent at least of prescribing and administering electricity for medical purposes, and until a reasonable number of Medical Practitioners have procured the necessary apparatus to properly treat diseases electrically. In other words, on proof that the Manitoba Medical Association does not teach electricity to its students, it would be impossible to convict those who are not graduates for administering electricity for the cure of disease.[129]

In other words, the lawyer was saying, it did not matter whether electricity was a useless treatment. If the College wanted to call it "medical treatment" it would somehow have to be part of regular practice.

To get around these difficulties a bill was proposed that would have further restricted unlicensed practice by including in the definition of medical practice:

> . . . prescribe direct, recommend, advise, administer, or apply . . . any drug or medicine or other agency or application, mechanical, medicinal or otherwise...[130]

In other words even the most informal of advice could attract prosecution. Still the bill failed; the

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129 Letter, Frank H. Phippen to CPSM, 19 September, 1903
130 *Bill #74*, Manitoba Legislature, 1900

Speaker ruled it should have been brought forward as a private bill and hence was out of order.[131]

In any case, there is evidence here of one of the processes of professionalization, the need to prevent "encroachment".[132] The aggressive assertion of monopoly is also a critical element of professional autonomy.[133] Yet the profession would argue that it is acting in the best interests of the public. It must make its goals the same as the public's.[134]

By the time of the next significant amendment to *The Medical Act*[135] a fair amount of controversy had developed. The 1906 bill, proposed by the College, provided for a more complete and restrictive definition of medical practice. It seemed not to have gone as far as the 1900 attempt, but there was opposition, particularly from the Christian Science community.[136] The College was also given the discretion to force even British graduates

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131 *Free Press*, June 13, 1900
132 Eliot Freidson, *Doctoring Together: A Study of Professional Social Control*, 1975
133 Magali S. Larson, *The Rise of Professionalism: A Sociological Analysis 1977*
134 Vernon K. Dibble, "Occupation and Ideologies" (1962), 67 Am. J. Sociology 229
135 *An Act to amend "The Medical Act"*, S.M. 1906, c. 43
136 *Morning Telegram*, March 2, 1906

to take licensing exams.[137] The debate which followed provides a few hints of some pockets of resentment against the medical monopoly:

> Mr. Val Winkler was unsuccessful in a suggestion that as the bill was supposed to be for the protection of the public, a scale of fees to be charged by medical men be inserted to prevent the overcharging that was now practiced.[138]
>
> . . . and J.D.. Riddell got after extortionate fees.[139]

The other problems the College had were more political than scientific. As noted, in various ethnic enclaves care was often provided by lay practitioners who maintained strong local support. In 1895 the College lawyer warned:

> There is a great deal of "Patron" jealousy latent in the legislature, in fact it is somewhat pronounced, and besides this, the Mennonites are to some extent a people of themselves. A bill therefore to repeal the clauses forbidding medical practice without registration might have strong support though we think it would fail of passing. Still a doubtful contest is not to be desired. We think therefore that the implied promise given to Mr. Winkler that if his bill were not put forward the two persons in question would not be further prosecuted by or at the instance of the Council was not very wisely given but under the circumstances was called for.[140]

The same concerns were restated in 1900:

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137 However the patriotic fervor of a world war caused the province to recognize British degrees again in 1916. S.M. 1916, c. 67, s. 1

138 *Free Press*, March 6, 1906

139 *Morning Telegram*, March 9, 1906

140 Letter, Hough & Campbell to CPSM, 20 June, 1895

> The Attorney-General says he thinks maintaining the conviction would produce a tremendous amount of feeling and might lead to an attack upon the Statutory powers of the College. He thinks that for strategic reasons you should recede and says that he is much inclined to think that the Lieutenant-Governor in Council might feel it necessary to remit the fine. . .
>
> In Morden and its vicinity any officers who attempted to institute a prosecution we were told would be in danger of making the acquaintance of Judge Lynch. As one gentleman phrased it tar and feathers would be a very light and merciful proceeding.[141]

Thus, it seemed, some attempts to prosecute ethnic practitioners were met with political opposition which, in some cases, seemed strong enough to threaten the College's very existence. Hence, the decision not to pursue these cases.

This suggests the need for a note of caution when looking at some theories of how the medical profession acquired its level of autonomy. Perhaps we have been dealing with straightforward "political" decisions made to solve a situation. Yet according to writers like Freidson and Blishen it is the *overt* display of control, the adherence to standards reflected in a code of conduct, and the claim of acting in the public interest which are necessary to maintain professional control.[142] Here the urge was to cut losses. Yet there is an early

141 Letter, Hough & Campbell to CPSM, 22 November, 1900
142 Bernard Blishen, *Doctors in Canada,* 1991, at 8

hint of the kind of threats which could confront the College's autonomy.

The final difficulty the College faced was where the putative "irregular" was the only practitioner of any kind for miles. To take such an individual out of the picture would prejudice the care available in several small towns. In these cases the College usually stepped back from a confrontation:

> I explained to Dr. Molecy that while we could not issue written authority to continue in practise at Whitemouth we could assure him that any objection to his so doing would not come from this end. I am sure your district is much in need of a resident practitioner and owing to its sparse settlement it would be difficult to obtain a regularly licensed man.[143]

> I took this matter up with the Council and it was the opinion of that body that we could not in any way be responsible for any of the good kind acts you are apparently doing in your community as under the Medical Act we could not do this; however no prosecution will come from this office if we are not importuned in the matter by physicians or parties interested in the community where you reside.[144]

In the end then, a reasonably pragmatic approach was necessary. There were indeed prosecutions for unlicensed practice but it seems only the most overt offences would attract attention. This may have been simply to preserve

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143 Letter, CPSM to R. M. of Whitemouth, 6 December, 1919
144 Letter, CPSM to J.H. Lowes. 24 March, 1921

an economic interest or it may have been to demonstrate the College's control.

The College and the Legislature

Some of the same themes appear in various legislative battles over access to practice. Some such battles were concerned with bills which would allow specific individuals to practice. For instance as early as 1887 several attempts were made to license a number of individuals by private acts.

The possible influence of the medical politicians can be seen in these debates. A Mrs. Powers had recently been prosecuted by the College for illegally practicing midwifery. A bill was proposed to allow her to do so legally despite *The Medical Act*.[145] The bill itself would licence anyone who had practiced midwifery before 1870. Doctor (later Premier) Harrison opposed the bill for thus opening the doors too wide.[146] This was despite the fact that there were no individuals other than Mrs. Powers who could qualify. Dr. D.H. Wilson, the Provincial Secretary, also spoke against the bill for the same reason. Another member argued the legislature would be insulting the College to override it in this way.

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145 *Bill #57*, Manitoba Legislature, 1887
146 *The Morning Call*, June 10, 1887

Opposing the medical community was a large petition signed by women in Winnipeg endorsing the bill. One member suggested that the legislature had already given too much authority to the College if the wishes of the populace could thus be ignored. It was noted similar bills had already passed allowing particular lawyers and land surveyors to register despite inadequate qualifications under existing legislation. At any rate the vote on the bill was a tie which the Speaker broke with a negative vote.[147] The two physicians who spoke against the bill were in the cabinet and might have carried some influence, although not with other cabinet members who supported the bill. What influence they had on backbenchers is uncertain. At least at this first attempt, the College's authority was preserved.[148]

However at that particular time there was also evidence of compromise or at least some deal-making. Correspondence from the College lawyer suggests the College would only succeed in stopping these bills if they acquiesced elsewhere. The College clearly was not

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147 The Speaker voting against the bill sparked another debate concerning the tradition that Speakers usually vote in support of legislation. *The Morning Call*, June 10, 1887

148 Bills authorizing licensure of two other individuals had to be withdrawn in 1888. *Manitoba Free Press*, May 17, 1888

keen on having every one of its denials of a license appealed to the Legislature. At the same time there was pressure to follow the Ontario lead and accept homeopathy. Thus to avoid recurrent private members bills the College acquiesced and licensed homeopathic practitioners and gave then representation on the College's Council.[149]

Consider also bills introduced in 1900 to allow Elizabeth Russell to provide the "Indian cure for cancer".[150] There was vigorous debate on both sides but the comments of one of the physician members are interesting:

> Mr. Grain, *as a medical man*, was opposed to special legislation in a case of this sort.[151]
>
> Dr. Grain stated that *he had been requested by the medical men of the city* to oppose the bill, as it would throw open the door for a host of quack practitioners who would immediately besiege the government for similar legislation . . . He felt certain she [Mrs. Russell] did not know the difference between various kinds of cancer.[152]
>
> If she could really cure cancer he [Dr. Grain] would have no objection to giving her the privilege, but *medical men who had spent years in studying scientific methods should be protected.*[153] (Emphasis added)

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149 Letter, Hough & Campbell to CPSM, 11 May, 1888
150 *Bills # 49, 68*, Manitoba Legislature, 1900
151 *Manitoba Free Press*, May 18, 1900
152 *Tribune*, May 18, 1990
153 *Morning Telegram*, May 18, 1900

When the bill was reintroduced the following month similar remarks were noted:

> Dr. Grain, *representing the medical profession*, opposed the bill. If legislation of this kind were begun there would be no stop to it.[154]
>
> Dr. Grain objected *on behalf of the medical profession*.[155] (Emphasis added)

Other members suggested the Legislature was ill-equipped to assess the merits of any treatment. The measure was defeated. It is interesting again here that this politician did not even pretend to be speaking on behalf of those who elected him. At least in these debates, he was representing and speaking for his medical colleagues.

Even after that "success" the College was advised by their lawyer not to pursue the case:

> As she did not appear to be taking away from the medical Fraternity cases capable of successful treatment, and as, by reason of the faith the patient must have in this woman before he would consult her, she was doubtless to some extent temporarily relieving the minds of incurable sufferers, it occurred to me that this was not a case where the Association should invoke legal assistance for the purpose of preventing her treating cases.[156]

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154 *Manitoba Free Press*, June 9, 1900
155 *Morning Telegram*, June 8, 1900
156 Letter, F.H. Phippen to CPSM, 7 October, 1903

After that though it was less often bills regarding licensing individuals that caused concern as those which sought to license an entire "sect" such as osteopathy and chiropractic among others. A standing committee existed for several years whose purpose was to monitor and lobby against any legislative initiative in this area.[157] While there was some economic concern at the heart of this, it really seems clear that established medicine did not see these schools as offering anything of value to patients. Regular practitioners saw these proponents as pretenders and quacks and viewed their approach with considerable disdain, almost vitriol. For example, in response to an enquiry from Ohio the Registrar stated that Chiropractic was illegal in Manitoba. This prompted the following exchange:

> Wish to advise you that the above reply is very indirect and un-explanatory, would consider it a great favor if you would cite me the statute of law sustaining your above statement.[158]
>
> I see that you sign yourself "Dr". I find that your name is not on the medical register of Ohio. If you would be good enough to inform me what your medical qualifications I should then be in a position to determine how to deal with your request.[159]

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157 The "Committee of Twelve" for a time included Dr. R.S. Thornton who also happened to be provincial Minister of Education.

158 Letter, J.T. Beckett to CPSM, undated

159 Letter, CPSM to J.T. Beckett, 29 August, 1924. Interstingly, the Registrar had pencilled in "regular" by Beckett's signature.

A proposal to prevent chiropractors and osteopaths from using the title "Doctor" was introduced in 1926.[160] The bill was withdrawn with the most vigorous opposition coming from a member who was studying chiropractic.[161] Of course, eventually chiropractic was accepted by the Legislature, although not by the physicians. For many years it was considered improper to have any contact with a chiropractor, especially not to share patient information or X-rays with one. Physicians were not even to rent space in the same building. Oddly, this attitude never really extended to other practitioners such as optometrists.

This sort of interprofessional disdain aside, in order to win the political battles, the profession had to assert its own validity. The secondary benefit was to maintain the value of the College, and like organizations, to the membership:

> In a period of change affecting the professional role, a professional association seeks to emphasize the legitimacy of its professional culture for the lay public and its own practitioners.[162]

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160 *Bill #109*, Manitoba Legislature, 1926
161 *Manitoba Free Press* , April 26, 1926
162 Bernard Blishen, *Doctors & Doctrines* 1969, at 163

The College and "FMG's"[163]

Another aspect of limiting access to practice was the licensing of foreign graduates. This subject frequently attracts the most scorn from critics of professional licensure. A body such as the College is essentially predisposed to ration opportunities to enter practice in order to protect the economic well-being of those already licensed. There is a further inclination to restrict entry as much as possible to those applicants who would best fit in to the existing medical milieu. Goode speaks of a professional community with shared identity, values, and language.[164] This may not only have been the identity acquired at medical school but also in the entire societal context in which the physician developed. Physicians whose ethnicity and culture put them outside the group could find entry difficult. There had been and is a tendency to select those most like the ones doing the selecting.

The College's response has always been that quality must be maintained. They could, based on their

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163 Foreign Medical Graduates. The term has attracted such a negative context over the years that the current preferred term is Graduates of Foreign Medical Schools (GOFMS) or, more recently, International Medical Graduates(IMG's).

164 William Goode, "Community within a Community: The Professions" (1957), 22 Am. Soc. Rev. 194

experience, judge applicants from schools they knew or who were already licensed in jurisdictions with standards similar to this one. An individual from somewhere else would have to be assessed by some means, such as exams or extra training, before they could be allowed to practice. Hence from early on European graduates were required to take exams in English and often repeat a final year of training. All this was for the sake of maintaining quality. Yet there could have been other concerns at work. Put bluntly, there could have been outright prejudice against foreign graduates. There are hints of this. For instance, in 1935, the city solicitor wrote requesting particulars on licensing his son-in-law, who was a physician in Hungary. The Registrar responded, first listing the exam and study requirements and then admitting:

> This is about the only condition under which the applicant from a foreign country could be admitted, and I must state that there is quite a prejudice on the part of The College of Physicians and Surgeons of admitting any such applicants into the Province. Some of these individuals have been admitted to other parts of Canada, and almost invariably have given a great amount of trouble after they have been allowed to carry on the practice of Medicine.[165]

These attitudes came under legislative scrutiny in 1939. A bill was introduced to allow Dr. Georg Kimel, a

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165 Letter, CPSM to J. Prudhomme, 15 October, 1935

Jewish refugee from Nazi-occupied Austria, to practice despite a ruling by the College that he must take an exam in English or French, neither of which he spoke.[166] The problem for the College was that he was eminent in his field. What motivated the College or its backers is unclear. There may be elements of anti-Semitism (the Medical College restricted Jewish admission then) or pre-war xenophobia. Still, of greater interest is the response of the legislators.

For instance, the premier, Mr. Bracken, initially supported Dr. Kimel but later stated he did not like the idea of overriding a body given the power to deal with medical affairs.[167] All three physician members of the House opposed the bill strongly and the measure failed. The defeat of the bill was sharply criticized in the media:

> Members who went off the deep end in booting the bill out may be unlucky enough to have a non-statesmanlike nightmare or two, as a result. Thomas Mann, one of the great twentieth century minds, claims that North America is to become the repository of cultural and scientific knowledge during Europe's forthcoming second Dark Age: and Winnipeg has in this instance put buttons on the collection plate.[168]

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166 *Bill #135*, Manitoba Legislature, 1939
167 Though it was mentioned in debate that the legislature had overruled the Law Society at least twice. *Winnipeg Free Press*, April 18, 1939.
168 "Under the Dome" *Winnipeg Free Press*, April 18, 1939

To take another example, a few years later the College received a request from the government to allow another refugee physician to work in a mental hospital. This was reluctantly approved "verbally" but only until the war was over. The College did not even want to be held to that commitment:

> There should be nothing in the minutes that would in any way commit the CPSM to words sanctioning the registration of the above-named doctor.[169]

In fact the College's difficulties in this area only got worse with the increasing number of refugees that arose after the war. At that point the following motion was passed:

> Whereas the sphere of greatest usefulness for these men is in the countries from which they originally came,
> Moved that no applications for licenses or enabling certificates be considered, unless the candidate works for the government and takes one year of medical college.[170]

Again one could speculate as to the motivation behind it. Perhaps it is the kind of reaction not uncommon during periods of increased immigration. There is, after all, no real concern expressed in the accompanying debate that these refugee physicians were of

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169 Minutes, Registration Committee, 11 December, 1942
170 Minutes, Council, 17 October, 1945, rescinded 19 May, 1948

low standard in ability, simply that they might not fit in.

The College and Medical School Admissions

Another important aspect of the control of entry into the professional circle is the admission of trainees. The College in Manitoba did not have a direct role in this but the topic arose frequently. Evidently the College felt it had some influence in the matter. A brief look at how some aspects of this were handled will at least highlight how certain attitudes were expressed.

From time to time there had been criticism of the admissions policy at the medical school. These complaints generally concerned claims that applicants were accepted or rejected for extraneous reasons such as family connections or ethnic group. To avoid such complaints, the medical school began to rely on academic criteria to a greater and greater extent by the 1940s. Prior to this, for instance, there had been limits on the admission of Jews. This was no longer to be the case. Now to put the best light on it, it was not so much that the school or the College did not feel Jews should not be doctors but that they might be overrepresented in the medical school for the size of their community. There is a discussion in 1945 at which the College heard that strictly scholastic

admission criteria would result in a class that was 30% Jewish. There was concern that this would "lead to bitter animosity" and the College should take a role to "maintain the peace". It was even suggested that Jewish community leaders be approached to find a way to limit Jewish application to medical school, although, in the end, no definite action was taken.[171]

A few years later the "marks only" question arose again. The discussion is the same one that continues to arise in professional schools to this day. There was a reluctance to rely only on marks but no other approach seemed satisfactory. Letters of reference could be sought but they seldom really enlightened. Then, as now, interviewing any large number of applicants could be impractical. Using academic criteria alone still seemed fairest although one member of the Council in 1949 expressed his frustration at selecting candidates by this method alone:

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171 Minutes, Council, 17 October, 1945. It is difficult in hindsight to judge attitudes. Consider the following exchange of telegrams:
CPS Alberta: "What do you know of Doctor J.L. Wiseman? What is his nationality?"
CPSM: Wiseman a Jew nineteen twenty-six graduate. (29 March, 1927)
Would we now assume nationality meant ethnic group and why would the Alberta Registrar want to know that in the first place?

> . . . which is impossible when only names, not necessarily the original ones, and yearly examination averages are available. The applicant for all I may know may be a stuttering, cross-eyed, misfit.[172]

The reference to "original" names is interesting. It could mean that the speaker wanted some information on a candidate's ethnicity which he might only be able to perceive from a name. It could mean that candidates, for this and other reasons, might change their name to conceal their origin.

If in this discussion some question is raised that certain members of the medical community had certain attitudes to foreign graduates or members of particular ethnic groups, then this should be kept in mind in the following discussion on discipline. In some cases it is not immediately clear why a proceeding yielded a particular result. It is at least possible that there are unstated prejudices at work.

Before turning to a review of the disciplinary process a few observations could be made. As far as the political history goes, it does seem that licensing legislation passed here with considerably less controversy that it had elsewhere. The possible role of the medical politicians in this has been discussed. Also

172 Minutes, Council, 19 October, 1949

of note is the lack of the kind of factionalism that had plagued the profession in Ontario and Quebec. In part this stemmed from the very different relationship of the College had with such forces as the medical school. For example, unlike elsewhere, the College never really had a role in examination of applicants for licensure, and from almost the beginning yielded this to the medical school. This avoided one source of conflicts that had arisen in both Ontario and Quebec. More fundamentally there is just no evidence of the power struggles that had occurred in the East. The relationship had been different from the outset. Part of this may have arisen because there had been a unity of personalities. Instead of two factions of physicians it was often the same physicians merely changing hats. Hence, both bodies appointed representatives to the other. In fact, for a time, the *University's* representative on the College's Council was the College Registrar.

According to some previously noted theories one would expect certain other factors to be evident in maintaining this level of solidarity. While Blishen notes that ethical codes are useful means of control by the group, others such as Larson and Freidson point to their value in maintaining group unity. Larson sees such codes

as modifying internal divisiveness. Freidson similarly then sees such codes as important in enhancing solidarity.

All one can note at this point, and as will be seen in the next part, is that a code or codes, at least in the sense of a written document, were never referred to in the early or mid years of the College's archives. As will be seen, there are clearly *unwritten* rules or ideologies by which physicians were judged, but there is no evidence that an enumerated code played any role. This is not what one might expect based on the concepts stated above. The Code of Ethics did not, play any role in discipline, or on the process of the maintenance and advancement of self-regulation.[173]

One finally might also note the same pragmatism which caused other Canadian colleges to respect the geography of the country and turn a blind eye to unlicensed practise when that was all that was available. Still, through admission and registration policies, the profession here as elsewhere sought to control the makeup of its membership.

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173 There was some form of Code of Ethics produced by the Canadian Medical Association since its founding in 1867. Gilbert Sharpe, *Health Law in Canada*, 1987

It also, like elsewhere, guarded its territory fanatically from alternative therapists. No lobbying effort was spared to stop bills legalizing optometry, chiropractic, or podiatry. It is possible the motivation was purely economic but there are other elements as well. In the case of chiropractors there is an almost Balkan level of distrust and dislike. It really does not seem that the College was particularly concerned that chiropractors had anything of value to offer the public. Internally they honestly did seem to worry though that a gullible public might accept and legitimize the alternative approach.

Again, of course, the value of advancing such battles at maintaining internal cohesion can not be underestimated. Rather than a body supervising their lives and occasionally acting *against* them, the College had to be seen as an entity which acted *for* doctors, individually and collectively.

It is against this background that a survey of the early disciplinary files of the College might offer additional insight into their professional motivations.

IV. THE DISCIPLINE OF PHYSICIANS IN MANITOBA

Methodology

To assess trends in medical discipline the archives of the College of Physicians and Surgeons of Manitoba, now deposited in the Provincial Archives of Manitoba, were reviewed. This material consisted mainly of recorded minutes and correspondence. Archival material older than fifty years is open to the public. More recent material can only be reviewed with permission which was obtained from the College. Thus there will be no particular attempt to conceal the identities of physicians disciplined in the earlier period since this is now part of the public record.[174] However identities will not be revealed for more recent cases, nor will the identity of patients or other private individuals be mentioned from any period.

Minutes were available from 1882 to 1971. Correspondence files covered 1882 to 1935. More recent correspondence was apparently largely discarded when the College moved offices. They had apparently not thought it would be of further interest. It should be noted that even in the correspondence files reviewed, which included

[174] As will be noted, at the time even those subject to erasure from the register were not necessarily revealed to the public nor to other physicians.

all letters sent and received in a given year, disciplinary matters comprise an extremely small part, certainly no more than 1%.

Another issue is the completeness of the files. It is impossible to be sure of this. Generally incoming and outgoing letters could be matched. Tentatively the files seem complete. One possible exception was when a letter received was then sent out, such as to the College lawyer. In the days before photocopiers this meant sending out the original, and hoping it was returned, or completely retyping a new version. Thus where a letter seemed missing, there was usually a reason such as that evident.

Presenting in some detail the results of disciplinary proceedings may illustrate some of the motivation and attitudes which affected the outcome. Perhaps even more so, noting those complaints which did not result in any sanction may also be revealing. Was the level of control as effective as authors such as Blishen claim?[175] Or did control consist less of imposing

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175 Bernard Blishen, *Doctors in Canada*, 1991, at 122

sanctions and more of "coopting" into a group ideology?[176]

In the discussion that follows there will no particular reference to disciplinary procedure, but rather on motivation. Suffice to say that for the period covered the process was essentially the same as in any such body. Complaints would be given a preliminary review by a committee which might recommend a formal inquiry. The latter might be done by the same group or a different one. Final decisions, at the time, would rest with the Council or, in some cases, the Executive Committee.

In other words, from the point of view of this paper, the internal workings of the College are not particularly relevant. An "opinion" or "ideology" can, for this purpose, be taken as more or less representing the view of the College, whether it is expressed by a committee or the Council. Internal divisions will be noted but whatever the source it will be assumed to be demonstrating a sense of the norms imposed and the ideals being advanced.

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176 Barbara and John Ehrenreich, "Medicine and Social Control", in *The Cultural Crisis of Modern Medicine*, (ed. John Ehrenreich), 1978, at 48-49

On another point, all correspondence passes to and from the Registrar. In the narrow view his opinions could be taken as being only his own. Nevertheless, he served at the pleasure of the College and, for these purposes, can be taken to again represent the collective view.

Unlicensed Practitioners and Their Friends

As discussed in the last Part, the College was preoccupied with eliminating unlicensed practitioners. When one of their own licentiates dared to associate with the latter, the College took a dim view. Hence the first four disciplinary actions ever launched by the College concerned this issue.

Feeling at risk of prosecution, some "irregular" practitioners associated themselves with licensed physicians who did the actual "practising". When the College had difficulty pursuing the unlicensed culprit, it found it could still wield its authority over its own licentiates. Thus the earliest element of "unprofessional conduct" was association with an irregular practitioner, and its commonly associated evil of improper advertising and promotion.

This may all seem like further advancement of the medical monopoly, but at least outwardly the purpose was

to protect the public, and many practitioners probably took this as an honest goal. They saw these itinerant therapists as extracting money from the public in exchange for what physicians considered useless or even harmful therapy. Hindsight has confirmed the view that there were no magic cures being provided. Still, even at that time, physicians perceived their patients at risk. The Registrar of the College regularly received letters from physicians describing the large sums desperate patients were paying for empty promises. In one letter, a Minnedosa physician wrote regarding Professor Olin Orville and the twenty-five dollars he charged for six months of "electric" treatments, with a cure guaranteed at the end of that time. Recognition of an economic threat to his patients and to himself may have precipitated the local doctor's slightly ambiguous closing remark:

> Hope you may be able to convict Orville and his staff as they take plenty of money out of the country if allowed to go on unmolested.[177]

Shortly thereafter the College took action against two physicians associated with Orville and another unlicensed practitioner, J.D. Kergan. Over the seal of the College two identically worded notices were prepared:

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177 Letter, W.J. Roche to CPSM, 15 June, 1887

> Whereas it has been alleged that one Charles Anderson McRae whose name is on the Register of the College of Physicians and Surgeons of the Province of Manitoba is and has been guilty of unprofessional conduct in assisting and serving and working in conjunction with one J.D. Kergan of Detroit, Michigan, U.S. who is not registered as above and who is adopting unprofessional methods of advertising the practice of medicine and medical treatment by flaring [*sic*] newspaper notices, street placards, and circulars, and otherwise, and whereas such conduct is opposed by the true professional spirit and practice of the medical profession . . .[178]

Within a week the doctors were to appear before the Council to defend themselves:

> . . . to hear the verification of the above statements and to hear what the said Charles Anderson McRae may have to show or say in cause or defence of his conduct and in answer to such charges and to consider the same . . . if he does not attend or his explanations or defence be deemed unsatisfactory, the Council may proceed and direct the Registrar to Erase his name from the Register of the College of Physicians and Surgeons of Manitoba and otherwise to deal with him as by law empowered as they may deem fit . . .[179]

Clearly in this case there was to be no presumption of innocence. The aggressive strategy likely originated with the College's solicitor who wrote to the Registrar on the same day as the resolution, also advising on how to ensure a conviction:

> In proceeding to get evidence against the accompanying registered physicians get sufficient admission of the four following points. You will get the admissions sufficiently by going straight to the

178 "Resolution and Notice", CPSM, 27 June, 1887
179 *Ibid.*

> parties, do not question them as to the facts, but assuming the facts, go asking for their reasons for the same. We merely suggest this as the best method.[180]

In what would seem unfortunate timing for the accused, prior to the "hearing" the College obtained a copy of a letter Professor Orville had written to a local hotel owner. On stationary containing the professor's picture and identifying him as "America's most successful specialist" was the printed by-line:

> Employing about 25 Homeopathic, Eclectic, Reformed, Osteopathic, Physicians and Surgeons, Expert Electricians, Specialists, and Lady and Gentlemen assistants, etc. They are having unparalleled success in the treatment of all difficult and supposed difficult and hopeless diseases of Men, Women, and Children.[181]

In the letter the professor acknowledged that while he did not know which disease the hotelier was suffering from, he was confident a cure would follow. He closed by assuring that :

> We are thoroughly equipped to give patients every satisfaction in the world. I am safe in saying that there is no such Institute as ours in the whole Dominion.[182]

The minutes of the hearing which followed contain no detail except the comment of one of the accused that he

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180 Letter, Hough & Campbell to CPSM, 27 June, 1887
181 Letter, Olin Orville to Proprietor, Queens Hotel, 30 June, 1887
182 *Ibid.*

had lost all respect for the medical profession.[183] There was no immediate decision to erase, possibly because the College saw a potential problem. One defendant, Dr. George Leslie Airth , was licensed in Manitoba by virtue of his British registration by the General Medical Council under the Imperial *Medical Act*. In a letter to the GMC the Manitoba Registrar expressed concern that Airth's British registration precluded him from being erased in Manitoba. The British Act would take precedence in the colonies. Even if he could be erased there was nothing to stop him from reapplying and demanding reregistration on the basis of his licensure by the GMC.[184] To get around this the College forwarded copies of all Airth's advertising materials to the GMC and requested they consider erasing him from their own register, thus precluding registration in Manitoba:

> As all your licentiates are subject to your authority our Council has directed me to notify you of these facts and ask your assistance in having Dr. Airth's name removed from your register. We think that the fact of his practicing unprofessionally in a colony does not remove him from your discipline. What is necessary [illegible] to have action taken?[185]

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183 Minutes, Council, 4 July, 1887

184 Which is what courts elsewhere have found: *Regina v. College of Physicians and Surgeons of Ontario* (1879), 44 U.C.Q.B. 564; *Metherell v. The Medical Council of British Columbia* (1892), 2 B.C.R. 186

185 Letter, CPSM to Registrar, General Medical Council, 12 July, 1887

Some months later the College was advised that nothing could be done:

> Unless the Royal College of Physicians withdraw their license from Airth it is not within the power of the General Medical Council to give any effectual help in regard to this matter.[186]

There is no further mention of Dr. Airth in the minutes although a motion to erase his co-accused, Dr. Charles Anderson McRae, was passed some weeks later.[187] However, it may be that this was not enforced as an identical motion was passed a year later.[188] This was despite warnings from the College solicitor that the College should not do so:

> The solicitor, Isaac Campbell, stated that it was not advisable to proceed against certain persons guilty of unprofessional conduct, such as those practicing with J.D. Kergan, until a precedent for such were established in some of the older provinces.[189]

There is one final reference to Dr. Airth in a letter from the Ontario Registrar who wanted to erase him from their register even if he did not seem to be practicing there. Any action would require a signed complaint by four physicians registered in Ontario. It was hoped there were four such in Winnipeg who might make

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186 Letter, Registrar, General Medical Council to CPSM, 2 November, 1887
187 Minutes, Council, 31 August, 1887
188 Minutes, Council, 5 September, 1888
189 *Ibid.*

such a complaint and provide the evidence. If all else failed, the Ontario Registrar noted:

> . . . it would be good corroborative evidence if he pursues a similar course in our province at some future time.[190]

Later that year another physician was found associating with J.D. Kergan and advertising his treatments. A petition from eight physicians prompted the Discipline Committee to recommend the erasure of John Hutchinson. The Annual meeting received their report but took no further action.[191] The College lawyer evidently thought the case was weak:

> Has anyone yet obtained an admission from Dr. Hutchinson that he was aware of the insertion or existence of the advertisement containing the statement that no one leaves the Kergan Physicians without being cured?
>
> The advertisement as it stands now in the Newspapers may be vulgar, but that sentence left out, we do not see that it involves a charge of quackery. We will want some proof of that kind and we will want or greatly like to know where it comes from before serving a Notice. We must prove that fact by a Witness of our own not by calling in Dr. Hutchinson, making him our witness and asking him to prove it, because anything else he may say will also be our own evidence.[192]

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190 Letter, College of Physicians and Surgeons of Ontario to CPSM, 20 August, 1889
191 Minutes, Annual Meeting, 16 October, 1889
192 Letter, Hough & Campbell to CPSM, 14 November, 1889

In a letter the next month it was noted that Hutchinson had left town. Still the lawyer expressed concern over the attempt to prosecute such cases:

> On the general question we think the whole offence was contained in one sentence which appeared in the earlier advertisements re the promise to cure all disease, etc. There is no medical case in which the word "unprofessional" has been treated with other meaning than in the sense of infamous or dishonorable. Vulgarity and bad taste are not necessarily unprofessional.
>
> The Ontario profession has not, so far as we are aware, been able to prevent this same combination's Physicians practising there and if we proceed knowingly on a basis too weak to hold a case in a matter intended for professional discipline, such an Act itself would be unprofessional.[193]

Proceedings had become more outwardly formalized by the next action against a physician for association with an unlicensed practitioner. In 1905 Dr. J.F. Landry faced a fairly formal trial, lasting three days, but spread over a month. Each side was represented by prominent local counsel. The events of the trial itself are perhaps less interesting than some of the side dramas.

For instance, Dr. Landry's lawyer, T.G. Mathers, sought to have an American physician testify on his client's behalf. He wanted assurances that such testimony of itself would not be considered unlicensed practice and

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193 Letter, Hough & Campbell to CPSM, 6 December, 1889

trigger a prosecution by the College.[194] The College's lawyer, Isaac Pitblado, responded that such a prosecution was unlikely but he was not in a position to promise anything:

> My retainer in the present matter only covers the proceedings in so far as Dr. Landry is concerned.[195]

The conflicts did not end on that matter. On April 10th Pitblado advised Mathers that the Council would meet in two days to consider the Discipline Committee's report.[196] Immediately Mathers complained of the lack of notice and time to prepare:

> If this is what the College of Physicians and Surgeons considers fair play in dealing with one of their own members they have a somewhat perverted idea of what British fair play means. They are the accusers, they supply the witnesses, they are the Judges and they employ a Counsel to prosecute before themselves and yet they with hold from the defendant information as to the time when he is to be tried and what he is to be tried upon, what report has been made either for or against him until the day before the trial is to take place. This to my mind is most unfair treatment and such as the meanest criminal would not be subjected to in any British court and makes the trial of Dr. Landry a mere travesty. . .
>
> Under the circumstances I refuse to be a party to any such farcical proceedings under the name of a trial but will bring the whole proceedings and the

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194 Letter, T. G. Mathers to Isaac Pitblado, 3 March, 1905

195 Letter, Isaac Pitblado to T.G. Mathers, 4 March, 1905

196 Letter, Isaac Pitblado to T.G. Mathers, 10 April, 1905

surrounding circumstances before the Court of King's Bench.[197]

As it turned out the Discipline Committee met the night before the Council meeting and so it was on the *morning* of the latter meeting that the report was forwarded to the defendant's lawyer. Mr. Pitblado evidently then received the letter of April 11th. He still took the position there was no need for more notice:

> The defendant was represented by Counsel at all the meetings of the Discipline Committee which were held, and therefore must know the evidence which will be presented to the Council.[198]

In the end the final motion to erase was carried two weeks later.

These cases are mainly of interest for the tone and attitude the College took in these first attempts at discipline. They certainly disapproved of unlicensed practice but were particularly hostile to itinerant promoters. It was these whose business had been expedited by association with licensed physicians.

There of course can be many motivations in the pursuit of these cases: the preservation of monopoly, the

197 Letter, T. G. Mathers to Isaac Pitblado, 11 April, 1905

198 Letter, Isaac Pitblado to T.G. Mathers, 12 april, 1905

control of "aberrant" behavior, and the urge to maintain a united front against incursions. In any case, it is clear that an aggressive stand was taken in these cases. Perhaps this came from the nature of the offence. One might also note that these were the earliest actions taken. Perhaps there was a certain lack of sophistication in the approach taken in these early episodes.

Other Early Complaints

After these cases it was some time before further formal action was taken up. There were a few complaints which were not pursued and few details survive. For example, in 1918, physician received a "reprimand", even though such was not contemplated in the legislation, for "irregular practice" regarding a specific patient.[199] No other information is available but what is interesting is that the College had had disciplinary authority for over thirty years before it had a complaint regarding care of a *patient*.

Oops!

Another case that arose in 1918 provides both a comic diversion and a look at the kind of case which the

199 Minutes, Discipline Committee, 2 October, 1918. The only disciplinary matter discussed in the intervening years was a warning to a physician for inappropriate advertising in an ethnic newspaper. Minutes, 12 February, 1913

College decided required no action. A Brandon surgeon had repaired a hernia for a patient and then encouraged him to file a disability claim despite the fact that the hernia had pre-existed the policy and hence would not be covered. Nevertheless, the surgeon wrote to the insurer stating the hernia had first appeared only months earlier and was the result of the patient pulling on a fence post. However, the scheme ran into two problems. Firstly the patient had already written to the company with a different explanation (instead of pulling a fence post in May, he was lifting nails in November). Secondly, on the same day he submitted his report to the insurer, the surgeon also wrote to the patient advising him on the "story" to be used. Unfortunately this letter was inadvertently sent to the insurer, not the patient. In the letter the surgeon explains his motivation:

> The Merchants Casualty Co., which by the way are a poor miserable firm to do business with, at least I think so, are evidently trying to squirm out of paying your indemnity. I had a letter from them today asking what time the hernia occurred.
>
> [After outlining the correct "version" to use] This company beat me once on an accident to myself, and I have always liked to take the opportunity to beat them if I get the chance. [200]

The insurance company complained to the College and eventually received the reply that the surgeon had not

200 Letter, W.A. Bigelow to T.K., 19 August, 1918

yet returned from an "extended trip". At any rate the College would take no action until hearing from him. Finally any such action would likely involve only a reprimand unless the insurer could obtain a criminal conviction.[201] That appeared to be the end of the matter. Whether the College's response was devious or realistic depends on the eye of the beholder. In previous cases they had been considering a problem which really motivated them, unlicensed practice. It is possible that they would express less concern over misleading an insurance company. Perhaps this transgression was just too minor in its impact on either the public or the profession. Perhaps it would simply not warrant the penalty of erasure, which in theory, was the only sanction they could impose.

Two other cases may also be mentioned for their curious facts. A physician was briefly erased in 1923 because, as the motion stated:

> . . . he did on or about the 11th day of August A.D. 1922, wrongfully take a specimen to wit a prostate gland from the operating room of the Portage la Prairie General Hospital and from the custody of the person entitled to the custody thereof and wrongfully retained the said specimen in his custody for a period of several weeks, and at the request of the operating doctor or hospital matron did refuse to deliver the same up to the persons or authorities

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201 Letter, CPSM to R.B. Graham, 30 October, 1918

> thereto entitled until the 31st day of August A.D. 1922 . . .[202]

In another odd case, a doctor was fined $200 for a narcotics offence. At a disciplinary hearing he was asked for an explanation:

> The Doctor stated that on the 24th of July last a patient of his had asked him for a prescription for heroin for a race horse owned by a friend of his. He gave the prescription for 25 grains of heroin and wrote across the paper that it was "for a race horse only". The prescription was raised to 75 grains and was found at the drug store by the Dominion Police hence the charge.[203]

The Temperance Two Dozen

An important event in the history of discipline by the College was the passage of *The Manitoba Temperance Act*.[204] Since the only alcohol now available would be that prescribed "medicinally", physicians became an obvious route to avoiding the rigors of the law. In 1920 the College approved the adding of "breach of any Manitoba statute" to felony convictions as a trigger for possible erasure.[205] Since this came a few weeks after receiving a list of physicians convicted for *Temperance*

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202 Minutes, Council, 23 January, 1923. There was never any explanation for the "theft". The motion only passed 12-7. He was restored a month later.
203 Minutes, Executive Committee, 29 April, 1925. No action was taken.
204 *The Manitoba Temperance Act*, S.M. 1916, c. 112
205 Minutes, Council, 4 February, 1920, *An Act to amend "The Medical Act"*, S.M. 1920, c. 74

Act violations[206] it is clear the amendment was aimed at including them specifically. What is not clear is the real motivation. Was the College really promoting "Temperance" or was it simply the breach of any law which they found offensive? The fact is that in the end these matters were handled relatively leniently, which makes it difficult to be sure of the real motivations.

As noted the College received reports from the Chief Inspector under *The Temperance Act* as to which physicians had been convicted of breaches, their specific crimes, and the fines levied, which ranged from $50 to $1000[207]. The numbers affected were not insignificant with twenty-six physicians facing disciplinary proceedings in 1921 alone.[208] One problem the College had was that the statute only allowed *erasure* as a penalty. After some debate they got around that by creating a scale of "criminal" magnitude based on the number of illegal prescriptions written[209]. The more such prescriptions the longer an offender would have to wait after erasure before being allowed to reapply. Thus some could reapply immediately and others after two or six months.

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206 Letter, J.N. MacLean, Chief Inspector, Temperence Act, to CPSM, 12 January, 1920
207 *Ibid*.
208 Minutes, 1920-21
209 Minutes, Council, 15 February, 1921

the English guilds. It was not for the public to enter this domain.

There is no direct evidence of either motivation. There is a hint that it was the College's own sense of collegiality that was at risk. The most severely punished physician at the time as Dr. Paul Wolochow. In one report from the Temperance Inspector he was the only one convicted for unlawfully selling liquor, as opposed to unlawfully prescribing. He also received the largest fine on conviction, $1000[211]. Still, when the matter came before the College he received the same penalty as several others, erasure with reapplication possible after six months.[212] However, as it turned out, while others were reinstated shortly after their six months had passed, he was still being refused after two years.[213]

A few months after his erasure Dr. Wolochow evidently sought employment in Calgary. A letter from a Calgary hospital superintendent sought information.[214] The Registrar responded:

> This man was a regularly licensed physician of Manitoba, but was convicted in Court and fined

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211 Letter, J.N. MacLean, Chief Inspector, Temperence Act, to CPSM, 12 January, 1920
212 Minutes, Council, 15 February, 1921
213 Minutes, Executive, 3 October, 1923
214 Letter, Hospitals Department, City of Calgary, 23 May, 1921

> $1000.00 for selling liquor. He evidently had been shipping liquor in and selling it in large quantities with no regard to his professional position.[215]

A few weeks later a second request for information on Wolochow was received, this time from a law firm representing the College of Physicians and Surgeons of Alberta.[216] The Registrar's response:

> I brought this matter before the Executive Committee of our Council and was instructed to hand your letter to our own Solicitor.[217]

While the Registrar may have felt this was a "legal" matter requiring response from a lawyer, it is interesting that not even the erasure is acknowledged, and this to representatives of another provincial College. Would a direct inquiry from the Alberta College itself have been similarly turned aside?

As a final piece of evidence there is a letter from a fraternal organization requesting that the College make public the names of doctors erased for *Temperance Act* offences:

> It is generally felt that if the names of the Doctors in question are not made public and any information withheld that it should know.[*sic*]
>
> It is further held that if the names are kept secret it will serve to strengthen the opinion that there

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215 Letter, CPSM to L.E.W. Irving, 26 May, 1921
216 Letter, Carson & Carson to CPSM, 6 July, 1921
217 Letter, CPSM to Carson & Carson, 8 July, 1921

> is one set of laws concerning the common people and another set of different laws for the privileged class.[218]

When the Registrar of the day received correspondence which he did not deem worthy of a reply, his standard approach was to simply pencil in the following which he did on the above letter:

> No reply made in any way.[219]

This would seem to support the idea that the College kept erasures secret not so much to protect the accused as to protect the privacy of the College's affairs. It was not to be the public's business who they chose to discipline.

In the end then, what is really going on with these *Temperance Act* cases is unclear. Since they kept their proceedings so secret it is hard to conclude they were in any way motivated by the need to keep appearances. There is no evidence that they were demonstrating to society at large that they were protecting its interests. They did not feel the need to be "observed" as effective at self-regulation.[220] The value they were evidently imposing, that of temperance, may have been linked to those of the

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218 Letter, International Order of Goodtemplars to CPSM, undated

219 *Ibid.*

220 Eliot Freidson, *Doctoring Together: A Study of Professional Social Control*, 1975

public[221], but they evidently did not feel the need to justify this.[222] Thus it seems more likely it was the fact of external punishment, the fact of getting caught, which caused the College to act. The motivation was punishment, less than deterrence.

Finally, concerning the question of secrecy, it should be noted that the physicians had already been publicly convicted. There was no reason to maintain secrecy to protect them. It was the College's sense of privacy which was to be protected. They were yet to feel any need to be *seen* to be doing their job.

Abortion and the College

Abortion is another area where the precise motivation to discipline may not necessarily be the obvious. At the time, performing abortions attracted criminal prosecution and was likely not approved of by many physicians. Thus, discipline could follow a conviction *qua* conviction, but it could also follow without a conviction if such conduct was viewed as "unprofessional", in the sense of unethical, by the medical establishment of the day. If the punishments levied were similar to those of the temperance cases it

221 Bernard Blishen, *Doctors & Doctrines* 1969, at 22
222 Vernon K. Dibble, "Occupation and Ideologies" (1962), 67 Am. J. Sociology 229

could be concluded that it was the conviction itself which attracted scorn. On the other hand, if the penalty was more severe then possibly it was the procedure itself to which the College took exception.

This would be the conclusion if one looks at the first case pursued in this area. It should first be noted that at least one earlier case in 1920 did not proceed past a preliminary investigation, although in that case evidently no charges had been laid.[223] However, in the case of Dr. F.S. Chapman the profession's displeasure was evident. He was charged with manslaughter after a patient died post-abortion. The College did not wait passively for the criminal process to reach a conclusion but actively took part in the prosecution, partly at the request of the Crown:

> It will be necessary to call at the trial certain medical and other evidence which was not put in at the preliminary hearing.
>
> Hence it would be most satisfactory to the proper conduct of the case if your Society will appoint counsel to be associated with Mr. Allen, Deputy Attorney General, who will be in charge of the case for the Crown. If your Society sees its way clear to do this, the Crown will pay the fees of such Counsel.[224]

In response Dr. Chapman registered his objection:

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223 Letter, CPSM to R.W. Craig, 23 January, 1920
224 Letter, Attorney General to CPSM, 3 March, 1921

> If the statement [that the College was providing Counsel for the prosecution] is true I hereby most emphatically protest against the injustice of such action. If it is not true I ask that you will see that it is publicly contradicted as it is obviously calculated to prejudice me in the public mind.[225]

The Registrar noted:

> Did not reply in any way.[226]

A further letter from the Crown advises the Registrar on the evidence he is expected to provide at trial as a medical expert.[227] The College not only provided counsel but significantly aided the pursuit of a conviction.

It is not surprising that once Chapman was convicted erasure by the College would follow. That did happen, and without much debate, but not for a year and a half.[228] The reason for the delay is not clear. It may be that Chapman was imprisoned immediately after his conviction and the College considered the status of his license moot until his release approached.

At any rate he apparently served about three years in prison. He then wrote requesting reinstatement:

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225 Letter, F.S. Chapman to CPSM, 29 March, 1921
226 *Ibid.*
227 Letter, Deputy Attorney General to CPSM, 2 April, 1921
228 Minutes, Council, 4 October, 1922

> I am sixty one years of age and am unfitted for any other calling having spent twenty six years in practising medicine.
>
> I have been severely punished for whatever wrong I was judged to have done.
>
> Having expiated that offence and satisfied the law by undergoing a long and arduous imprisonment, I suggest that it would be very unjust to punish me still further by depriving me of my only available means of making my livelihood and providing for those dependent upon me.[229]

This precipitated a long debate at the next Council meeting.[230] It was argued that in view of Chapman's age it would be "capital punishment" to keep him from practicing. The motion to reinstate was carried. Immediately four members of the Council protested the vote for procedural reasons, the merits of which are dubious.[231] Some months later though the Council rescinded its earlier motion.[232] A final motion to reinstate was defeated.

Chapman's offence does not seem to be one for which the College was to easily forgive him. It could be that it was only abortion of which the College disapproved. Yet this is not likely the whole story. Only a few years later no action was taken against two physicians for performing an abortion on the ground they did not have

229 Letter, F.S. Chapman to CPSM, 18 September, 1924
230 Minutes, Council, 1 October, 1924
231 Letter W.G. Campbell to CPSM, 3 October, 1924
232 Minutes, Council, 1 June, 1925

criminal intent.[233] Perhaps doing an abortion without being prosecuted makes the matter less reprehensible in the College's view.

There may be other factors at work. In the next case to arise along these lines a physician was imprisoned and subsequently erased for performing an abortion.[234] This was twenty years after Chapman's case and perhaps attitudes had become more "enlightened" and the College inclined to forgive. An attempt to reinstate this physician after a year was defeated but the physician was allowed to work under supervision in a northern town.[235] A year later he was fully reinstated.[236]

A few cases spread over twenty years hardly allow sweeping conclusions but there is one final hint of what was really motivating the College in Chapman's case. Even before his erasure a patient of his wrote to the College asking for help in gaining his release from prison. The Registrar responded:

> Personally I have a great deal of sympathy for the Doctor as he was a fellow graduate of mine and greater still for his unfortunate family, but the character of the practice that Dr. Chapman appeared inclined to follow meets with the disapproval of all

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233 Minutes, Council, 16 May, 1933
234 Minutes, Council, 12 May, 1943
235 Minutes, Council, 12 May, 1944
236 Minutes, Council, 18 May, 1945

> real physicians and thus any Medical Board could hardly intervene on his behalf.[237]

What raised the College's ire was apparently not the conviction or the procedure itself but the "character of the practice". This could mean anything. Perhaps it was his morality, his style, or even his competence that placed him on the "fringe" as far as other physicians were concerned. It does seem to be the way he practiced not what he did which placed him at odds with the College.

Again the College's attempt to control the situation shows a particular urge to punish the offence. Here, though, their role was much more public. Yet they did not show any inclination to justify their approach to a larger audience. Instead, it seems, that was all part of their disdain for the situation in front of them. There was to be no "private" erasure with prompt reinstatement.

Other Criminal Convictions

The impact of criminal conviction as a grounds for discipline could also be assessed by looking at how convictions for other offences were viewed by the College. What sort of behavior attracted concern? Suffice to say it may not be so much the conduct itself, but

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237 Letter, CPSM to Mrs. M.W., 25 March, 1922

rather how the individual was viewed by his colleagues that may be determinative.

For instance, in 1930 a physician was convicted of assaulting his wife and given a suspended sentence. The College tabled any discussion of erasure.[238] It appears such a crime did not raise their ire the way Temperance cases did. On the other hand, they may have acknowledged the suspension of the sentence by the court as suggesting the matter warranted no further atonement. There is of course little doubt that the court and the College reflected the attitude of the time to wife abuse. At the same time, unlike Temperance and abortion cases, the criminal activity did not arise in a professional context nor would they view it as taking advantage of one's status as a physician. Nevertheless, nine years later the same doctor was convicted again but there is no reference at all to the type of offence. Still, at that point he was erased from the register.[239]

The next three cases to arise were all related to convictions under the *Narcotic Control Act*. Again besides the conviction itself there were other sources of disapproval by the College. As in the *Temperance Act*

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238 Minutes, 26 June, 1930
239 Minutes, Council, 17 May, 1939

cases, these physicians had taken advantage of their positions. Secondly, the College would be unlikely to approve of the kind of medical practice that included the selling of narcotic prescriptions. Finally, such offences could, and did, often go hand in hand with addiction problems on the part of the physician himself. To further complicate this issue, the College had difficulty disciplining somebody who was the only doctor in a small town. No matter what their level of indignation, there were always practicalities to consider.

The first such case to arise involved a conviction for selling narcotics. The physician received a two year prison sentence and was immediately erased by the College.[240] There is some evidence that he suffered addiction problems himself, with hospital reports to that effect being forwarded to the College after he left prison. He was eventually reinstated after six years in 1938.[241] Of interest though is a letter the Registrar wrote three years earlier. He told the editor of a medical directory that this doctor was erased but was

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240 Minutes, Annual Meeting, 12 October, 1932
241 Minutes, Annual Meeting, 19 October, 1938

still allowed to practice.[242] In other words, there was no real punishment involved.

Another case arose on the same day in 1932. The doctor had been fined for a narcotics offence and had been erased in Ontario.[243] His name had actually already come up twice before the College in unrelated matters.[244] Still, despite that, he suffered no sanction when the matter of the conviction was first considered. Three years later the College was advised that the doctor's drivers license had been revoked apparently due to alcohol related problems. He was also described as "carrying on" in general. At that point his name was erased.[245] Thus they seem to have ignored the criminal conviction and responded only to the drivers licence suspension, hardly a crime of moral turpitude at the time.

Later developments shed some light. The College received several appeals from the town in which this physician worked, asking for him to be reinstated. The

242 "His name has not yet been restored to the Register . . . but the Council is allowing him to practice." Letter, CPSM to F.V. Cargill, 30 April, 1935

243 Minutes, Annual Meeting, 12 October, 1932

244 "Irregular practice" regarding a case. Minutes, Discipline Committee, 2 October, 1918. "Illegal operations" Letter, CPSM to R.W. Craig, 23 January, 1920

245 Minutes, Annual Meeting, 9 October, 1935

College consistently refused.[246] The town complained they could not get a replacement but it was also noted he was still working.[247] In other words, at that point, two years *after* erasure, he was still practising to some extent. Hence the College was faced with competing forces. They may regard his conduct with distaste but they were also reluctant to deprive a town of its lone practitioner.

A third case, also involving narcotics, arose in 1941. This time the College voted for immediate erasure.[248] The physician had been doubly damned by prescribing narcotics for himself and by associating with an irregular practitioner. Appeals to restore his license soon came from the religious order which ran the town hospital and from a local priest. All were refused.[249] The College noted, in these discussions, that it was "known" that the doctor was still issuing illegal liquor prescriptions. In other words, he evidently was still practicing. More interesting were the spurious rumors which could be the basis for decision making. It seemed enough for a Council member to have "heard" a bit of news for that to become entered into the debate. In time they

246 Minutes, Council, 12 May, 1936
247 Minutes, Council, 19 May, 1937
248 Minutes, Council, 14 May, 1941
249 Minutes, Council, 15 October, 1941 and 21 May, 1942

actually did get official reports of abuse from the liquor inspector and they continued to refuse to reinstate.[250] Finally, there is a reference, in 1943, to his admission to a mental hospital for some form of addiction.[251]

What is really telling in this case is an exchange of letters a full eight years before any disciplinary proceeding. In 1933 a Montreal pharmaceutical company wrote to the College regarding the doctor:

> This physician would like to be inscribed upon our medical list for samples and literature, and before doing so, we want to receive information from your part.[252]

The Registrar wrote *two* letters in response. The first simply stated:

> Replying to your letter of July 6th, 1933, I beg to state that Dr. Robert Guilmette is registered with the College of Physicians and Surgeons of Manitoba.[253]

The second, of *the same date*, was labelled "Confidential" and added:

> In further reference to your letter of the 6th instant, re Dr. Guilmette, Elm Creek, Manitoba, it might be to your interest that information that this

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250 Minutes, Executive, 2 February, 1943
251 Minutes, Council, 20 October, 1943
252 Letter, Rougier Freres to CPSM, 6 July, 1933
253 Letter, CPSM to Rougier Freres, 10 July, 1933

> office could supply you would not place this man's character in a very high category.[254]

Such comments were not directed to another licensing authority or even another physician. Suffice to say it would not be surprising that the College responded as they did eight years later given that preconception.

Other cases in this group are rather lacking in detail. For example, one physician was convicted for a narcotics offence in 1942, received an eighteen month sentence, was immediately erased, and never heard from again.[255]

Of more interest was the handling of a case by the Council in 1946. A newspaper reported the conviction of a physician for an unnamed offence. No other information appeared at hand. It was noted that the Discipline Committee would not be meeting for some time. Without any further hearing the Council immediately proceeded to erase the doctor from the register.[256] He was, though, reinstated a year later.[257]

Other cases also arose as the result of criminal convictions. At times the approach taken was almost

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254 Letter, CPSM to Rougier Freres, 10 July, 1933
255 Minutes, Council, 13 May, 1942
256 Minutes, Council, 16 October, 1946
257 Minutes, Council, 15 October, 1947

constructive. In 1947 a doctor received a three year sentence for an unspecified offence. He was immediately erased.[258] However, on his parole he was allowed to practice up North under supervision.[259] A year later he was reinstated.[260]

Finally, in 1957, another physician was jailed for assault. In contrast to the 1930 case he was summarily erased and there is no further reference to him in the records.[261]

It is difficult to come to firm conclusions about the influences affecting the College in this area. Erasure for criminal conviction had been an enumerated cause for erasure since 1886. Such a conviction could even disqualify a candidate from the outset. Such a stigma meant an individual did not even "deserve" to be a doctor. On paper it was certainly a serious matter. In practice, too, there were times when the College wasted no time in taking advantage of the section. Yet there were other occasions when a somewhat gentler approach was taken. "Erasures" only lasted a few months when they could have been permanent. It might even be possible to

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258 Minutes, Council, 16 May, 1947
259 Minutes, Council, 20 October, 1948
260 Minutes, Council, 19 October, 1949
261 Minutes, Executive, 10 July, 1957

continue practicing since practically no one but the College would be aware of the erasure. This seemed especially true for those in isolated rural practice.

Nevertheless, there were others for whom no leniency was granted. This seemed *not* to be directly related to the kind of offence that attracted the original conviction. Results did seem to be influenced by the kind of doctor one was or the kind of practice one pursued. It might have been as much an attitude and an approach to medicine that the College sought to expunge. While this was evidence of the College's disciplinary control it is interesting that these all relied on external findings of guilt. It was not the professional ideology or code that was being enforced but a code of conduct imposed by society, as the state. Supposedly the values imposed externally and internally were shared so there was no problem justifying the action, if they felt they had to. In the end though one cannot help but conclude that these physicians were really disciplined for "letting the side down".

One final incident here may further demonstrate that it was who an offender was rather than the offense that directed the action to be taken. In 1932 the Registrar received a report about a Dauphin doctor from the

narcotics inspectors.[262] As it turned out the individual was not even registered with the College but an inquiry to a clinic in Dauphin yielded the following explanation:

> Doctor Beauchamp has been in Dauphin for about fifty years. He is eighty-six years of age and is a very fine old gentleman. He has been doing a certain amount of practice as long as I have known him.
>
> The College of Physicians and Surgeons would make a grave mistake if they prosecuted him in any way. He does very little except among some of the poor people and the people of the community feel that when there was no other Doctor he did the best that he could. He has many friends in the district. If he is breaking the Narcotic Act in any way I think a letter would be all that would be necessary, warning him of this.[263]

One would think an unlicensed physician would attract no sympathy especially one overprescribing narcotics. Still the Registrar advised the Narcotics Division:

> It would seem to me that a letter from yourself or from this office would be all that is necessary to prevent this man from transgressing any further.[264]

He further thanked his contact in Dauphin:

> May I thank you for this prompt and satisfactory report, which is the very type of response which helps us to arrange a satisfactory settlement. I wish I could get more co-operation of this kind from other members.[265]

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262 Letter, C.H.L. Sharman to CPSM, 15 December, 1932
263 Letter, W.J. Harrington to CPSM, 20 december, 1932
264 Letter, CPSM to Chief, Narcotic Division, 22 December, 1932
265 Letter, CPSM to W.J. Harrington, 22 December, 1932

Even the narcotics people were satisfied:

> In reply might I state that I quite appreciate the situation as it exists and I would indeed be glad if you would be kind enough to forward a letter to him, explaining his position insofar as the issuing of prescriptions for narcotics or narcotic preparations is concerned.[266]

Finally the Registrar wrote to the offending physician:

> I hope you will accede to this request and commit no further offence. Should you be again guilty of a like indiscretion, I think it would be impossible for me to prevent the Dominion Police undertaking prosecution, which in your case would be a Gaol sentence.[267]

This may have been the right approach in this situation but seems strikingly benign when compared with others who failed to register or who abused their prescription privileges. Here they were quite content to let this old physician carry on as long as he attracted no further attention. That is not what happened. Two years later similar complaints arose but no further action was taken although perhaps there were second thoughts:

> It would seem better that your Department warn Dr. Beauchamp of any irregularities he may be committing against the Narcotic Act, as no doubt, Dr. Harrington's and my warnings have not proven sufficient.[268]

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266 Letter, K.C. Hossick to CPSM, 28 December, 1932
267 Letter, CPSM to P.J. Beauchamp, 31 December, 1932
268 Letter, CPSM to K. C. Hossick. 19 November, 1934

Physicians and Third Parties

There are third party relationships other than with the courts and the police which may create potential disciplinary issues. For instance, although in the past most patients paid directly for their own care, there were a few situations where the bill would go elsewhere. Occasionally a problem with such billings would precipitate a complaint.

In the first such case a physician suffered a one month "erasure" for "falsifying an account against the Workmen's Compensation Board".[269] Thus, as a crude measure, this offence was viewed as having about the same gravity as the liquor offences.

A year later a surgeon billed the Unemployment Relief Department for an operation performed by another.[270] As it turned out the surgeon who had actually done the procedure had exceeded his billing ceiling under the scheme. His accommodating colleague was to submit the bill and then reimburse him. All the College issued was a warning.[271] Supposedly neither physician was out to gain unjustly. Such a limit on billing might also not attract much respect from the College. Hence attempts to

269 Minutes, Executive Committee, 19 January, 1935
270 Minutes, Executive Committee, 12 June, 1936
271 Minutes, Discipline Committee, 26 June, 1936

circumvent such a ceiling would not warrant significant sanction.

In some contrast is a case not of billing fraud but of failure to make timely reports to the Workmen's Compensation Board. While the physician gained nothing from this it did reflect on his level of organization and perhaps more so, on the level of care he could provide. The College termed the offence "gross negligence" and "unprofessional conduct".[272] This could have reflected a concern for the doctor's patients who might have been disadvantaged by his organizational shortcomings. It could also have reflected some disapproval of the doctor's "style" of practice. At any rate his name was erased but he was allowed to reapply immediately.

More recently, as third party insurance became almost universal in the 1960s with the Manitoba Medical Service[273], increasing opportunities for inappropriate billing arose. Only one case attracted significant sanctions. A physician was suspended for three months for billing both the MMS and the Workmen's Compensation Board for the same care.[274]

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272 Minutes, Discipline Committee, 13 June, 1939
273 A private forerunner of Medicare.
274 Minutes, Executive Committee, 23 September, 1965

At this point then there is evidence of the profession's resistance to any form of control but there own. Third party payers represented a threat that presaged state intervention. Yet the response of the College is ambiguous. While they may have resented anyone telling doctors how to bill, there was at least some level of annoyance at colleagues who were caught by these external rules.

As was noted in the Introduction, what threats they did not respond to can be just as revealing as the ones they did acknowledge. For instance, Blishen and others note the watershed event of the 1962 doctors' strike in Saskatchewan in response to a medicare bill there. For one thing, it is interesting that this strike was organized by the Saskatchewan *College*, not the medical association. Secondly, despite that and the impact of the event, there is no reference to it at all in the records of the College in Manitoba.

Doctors vs. Doctors

Central to the concept of professionalism are the norms of how professionals are to relate to each other. Indeed most early codes of conduct spent more time on those relationships than of that between the professional and the public. From the outset norms were imposed on how

professionals deal with each other and how they relate to the rest of the professional community as a whole.

Another factor, also part of most concepts of professionalism, concerns economic motivations. The classic professional was not to be overtly concerned with enhancing his income, he was not to be competitive in the free market sense, and was never to place himself before the public as superior to his colleagues. Almost any form of advertising was thus prohibited.

How these attitudes were reflected by the College should illustrate how these norms were applied. How did the College handle disputes between individual physicians? How aggressively was advertising curtailed?

Most physicians would consider it inappropriate to lure patients to their practice by anything other than establishing a reputation that would attract them of itself. No one had property in a patient but one could take legitimate offence if another doctor contacted one's patients directly to promote his own cause. Nevertheless, where these complaints arose the College's response was strikingly "hands off".

For instance, in 1923 a physician complained that another had stolen his patient. The patient had been

referred in from out of town. Somehow the patient's cab delivered him to the office of another doctor, who, it was claimed, discarded the letter of referral, admitted the patient and performed the necessary surgery. The complaint went to the Discipline Committee but no further action was taken.[275]

The next year a surgeon was accused of approaching a colleague's patient in the hospital, obtaining consent for surgery, and would have performed the operation but he was stopped by the nursing supervisor.[276] The College gave this even less shrift and wrote to the complaining doctor asking him to withdraw the charge.[277]

An even more volatile situation arose in a dispute between two doctors with offices in the same North End building. Each claimed the other was stealing patients. Office staff was supposedly accosting patients outside the other's office and even in the other's waiting room to see if they would not rather see the competition. The tone of the complaints decidedly lacked "professional" decorum:

> This is to notify you that I am reporting your unethical conduct re the above named patient to the Manitoba College of Physicians and Surgeons. When

275 Minutes, Executive Committee, 27 June, 1923
276 Letter, J.A. Gorrell to CPSM, 28 january, 1924
277 Minutes, Executive Committee, 10 April, 1924

> patients are under my treatment you have no right to approach them and offer them your treatment.[278]
>
> Dr. Dyma promised to make it hot for me should I move into an office next door to him. He is evidently carrying out his unethical threat! He told me that as I was not an Ukrainian I had no business to settle at above address. I told him that I was a Canadian and was not going to be bothered by national question of the neighborhood and that my business was to cure or help those who would call me![279]

Supposedly such behavior would be scorned as unprofessional. On the other hand, a certain amount of this conduct might have been acceptable as part of the "business" of medicine. The reason for the College's complete lack of interest are still not clear. Perhaps it relates to the individuals. A dispute between two downtown consultants might have been handled differently from that between two North End ethnic physicians.

Other cases involving diverting patients also produced no reaction in 1935 and 1936.[280] Perhaps the behavior was not egregious enough. In 1937 the College issued a "warning" to a doctor who had written to the patient of another promoting a new treatment for cancer.[281] Somewhat more ambiguously handled was a complaint in 1940 against the same Dr. Rybak involved in

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278 Letter, B. Dyma to F. Rybak, 21 October, 1926
279 Letter, F. Rybak to CPSM, 9 November, 1926
280 Minutes, 27 July 1935, 21 October, 1936
281 Minutes, Executive Committee, 21 April, 1937

the 1926 dispute with his "neighbor" described above. He was accused of "influencing patients to discharge their attending doctor and accept his services." At the Discipline Committee it was held that the "evidence failed to prove this complaint".[282] They felt the patient had changed doctors on his own initiative. Nevertheless, at the Council meeting later the same day it was generally felt that Dr. Rybak had acted unethically but no action was taken.[283] Here, as elsewhere, it may have been more than just the substance of the charge which influenced them. They may have been aware that similar complaints had arisen in the past. This might have created a mood of disapproval even if in the end nothing further was done.

Somewhat oddly the most aggressively pursued case along these lines is of more recent vintage. In 1965 a Selkirk physician left the clinic where he was working as an assistant to set up his own practice near by. This assertion of "free enterprise" did not sit well with the College. Although the assistant had no contractual obligation to leave the neighborhood, it was alleged this action contravened the Code of Ethics. Several meetings were held including a public one in Selkirk. Factions

282 Minutes, Discipline Committee, 16 October, 1940
283 Minutes, Council, 16 October, 1940

arose within the town. In the end though the College lawyer advised them that nothing could be done because no "specific complaint" had been received.[284]

Advertising

In some contrast, the College's approach to any form of advertising was anything but "hands off." Theoretically at least the College would take an intolerant approach in order to protect two interests. One concerned the relationship of a physician with his colleagues as a group. Promoting oneself was unprofessional because, among other things, it was an attempt to place oneself above one's colleagues and to entice patients by doing so. Now the approach the College took to the one-on-one conflicts described above could raise some skepticism about professional comity being the true aim.

The other claimed interest was the protection of the public. They were to be protected from false claims. One could see some utility in preventing misleading advertising containing dubious claims. However, an examination of the sort of advertising that was actually attacked by the College suggests less lofty goals. When the most trivial of transgressions of the advertising

284 Minutes, Executive Committee, 26 July, 1965

rules attracts threats of sanctions other motivations must be considered.

Now, to be sure, there were situations where false claims were being made and the College could be said to be protecting the public. In 1932 a physician was cautioned for advertising a treatment for goitre.[285] Interestingly two years earlier he had been the subject of a complaint regarding his use of an "Abrams" machine, a gadget which had brief popularity among "alternative" therapists. The problem was that only other physicians were bothered by this. No patients would give evidence and no action was taken.[286] Along the same lines was the censure of a physician for distributing handbills advertising the visit of an itinerant unlicensed practitioner.[287]

Over the years, the College repeatedly had trouble with doctors who placed ads in ethnic newspapers.[288] When cautioned all asserted they were just doing what they had done in the "old country".[289] It seemed to be something

285 Minutes, Executive Committee, 29 March, 1932
286 Minutes, Executive Committee, 14 February, 1930
287 Minutes, Council, 11 October, 1933
288 Minutes, Discipline Committee, 12 February, 1913, Executive Committee, 7 September, 1934
289 These included some of the same physicians who attracted no response when their behavior only aggrieved a single local colleague, such as Dr. F. Rybak, Minutes, 16 May, 1933

about touting oneself to a larger, even if limited, audience which caused concern. Hence, it must have been something about the appearance of the ads *per se* which was objectionable. Perhaps it relates to one of the professional tenets about not being profit-motivated, or at least not appearing to be. Part of this then relates only to appearances, to preserving a myth of altruism. It may be a myth the College and its members almost believed in, but it could hardly be so intense that it motivated them to punish those discussed earlier who had been accused of patient-tampering.

To extend the same idea, it is possible that even if the reasons for banning advertising have waned in importance, the ban itself may become self-perpetuating. Advertising would become a "sin" even if it cannot really be shown to cause harm. It would just not seem "right" for a doctor to promote himself. It is easy to see this attitude even today. If one travels to a jurisdiction where advertising by physicians and lawyers is common, as in many American states, one may find such ads somehow unseemly or improper. Interestingly this applies whether one is a professional or not. It will not be because those advertising are casting aspersions on their colleagues or that the public may be misled that one may

be troubled. We are bothered by such advertising simply because we have not seen it before and we are not used to it. Our sense of what is normal is influenced by what we have come to expect, not what fits some ethical code.

A look at several cases handled by the College highlights their attempts at preserving decorum. One complaint concerned an announcement card. It was supposedly misleading:

DR. FRANK W. BOYD
PHYSICIAN
ASSOCIATED IN PRACTICE WITH DR. S.C. PETERSON
WISHES TO ANNOUNCE THE REMOVAL
OF HIS OFFICES ON MARCH 1ST
TO
307 McARTHUR BUILDING
TELEPHONE 93 075

Dr. Peterson complained. He said Dr. Boyd was only an employee, never an associate, that he never had an office to "remove", and that patients might be mislead into believing that Peterson himself had moved.[290] Further he wanted to create his own announcement card:

> Dr. S.C. Peterson begs to announce that Dr. K.J. Backman, Specialist, is now associated with him and that he is continuing his practice with offices at the same address 703-704 McArthur Building, Winnipeg.
>
> He further begs to announce that Dr. F.W. Boyd is no longer associated with him in any way.[291]

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290 Letter, S.C. Peterson to CPSM, 3 March, 1933
291 Letter, S.C. Peterson to CPSM, 3 March, 1933

The Registrar responded that the above was in order.[292] He agreed that Dr. Boyd's announcement was "unprofessional" for the reasons stated. Boyd was "censored" for such.[293] Dr. Boyd responded quizzically.[294] The only response from the College was that the card was "ambiguous" regarding the nature of his association with Peterson and the matter of the "removal" of offices.[295]

In defence the issue here may be one of honesty rather than lack of decorum but other situations suggest the latter would always be an issue. For instance a physician asked for advice on what would be an appropriate type of sign to place on a medical building.[296] The response could only be considered partially helpful:

> We feel we have no right to dictate the nature of this sign, but suggest that it be kept in the bounds of ethics. We would further suggest that an illuminated sign might be interpreted as unethical.[297]

The College also took a dim view of passive promotion of one's practice. They considered taking

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292 Letter, CPSM to S.C. Peterson, 4 march, 1933
293 Letter, CPSM to F.W. Boyd, 25 May, 1933
294 Letter, F.W. Boyd to CPSM, 5 June, 1933
295 Letter, CPSM to F.W. Boyd, 5 June, 1933
296 Letter, P.H. McNulty to CPSM, 5 December, 1934
297 Letter, CPSM to P.H. McNulty, 13 December, 1934

action against a physician who had a newspaper article written about him. The physician claimed that he had had only a casual conversation with a patient who happened to be a reporter. He did not know in advance it was going to be published. The story itself contained considerable detail about an international conference the doctor had attended. The College's concern may have reflected some skepticism on their part but in the end they took no action.[298]

Finally as a last point in this section one might note an edict issued by the College in 1939. Winnipeg physicians were no longer to have listings in the rural phone book.[299] Whether this was a convenience to patients or not, or whether limiting competition was the real goal, it is clear that merely wanting to promote yourself in this limited way was enough to cause concern.

This again suggests a theme raised earlier. It was the very idea that a physician wanted to promote himself that bothered his colleagues. To paraphrase an earlier comment, it was how the profession viewed the advertiser not the advertisement.

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298 Minutes, Discipline Committee, 15 February, 1936
299 Minutes, Executive Committee, 4 january, 1939

In this section, several observations arise. There is the enigma of the response to "unprofessional" toting. It was tolerated between physicians, but it was a serious matter if the touting went to a larger audience. Supposedly, in the latter case, the College would attempt to impose a norm of the altruistic professional, unsullied by baser economic motivations. Yet they enforced these norms with varying degrees of vigor. Perhaps they were leaning from disciplinary control to cooptative control.[300] Rather than seeing a sin and punishing it, the College would want to demonstrate to its members its value in protecting them from the forces of the open market. They would need to so demonstrate if the "sin" was widely apparent as in the case of advertising. There would be less motivation if it was only one member complaining about another.

One might note two other aspects which arose in this context. Regarding the 1965 case of the physician seeking to locate near a former colleague, one notes the *first and only* direct reference to a Code of Ethics in any of the material reviewed. One need only observe at this point that such a code was hardly the "powerful weapon" Blishen claims.[301]

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300 Ehrenreich, *supra* n. 176
301 Blishen, *supra*, n. 175, at 188

The same case also reveals possibly the first real large scale attack on the College's authority, the first real assertion of "communal control".[302] The public in Selkirk organized meetings to protect the College's attempted action. For whatever reason, the College backed down.

Physicians and Patients

It is perhaps in defining the relationship between physicians and individual patients that the College showed both the most ambivalence and the greatest potential for evolution. Physicians' attitudes changed but so did patients' expectations. Thus concerns about the quality of care, and hence complaints concerning it, did not really arise until the 1930's. However before that there had already been several complaints about doctors who failed to respond to requests for assistance. In other words, their first expectation of a doctor was to be there when you needed him. Patients were only more recently able to assert that they could have any control over what was done to them once they were seen.[303]

Failure to Attend

One could see how those cases complaining of a lack

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302 *Ibid.* at 145
303 *Ibid.*

of attendance could pose some difficulty for the College. On first principles they may have been uncomfortable with a colleague who refused to attend the ill. However their basic liberalism would have prevented any notion of obligating a physician to attend anyone. And there were other realities. In rural areas, and in the days of housecalls, there could many demands on a physician, including those from other patients. Clearly this might preclude the kind of response the patient might wish. Still, what the public had trouble with was when the doctor refused to attend for other reasons, whether personal or financial. Oddly, it was *because* a particular doctor was the only help for miles, that the public inferred an obligation on his part to attend to everything that came up. The more difficult it might be for a doctor to attend to all who asked, the more he might be expected to do so.

These difficulties were evident in the College's response to two complaints that arose in 1921. Both involved rural physicians. In one, a husband complained that a doctor had refused to attend his wife's confinement even though he had even driven to the doctor's house to pick him up.[304] The writer included

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304 Letter, RJK to CPSM, 24 March, 1921

several "incidents" where he felt the doctor should have been obligated to attend simply because he was the only one available to do so. The Registrar responded:

> In reply will say that apparently Dr. Belanger is not satisfactorily filling the position of physician in the community in which he practices, but in all the cases you quote I cannot see where this Council can prosecute him as he cannot be obliged to attend any case.[305]

Later that year a fraternal group reported that another rural doctor had refused to attend one of their members. Further, when the man's wife had used another doctor for her delivery, the first one threatened to sue her for breach of contract:

> We do contend that it is absolutely wrong that in a country like this with Doctors so few and far between, that a Doctor should refuse to give treatment when asked.[306]

While the Registrar acknowledged some sort of duty, his response implied no sympathy for these patients:

> It would appear to me that Dr. Moore while he may legally refuse to attend Mr. B. he would not be living up to the high ideals and ethical standard that the medical profession wish our members to maintain.
>
> On the other hand I think a little more courtesy might have been extended to Dr. Moore by Mrs. B. If she had changed her mind about having Dr. Moore attend her in her confinement . . . she should at least made this known to Dr. Moore as any physician

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305 Letter, CPSM to RJK, 24 March 1921
306 Letter, Imperial Veterans in Canada to CPSM, 19 December, 1921

> may have made considerable sacrifice as to time and plans in order to attend the lady on a certain date.
>
> It is to be regretted that difficulties of this nature come into the life of medical men and when the whole matter is sifted to the bottom, there is usually fault on both sides.[307]

It may have been the impertinence of the complainants which really bothered the College. Here it was the lay public, not other professionals, who were attempting to dictate professional conduct. Thus the Registrar did not even reply to a Winnipeg father whose child died without a physician attending.[308] The doctor had repeatedly promised to come over and other doctors had refused to see his patient without permission from him. Now we would argue that such a child should be taken to hospital but, at that time, expecting your doctor to attend may not have been unreasonable, at least in the public's eye.

That same year the College received an inquiry, that mentioned no names, regarding the propriety of refusing to attend a patient who still owed on a bill.[309] As was common then, the doctor was actually employed by the

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307 Letter, CPSM to Imperial Veterans in Canada, 28 December, 1921
308 Letter, JB to Attorney-General Manitoba, 18 May, 1927
309 Letter, AM to CPSM, 17 October, 1927

company that ran the town's main industry. This suggested the following response from the College:

> I will say that no physician, whether past fees are paid or not, can be forced to attend. According to the ideals of our profession they should leave nothing undone in their attention to the sick, but legally this cannot be enforced.
>
> I would advise you to take this matter up with the Company's manager.[310]

At any rate it seems likely that expectations changed. There were fewer such complaints as time went on. The College saw no point in acting on any of them. They may have felt that the public continued to be unrealistic when a doctor was accused of "not hurrying an evening meal" in order to see a girl with an injured arm.[311] And later a doctor *was* reprimanded after a complaint that he had failed to make a Sunday house call. However, the sanction was not for that omission but for failing to respond to letters from the Registrar.[312]

Negligence and Discipline

A problem which continues to cause consternation for the College and similar professional bodies is the

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310 Letter, CPSM to AM, 21 October, 1927
311 Minutes, Annual Meeting, 19 October, 1938
312 Minutes, Council, 25 May, 1957. Actually this may have been the first hint of later trouble. Two years later he was suspended and then erased for psychiatric difficulties. Minutes, Council, 2 May, 1959

appropriate response to complaints of mismanagement regarding specific cases, in other words, accusations of negligence. In part this difficulty stems from the fact that the College had only seen misconduct as one of several recognizabe "sins", such as criminal conviction and advertising. It was these crimes which clearly attracted sanction. The so-called "error in judgment" was not yet among them. Making a mistake with a given case was not "unprofessional" as the term had come to be used.

At the same time, the College's avowed goal of maintaining quality had really only included scrutiny of those whose entire pattern of practice suggested a danger to the public. Thus a single complaint in an otherwise respected career would not seem to warrant the same attention that chronic alcohol abuse might.

The College would also have some difficulty again accepting complaints which originated with the public. Just as in the last section, the College resisted any attempt by the laity to determine what was appropriate care. The College could always take the out that a civil suit was the appropriate venue for an aggrieved patient to pursue, although the result would still be non-physicians determining standard of care.

That said, it might still be possible to imagine a case where there was such abandonment of professional standards that disciplinary action was warranted. That may have been the situation in a case already mentioned. In 1918 the Discipline Committee considered the handling of a specific patient by Dr. Albert Laidlaw, who was to get into more trouble later. Their finding was that his management had been "irregular". No action other than a "reprimand" was taken.[313] In truth, the lack of detail prevents being certain this was an allegation of negligent or reckless care. At any rate it was not until 1933 that the College received another complaint regarding a specific case.[314] In other words, at the most, there was only one such complaint in the first sixty years of medical regulation in Manitoba.

Even after that, cases only arose intermittently. For many little detail survives. Thus when no action was taken by the College, which was the case in each and every instance, it is impossible, even with hindsight, to read between the lines and determine the motivation. Certainly in some cases the care complained of was quite proper and the results which followed were unavoidable. Even if there was some mishandling of the case, it may

313 Minutes, Discipline Committee, 2 October, 1918
314 Minutes, Council, 16 May, 1933

not have been to such a degree as to warrant a penalty. Finally, there may have been other times where the College could have recognized "malpractice" but felt inclined to leave the matter for the courts.

That may have been almost the case in a 1936 complaint. As soon as the College heard that the complainant had received an indemnity of $1250 and signed a release, they abandoned all action.[315] If redress had already occurred, there evidently was nothing else that needed to be done.

There were other occasions when such cases were given short shrift, but perhaps for different reasons. In one instance two nurses in a rural hospital wrote to complain about several errors in diagnosis by a local doctor. The College was evidently satisfied with the doctor's explanation and instructed a letter be written to the nurses:

> . . . informing them they are unethical in criticizing the medical profession; and that they may be subject to a libel suit.[316]

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315 Minutes, Executive Committee, 15 February, 1936
316 Minutes, Annual Meeting, 20 October, 1937

Several cases over that same year were filed without even a response. The doctors were not always even asked for an explanation.[317]

Interestingly, in the next case, even a complaint from another physician failed to attract the College's interest. Six days after an appendectomy in a rural hospital, the patient appeared in Winnipeg in a gravely ill state. The Winnipeg doctor notified the College. There was evidence that the rural hospital was ill-equipped, that there was insufficient nursing assistance, and that the rural doctor had only performed one such procedure previously. The College's response to the Winnipeg doctor:

> The College of Physicians and Surgeons has no jurisdiction in this case as Dr. Matas is duly registered and the hospital is licensed.[318]

There was also a motion to write to the rural doctor:

> . . . expressing sympathy regarding this case but it was suggested he have an assistant the next time.[319]

The College's reaction here suggests a persistent reluctance to criticize the management of any particular case. Perhaps this was simple professional comity. It is

317 Minutes, Executive Committee, 7 December, 1937
318 Minutes, Executive Committee, 4 January, 1939
319 *Ibid.*

also possible they saw the rural physician here as doing the best he could under the circumstances. An emergent situation, no matter what the shortcomings of the facilities or his experience, had to be handled. They would accept infection as not an uncommon complication from that sort of surgery. There had been no real causal connection established, hence, their "sympathy" to their rural colleague.

In fairness, by the 1950's such complaints began to receive much more attention from the College. While there remained some which, on their facts, could quickly be determined to be without merit, many others called for extensive investigation. As an illustration, in one of the earlier cases given a closer look, a woman alleged a surgeon had negligently left a gauze swab in her abdomen at surgery. He claimed that, based on where he found it at a second operation, she must have swallowed it.[320]

The executive requested a written response from him and a review of the hospital records. The surgeon reiterated his belief that the swab had been swallowed. The hospital records were indeterminate. A further

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320 At least that was the surgeon's comment when he "ran into" the Registrar at a medical meeting. Minutes, Executive Committee, 20 December, 1955

opinion from the original assisting surgeon was requested.[321] After several months all information and opinions that could be obtained were obtained and it was concluded there was no evidence of inadequate care. Still, after all that, the wording of the final motion might have raised doubts in the patient's mind about the fairness of her hearing:

> That the Council, having fully considered this case, find no cause for complaint and advise Dr. M. of the decision, expressing sympathy to him in this matter.[322]

It may be that the evidence was too inconclusive for the College to find any shortcomings in care here. At least the minutes record a reasonable investigation. The question remains what if they had found such evidence. Negligently performing a single operation may not warrant any formal sanction. Here especially they could have argued a civil suit was the appropriate approach. After all the patient had sought no other redress than having the second operation paid for.[323]

Whether they could if they wanted to, it is clear that the College had very little control over how medical care was actually delivered. This contrasts with

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321 Minutes, Executive Committee, 28 March, 1956
322 Minutes, Council, 26 May, 1956
323 Minutes, Executive Committee, 20 December, 1955

Blishen's assertions, which may arguably still not yet be valid. For most, if not all, of its history the College took little or no interest in the interactions of individual physicians with their patients.

The College and Willful Misconduct

Clearly a growing concern for medical disciplinary bodies is where the conduct at issue is not negligent but willful. This can take a variety of forms. Nevertheless, a historical search reveals that this is the area of discipline where the greatest change has occurred.

Fee Disputes

Sometimes such change has come for external reasons. For instance, in days when patients paid their own bills, complaints could arise about fees. The College had a Taxing Committee to consider these matters. In many cases adjustments were made. Without a sense of what charges might be normal for the time, it is impossible to retrospectively judge these cases. It is clear though that early on billing was seen as more or less a "business matter" and not generally part of the activity which the College took great interest in overseeing. For example in 1932 an editor of a local paper complained about the conduct of a local doctor:

> I am taking the liberty of reporting to you what I believe was an unethical practice of a physician registered with your organization.
>
> I had occasion to send to a Dr. Montgomery in the Somerset Building a young lady who had a slightly infected finger. I asked to have this attended to, which was no doubt capably done.
>
> However, it was brought to my attention that because the young lady failed to have sufficient money in her possession to pay a fee of $3.00, that she was detained until she agreed to leave on deposit a diamond ring until she returned with the necessary money.[324]

The Registrar responded:

> I consider his dealing with the young lady in question was quite justified and that there was no breach of medical etiquette.
>
> There are too many people expecting Doctors to do work for nothing, and if the profession would take steps to curb such practice, a benefit would be advantageous to all concerned.[325]

At any rate, up until the 1960's, there was only one case where the fees charged were so extreme as to suggest further action by the College. In 1934 a well-known Winnipeg physician charged an elderly female patient over $6000 for six months care. This included daily office or home visits as well as accompanying her on an extended trip south. During the latter he also charged for lost income while he was away from his practice. The trustees of her estate complained. While the Taxing Committee had

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324 Letter, Winnipeg Tribune to CPSM, 4 October, 1932
325 Letter, CPSM to Winnipeg Tribune, 18 October, 1932

no trouble with the propriety of the "paid vacation" aspect, they did attack the quantum. They reduced the overall bill by about half and termed the fees charged "excessive, unreasonable, improper".[326] The matter was referred to the Disciplinary Committee but no further action was taken.[327]

As noted earlier, with universal insurance direct disputes with patients over money have been eliminated except for billing for uninsured items. Still, though, in 1965 one physician was subject to an inquiry for allegedly billing both the insurer and the patient for the same service.[328]

Other Financial Dealings

Money can also be the nidus for a complaint when physicians have appeared to take financial advantage of their patients. It is now considered improper if a physician becomes a beneficiary in a will, becomes a committee for a patient's affairs, or borrows money from

326 Minutes, Executive Committee, 6 April, 1934
327 Minutes, Annual Meeting, 9 October, 1935. Interestingly the same physician was investigated in 1936 for trying to extract $200 in advance from a patient to treat his syphilis. There was a hint that the blood test had been faked but no action was taken. Minutes, Executive Committee, 15 Febrary, 1936
328 The only sanction imposed was an order to reimburse the patient. Minutes, Discipline Committee, 6 July, 1965

a vulnerable patient, but in the past it seems this was tolerated.

In the only case along these lines, in 1921 a Winkler man wrote that the local doctor had implored him to lend $50 and now was refusing to pay it back.[329] It is hard to tell whether these were two "competent" adults disagreeing over money or whether this was a physician acting improperly by taking advantage of his position and later breaching the trust that position imbued. Without any investigation the College took the former view, that this was only a "matter of debt" for which the appropriate remedy was in the courts.[330]

Sexual Misconduct

Compared to contemporary concerns regarding sexual impropriety with patients, the archival record is striking in the virtual absence of these concerns in the past. Clearly that could be for a lot of reasons. Certainly there is no reason to believe that improper conduct was not occurring. From the records which survive, though, it seems the College received few such complaints. One of these was written by a rural school official regarding the local doctor and a teacher. It is

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329 Letter, FP to CPSM, 23 March, 1921
330 Letter, CPSM to FP, 29 March, 1921

not clear that she was a patient but the official was concerned:

> I found Doctor Rutledge had absolutely ruined this girl, took her to different hotels, registering as man and wife, keeping her in his office for immoral purposes, etc. She was a very fine girl belonging to a good family until he got her in his power. He is reported to have done the same with others. This girl also says that he caused an abortion on another girl, a friend of hers, who was also a school teacher.[331]

The College's response is oddly toned. There is no record of any further action after they replied:

> I am sorry to learn of the statements you make therein. I can assure you that the Council of the College are only anxious to do the right thing in all such cases.
>
> I must ask you to send me the fullest evidence that you can procure relating to this matter, and such evidence must be of such a nature that it would be accepted in a court of law.
>
> On receipt of this evidence I will bring the matter to the attention of the Council and let you know what steps they think should be taken.[332]

If that incident was ambiguous the only other one from the early years of the College was less so. In 1929 a doctor was accused of unspecified misconduct towards a nurse. The Disciplinary Committee found "gross misconduct on the part of the physician".[333] However they held there was "no definite action" they could take and there the

331 Letter, SGB to CPSM, 19 March, 1923
332 Letter, CPSM to SGB, 28 March, 1923
333 Minutes, Executive Committee, 19 April, 1929

matter ended. They thus seemed both intolerant and tolerant of the behavior. They chastised the doctor but imposed no penalty. The only other information recorded was that no criminal charges had been laid against the doctor. This may be the critical point because almost all the previous disciplinary actions to that point had been for some sort of conviction. In other words, the kind of conduct which, at that time, reasonably attracted sanctions had been that deemed inappropriate by society at large as expressed through prosecution. It is possible then that, in this case, the College felt some external intervention such as a criminal conviction was necessary before they could do anything.

Another case could be mentioned here. It may not be a case of sexual misconduct but it suggests how ambivalently such cases might have been handled. In 1959 the College received a letter from a Crown Attorney concerning possible charges against a doctor for two "incidents" in a hospital. There was some difficulty getting evidence, but, even so, the Crown was reluctant to prosecute because of "the publicity effect on the Doctor, his family, the hospital, and the medical profession". The Crown wanted the College to handle the matter. The College lawyer thought it was the Crown's

job. At any rate the physician was interviewed and asked to resign voluntarily. He refused and the matter was referred back to the Crown. That is the last heard of the matter.[334] One could speculate that little might come of certain "incidents" if no one was willing to pursue them.

Two somewhat more recent cases are also illustrative. In 1969 the College received a complaint that an eighteen-year-old prospective employee had been interviewed by a doctor in a local hotel room. After offering her a cigarette and a drink, he suggested she required a physical examination and then attempted to discuss her sexual history. After an "informal inquiry" the Discipline Committee ruled:

> The Committee is of the opinion that no further action is warranted but considers that a letter should be written to Dr. B. to the effect that in the opinion of the Committee his method and manner of interviewing applicants for employment is indiscreet.[335]

A year later, in 1970, arose the first complaint that unequivocally concerned sexual impropriety towards a patient. A doctor was alleged to have acted inappropriately during an examination. The Executive's first concern was how to pursue this without any witnesses. One member speculated that the patient did not

334 Minutes, Discipline Committee, 20 October, 1959
335 Minutes, Discipline Committee, 28 August, 1969

know what a "full physical" was. No enquiry was held and a letter was written to the doctor stating:

> The College is concerned about the complaint and hopes there will be no repetition in the future.[336]

Those cases aside, the real point is that, as far as one can tell now, the College did not deal with these issues because they were not made aware of them, at least not through formal complaints. Granted, it is possible that somehow complaints were received but then "lost" so no record survived. There is certainly no guarantee that the archives are complete. However, for the records to be so devoid of this issue would require a policy of "losing" such complaints that went on for decades. The conclusion remains that few complaints were actually received.

Assuming this behavior was going on then, the College can still seem blissfully unaware or perhaps willfully blind. It is clear that, then as now, the onus was on the complainant to come forward. If they did not it is hard to see how much further the College could go. Of course later such bodies would attract criticism for not responding to the complaints they did receive, but at

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336 Minutes, Executive Committee, 16 November, 1970

least in the early years, there is only isolated evidence of that.

Unfitness to Practice

Any professional licensing body will offer, as its most important reason for existence, the maintenance of standards and competence. Such bodies as the College must be able to identify those individuals who have become a danger to the public by reason of substance abuse, psychiatric illness, advancing age, or incompetence. The College must be able to cull those who have become "unfit to practice". The question arises when such was attempted: were those thus identified really a danger to the public or had they simply become "unfit" to be doctors in the subjective view of their medical colleagues?

It can be said that maintenance of quality, despite its importance, was a role the College exercised rather tentatively, even timidly, at first. For example, in 1926, a rural clergyman wrote about the chronic drunkenness of the local doctor and the adverse effect this had on the quality of his care. He provided the names of several townspeople who could document various incidents.[337] The Registrar responded that the College

337 Letter, WTH to D.A. Stewart, 25 November, 1926

had the authority of a court to prosecute physicians but he would require proper evidence in affidavit form. The College would only take the matter up after the reverend had provided such affidavits.[338] In other words, it was not up to the College to take the lead role.

An exchange of letters in 1928 showed the College to be only slightly more helpful to another rural community. Town officials wrote to the College imploring that their doctor be replaced for incompetence.[339] The Registrar acknowledged the difficulties but saw the best approach as getting a new doctor and having the old one leave voluntarily. Since he would not, it would be impossible to bring someone into a town that could support only one physician.[340] There was no suggestion that the College, on its own, could or would remove the offending physician.

Such issues did not arise again until 1940. For some reason the College suddenly became concerned about physicians who might be admitted to psychiatric hospitals. Could they be erased under the *Act* for "professional incompetence"? It was proposed by the Dean of Medicine, who was also Director of the Psychopathic

338 Letter, CPSM to WTH, 3 December, 1926
339 Letter, Town of Oak Lake to CPSM, 16 August, 1928
340 Letter, CPSM to RHH, 20 August, 1928

Hospital, that all hospitals should notify the College of any physicians admitted for "treatment of mental disease, drug addiction or alcoholism". A motion to that effect was passed. There was immediately another concern:

> The members of Council considered that such action might discourage the physicians from submitting themselves for treatment. For this reason the following resolution was passed:
>
> "That the minutes referring to this question be deleted from publication." CARRIED[341]

These motions did not result in any increased aggressiveness. That same year Dean (and Director) Mathers reported the Psychopathic Hospital admission, for the seventh time, of a physician for "drug addiction and alcoholism".[342] It was decided that since he admitted himself voluntarily, and his patients supported him, no action would be taken. It was, in fact, not until 1949 that a physician was erased for incompetence based on psychiatric illness.[343] Finally, in 1952, a motion calling for the automatic suspension of members suffering mental disease was passed,[344] although again there is no evidence this precipitated any change in approach.

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341 Minutes, Council, 15 May, 1940
342 Minutes, Executive Committee, 30 September, 1940
343 Minutes, Council, 19 October, 1949
344 Minutes, Council, 17 May, 1952

By the late 1950s and 1960s almost all of the College's disciplinary focus was on fitness to practice. None of the earlier preoccupations continued to any significant extent. While individual patients still complained about their own particular treatment, it was only when a doctor's entire practice became suspect that the College seemed to respond. There were a few erasures ostensibly for incompetence based on mental illness or substance abuse. But in many cases the College's approach could be described as fairly temperate, even remedial.

One case in particular shows considerable patience. A physician was cited in 1955 for "professional incompetence". It was decided to "suspend judgment" for one year so long as the physician obtained psychiatric treatment and refrained from any surgery or operative obstetrics. The doctor accepted those conditions. The only question concerned notifying the local hospital where he practiced. It was decided a discrete phone call would "lessen any unfavourable publicity".[345]

The case was reassessed a year later. The psychiatric opinion was that the earlier troubles were acute, short-lived, and not likely to need further treatment. There were several letters filed in support of

345 Minutes, Executive Committee, 7 September, 1955

the doctor. However, he had been recently fired from a hospital job for excessive drinking. He had also been caught drunk driving. It was decided to renew the restrictions for another year.[346]

Another year passed and the physician appeared seeking lifting of the restrictions. The Council refused and reimposed them for another year to which the doctor agreed.[347]

Unfortunately within a month he had three more drunk driving convictions. Erasure was considered as was suspension but even that was felt too harsh:

> However, the opinion was that such action at this time would have a very drastic effect upon Dr. B. and his family, and that it would probably precipitate further deterioration in Dr. B.'s personality problems.[348]

After the passage of another two years the doctor seemed to be doing well in overcoming his problems with alcohol. By 1960 the restrictions were lifted.[349]

All was quiet for another two years. Then, in 1962, there was another admission for an acute psychiatric episode. The restrictions were reimposed.[350] However by

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346 Minutes, Discipline Committee, 4 October, 1956
347 Minutes, Council, 2 November, 1957
348 Minutes, Discipline Committee, 24 March, 1958
349 Minutes, Discipline Committee, 24 October, 1960
350 Minutes, Council, 12 May, 1962

1964 the College became concerned that he was again practicing surgery in breach of the "judgment". The Discipline Committee initially voted to only warn him[351] but there was a move to overrule them at the Annual Meeting. It was proposed to initiate formal proceedings, not because he may be a danger to the public, but because he had "broken his word" not to operate. The motion was defeated.[352] Eventually the restrictions were all lifted. Incidentally, perhaps the College's patience here was not misdirected as almost thirty years later the doctor is still in practice in Winnipeg.[353]

This concludes the detailed presentation of representative cases through to 1971. Conclusions, at this point, will be limited to those tentative ones interspersed in the preceding discussion. It is also acknowledged that the detail presented here may be distracting but in some cases such detail offers some enlightenment as to what is really going on. In the end, of course, actions will speak louder than words, and bodies like the College will be judged by the actions they take.

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351 Minutes, Discipline Committee, 24 October, 1964
352 Minutes, Annual Meeting, 7 November, 1964
353 Register, CPSM, 1991-2

V. DISCIPLINE IN CONTEXT

Other Studies?

The question arises as to whether the review of disciplinary cases from Manitoba has any application beyond the province. It would be helpful to know if this material was representative of developments elsewhere. To show that it is would require comparable information from other jurisdictions. The problem is that no easily obtainable data is available to support or deny the assumption that physicians behavior will likely be similar no matter what the locale. No longitudinal study of disciplinary proceedings seems at hand.

What has been done are several cross-comparative snapshots over the last several years, particularly from the United States.[354] Perhaps, then, a look at even a few such reviews might create a limited sense of evolution, even if only over a short period.

However, when one considers any of these reviews problems quickly arise. The first clue is the large

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354 Frank P. Grad and Noelia Marti, *Physicians' Licensure and Discipline, The Regulation of Medical Practice*, 1979. Robert C. Derbyshire, *Medical Licensure and Discipline in the United States* 1969. Joseph Post, "Medical Discipline and Licensing in the State of New York: A Critical Review" (1991), 67 Bull. N.Y. Acad. Med. 66

variation in disciplinary activity among the different states. Furthermore, some states have ten or twenty times the rate of actions compared to others.[355] Some states with populations much larger than Manitoba's have, even in recent times, had years without *any* disciplinary activity at all.[356]

To take things a step back a bit it might be useful to start with a tentative presumption, that physicians' behavior is more or less similar throughout a variety of jurisdictions. In other words, there should be roughly a similar magnitude of incompetence, substance abuse, or sexual impropriety. The extreme variations in disciplinary activity noted in American studies will not therefore truly reflect a real difference in professional personality. It clearly must say much more about the disciplinary apparatus itself. Thus in a search for comparative data one might instead find useful lessons about the effectiveness of these various disciplinary approaches.

Since much of the available data is American, a quick look at the similarities and differences with

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355 Richard Jay Feinstein, "The Ethics of Professional Regulation" (1985), 312 *New England Journal of Medicine* 801

356 *Ibid.*

Manitoba should be useful. A first point is that, unlike the disciplinary authorities in Canada, only three states have direct election of their governing authorities by the profession itself. In almost all of the others the Medical Boards are appointed, usually by the governor. Nominations for these boards will , in fact, often come from state medical associations but in only fourteen states is the governor obliged to consider only those thus proposed.[357]

On first look it might seem to the critic to be a positive step for there to be some form of governmental or quasi-public input into the process. The problem is that these appointments have more often than not been made on the basis of political bloodlines rather than medical stature. Some states even mandate a specific political breakdown for their boards.[358] As well, these boards have always been at risk of summary replacement at the whim of their political masters.[359]

Still, even at that, it should be remembered that, except for occasional lay members, these boards are composed of physicians. The basic premise of self-rule by

357 Robert C. Derbyshire, "Politics and Discipline" (1984) 19 *Hospital Practice* 198

358 *Ibid*. More recently there has been pressure to make appointments on the basis of gender or color.

359 *Ibid*.

the profession still holds. Especially given the political realities, there is no particular reason to expect a board such as this to be more aggressive in matters of discipline. As noted above the experience seems to be just the opposite. Many state medical boards are almost inert compared to their Canadian counterparts.[360]

This level of inactivity may be attitudinal but other realities must be considered. For instance, even if the will to pursue a disciplinary action existed resources may be lacking to do so. In Canada all of the provincial colleges obtain their revenue from the physicians themselves through licensing and registration fees. Some American boards function the same way but in many cases fees are but a fraction of that collected in Canada.[361] There is thus a proportional decrease in resources to investigate and pursue cases. Other boards, as arms of the state government, must extract their wherewithal from state resources. Paradoxically, public

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360 Richard P Kusserow *et al*, "An Overview of State Medical Discipline" (1987), 257 *Journal of the American Medical Association* 820

361 Arnold S. Relman, "Professional Regulation and the State Medical Boards" (1985), 312 *New England Journal of Medicine* 784. The fees in some American states are still at the same level as Manitoba had in 1965 ($25).

interests might very well be better protected under the more independent system developed in Canada.

The question remains, though, whether the difficulties faced by some boards create such problems that analyzing their disciplinary data becomes of little or no use. The conclusion seems to be that this is probably the case. Consider the question of sexual misconduct. If we presume that such activity has been fairly common for some time, one might look at the material from Manitoba and conclude two things. There were few complaints in the past and what there was did not generate a very concerned response from the College. An increase in the disciplinary activity for these offenses could reflect both a growing number of complaints as well as a greater responsiveness on the part of the College. Contemporaneously there were American states of similar size where even recently *no* actions, involving sexual misconduct or any other offence, had been taken by their medical boards. This likely does not represent better behaved doctors. What it does likely represent is few complaints (why bother?), more limited investigation (no money) and more timid enforcement (why rock the boat?). The evidence then

available from the States is by and large not of sufficient quality to comparisons useful.

There may be other possibilities for obtaining comparative data but these too are limited. Other Canadian provinces have similarly structured Colleges to Manitoba. Perhaps their disciplinary experience will be similar. To know this for sure would require a similar archival approach which, as far as is known, has not been done. Other sources such as annual reports have, particularly in the past, seldom provided any detail as to reasons for disciplinary action. For example, only erasures might be reported, and even then without reasons. Thus similar comparable data is not at hand. Other approaches will have to be considered.

Case Law

There is one other qualitatively poor source of information: reported cases of judicial review of disciplinary actions. The shortcomings of this information are many. Disciplined physicians may not have gone to court, judgments may not have been reported[362], and even those that were may only contain oblique references to the grounds for discipline. Still if an

362 The first reported case from Manitoba was not until *Young v. Johnson* (1960), 33 W.W.R. 77 aff'd 34 W.W.R. 385.

effort is made to obtain as complete a case list as possible some picture may develop.

Thus in cases identified through abridgements, digests, and indexes of report series, one can see, albeit somewhat vaguely, a pattern of disciplinary actions at least *compatible*, if not congruent, with that in Manitoba. For example, while nineteenth century cases in Manitoba concerned practicing with an "irregular", reported cases from elsewhere included attempts at disciplinary action for advertising[363] as well as for criminal convictions.[364] In more recent cases, even by the middle of this century improper advertising continued to attract scorn but, as in Manitoba, the question of fitness to practice had begun to arise, particularly in the context of alcohol abuse.[365]

A more specific look at some reported cases might also give a glimpse of a college's motivation. Of course each of these cases, as well as those in the archives,

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363 *Re Washington* (1893), 23 O.R. 299 (Q.B.)

364 *R. v. College of Physicians and Surgeons of Ontario, In re John McConnell* (1879), 44 U.C.Q.B. 146

365 *Hunt v. College of Physicians and Surgeons of Saskatchewan*, [1925] 4 D.L.R. 834 (Sask.K.B.); *In re Medical Profession Act, In re Carefoot*, [1926] 1 W.W.R. 49 (Sask.K.B.); *Reich v. College of Physicians and Surgeons of Alberta* (1970), 75 W.W.R. 561 (Alta.C.A.)

will turn on their own facts which may not always be adequately disclosed.

One can, though, see a fairly aggressive attitude to abortion echoed in the reported cases. For instance an Ontario physician was erased in 1912 even though he had been acquitted criminally.[366] A few years earlier a physician in British Columbia was also erased despite a criminal acquittal.[367] In that case the patient had died. However, what really attracted the ire of the College was the doctor's attempt to conceal the abortion. He had made an incision in the patient to make it look like she had had an appendectomy. It was clear this was only to deceive the patient's parents. This did not sit well with the College and they had no trouble in condemning his actions.[368]

One could also contrast the leniency with which the Manitoba College handled disputes between doctors with the way a case was handled in Alberta in 1909.[369] A doctor who had a contract with a mining company to look

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366 *Re Stinson and College of Physicians and Surgeons of Ontario* (1912), 27 O.L.R. 565 (Div.Ct.)
367 *In Re Robert Telford* (1905), 40 B.C.R. 355
368 On the topic of convictions, there is also a reported case for *Temperence Act* violations: *Re Cherniak and College of Physicians and Surgeons of Ontario* (1919), 51 D.L.R. 522 (Ont.C.A.)
369 *Re Bechtel* (1909), 10 W.L.R. 473 (Alta.)

after its workers complained that another physician was inducing patients away. The College agreed and voted to erase. Interestingly it was the reviewing court which held that such behavior was all part of the "business". Further the Court made it clear that the *Medical Act* was there to regulate relations between physicians and their patients not with other physicians. Furthermore, the Court said, if such conduct was to be regulated by the Act, the punishment of erasure was an "outrage".

We might also compare the "failure to attend" cases discussed earlier with a 1947 case.[370] A physician left on vacation about the same time his patient was going into labor. He had arranged substitute coverage and informed all concerned except the patient. The College found him innocent of all specific allegations but still voted to suspend. No reasons were given. Ironically, this saved the case for the doctor. In the absence of the reasons for a decision, how, the Court asked, could it be determined that the behavior was "unprofessional" within the meaning of the Act?

The message is even more mixed when one looks at discipline concerning specific allegations of negligence. As noted in the Manitoba cases, there persists a

370 *Re Lesk*, [1947] 3 D.L.R. 326 (B.C.S.C.)

reluctance to criticize the handling of a specific case no matter how inadequate the care has been.

For example, in 1902 a British Columbia physician mishandled a maternity case. He was evidently quite drunk, made several errors, and then left the patient for a time. By the time he finally returned she was dead. He then allegedly removed the fetus surgically. The College initially refused to consider the case, taking the position that it was a matter for the civil courts. The patient's husband unsuccessfully sought an order of *mandamus*.[371] Later the College did rule on the matter but found the doctor innocent. The ruling was challenged by the husband with some initial success. On further appeal the acquittal was restored, the Court holding that it was not up to them to interfere with the findings of a professional body like the College.[372]

There have been few reported cases where the issue has been more willful misconduct. In one case that arose at about the same time as a similar Manitoba case, a physician was erased for sexual misconduct in 1931.[373] More recently a Saskatchewan physician was suspended for

371 *In Re The Medical Act: Ex Parte Inverarity* (1903), 10 B.C.R. 268
372 *Re Hanington* (1907), 6 W.L.R. 37 (B.C.)
373 *Latimer v. College of Physicians and Surgeons of British Columbia*, [1931] 3 D.L.R. 304 (B.C.C.A.)

similar conduct in 1966 even though the patient had extorted money from him to keep quiet.[374] One can only contrast this very small number of cases with the fact that fully half the cases reported in more recent years involve sexual conduct.

In the final analysis then it seems likely that the driving forces in disciplinary matters were similar in Manitoba as in the rest of Canada, at least as far as the limited case law reveals. The question will probably still have to remain unsettled especially until a comprehensive analysis is done in a larger province.

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374 *Re Miller and Saskatchewan College of Physicians and Surgeons* (1966), 59 D.L.R.(2d) 736 (Sask.Q.B.)

VI. AUTONOMY IN CONTEXT

This paper has attempted to look at *how* physicians in Manitoba obtained professional autonomy. Since only archives from a single source were reviewed, and the view is hence limited, the whole picture may not emerge, only some hints. Thus it is evident that similar levels of autonomy had already been achieved elsewhere in Canada by the time of the first Manitoba legislation. On another note, it also appears that some medical leaders were part of the early *political* leadership of the province. It is less clear whether they were also part of the *social* leadership, at least in terms of income and status. There is no reason to think they were not, except perhaps the much travelled image of the all-serving country physician whose fees might have been paid with produce rather than cash. Whether that is a myth or not would require a deeper look at early Manitoba society. And, of course, this begs the question as to whether or not it would really make any difference.[375]

Given that limitation, that only part of the picture is here, one is still left with the historical fact that

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375 Some authors think it would. Status precedes autonomy. See Magali S. Larson, *The Rise of Professionalism: A Sociological Analysis*, 1977

more or less similar levels of autonomy were reached in different jurisdictions.

Commentators such as Hamowy have offered views on how Canadian medicine developed.[376] There are of course similar views expressed, specifically or generally, based on an American perspective.[377] To avoid this parochialism one must either ignore what happened elsewhere or minimalize it.

Of course, the latter approach, that of minimalizing developmental differences, is necessary if one seeks to develop meaningful, and singular, conclusions about these events. Thus, if one says, for example, that physicians in Canada and the United States enjoy roughly comparable levels of autonomy, and if one further acknowledges that the paths taken to reach this are different, then one must either minimize the differences or develop concepts which allow both stories to fit. Thus, for an analogy, if one acknowledges a similar level of "democracy" in the two countries, which evidently arose via different

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376 Ronald Hamowy, *Canadian Medicine, A Study in Restricted Entry*, 1984

377 For example Paul Starr, *The Social transformation of American Medicine*, 1982; Larson, *supra* n. 375

routes, then one would try and look for underlying processes and themes that may be common to both.[378]

One would have to do so, at least, unless one was determined to make the facts fit the theory. It was noted earlier that Freidson warned that many analysts had a propensity to advance an approach without factual bases.[379] Alternately one could be selective as to what facts are relevant if one has already reached some conclusions. In a fairly revealing comment, Blishen seems to admit this:

> Understanding the nature of these developments requires a systematic analysis of the manner in which the profession evolved. Such an analysis should be based on a set of concepts that allows the investigator to identify the significant events in the history of the profession that have led to its present form and provide insights into the dynamics of the relationship between doctor and patient. The concepts chosen for this purpose will, of course, depend upon the theoretical perspective of the analyst, in this case a sociologist.[380]

Thus whether one wants to advance a functionalist approach,[381] a control approach,[382] or a Marxist

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378 Such as the theme that democracy is something we all value and strive for. John Hart Ely, *Democracy and Distrust*, 1980

379 Eliot Freidson, "The Reorganization of the Medical Profession" (1985), 42 Med. Care Rev. 11, at 22

380 Bernard Blishen, *Doctors in Canada*, 1991, at 4

381 Talcott Parsons, "Professions" (1968), 12 Int. Encyc. Social Sciences 536

382 Terence Johnson, *Professions and Power*, 1972

approach[383] it is the "concept" which must be advanced before the "facts" can be assessed. That is, of course, if one even acknowledges that facts are necessary.[384]

Still, to start with a few observations to add to those already made we might briefly look even farther afield for a perspective. As has been discussed, the variety of structures and the varied relationships with government do not betray the basic autonomy of the profession whether it is in Canada, the United States, or Britain.[385] In a first look farther afield it can be seen that the situation is much the same in Australia[386], New Zealand[387], or Ireland[388].

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383 Magali S. Larson, *The Rise of Professionalism: A Sociological Analysis*, 1977

384 Eliot Freidson, *Doctoring Together: A Study of Professional Social Control*, 1975

385 Nor does this autonomy seem affected by processes which include lay members or the judiciary in decision-making. *Medical Profession Act*, S.S. 1980-81, c. M-10.1, *Health Disciplines Act*, R.S.O. 1980, c. 196; See also Russell J. Fraser, "The Health Disciplines Board: Its Functions and Procedures" (1986), 7 Advocates' Q. 38 and John R. Carlisle, "The Investigation of Complaints and the Disciplining of Doctors in Ontario" (1986), 7 Advocates' Q. 28.

386 For example *Medical Practitioners Act 1983* (South Australia), *Medical Act 1959* (Tasmania), *Medical Practitioners Act 1970* (Victoria), *Medical Practitioners Act 1938* (New South Wales)

387 *Medical Practitioners Act 1968* (N.Z.)

388 *Medical Practitioners Act 1978* (Ireland)

The issue becomes joined when one looks beyond the English-speaking common law world. For instance, based on the information available, physicians have a similar level of autonomy in matters of discipline in many or all the countries of Western Europe.[389] There may be a bit more tendency to involve administrative judges or even courts at an early stage of an assessment, but basically the profession controls what constitutes unacceptable behavior and has a great deal to say regarding what is to be done about it.

The only exceptions to the pattern are in Scandinavia. Of particular note is Sweden[390] where a government committee composed of political and trade union representatives makes disciplinary decisions. There is at least one physician on the board and the cases are

389 Information was received on the following countries: Germany (German Medical Council, France (Ordre de Medecins), Switzerland (Swiss Embassy, *Swiss Civil Code*), Austria (Association of Austrian Physicians), Netherlands (Cenraal Medisch Tuchtcollege) as well as regarding Spain, Italy, Belgium, Greece, Portugal, and Luxembourg (see "Les differentes structures ordinales au seuil de l'Europe des 12" *Bulletin de l'Ordre des Medecins*, February, 1991).

390 There seems to be similar government involvement in Finland (Information from the Finnish Medical Association) and in Denmark (*Bulletin, supra* n. 457). However there is considerably more information available on the Swedish approach. See *Supervision of Health and Medical Personel Act 1980* (available from the Swedish Embassy) and Marilynn M. Rosenthal, *Dealing with Medical Malpractice: The British and Swedish Experience*, 1988.

prepared and explained by a "Presenter" who is a physician. That, and the influence of the medical profession, arguably means little autonomy has been lost: (Of course the Swedish approach is unique in other ways: continuous care by one physician is uncommon and medical malpractice claims are covered by a no-fault scheme.)

> The Swedish evidence suggests that it is medical knowledge, in the final analysis, that influences how complaints against physicians are handled on the Medical Review Board which is looking at many cases of possible negligence. The medical profession does not regulate itself in Sweden, it has lost overt control but it continues to dominate and influence the disciplinary decision-making process. It is also protected in broader ways by the overall Swedish approach. Although it has not had significant control over its own regulation since the early 1900s, the trade-off is broad protection from liability and severe discipline. The medical profession in Sweden has been well able to protect its interests without the trappings of overt dominance and control.[391]

The question remains as to the source of this result. Physicians believe and will argue that as the repositories of valuable skill and knowledge, it only makes sense to leave such matters as discipline to them. It would seem, for the most part, society here and elsewhere seem to have accepted that. They have granted to the medical profession the level of power, privilege, and prestige that would lead to the kind of autonomy at issue.

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391 Rosenthal, *supra* n. 390, at 242-3

The question then suggests itself: What circumstances were necessary in these various jurisdictions before the medical profession achieved this level of autonomy? As was noted earlier, Larson argues that political recognition *followed* the achievement of social status. Carr-Saunders had even suggested that this status followed, or at least coincided with, obtaining high levels of remuneration.[392] The real answer is not at hand. In his work on occupational prestige[393], Treiman refers briefly to the levels of remuneration and status evidently achieved in times past. Medical practitioners were at or near the top of any ranking.[394] At least *some* physicians seemed to have done well in the past.

One might also look at the more contemporary aspects of Treiman's work on "occupational prestige". He shows that, even allowing for the methodological problems, in most modern societies a high level of "prestige" is

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392 See Introduction, *supra*.

393 Donald J. Treiman, *Occupational Prestige in Comparative Perspective*, 1977. For an earlier work see Alex Inkeles and Peter H. Rossi, "National Comparisons of Occupational Prestige" (1956), 61 Am. J. Sociol. 328

394 Societies reviwed include fifteenth century Florence (Edgcumbe Staley, *The Guilds of Florence*, 1906), Revolutionary America (Jackson Turner Main, *The Social Structure of Revolutionary America*, 1965), nineteenth century Canada (Michael B. Katz, *The People of Hamilton, Canada West: Family and Class in a Mid-Nineteenth-Century City*, 1975)

attached to the profession of medicine. He goes on to suggest how such attitudes might arise:

> Man is an evaluative animal, holding some objects, ideas, and attributes to be more worthy than others; the propensity for invidious distinctions is a fundamental aspect of human nature.[395]
>
> In all complex societies, industrialized or not, a characteristic division of labor arises that creates intrinsic differences in privilege; and power and privilege create prestige.[396]

Yet at this point we are really not much farther ahead. It is still not clear which is the chicken and which is the egg. Physicians, it seems, generally have status within their communities, a commensurate income, and autonomy as a group. Physicians argue all of this follows performing a service which society values. Treiman seems to agree. In contrast others argue that it was the autonomy, and with it the ability to control the process from top to bottom, which contributed to the status and income of physicians.[397] Perhaps, though, the process was more circuitous. The profession had "control", this control allowed it to obtain status and income, and self-regulation and autonomy followed.[398]

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395 Treiman, *supra* n. 393, at 19. He admits to using "invidious" in the less common way of "applying a value or worth."
396 *Ibid.*, at 128
397 Terence Johnson, *Professions and Power*, 1972
398 Magali S. Larson, *The Rise of Professionalism: A Sociological Analysis*, 1977

Perhaps, it could be suggested, that this really does not matter so much as the fact that it seems all of these facets occur together. Income, status, and autonomy *seem* to go hand in hand. One could expect exceptions to this and certainly there must be some.[399]

The temptation then is to conclude that one aspect will not occur without the other, that they are interdependent. Yet beyond the scope of medicine, one may find less concordance. Treiman found that university professors and airline pilots will often be in a position to claim status or income, or both. Yet they may not have acquired the autonomy that the medical profession enjoys. The variable then might be the task performed. It is tempting to look at the service, the provision of medical care, as being of such value that status, income, and autonomy will accrue to its providers. This temptation should be resisted until we can assess whether it is the service, or how physicians have had the service perceived, that is the driving force. Arguably it is both. "Control" theorists see control extending over the interaction, how the interaction is viewed, and how it is compensated.

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399 As far as physicians are concerned, socialist countries like China and the former Soviet Union come to mind, although Treiman found the prestige levels there still relatively high.

In the end one is left with suspicions rather than conclusions. The suspicions include one that an easy theory of professionalization does not follow from the paucity of facts many analysts adhere to. Nor does such an easy theory follow from the divergence of experience in different jurisdictions. And the narrowness of this focus of this review from Manitoba also precludes grand conclusions. However, rather than giving up and claiming "it is because it is", a better approach, for another day, would be a further look at some of the themes suggested.

For example, regarding the acquisition of autonomy the real role of the medical politicians needs to be clarified. And the place of physicians in general in early Manitoba society remains a bit ambiguous as well. Perhaps some parallel information on provinces going through the same process, *at the same time*, could enlighten.

Accepting this non-conclusion for the moment one can now turn to the other focus of this paper: how the profession in Manitoba used their authority, and maintained it, against threats internal and external.

VII. DISCIPLINE THEN & NOW

It is one matter to catalogue past transgressions of Manitoba physicians and the College's response to them. It is another to elucidate the rules that were evidently being broken and the criteria for the sanction imposed.

As was noted earlier, much has been said on the value of professional codes in the disciplinary process.[400] It is true that for some time physicians have had various oaths and Codes of Ethics to point to as evidence of their moral fibre. Critics may claim that such Codes have been promulgated over the years as either being self-serving for the profession or only a smokescreen of high sounding phrases. They are probably a bit of both. The first "modern" code was that of Thomas Percival who wrote *Medical Ethics* to arbitrate a dispute among doctors at the Manchester Infirmary.[401] It thus is largely aimed at intraprofessional relations with only a small part devoted to dealings with patients. This is not to say that it did not reflect the priorities of the day,

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400 Bernard Blishen, *Doctors in Canada* 1991, at 118; Larson, *supra* n. 398; John Kultgen, "The Ideological Use of Professional Codes" in *Ethical Issues in Professional Life* (ed. Joan C. Callahan), 1988

401 Thomas Percival, *Medical Ethics or a Code of Institutes and Precepts adapted to the Professional Conduct of Physicians and Surgeons*, 1803

only that it was written for a particular purpose.[402] In the same way there is no reason to believe that codes derived from Percival's effort were not written at least in part from a public relations perspective.[403] The real point, though, is that these efforts were largely irrelevant. Published codes were simply not an important authority for physicians. For example, in none of the cases reviewed in the Manitoba archival material was there any specific reference to a Code of Ethics. The College did not look to such a Code to define the "evils" to which they wished to respond. In the end then, one must seek out other facts other than the enumerated rules to get the real picture.

Some matters may be relatively easy to deal with, such as the aggressive pursuit of unlicensed practitioners and their co-conspirators. The whole point of the College's early existence was to control entry into the professional community of the province. They evidently had difficulty obtaining convictions for unlicensed practice. These practitioners evidently also found ways of avoiding even that risk by associating with physicians who were licensed. Hence, prosecuting the

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402 Carleton B. Chapman, *Physicians, Law, and Ethics*, 1984

403 Kultgen, *supra* n. 400

latter was a means to accomplish an important goal of the College.

What is a bit less clear is why the severity of the approach. It is granted that erasure was the only penalty formally provided under the *Act* then. It is also granted that these were the earliest actions taken by the College. Thus there is an argument that they had no alternative and indeed saw no alternative as available.

Still, though, it remains more than likely that a severe approach would have been taken in any case. In part this would be due to the fact that the conduct at issue really went to the very heart of the College's existence. To allow such encroachment on their monopoly would make their whole rationale suspect. Which leads to the other aspect of the process. While physicians may chafe at even the notional control the College might exercise over them, they would certainly expect it to protect their interests. Otherwise, what would be the point of belonging. Participation in the elimination of unlicensed practice would hence be a benefit of membership. Rather than an authority figure, its members would see it as a protector of their interests.[404]

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404 Bernard Blishen, *Doctors & Doctrines* , 1969, at 15

In any case, the next issue to arise chronologically, the criminally convicted, presents a more ambiguous picture. Looked at narrowly, criminal conviction had always been a reason for denying a license or taking it away. Supposedly such a stigma was sufficient evidence one's unsuitability for the profession. Yet clearly there were other factors. After all, the College itself sought the amendment which allowed it to act on *Temperance Act* convictions. They felt the need to punish, but not necessarily severely, those caught for these offences, Perhaps, then, the key word is "caught". Were these physicians embarrassments to the rest of the profession? Or would only certain types of physicians allow themselves to get into that situation? Perhaps only a certain group were involved in liquor prescribing. Perhaps it was only those with a certain kind of practice or clientele. It does not seem that it was "Temperance" for its own sake that was driving this. Otherwise one would expect a severity of punishment more in keeping with those actions taken before and after. Clearly more need be known about contemporary attitudes before a thesis here can be advanced.

In any case, practice with irregular physicians, temperance violations, and even abortion have become disciplinary non-issues with time.[405] Nevertheless, the approach to doctors who suffer other criminal convictions remains a problem, especially if not related directly to medical practice.[406] One wonders how the College at the time of the temperance convictions in 1920 would have reacted to a conviction for income tax evasion.[407]

One might contrast the response of the College to this sort of external control, criminal sanctions, to another source, that related to billing to third parties. At least in the early cases, there is no evidence of a significant response being engendered. Clearly then professional autonomy meant freedom from such external controls as having one's billings questioned.[408] The College and its members will resist what Johnson called "mediative control".[409] A physician who crossed swords

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405 Although the New Brunswick act still specifically labels as "professional misconduct" performing an abortion outside of a hospital. *Medical Act* , S.N.B. 1981, c. 87, s. 56, am. S.N.B. 1985, c. 76, s. 1.

406 *Sreedhar v. College of Physicians and Surgeons of Saskatchewan* (1985), 16 Admin.L.R. 290 (Sask.Q.B.)

407 *Re Qureshi and Nova Scotia Medical Board* (1984), 8 D.L.R.(4th) 476 (N.S.C.A.); *Squires v. Black*, [1980] 2 W.W.R. 211 (Sask.Q.B.)

408 Talcott Parsons, "Professions" (1968), 12 Int. Encyc. Social Sciences 536

409 Terence Johnson, *Professions and Power*, 1972

with a third party payor would attract more sympathy than scorn.

Times have changed. Virtually all billing is to a third party which now makes a great effort to control the process. Outright overbilling is not an uncommon problem although only in some provinces is it handled as a disciplinary matter.[410] In some contrast, the profession seems now scornful of other arrangements as well, such as kickbacks and improper profit-sharing with labs and pharmacies.[411] While making a profit from medicine may be acceptable, some ways of doing so are not.

The ambiguousness of the College's response to intraprofessional disputes has already been noted. Except to perhaps enforce some sort of vision of what normal professional behavior should be, it is unclear what was really at issue in disputes between physicians. What would cause the profession to scorn even the most innocuous of advertising and ignore a physician's direct

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410 *Dwyer v. College of Physicians and Surgeons* (1989), 98 A.R. 81 (Q.B.). In Manitoba and elsewhere a completely separate mechanism handles billing matters.

411 *College of Physicians and Surgeons v. Casullo* (1976), 67 D.L.R.(3d) 351 (S.C.C.);*Re Isabey and College of Physicians and Surgeons of Manitoba* (1975), 56 D.L.R.(3d) 156 (Man.Q.B.);*Re Tse and College of Physicians and Surgeons of Ontario* (1979), 23 O.R.(2d) 649 (Div.Ct.)

interference with another's patients? Ironically things may have evolved here in opposite ways. Clearly, advertising is less of a sin than it was. Yet there seems no less intolerance of bipartisan disputes. At least there is no overt evidence that such are ignored. The behavior would still be considered "unprofessional" by most physicians. Any change on either count has not been in response to any cry from the public. Their interests can only minimally be served by increasing advertising. It is also unclear how they really come out ahead with aggressive enforcement of the other matter. How these issues are handled remains at the instigation of the profession. It is perhaps, though, only elements within the profession[412] who have changed the approach to advertising. Even if most doctors might have objected, some wanted to alter the rules and have accomplished this.[413]

As was noted, by the 1950s most disciplinary proceedings in Manitoba involved questions of fitness to practice. Here and elsewhere these continue to be an important focus.[414] There is often an additional

412 Rue Bucher and Anselm Strauss, "Professions in Process" (1961), 66 Am. J. Sociology 325

413 With the help of the courts. *Rocket. v. Royal College of Dental Surgeons of Ontario*, [1990],2 S.C.R. 232.

414 *Charalambous v. College of Physicians and Surgeons of British Columbia* (1987), 27 Admin.L.R. 289

complication. Many of those charged with practicing incompetently argue they are only using alternative approaches that have yet to be accepted by traditional thinkers. They are, they claim, being victimized for being different.[415]

Other issues have arisen which were only rarely if at all encountered before. Breaches of confidentiality have always been officially scorned but for some reason the issue never arose in earlier times.[416] More dramatically is the rise in cases alleging sexual misconduct.[417] The latter is obviously a whole issue in

(B.C.S.C.); *Kuntz v. College of Physicians and Surgeons of British Columbia* (1987) 24 Admin.L.R. 187 (B.C.S.C.); *Rosenstock v. College of Physicians and Surgeons* (1989), 64 Alta.L.R.(2d) 193 (Q.B.); *Re Jain and Council of College of Physicians and Surgeons of British Columbia* (1974), 52 D.L.R.(3d) 616 (B.C.S.C.)

415 *Green v. College of Physicians and Surgeons* (1986), 51 Sask. R. 241 (C.A.); *Re Patterson and College of Physicians and Surgeons of British Columbia* (1974), 49 D.L.R.(3d) 219

416 *Re Shulman and College of Physicians and Surgeons of Ontario* (1980), 111 D.L.R.(3d) 689 (Ont.Div.Ct.) In this case the disclosure was in a newspaper article. It suggests that only written disclosures may attract sufficient attention.

417 See *Saskatchewan College of Physicians and Surgeons v. Camgoz* (1982), 20 Sask. R. 400 (C.A.); *Re Bernstein and College of Physicians and Surgeons of Ontario* (1977), 15 O.R.(2d) 447 (Div.Ct.); *Re Gillen and College of Physicians and Surgeons of Ontario* (1989), 68 O.R.(2d) 278 (Div.Ct.); *Re College of Physicians and Surgeons and V* (1985), 20 D.L.R.(4th) 765 (Ont.D.v.Ct.); *Hirt v. College of Physicians and Surgeons of British Columbia* (1985), 63 B.C.L.R. 185 (S.C.); *Patterson v. Council of College of*

itself but at least bears evidence of some change in approach, no matter what precipitated it.

Perhaps as a final point of perspective one might take a contemporary snapshot of modern discipline with a look at the most recent Newsletter from the Manitoba College.[418] Among the curiosities is news that Osteopathy will be recognized, a point of contention back to the beginning of this century.[419] Of interest as well are the disciplinary summaries. Among others it includes the first physician to be erased in several years. The elderly physician had kept little or no records, mismanaged several cases, and repeatedly overprescribed narcotics.

Also noted is a psychiatrist who was censured for improperly charging a "standby fee". The fee itself was

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Physicians and Surgeons of British Columbia (1988), 25 B.C.L.R.(2d) 199 (S.C.)

418 28 *CPSM Newsletter #2*, April, 1992. Other perspectives are also possible. Unlike the lack of historical data there is much more material available if one is looking for a contemporary picture. Information is also available from farther afield. Recent analysis of complaints and discipline can be reviewed from Britain and Sweden (Rosenthal at 193), France (*Bulletin de L'ordre des Medecins*, 1991), New Zealand (*Medical Practitioners Disciplinary Committee Annual Report*, 1990), and Australia (*Tenth Annual Report of the Medical Board of Victoria*, 1989/90). With the exception of Sweden the patterns of misconduct are strikingly congruent.

419 Minutes, Annual Meeting, 5 October, 1921

not improper but it had not been properly disclosed. Unlike the archival cases there is actually specific reference to the Code of Ethics.

Finally a family doctor was reprimanded for mismanaging a pregnant patient. In other words a specific act of negligence was acknowledged and penalized.

Thus it may well be in this last area that the greatest changes may have occurred.[420] This, in part, relates to the rise of what Blishen calls "communal control".[421] A more educated public will be more in a position to challenge the authority of the physician. In the past they were not. They may have been presumptuous enough to complain about a physician not being available, but not about the care that might have eventually been provided.

The profession had to respond to this new threat, that from their patients. To not do so invited more aggressive intervention from the state or the courts. Physicians had to provide greater evidence that they were acting in the public interest not their own:

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420 Compare Sweden where the majority of complaints concern specific cases of negligence. Marilynn Rosenthal, *Dealing with medical malpractice: The British and Swedish experience*, 1988 at 193

421 Bernard Blishen, *Doctors in Canada* 1991, at 145

> The granting of self-government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power is not conferred to give or reinforce a professional or occupational status. The relevant question is not, "do the practitioners of this occupation desire the power of self-government?", but "is self-government necessary for the protection of the public?".[422]

Thus, if discipline began to become more and more a question of assessing the quality of care then eventually the profession may becoming closer to the degree of control Blishen alleges.[423] While there can be little argument that doctors as individuals continue to exercise significant control over encounters with their patients, there is no evidence, then or now, that bodies such as the College could exert real control over the same discrete events. If one looks at any of the cases lifted from the archives one will find few references, and no interventions, into the dynamics of such events as an office visit. While the College may have controlled a great deal about what physicians could or could not do in their public persona, there was no evidence of any efforts to get "behind closed doors."

What is really interesting is whether this has changed much. As noted above cases do arise now. Has the

422 *Report of the Royal Commission into Civil rights, province of Ontario*, Report No. 1, Vol. 3, 1968, at 1162

423 Blishen, *supra* n. 421, at 122

College any more control? Blishen asserts that, in fact, organizations such as the College have a "great deal of control." His only evidence for this is the peer assessment program in a few provinces. He fails to detail how such control can arise from a *voluntary*, nondisciplinary office inspection that only involves a handful of doctors in a given year. Of course there are other opportunities for "observation" by peers.[424] Most physicians operate in communities, or within hospital settings. Yet rarely, if at all, will one see a patient in another doctor's presence. Certain aspects of their clinical judgment and knowledge may get informally assessed but much will not.

So in the end, there remain but few conclusions to be drawn, only the observations that have been made along the way. Clearly the approach and focus of medical discipline has changed. As the early cases from Manitoba and elsewhere showed the disciplinary process was originally directed at behavior among physicians. Licensing bodies tended to function like private clubs which expelled those who broke the rules. Somewhat later they began to respond to external forces, especially in the context of criminal prosecution. The real force

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424 *Ibid.*

behind these actions remains unclear, but seems, in part, an attempt to express disdain for those caught up in outside forces. The leniency of their response in some, but not all, cases underlines a rather equivocal attitude to these individuals.

Eventually there began an effort to respond to the public, which even by the end of this period looked at was hardly enthusiastic. Still there was evidence of change. Likewise the public's expectations have changed. Have these changes been significant? That really depends. Obviously in specific areas, such as sexual misconduct, one can never be sure if enough has been done. At least some of this uncertainty arises because other aspects of misconduct remain unexplored. Only recently has the question of predisposing factors to misconduct begun to be addressed.[425] What factors predispose a physician to take sexual advantage of a patient? In the same vein, do those who overbill first get themselves into financial trouble with bad investments? What is the role of substance abuse in misconduct or incompetence?

In the end, though, there will always be some level of inappropriate activity. There will always be some

425 "Why do they do it? Unveiling the dynamics that drive doctors to sexually abuse patients", *The Medical Post*, June 9, 1992

whose actions attract sanctions. Perhaps the scene would improve if the profession demonstrated greater enthusiasm for taking appropriate action. This need not mean public pillorying of wrong-doers. It may mean responding to the expectations of the public. After all, professional self-regulation only exists at the whim of the public and its legislators.

This, finally, suggests the key to getting closer to a better system. It is not so much how a disciplinary matter concludes that matters, so much as how it begins. There was a deliberate attempt to ignore process and procedure in this review. Yet here is the easiest way to begin to influence the system. An aggrieved member of the public should at least be sure that their complaint has been adequately addressed. A form letter to the patient that the care provided was "acceptable" and a letter of apology *to the doctor* for all of the trouble hardly seem likely to inspire confidence. It is at that minimal level that the profession will have to respond if it hopes to continue to enjoy the privilege of autonomy it feels it has earned.

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