Second Opinions: Why Canadian doctors do not always defend medical dominance

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ABSTRACT

Organized medicine is a uniquely powerful political force in Canada, with physician colleges and associations exerting extensive influence over healthcare provision. Their influence has contributed to what social scientists describe as medical dominance, or the exceptional power of the medical profession within the healthcare system and wider society. However, Canadian medical organizations do not consistently defend this dominance; rather, they have occasionally lent support to policy changes that, on their face, would appear incompatible with traditional conceptions of medical power and authority.

Typically, these instances are explained as a simple matter of strategic retreat: medicine conceding defeat on a particular issue in an effort to save face or conserve resources, without any change in underlying beliefs. This dissertation questions that assumption, asking if at times organized medicine's support for threats to medical dominance is instead a function of more fundamental shifts in core policy beliefs. Through a series of interviews exploring how organized medicine responded to the re-emergence of midwifery and expansions of pharmacy scope in four provinces (Alberta, Ontario, Quebec and Nova Scotia), the analysis determines that, while medicine only supported expanded pharmacy scope out of strategic retreat, there are signs of more substantive shifts in belief with respect to midwifery. This suggests that the relationship between organized medicine and traditional medical dominance is more flexible and dynamic than has been assumed.

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1. Introduction: Medical politics and medical dominance

"On immunization, minor ailment prescribing and ordering and interpreting tests, there have been significant regulatory changes to allow pharmacists to perform those functions. And I think it's safe to say for the most part we've been very supportive of those as an association."

– Kevin Chapman, Director, Partnerships and Finance, Doctors Nova Scotia (Interview, Halifax, Apr. 27, 2016)

"[On midwifery,] I had no pushback from Doctors Nova Scotia. Zero. Zip. None."

– Maureen MacDonald, former Nova Scotia Minister of Health and Wellness (Interview, Halifax, May 2, 2016)

Normally, in stories of health policy change, doctors are the antagonists. They are the elite, against whom social movements and up-and-coming providers make their claims. When medical power is threatened, physician organizations are expected to mobilize to protect it and maintain doctors' privileged position (Meslin, 1987; Stevenson, Williams, & Vayda, 1988; Tuohy, 1976, 1999; Vadeboncoeur, 2004). However, when Nova Scotia was considering expanding pharmacists' scope of practice to include prescription responsibilities in 2010, organized medicine did not resist. Traditionally, prescribing falls squarely within physician territory. However, there was no sign of any public pushback from medicine; in fact, despite trepidation from individual physicians, medical organizations publicly supported elements of the new regime once it was in place (CBC, 2015a, 2015b).

This is not the only case of Nova Scotia physicians supporting an intrusion into their traditional territory. Just before its consideration of expanded pharmacy scope, the province made the decision to reintegrate midwifery in the mainstream health system. Again, medicine did not push back; in fact, when the midwifery pilot program was later

facing severe challenges, the president of Doctors Nova Scotia defended the program and argued that it should be expanded, not scrapped (Cardwell, 2011) – this despite the fact that Canadian doctors have traditionally supported a medicalized vision of birth, one fundamentally at odds with the profession of midwifery, and had fought to obtain a near-monopoly over birth attendance (Biggs, 1983; Bourgeault, 2006).

These cases could perhaps be read as examples of Maritime exceptionalism, that policy debates are simply less acrimonious east of Quebec – indeed, there is some evidence that Atlantic Canadian doctors prefer to air their grievances behind the scenes rather than out in the open (Lomas, Charles, & Greb, 1992; Tuohy, 1999). However, Nova Scotia physicians were not alone in their amenability to either of these policy changes. To take another example, long before the Nova Scotia decision to bring in midwives, Ontario announced in 1986 that it would become the first province to reintegrate midwifery into mainstream healthcare provision. Here, doctors' resistance was also weaker than expected, with medical organizations coming around to more supportive positions as the province ironed out the details of the new regime (see Bourgeault, 2006; Vadeboncoeur, Maheux, & Blais, 1996). On pharmacy scope, Quebec physicians expressed conditional support for their government's action to grant prescription rights to pharmacists, and worked collaboratively with pharmacists on the details of the new regime (Fédération des Médecins Omnipraticiens du Québec, 2011; Leduc, 2011b).

When governments introduce changes like these, they threaten medical dominance – that is, the exceptional power of doctors within the healthcare system and society writ large, as understood by social scientists (Freidson, 1970; Lupton, 2012;

Weitz, 2007). In Canada, medicine is dominant because the state grants it significant autonomy over its own work, permitting doctors to self-regulate through colleges of their peers. Medicine is also dominant because it holds a state-sponsored monopoly on a wide swath of professional territory, and controls the work of other professionals, such as nurses and pharmacists. Finally, medicine is dominant because it has established and benefitted from the guiding belief system of western healthcare, one that privileges physicians by granting near-exclusive legitimacy to a medical, interventionist model of care. In this way, medical dominance extends beyond directly empowering physicians as a group, to determining the substance and boundaries of acceptable and 'medically necessary' care.

As the cases outlined above demonstrate, provincial/territorial-level medical organizations do not always defend traditional dominance. In this dissertation, I ask if doctors' occasional support for threats to medical dominance can be exclusively explained by strategic calculus – i.e., medical organizations nominally backing a policy in an effort to influence implementation, save face, conserve resources or win favour with those in power in the face of what appears to be a *fait accompli* – or if medical organizations' support for these policies can be in part traced to substantive shifts in their beliefs on key underlying elements of medical dominance, such as the medicalization of birth and medical control over diagnosis and prescription. Both scenarios can be understood as examples of learning – that is, a set of actors shifting its positions according to new evidence or changing circumstances (see C. M. Hall, 2011; Jenkins-Smith, Nohrstedt, Weible, & Ingold, 2017; May, 1992; Sabatier, 1988). However, they represent different kinds of learning, with significant consequences for how we think

about organized medicine. If cases in which medical organizations support medical dominance can be consistently traced to political learning and strategic retreat (the abandonment of objectives for strategic reasons, see Hall, 2011; May, 1992; Nilsson, 2005) then one might argue that medical support is not *really* support at all, as there is nothing to suggest that organized medicine is anything but inherently defensive of its traditional dominance. However, if such shifts are due at least in part to medical organizations engaging in what May (1992) labels "social policy learning" and reconsidering their beliefs on core tenets of medical dominance, then the relationship between organized medicine and medical dominance – and indeed, the very nature of medical organizations as political actors – needs to be re-evaluated (C. M. Hall, 2011; Nilsson, 2005).

This question is addressed through an examination of how medical organizations have responded to the re-emergence of midwifery and the empowerment of pharmacists to prescribe independently across four provinces: Alberta, Ontario, Quebec and Nova Scotia. In some cases, doctors responded as expected, strongly resisting the proposed threats to their power (Arrowsmith, 2006; McKendry & Langford, 2001; Section on General and Family Practice, 2009; Vadeboncoeur, 2004). However, as outlined above, in other cases the medical profession adopted a more amenable posture. In considering how organized medicine sometimes comes around to support threats to what have been traditionally understood as key elements of dominance – as well as why, in some cases, medicine remained sceptical – the analysis differentiates between two different kinds of learning: political learning, which leads to strategic retreat, and social policy learning (ibid). Following this inquiry, I argue that, for pharmacy scope, cases of medical support

are indeed a product of political learning and strategic retreat. However, in the case of midwifery regulation, changes in medicine's position are due in part to social policy learning and substantive support for midwives' claims.

This finding has significant implications for how social scientists think about Canadian organized medicine. While traditional medical dominance remains important to medical politics, organized medicine has not defended it in all circumstances. Moreover, when medicine has taken such counterintuitive positions, it cannot necessarily be dismissed as cynical or strategically-motivated; rather, in the case of midwifery regulation, in some provinces the medical establishment shifted its core policy beliefs with respect to the medicalization of birth, which had previously been a critical part of doctors' consolidation of power in Canada (see Biggs, 1983; Bourgeault, 2006; J. T. H. Connor, 1994). The relationship between organized medicine and medical dominance is then a flexible one; it is possible for doctors' organizations to tolerate, and even support, policies that fundamentally undercut medical dominance in Canadian healthcare provision. This represents a departure from how Canadian medicine's political activity has been understood in the past, as discussed in the following section.

The Literature: Organized medicine and medical dominance

This thesis positions itself against prevailing understandings of Canadian organized medicine's political activity and its relationship with medical dominance. Threats to medical dominance are often studied without much consideration of whether and how doctors push back (see Coburn, 2006; Coburn et al., 1983; McKinlay & Marceau, 2002; Weitz, 2007; Willis, 1983). It is understood that medical organizations should find these

changes undesirable, since their mandates and the interests of their members are so bound up in the power of doctors within the healthcare system.

However, neither associations nor colleges consistently defend medical dominance, at least publicly. This phenomenon warrants explanation not only in its own right, but also because of the historical position of Canadian doctors within health policy debates. Canadian medicare was founded on a grand bargain between medicine and the state, in which doctors maintained significant autonomy within provincial and territorial systems of publicly-funded insurance (Hacker, 1998; Tuohy, 1999). This move also ensured that medical organizations would remain extremely politically powerful forces within the new regime, setting up the system at the intersection of medical and state authority. Tuohy describes medicare as a "fundamental accommodation between the medical profession and the state" (1999, p. 30), while Hacker argues that, in establishing fee-for-service as the dominant system of remuneration,[1] the regime "froze into place a framework of medical delivery that would make Canadian healthcare among the world's most costly" (Hacker, 1998, p. 100). Indeed, since then, physician payment and the incentive structures attached thereto have been a perpetual thorn in government's side, routinely flagged as a driving force behind rising costs and an impediment to system reform (Evans, 1974; Lazar, Forest, Church, & Lavis, 2013; Lewis, 2005). However, there has been little attention paid to organized medicine as a political force, including how medical organizations function within the system and why they take the positions they do. When these organizations' policy positions differ across provincial lines, that signals a certain complexity and even malleability that warrants examination.

[1] Fee-for-service is a system of remuneration by which physicians receive a set payment for each service provided.

The observed differences between provincial medical organizations also present an opportunity to better connect the theoretical concept of medical dominance to Canadian medical politics – that is, the medical profession's political organization and how it advocates for its interests and beliefs (Silver, 1976). The theoretical literature around medical dominance recognizes that dominance is not static; it waxes and wanes to varying degrees in different jurisdictions according to political and cultural trends, and, as many have argued, has been in general decline since the mid-20th century (see Coburn, Torrance, & Kaufert, 1983; Weitz, 2007; Willis, 2006). As such, debates within healthcare provision are frequently understood according to how they reinforce or challenge traditional dominance. The rise of evidence-based medicine threatens dominance by constraining individual physicians' clinical decision-making (White & Willis, 2002; Willis, 2006), for example. In contrast, fee-for-service reinforces dominance by allowing doctors to function as independent contractors with significant professional autonomy (Hacker, 1998; Tuohy, 1999). Just about any question about the substance or structure of care delivery has implications for medical dominance, either granting power to or taking it away from the medical profession. However, the concept of medical dominance has not been well applied to the organizations representing Canadian doctors. Beyond references to medical protectionism in larger stories of policy change (see Bourgeault, 2006; Coburn et al., 1983; Tuohy, 1999), there has been little interest in understanding how doctors and their representative organizations actually engage with what social scientists understand as medical dominance. As such, and in light of the variation between provinces noted above, rigorous examination of the relationship between organized medicine and medical dominance is warranted.

The current literature on Canadian health policy does not ignore or deny that physician organizations sometimes take such counterintuitive positions. However, in such cases doctors' motivations have been read as self-evident. Medical associations and colleges are widely seen as inherent guardians and even manifestations of medical dominance – indeed, Coburn (2006) calls them the "social embodiment of professional autonomy and self-regulation," their power and independence an indicator of dominance itself (p. 440). Weitz (2007), writing in an American context, agrees, citing the weakening power of the American Medical Association as not just among the reasons why American medical dominance has declined, but as actually constituting part of the decline (see also Coburn et al., 1983; McKinlay & Marceau, 2002). Colleges of Physicians and Surgeons are even more tightly connected to dominance than are associations. They are the enforcing bodies of the profession's guiding beliefs and norms, charged with pursuing charlatans and 'alternative' practitioners to ensure that recognized, legitimate care is conducted according to the belief system held by the medical establishment. Their power is then also read as an expression of dominance, directly granting doctors control over the system (see Coburn, 2006; Coburn et al., 1983; Gidney & Millar, 1994).

If these organizations are so inherently tied to medical dominance, then why do they sometimes support threats to that dominance? The most obvious answer is strategic calculus. Medical organizations are by nature highly involved in health policy debates, and need to conserve resources and maintain productive relationships with government. They must know when to cut their losses. Doctors might very well support a policy on paper, but only do so out of strategic considerations in service of some higher objective.

If they view a particular policy change as inevitable, they may be inclined to nominally support it to ensure their ability to shape the implementation process, win favour with the powers that be or simply avoid spending money and political capital on a lost cause. This kind of nominal support is thin and unsubstantive; it remains comfortably in line with the idea that medical organizations are inherently protective of medical dominance.

This is a sort of 'default' explanation for instances in which medical organizations have taken counterintuitive positions. It has been applied particularly consistently to accounts of the re-emergence of midwifery in Canada, which tend to emphasize how medicine a) did not always have the necessary resources to strongly oppose midwifery, and b) would conveniently change its position once it appeared inevitable that the midwives would win (Bourgeault, 2006; McKendry & Langford, 2001; Vadeboncoeur, 2004). Bourgeault, for example, describes how Ontario midwives made their push in the context of a larger reconsideration of multiple health professions' scope of practice, resulting in a "lack or diffusion of interest" from the medical establishment in the midwifery issue and an associated "diffusion of resources" to engage on it (Bourgeault, 2006, p. 267–268). Beyond the midwifery case, the strategic explanation has been applied to cases in which doctors and their representative organizations accepted a stronger role for pharmacists (Coburn et al., 1983; see also Clark, 1991; Malleck, 2004), took up elements of complementary and alternative medicine (Kelner, Wellman, Boon, & Welsh, 2004) and shifted their posture on publicly-funded medical insurance (Hacker, 1998; Tuohy, 1999; see also Stevenson et al., 1988).

These discussions all start from the premise that organized medicine has a fundamental tendency to protect dominance. As such, medical organizations will only

waver from that mission out of strategic calculus. However, this proposition has never been tested through an empirical exploration of the relationship between medical dominance and Canadian medical politics. Rather, medical pushback (or lack thereof) has been treated as a minor consideration in larger stories of policy change. In these stories, organized medicine is only discussed as the antagonist to the change-makers, its motivations and internal machinations left largely unexplored. A renewed focus on organized medicine itself could reveal new insights about how the profession's political positions change and evolve.

Moreover, there is ample reason to seriously consider alternative explanations for organized medicine's occasional support for threats to medical dominance. First is the long history of dissenting figures within the medical profession. Studies of opinion within medicine suggest that individual doctors' views on key issues of medical dominance do vary (Blais, Lambert, & Maheux, 1999; Stevenson et al., 1988). The most high-profile example concerns the early days of medicare, which were marked by a bitter, high-profile doctors' strike. During this tumultuous time, physicians who supported medicare spoke out and broke the strike, even at the risk of being branded "heretics" (Badgley & Wolfe, 1965, p. 470; see also Naylor, 1986). To take another example, even as midwifery lost its independent professional status and home births were banned or discouraged across the country, allied physicians helped expectant parents find midwives and often oversaw midwife-attended home births (Bourgeault, 2006; James & Bourgeault, 2004). Doctors have even broken ranks on purely fiscal matters; in 2017, left-leaning physicians took to the microphones at the Canadian Medical Association's Annual Meeting to support the Liberal government's changes to the tax code, in contradiction to the position of the

association (Collier, 2017). Dr. Monika Dutt, then a Cape Breton-based physician, lost her position on the board of Doctors Nova Scotia after speaking out publicly in favour of the changes, which would result in higher taxes for incorporated physicians (Ayers, 2017).

Second, the medical profession is changing. Most obviously, women have been rapidly entering Canadian medical practice over the past few decades; while critics could once contrast female-dominated professions with the dominant "medical men" (see Williams & Levy, 1992; Willis, 1983; Witz, 1992), female physicians have dramatically increased in number to the point where it is no longer appropriate to refer to medicine as male-dominated. Recent medical graduating classes have been heavily tilted toward women, and the overall gender composition of the profession is quickly approaching parity (Canadian Institute for Health Information, 2019b; Canadian Medical Association, 2018). This alone does not imply a change in how the profession functions or its prevailing ideology. However, there also is evidence that this demographic shift has occurred in concert with a change in priorities, as younger physicians, regardless of gender, tend to express different values than the older generation, particularly with respect to work-life balance (see Crossley, Hurley, & Jeon, 2009). This impacts how medicine might engage with different kinds of dominance; most critically for the purposes of this thesis, it impacts the degree of competition posed by midwives, as more and more doctors have been leaving obstetrics due to its time-consuming and unpredictable nature (Barrington, 1985; Bartlett, 2004; Cohen, 1991).

Finally, as previously mentioned, public policy literature delineates different kinds of collective learning that can incline actors to change longstanding positions (Grin

& Loeber, 2006; Heclo, 1974; May, 1992; Nilsson, 2005). With respect to organized interests, political learning is the most commonly cited – this entails groups shifting their tactics while maintaining underlying goals, and can serve as a theoretical base for strategic retreat (May, 1992; Sabatier, 1988). However, May (1992) notes that interest groups and social movements can experience other kinds of collective learning as well, including more fundamental alterations in how problems are defined and issues are understood (see also Grin & Loeber, 2006; C. M. Hall, 2011; Nilsson, 2005). The advocacy coalition framework also puts forward several conditions under which learning can take place across opposing coalitions, resulting in policy change as one side of a debate shifts its beliefs (Jenkins-Smith et al., 2017; Sabatier, 1988; Weible, Sabatier, & McQueen, 2009). We cannot then entirely preclude the possibility that organized medicine can change its substantive understanding and opinion of certain elements of medical dominance.

There is then ample reason to re-evaluate organized medicine's relationship with medical dominance at this juncture. The connection between the two has never been rigorously explored, and cases of medical support for threats to dominance have been explained away as strategically motivated (see Bourgeault, 2006; McKendry & Langford, 2001; Vadeboncoeur et al., 1996). However, there are both empirical and theoretically-based reasons to believe that organized medicine may hold a more complex, evolving relationship with traditional dominance (Collier, 2017; Crossley et al., 2009; May, 1992). This thesis begins to fill this gap, reconsidering longstanding assumptions about how Canadian organized medicine responds to threats to medical dominance. It finds that, on the midwifery case, medical supports stem in part from substantive shifts in its positions

on key tenets of medical dominance, ultimately suggesting that the profession is not as inherently protective of its dominance as has been assumed.

Theoretical framework and design of the study

The question at the heart of this dissertation concerns how organized medicine moves from one position to another. In addressing this question, I explore the possibility that doctors will not respond in the same way to every kind of threat to their dominance. Willis (1983) delineates three "levels" of dominance – autonomy, authority and sovereignty – each of which empowers medicine in a distinct way and affects a particular aspect of healthcare provision. Autonomy refers to doctors' freedom from state intervention, authority refers to their control over the healthcare division of labour and sovereignty refers to the ubiquity of medicalized conceptions of health and what healthcare should look like (see also Willis, 2006). These are distinct elements of medical dominance; critically, authority and autonomy have direct impacts on doctors' material well-being, while sovereignty is more strongly connected with medical philosophy and what physicians traditionally believe constitutes good and appropriate care. To capture this distinction, this dissertation examines one threat to authority and one threat to sovereignty.

Midwifery represents a threat to medical sovereignty. As part of their consolidation of power in the mid-20th century, Canadian doctors successfully pushed midwives to the margins of care provision, arguing that practitioners were dangerously incompetent and that births should only be attended by those qualified to quickly perform invasive interventions in cases of possible complications – allegedly to minimize risk

(Biggs, 1983; Bourgeault, 2006; Duffin, 1999; Plummer, 2000). This argument medicalized birth and brought it under physician jurisdiction. In the context of perinatal care, medicalization entails the belief that birth attendance *should* be interventionist, forecasting the rise in popularity of forceps and caesarean sections (Biggs, 1983). Interventionism and risk aversion are core elements of medical sovereignty, the aspect of medical dominance that privileges scientific expertise and characterizes physicians' relationship with society (Willis, 1983, 2006). Midwives successfully sought reintegration into Canadian health systems toward the end of the 20th century, challenging these assumptions head-on (Bourgeault, 2006). However, upon their re-emergence midwives had little effect on authority, as doctors were increasingly abandoning birth attendance at this point regardless of any competition from another profession (Barrington, 1985). The debate then largely concerned what birth should look like, rather than who specifically should be attending it.

In contrast, independent prescribing by pharmacists represents a threat to medical authority, while having minimal effect on sovereignty. Pharmacists fully endorse and take up medical sovereignty; their history of conflict with medicine has been about trying, often successfully, to beat doctors at their own game by painting their own education as more scientific, more specialized than medical training (Clark, 1991; Malleck, 2004, 2006). They want to be able to do what doctors can do, without changing the nature of the tasks in question. This has historically created significant conflict between the two professions over the boundary between their respective practices (ibid). One of the more recent of these conflicts has been over whether pharmacists should be allowed to initiate drug therapy, something that Canadian provinces have been

considering to varying degrees since the end of the century. Independent prescription represents a significant intrusion into what has traditionally been exclusively physicians' territory; Freidson writes that doctors' rights to "diagnose, cut and prescribe" are particularly important to their power over other professionals (1970, p. 69). In asking for the ability to prescribe independently, pharmacists encroached not only on prescription but also diagnosis, as initiating a prescription inherently involves diagnosing an ailment. Diagnosis places physicians at the centre of healthcare provision, as all other care decisions revolve around it. While pharmacists would not be the first to challenge physicians' monopoly in this domain (nurse practitioners provide another example, see Bourgeault & Mulvale, 2006; McMurray, 2011), their claim represents a fundamental challenge to medical authority.

Across these two cases, the analysis considers organized medicine's position as the dependent variable. While independent variables are identified, what is particularly important is the mechanism by which they produce change in the dependent variable. For example, I need to not only identify those independent variables that prompted medical support for midwifery in Nova Scotia, but also whether those variables prompted organized medicine to change its posture out of strategic retreat or out of a more fundamental shift in belief. To accomplish this, the analysis needs to have at its disposal a theoretical framework and methodology that can move from *why* change occurs to *how* it occurs.

To this end, I take up May's (1992) distinction between political and social policy learning as the theoretical basis for this study (see also Grin & Loeber, 2006; C. M. Hall, 2011; Nilsson, 2005). Both political and social policy learning capture *how* positions

change, rather than the independent variables that prompt such change. Political learning is what results in strategic retreat; this is simply a matter of backing away from opposition in the face of apparent long odds or defeat. In contrast, social policy learning entails a fundamental reconsideration of core policy beliefs and goals. Existing literature portrays organized medicine's core beliefs as static, and shifts in formal position as occurring through political learning and strategic retreat (Bourgeault, 2006; McKendry & Langford, 2001; Tuohy, 1999; Vadeboncoeur, 2004). This dissertation questions that depiction, and explores whether medical support might stem in part from social policy learning within the medical establishment.

This analysis is primarily concerned with the type of learning that occurs rather than solely focusing on the independent variables that prompt changes in medicine's formal positions. Accordingly, it adopts an inductive posture, identifying explanatory factors as the research proceeds. However, additional theoretical insights can nevertheless guide the data collection process by suggesting causes of different kinds of learning (Falleti, 2016). As such, I employ an element of the advocacy coalition framework (ACF), which is itself concerned with conditions under which opposing coalitions can learn from one another to reconsider their core beliefs (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988; Weible et al., 2009). For the purposes of this project, I focus exclusively on factors that might prompt one side of the debate – namely, doctors – to change their core beliefs. Specifically, studies of the ACF identifies the presence of brokers or extremists, the availability of evidence and the features of forums for dialogue between opposing coalitions as among the conditions that make this kind of learning possible (Ingold & Varone, 2011; Jenkins-Smith et al., 2017; Sabatier, 1988). Studies of

the ACF also suggest that the presence or absence of these factors do not on their own pre-determine social policy learning (see Weible et al., 2009). However, they serve as a theoretical starting point for the analysis, allowing me to begin by looking for these conditions in each of the provinces selected.

Political and social policy learning are causal mechanisms, describing the specific type of relationship between independent and dependent variables. Identifying causal mechanisms is among the chief tasks of process tracing analysis, which is concerned with closely examining the interaction between observed variables to determine how exactly changes occur (see George & Bennett, 2004; George & McKeown, 1985). Process tracing is frequently used for single-case analysis, as it overcomes the need to isolate variables via controlled comparison, considers context as integral to explanation and generally shies away from the pursuit of universal laws and patterns (Falleti, 2016; George & Bennett, 2004; George & McKeown, 1985). However, this dissertation considers four provinces within each policy case,[2] as including multiple provinces allows the analysis to a) highlight conditions for different kinds of learning by considering jurisdictions in which medicine remained relatively sceptical of either midwifery or expanded pharmacy scope (see Falleti, 2016), b) account for instances of equifinality, in which the same outcome is reached via different paths (see Beach & Pedersen, 2019; A. Bennett & George, 1997), and c) understand and integrate contextual differences between provinces, including how change in one jurisdiction impacts another. As such, provinces

[2] Cross-provincial comparisons are common in studies of Canadian public policy (see Boychuk, 2014; Haddow & Klassen, 2006; Wallner, 2014). However, this project is not structured as a traditional controlled comparison, as context and intervening variables are not controlled for between provinces.

were selected to account for a range of contexts that were anticipated to impact conditions for social policy learning.

The four provinces examined are Alberta, Ontario, Quebec and Nova Scotia. These were chosen according to order – the first province to institute each policy change was selected – and to represent a range of different traditional dynamics of interaction between the state and the medical profession. Both of these were expected to impact conditions for learning. In the case of order, discussions of learning have noted that actors can learn from one another's experiences rather than just their own (Kingdon, 1984; Rose, 1993; Schneider & Ingram, 1988). In the case of traditional dynamics, the way in which medical dominance is institutionalized and expressed differs across provinces, which may impact whether and how organized medicine reconsiders its views on particular threats; specifically, some provinces have histories of open conflict between the state and the medical profession, while in others such clashes are less common and/or politically acceptable (Lomas et al., 1992; Tuohy, 1999). Chapter 3 provides additional discussion and justification for the provinces selected.

In the case of pharmacy scope, the contrast between these four jurisdictions is immediately visible. In Alberta and Ontario, medical organizations opposed their provinces' efforts to introduce independent prescribing by pharmacists (Arrowsmith, 2006; Lang, 2006; T.-K. Lee, 2006; Metro, 2009; Ontario Medical Association, 2009). In Nova Scotia and Quebec, however, physician associations and colleges were brought around to positions of support before the reforms were made official (Kevin Chapman, interview, Halifax, Apr. 27, 2016; Fédération des Médecins Omnipraticiens du Québec, 2011). In contrast, the midwifery case requires a deeper dive into the process to delineate

differences between medical organizations. In all provinces, doctors dropped any formal, wholesale objections to midwifery once the profession was legalized (Bourgeault, 2006; McKendry & Langford, 2001; Moulton, 1999; Vadeboncoeur, 2004). Differences between provinces can be identified according to how and when physician organizations move from strategies of incorporation to deskilling, two concepts outlined by Witz (1992). Incorporation refers to instances when a dominant profession assumes its rival's responsibilities, relegating it to the margins of the system or eliminating it entirely (p. 101). In contrast, 'deskilling' is when the dominant profession accepts its rival's existence, but seeks to control or limit its work in ways that keep power concentrated within the dominant profession and its governing bodies (ibid). Through employing these concepts to trace medicine's posture, it is observed that organized medicine was more staunchly opposed to midwifery in Quebec than any of the other provinces studied, and was most collaborative in Ontario. Nova Scotia and Alberta fall in between these extremes, with Alberta doctors emerging as the more resistant of the two due to a last-minute switch back to incorporation by the College of Physicians and Surgeons.

In this dissertation, I examine both medical associations and colleges. In most provinces the associations studied are affiliates of the Canadian Medical Association (CMA), the federalized body representing physicians across Canada. However, in Quebec, the CMA affiliate is not the recognized bargaining agent for physicians in remuneration negotiations. Rather, that responsibility is split between the Fédération des médecins omnipraticiens du Québec (FMOQ), which represents general practitioners, and the Fédération des médecins spécialistes du Québec (FMSQ), which represents specialists. In Canada, a divide has frequently emerged between specialists and family

general practitioners, with general practice seen as less prestigious – in Quebec, the separate associations reinforce this divide, which is made explicit through separate contracts and fee schedule negotiations (Collier, 2018; Picard, 2018). The FMOQ and FMSQ come closest to the role played by other Canadian medical associations; as such, they are the primary subjects of the Quebec investigation. Furthermore, the Ontario Medical Association (OMA) is unique in that it includes powerful semi-autonomous 'sections,' some of which occasionally break with the OMA itself; these sections are also considered as part of the OMA discussion. Finally, I chose to include medical colleges in this research, as they are the *de facto* enforcers of medical sovereignty, pursuing irregular practitioners and setting many of the rules by which physicians must comply; this direct power gives them a greater ability to obstruct than associations. Colleges often weigh in on public policy issues, and were publicly active on both of the cases discussed in this dissertation. More often than not, their opinions line up with those of the medical associations.

Process tracing entails relying heavily on primary sources, particularly when the examination involves focusing on beliefs and perceptions (Maxwell, 2008; May, 1992). These are phenomena most clearly understood when observed directly and from multiple angles. As such, this study rests on two main streams of primary sources. First, I examined archived news material to establish timelines of change and identify the official positions of different groups. Second, I conducted 42 on-the-record semi-structured interviews with informants in each province from organized medicine, midwifery, pharmacy, nursing, government, the not-for-profit sector and activist circles. These interviews provided the opportunity to discuss interviewees' own motivations as well as

their assessment of medicine's motivations. Hearing from informants outside medicine was particularly significant, as it allowed me to integrate a wide spectrum of perspectives and either validate or challenge the claims heard from medical sources and informants (see Kay & Baker, 2015; Maxwell, 2008; Tansey, 2007).

I interviewed people from an extremely wide range of backgrounds, with a fascinating array of perspectives and experiences. Despite the age of some of these cases, several interviewees were able to quote decades-old documentation verbatim (which I then independently verified). I believe that this speaks to the salience of these issues and the weight these debates continue to hold. Through the active participation of such a diverse set of interviewees, I was able to obtain a clear picture of the discussions that took place around midwifery and pharmacy across the country during this period.

Outline

Six additional chapters make up the thesis. In Chapter 2, I further consider the existing literature on medical dominance. Discussions of dominance focus extensively on sources of dominance and its manifestations; while these insights are important to understanding medical power, there has been little interest in bridging medical dominance as an overarching concept to the day-to-day activities of Canadian medical colleges and associations. As a result, as previously mentioned, we are left with the assumption that medical organizations are the guardians of dominance in all situations, only wavering in their positions on specific cases for strategic reasons (Bourgeault, 2006; McKendry & Langford, 2001; Tuohy, 1999; Vadeboncoeur, 2004).

Chapter 3 then considers the theoretical framework and methodology employed, exploring the concept of learning and its importance to the research question. For the purposes of this dissertation, learning refers to any collective change in belief. In identifying instances of social policy learning, it is most critical to differentiate it from strategic retreat, in which a group backs away from a particular position when it appears to be a lost cause (see May, 1992). In cases of strategic retreat, the group's deeper belief on the issue remains unchanged. In contrast, in cases of social policy learning, positions shift out of substantive change in opinion or ideology, resulting in a change in fundamental goals and objectives. To delineate the difference between strategic retreat and social policy learning, I employ process tracing, a method of analysis that considers *how* variables interact with one another (see Falleti, 2016; Falleti & Lynch, 2009; Kay & Baker, 2015). While specific independent variables are identified as the analysis proceeds, I draw from the advocacy coalition framework to identify common causes of social policy learning (Ingold & Varone, 2011; Jenkins-Smith et al., 2017; Sabatier, 1988). This allows me to strategically select provinces and guides my data collection process (see Falleti, 2016).

Chapter 4 presents the political history of medicine, pharmacy and midwifery in Canada. In doing so, it accomplishes three main objectives. First, it explores the historical roots of Canadian medicine's protectionist reputation. Organized medicine has a long history of resisting high-profile threats to medical dominance in Canada (Hacker, 1998; Tuohy, 1999); it is then perhaps justifiable that, up until now, its political activity has been largely ascribed to conservative tendencies. However, these same historical events have featured high-profile dissenting voices within the medical establishment (Ayers,

2017; Badgley & Wolfe, 1965; Collier, 2017; Naylor, 1986), a phenomenon that has become all the more important given the changing demographics, values and expressed priorities of the profession (Canadian Medical Association, 2018; Crossley et al., 2009). Second, Chapter 4 further justifies the link between pharmacists and midwives and the types of medical dominance that each threatens. Medicine's ideological affinity with pharmacy is well-documented, with each profession engaging with patients and the wider public in a similar fashion (Clark, 1991; Malleck, 2004, 2006). However, the two professions have perpetually struggled over the 'grey area' between their respective competencies. Meanwhile, while midwifery has long clashed with the ideological assumptions underpinning medicine, the economic threat it poses to physicians has faded in recent decades (Barrington, 1985; Biggs, 1983; Bourgeault, 2006). Finally, this chapter's historical discussion lays the empirical groundwork for the cases discussed in Chapters 5 and 6, providing the political and policy context for each debate. This includes why and how midwifery became a marginalized profession in Canada in the first place, why pharmacists' work has been so historically malleable and why Canadian physicians have remained such a powerful political force.

Chapter 5 discusses the pharmacy case. In all jurisdictions studied, proposals to empower pharmacists to independently prompted questions about whether they were qualified to perform this new task (Arrowsmith, 2006; Ordre des infirmières et infirmiers du Québec, 2011; Kevin Chapman, interview, Halifax, Apr. 27, 2016; Puxley, 2008). Ultimately, Ontario and Alberta doctors opposed their provinces' efforts to introduce independent prescribing by pharmacists, while Nova Scotia and Quebec doctors were eventually brought to support proposals in their provinces. Through a series of 24 semi-

structured interviews (out of a total of 42 conducted for this dissertation), this chapter confirms that, in this case, organized medicine did not change its positions through social policy learning on core policy beliefs. Instead, cases of support stemmed from a degree of comfort that the proposed reforms would not significantly intrude on doctors' near-exclusive right to diagnose, as well as the established norms of medical politics and strategic interests at play in each jurisdiction.

Chapter 6 discusses the midwifery case. Again, in all jurisdictions studied, midwifery inspired significant debate. As these debates wore on, Ontario and Nova Scotia doctors were brought around to support the re-introduction of the profession, while Quebec and Alberta doctors stood firmer in their opposition. This might be again chalked up to differences between jurisdictions in strategic imperatives; or, doctors in Ontario and Nova Scotia might have taken a different path to support. Drawing from 25 interviews,[3] this chapter finds that, while political learning and strategic retreat are indeed present, there is also a significant thread of social policy learning that helps to explain why physician organizations in some provinces came around to support regulated midwifery.

Chapter 7 offers a discussion of the findings that emerge from the two cases and their implications for how analysts think about Canadian organized medicine's relationship with medical dominance. It is found that, while differences in organized medicine's posture on pharmacy scope can indeed be traced to strategic considerations and imperatives, there are noticeable examples of more substantive shifts in opinion on midwifery. The final chapter also discusses the limitations of this research, as well as some avenues for future research exposed by this thesis. The dissertation puts forward a

[3] Seven of the 42 interviewees were able to speak to both policy cases.

new and different way of thinking about doctors' political activity, one that creates opportunities for further examination of organized medicine and medical dominance.

Doctors are a uniquely powerful political force in Canada. Their associations and colleges have critical roles to play in shaping healthcare policy and politics. However, social scientists have not yet closely examined how these organizations engage with and relate to medical dominance. As such, this dissertation takes a step toward a more robust understanding of the relation between organized medicine and medical dominance, through the empirical exploration of different medical organizations and their positions on contentious healthcare policy debates.

2. The literature: Deconstructing medical dominance

Medical dominance is an all-encompassing term addressing multiple sources, expressions and consequences of physician power. The concept has long shaped social scientists' understandings of medicine's privileged position within healthcare systems as well as wider political arenas. However, there are significant gaps with respect to how theoretical discussions of dominance have been applied to Canadian organized medicine, signalling a need for a more robust understanding of how different medical organizations across the country actually engage on questions affecting the profession's power.

The task of this chapter is to review the literature on medical dominance and highlight those gaps that this dissertation aims to address. This discussion proceeds in two parts. First, I review the literature on dominance through discussions of three main veins – functionalism, political economy and critical and feminist approaches – in order to delineate what medical dominance is and how it can be systematically approached. I discuss how doctors' power is considered within each vein, paying particular attention to medicine's relationship with the state, other healthcare providers and the public, as well as how medical ideology shapes doctors' own beliefs about what constitutes good care. These insights are applied to the selection of policy cases as discussed in Chapter 3, with cases chosen to correspond to different kinds of threats to medical dominance.

The chapter's second section then discusses interrelated gaps in this literature and how medical dominance has been applied to the Canadian context. First, I highlight the general lack of interest in studying Canadian organized medicine as a political force.

Canadian doctors are important and powerful actors, and it is surprising that they have not been the subject of much academic inquiry. I then note how, while it is indeed common to apply conceptions of medical dominance to particular jurisdictions (Bourgeault & Mulvale, 2006; Coburn, 1993, 2006; Weitz, 2007; White & Willis, 2002), authors rarely acknowledge how state and substate jurisdictions shape the medical marketplace, thereby impacting how doctors might perceive and engage with issues concerning medical dominance. Finally, I discuss how the theoretical literature on medical dominance (most of which is situated in the American context) is only tenuously connected to the day-to-day political activity of Canadian colleges and associations. As a result, discussions of policy debates in Canadian healthcare typically treat physician organizations as extensions of dominance itself, only wavering on questions of dominance out of strategic considerations (Bourgeault, 2006; Coburn et al., 1983; Kelner et al., 2004).

The literature surveyed here presents an opportunity to reconcile theoretical understandings of 'medicine' as a profession with the on-the-ground activities of physician colleges and associations. Through an examination of organized medicine's response to midwifery and expanded pharmacy scope in four provinces, we can elucidate why, in each policy case, medical organizations sometimes took positions that seemingly undermined medical dominance. Answering this question contributes to a deeper understanding of how dominance actually functions in the Canadian context, making a strong contribution to the literature on professional power, medical dominance and Canadian organized medicine.

Medical dominance in social science

Professionalism is a consequence of trustworthiness. Those occupations recognized as 'professions' exert exceptional control over the content of their own work, control that is granted by the state to those judged to merit it. In the opening lines of his seminal work *Profession of Medicine* (1970), Freidson describes the standards according to which professional status is conferred. He writes:

> ...it is useful to think of a profession as an occupation which has assumed a dominant position in the division of labour, so that it gains control over the determination of the substance of its own work. Unlike most occupations, it is autonomous or self-directing. The occupation sustains this special status by its persuasive profession of the extraordinary trustworthiness of its members. The trustworthiness it professes naturally includes ethicality and also knowledgeable skill (p. vii).

Professional status is then granted to those occupations perceived to exude both competence and high moral standards. This is a function of societal belief rather than explicit, substantive criteria; Freidson writes that professions become professions by convincing others that they are worthy of trust, regardless of whether or not that trust is always warranted (p. 187).

Professions have been judged trustworthy enough to exercise considerable control over their own activities. Control is split between the individual professional and the collective profession; single practitioners are allowed significant latitude in decision-making, while most necessary restrictions and best practices are set and enforced by a governing body made up of professional colleagues, a practice called self-regulation. Hughes (1963) lays out two defining features of professional control: license and mandate. License refers to a profession's ability to perform tasks that nobody else can, and is primarily exercised by the individual professional. Hughes writes, "the

professionals claim the exclusive right to practice, as a vocation, the arts which they profess to know, and to give the kind of advice derived from their special lines of knowledge" (p. 656). Mandate, in contrast, is about collective control. It refers to a profession's right to collectively set its own standards and boundaries, effectively defining the nature of the work it conducts; this right flows from license and professionals' perceived unique insight into their domain (p. 657).

Professional power implies freedom from and control over others. This is most immediately apparent with respect to the state, which abdicates a degree of authority over the professions. Rather than seeking to directly intervene in professional practice, the state trusts governing bodies to develop rules of conduct and dole out appropriate punishment to violators. This retreat is based on the perception that the state is unqualified to weigh in on issues of professional competencies; only the professionals have the ability to adequately judge their own practice (Freidson, 1970; Hughes, 1963).

Freidson writes, "if anything 'is' a profession, it is contemporary medicine" (1970, p. 4), surmising that anything we conclude about medicine's professional power constitutes a conclusion about professionalism itself. Medicine is the bar against which other professionals, such as lawyers or the clergy, are measured (see also Dingwall & Lewis, 1983). Certain aspects of medical knowledge and practice, unique to the healthcare field, structure medicine's relationships with the state and with other healthcare providers. Doctors enjoy a form of power that, in most western jurisdictions, extends beyond Hughes' concepts of license and mandate (Hughes, 1963). First, unlike other professions, medicine also enjoys control over a vast number of other health occupations. Known as para-professionals or 'paramedical' occupations, these are the

healthcare providers whose work ultimately falls under physicians' jurisdiction. Freidson writes:

> Physician control is manifested in a number of ways. First, much of the technical knowledge learned by paramedical workers during their training and used in their work tends to be discovered or enlarged upon or at the very least approved of by physicians. Second, the tasks performed by paramedical workers tend to assist rather than replace the focal tasks of diagnosis and treatment. Third, paramedical workers tend to be subordinate, in that their work tends to be performed at the request or "order" of, and is often supervised by, physicians. Finally, the prestige assigned to paramedical occupations by the general public tends to be less than that to physicians (1970, p. 49).

These relationships are frequently gendered; the medical profession has historically been male-dominated (although this is changing), while nursing, the largest paramedical occupation, is largely female. This dynamic has been extensively explored and debated throughout the literature on medical dominance, as will be explored later in this chapter (Biggs, 1983; Lupton, 2012; Malterud, 1999; Weitz, 2007; Willis, 1983; Witz, 1990).

Medicine is also by nature a consulting profession. The crux of its work lies in its relationship with the client (or, more precisely, the patient), who must be consulted and give consent before the physician can embark on any course of action (Freidson, 1970, p. 11). However, this relationship is not between equals; the physician has at their disposal extensive knowledge of medical science and technology, the consequence of which is a societal expectation that the patient will defer to their expertise (see Freidson, 1970; Lupton, 2012; Parsons, 1951; Weitz, 2007; Willis, 1983). Willis writes that so strong is the connection between medicine and scientific knowledge that to doubt medical expertise is seen as tantamount to doubting science itself (Willis, 1983, p. 26; see also Willis, 2006).

If professional power is held over others, then it is easy to see why physicians are so powerful; the particularities of their professional status dramatically impact a huge swath of other providers as well as their clientele (which is essentially everybody). The scope of doctors' professional power has led to the development of the term 'medical dominance,' the concept at the heart of this dissertation. While Freidson is credited with developing the original medical dominance thesis (Coburn, 2006; see also Freidson, 1970), doctors' unique social status had been recognized for many years prior to his writing. The following pages outline three different conceptions of medical dominance: functionalism, political economy and critical and feminist perspectives. While each builds on its predecessor, they emphasize different sources, aspects and consequences of medical dominance. The first is functionalism, against which Freidson initially set his medical dominance thesis. Functionalism does not mention medical dominance by name. Even so, it recognizes the exceptional nature of doctors' professional status, particularly as it structures the physician-patient relationship.

i. Functionalism

Drawing from Durkheim's (2014[1893]) theory of the division of labour, Talcott Parsons initially developed the functionalist understanding of medicine's professional status in the mid-twentieth century. In *The Social System* (1951), Parsons outlines a conceptual framework for understanding contemporary social structures and relationships. Unlike Marxists, whose arguments concerned the unsustainability of capitalist structures, he bases his thesis on an assumption of stability. In short, he asks why societal relations generally function harmoniously when people act according to assigned roles. Parsons

applies this lens to physicians in a chapter which, while now theoretically outmoded, lays the groundwork for how later thinkers conceptualize key aspects of medical dominance.

Parsons focuses on the relationship between the doctor and the patient, who he sees as occupying a "sick role" (1951, pp. 436–437). One filling the sick role is excused from regular societal responsibilities and is not expected to recover entirely of their own accord. However, they are expected – obligated, even – to find sickness undesirable and to seek "technically competent help" (p. 437) to render themselves cured and once again able to function normally. In this way, Parsons paints the sick role as debilitating, rendering the occupant in need of management by another – namely, the learned and skilled physician. Parsons describes the physician as a neutral, objective assessor of the patient's condition; they are to be scientifically-oriented and free of emotion or bias in their judgement. Nevertheless, Parsons recognizes a deep-seated propensity towards 'doing something' in medical care, which underlies a preference among physicians for intervention (p. 467). This observation in particular continues to structure more critical conceptions of medical power and ideology.

In emphasizing stability in social structures, Parsons does not take into account the possibility of change in the physician role. This gap is particularly significant as *The Social System* was written at the apex of medical dominance in the United States and Canada; in the former, doctors would eventually be displaced by private insurance and Health Maintenance Organizations, while in the latter, the state began to seek a more active role in structuring care (Hacker, 1998; Naylor, 1986; Tuohy, 1999). Normatively, it is also an extremely pro-status quo argument, coming just before a time when analysts would begin viewing physicians in a more critical light (see Freidson, 1970; Hughes,

1963). In short, the timing of this particular argument was poor, its empirical observations quickly losing relevance as medical dominance in North America began to wane in the latter half of the 20th century.

Moreover, even as he models the privileged status of the physician in managing treatment of those occupying the 'sick role,' Parsons overlooks the power dynamics inherent in this relationship. Critics would later argue that he viewed the physician-patient relationship through rose-coloured glasses, ignoring the possibility for conflict when a patient disagrees with their doctor (Lupton, 2012; Turner, 1995). The absence of conflict comes as a consequence of Parsons' description of the sick person as a passive receptor of medical expertise, rather than an active participant in managing their own care. Not only is this description empirically shaky, but it is based on moralistic and ableist assumptions about the sick person's obligation to return to normalcy. Under such a view, anything considered as sickness is inherently undesirable, with no consideration for how the patient might wish to manage their own health. Patients must simply fulfill their social obligation to 'get better' – and what exactly that entails is determined by the physician.

Nevertheless, Parsons' writing lays the foundation for discussions of doctors' professional power. In particular, he sheds light on an aspect of medical dominance – the physician-patient relationship – that sets medicine apart not only from society writ large but also from other professions. Future conceptions of dominance would have to take these dynamics into account, even as they would focus more heavily on the relationship between doctors and the state or doctors and other healthcare professionals. The picture

Parsons paints, while reasonably criticized as distorted, provides a critical piece of the medical dominance puzzle.

ii. Political economy

In the 1970s and 1980s, political economy (also called critical structuralist) approaches brought power into discussions of the medical profession and popularized the term 'medical dominance.' Here, the medical profession's characteristics are not a function of societal need, but rather function to preserve medicine's own power as well as that of the societal elites who sponsor the profession. Drawing from Marxist critiques of capitalism, adherents argue that doctors ultimately serve to keep society productive in order to serve the needs of elites at the top of the economic system (Lupton, 2012; see also Baer, Singer, & Johnsen, 1986; Freidson, 1970). Nevertheless, these writers view physicians' power as far more precarious than that posited by Parsons; its persistence is dependent on whether or not the ruling classes continue to see it as useful. Freidson, the foremost contributor to this approach, writes:

> The profession's privileged position is given by, not seized from, society, and it may be allowed to lapse or may even be taken away. It is essential for survival that the dominant elite remain persuaded of the positive value, or at least the harmlessness, of the profession's work, so that it continues to protect it from encroachment (1970, p. 73).

The state's power to withdraw professional sponsorship is not just a hypothetical ability; governments have on occasion exercised this ability to rein in other misbehaving professionals. For example, following a corruption scandal, the province of Quebec reduced the self-regulatory power of its engineering profession by placing its governing

body under trusteeship (CBC, 2016). Professions need to retain society's confidence, lest they see their status reduced or eliminated.

Political economists describe medicine's power as a state-sponsored monopoly. Willis (1983) describes this monopoly as comprising three 'levels' of dominance. The first is *autonomy*, or freedom from state intervention. Willis describes autonomy as "control over medicine's own work...based upon the claim to professionalism" (p. 8). A key aspect of autonomy is mandate to self-regulate (see Hughes, 1963), of which Freidson writes:

> Professional people have the special privilege of freedom from the control of outsiders. Their privilege is justified by three claims. First, the claim is that there is such an unusual degree of skill and knowledge involved in professional work that nonprofessionals are not equipped to evaluate or regulate it. Second, it is claimed that professionals are responsible – that they may be trusted to work conscientiously without supervision. Third, the claim is that the profession itself may be trusted to undertake the proper regulatory action on those rare occasions when an individual does not perform his work competently or ethically (1970, p. 137)

When autonomy has to be taken from the individual clinician, then, it is the collective profession rather than the government that enforces restrictions. Aside from self-regulation, the most oft-cited aspect of Canadian physicians' professional autonomy is the persistence of fee-for-service payment structures, which continue to account for almost three quarters of clinical payments and is utilized to some extent by 98% of physicians (Canadian Institute for Health Information, 2019b). Under this formula, physicians receive a set payment for each procedure they perform. This structure ensures that the government does not actually 'employ' physicians and limits the public's knowledge of how much money doctors take home each year (ibid). Past and present threats to medicine's autonomy include the *Canada Health Act's* ban on extra billing in

1984 (Meslin, 1987), the Office des professions' ability to oversee all professions (including doctors) in Quebec (Office des Professions du Québec, 2018) and the ever-present pressure on governments to move away from fee-for-service, which has long been heavily criticized for incentivizing inefficient care provision (see Evans, 1974).

Willis' (1983) next level of dominance is *authority*, or control over the work of other healthcare providers. Authority has its roots in Hughes' (1963) conception of license, or professionals' exclusive right to perform certain tasks. To maintain this monopoly, it is also necessary to specify the content of medical care in such a way that controls entry to the profession. This presents its own balancing act. Larson writes:

> It must be specific enough to impart distinctiveness to the professional "commodity;" it must be formalized or codified enough to allow standardization of the "product – which means, ultimately, standardization of the producers. And yet it must not be so clearly codified that it does not allow a principle of exclusion to operate: where everyone can claim to be an expert, there is no expertise (1977, p. 31).

However, physicians also must balance their desire for protection from competing providers with the need for a veritable army of healthcare workers in modern medical systems. As such, medical authority is not just a matter of doctors' exclusive ability to perform certain tasks, but also their ability to control the tasks performed by a whole system of other providers, described by Freidson as "paramedical" (1970, p. 49). This is due in large part to the positioning of medicine's work within the healthcare division of labour; Freidson highlights how medicine is charged with performing those tasks "around which the work of many other occupations swings" (p. 69). Even when a doctor is not in a position to exert direct, formal control over another professional, then, the nature of

their work is such that they are in a position of authority vis-à-vis their colleagues from other professional backgrounds.

Medicine is unique in dominating the work of such a vast number of other providers. While lawyers and professors do enjoy extensive aid from paralegals and teaching assistants, for example, both of these occupations only exist because of the profession that they support. Nurses, pharmacists and midwives can exist independently of physicians – and yet, Canadians physicians have controlled the work of each to varying degrees (Biggs, 1983; Bourgeault, 2006; Clark, 1991; Duffin, 1999). Threats to doctors' authority include the introduction of highly-educated nurse practitioners and proposals to allow pharmacists to prescribe medication independently. Such changes introduce economic competition to physicians in critical areas of their professional scope, and reduce medical control within the healthcare division of labour.[4]

Willis' (1983) final level of medical dominance is *sovereignty.* This concept builds upon Parsons' physician-patient relationship – albeit again from a far more critical angle. For political economists, doctors' relationship with their patients serves as another venue through which they can control and dominate the medical marketplace. Larson writes, "state sanction can eliminate competitors, but it cannot force consumers to consume" (Larson, 1977, p. 24). In short, in order to complete their domination over the healthcare marketplace, doctors must turn to their relationship with their patients, as

[4] Authority is also addressed in part by occupational closure theorists (Abbott, 1988; Murphy, 1988; Parkin, 1979; Witz, 1992), who depict occupations as strategically delineating professional boundaries in order to establish and protect monopolies. This perspective differs from Marxism and political economy in that it focuses more on individual actors and less on structures and context. As such, while often useful for framing discussions of strategy, it has been criticized as struggling to explain broader changes in professional power (see Coburn 2006, which provides a critique of closure theory as it relates to medical dominance). Literature from this tradition (specifically Witz, 1992) is mobilized in this dissertation in reference to specific strategies and political positions.

previously emphasized by Parsons (1951). However, in contrast to Parsons' functionalist approach, political economists see medicine as occupying a privileged position due not to the helplessness of the patient or the inherent superiority of the physician's knowledge, but to doctors' successful co-opting of science and scientific language (Larson, 1977; Willis, 1983). Larson writes, "because scientists are the only producers of science, the lay public has no other choice but to accept, without sharing them, their definitions of scientific practice and scientific progress" (1977, p. 32).

Willis uses the word sovereignty to describe the "level at which medical dominance is sustained in the wider societal arena" (p. 18), as it is, essentially, broad acceptance of medical ideology and the consequences thereof for patient care. This ideology includes a bias towards interventionism, the medicalization of natural bodily processes (particularly those affecting women's bodies) and the prioritization of impersonal care geared towards curing patients of abnormal conditions rather than improving or maintaining their comfort and well-being (Fuchs, 1968; Parsons, 1951; Weitz, 2007). Threats to medical sovereignty include declining trust in physicians and authority figures in general, the presence of complementary and alternative medicine providers (which are typically discussed among doctors as 'worse' than other competing professions, see Willis, 2006) and the demedicalization of natural biological processes such as birth and death. While some of these threats might come with significant financial consequences for physicians (especially reducing interventionism under a fee-for-service system), something does not have to directly affect doctors' pocketbooks to threaten medical sovereignty.

Political economy discussions constitute the beginning of medical dominance as it is understood today. Political economists openly discuss medical dominance as an undesirable phenomenon that warrants remedying. Freidson, for example, calls for increased diversity within the medical profession to include more practitioners who are not already "socialized to the professional mystique" (1970, p. 372). Dominance is also considered as dynamic and reversible; Coburn and his colleagues, for example, discuss instances of paramedical occupations professionalizing and "wriggling out" of medicine's control (Coburn et al., 1983, p. 420; see also Coburn, 1993, 2006).

Gaps do exist in political economy discussions of medical dominance. For one, they often fail to address what follows when medical dominance is threatened. Critics of Freidson often target how he portrays vaguely-defined 'elites' as sponsors of medicine's power, but does not take into account societal context (Coburn, 2006; Navarro, 1988). However, allegations of imprecision are not the only issue with this model; emphasizing sponsorship of medical power in this way also leaves open the question of what happens when societal elites and/or the state decide to rein in professional power. Willis writes, "the state giveth and the state taketh away" (Willis, 2006) – this portrays medicine as relatively helpless in the face of a withdrawal of state sponsorship.

Moreover, political economy's conception of medical sovereignty sees doctors as holding power *over* society through the predominance of medical ideology (Larson, 1977; Willis, 1983). The glorification of scientific knowledge is painted as a sort of propaganda tool, actively employed by physicians to maintain their privileged position vis-à-vis society and their patients. Physicians, however, are a part of society themselves. This 'propaganda' affects doctors perhaps even more than the average person, as they are

inundated with medical ideology throughout their training. Critical and feminist perspectives on medical sovereignty, which draw from Foulcauldian conceptions of power, seek to address this gap. This approach is outlined over the following paragraphs.

iii. Critical and feminist perspectives

In their discussions of medical dominance, social constructivists and critical theorists re-emphasize the encounters between doctors and their patients first discussed by Parsons (1951). The roots of this perspective are found in Foucault's argument about truth – in a nutshell, that what is accepted as truth is socially constructed and a product of power relations (Foucault, 1977). This assertion appears quite compatible with political economists' emphasis on doctors' co-opting of scientific knowledge. However, for Foucault power is far broader than the image put forth by political economists; it serves not only to repress, but also to generate beliefs and produce accepted knowledge. Foucauldians distinguish between 'sovereign' power, which constrains a subject and enforces rules by threat of physical punishment, and 'disciplinary' power, through which normalcy is determined and deviance is subtly discouraged; the medical encounter falls under the latter category, especially when doctors encourage patients to adopt 'healthy' behaviours (Armstrong, 1987; Foucault, 2012[1963]; Lupton, 2012).

The implications of Foucault's reorientation of power are copious and reverberate throughout numerous streams of constructivist, critical and feminist thought. This discussion does not aim to address all or even most of them. However, two insights are especially important to this dissertation. The first is that, if power is dispersed throughout societies and structures, medical knowledge is not just a tool by which physicians can

oppress others. Rather, it produces and shapes physicians' own ideologies and assumptions. Doctors are as much subject to medical dominance – and specifically medical sovereignty – as they are its beneficiaries. While political economists such as Willis (1983, 2006) portray sovereignty as actively weilded by physicians, this approach sees sovereignty as co-created by physicians and society and deeply internalized by individual doctors; in short, physicians come to believe that sovereignty is tantamount to providing good patient care (Lupton, 2012; Weitz, 2007). Individual doctors do not excessively encourage C-sections because they want to harm women or uphold patriarchal structures; rather medical ideology has instilled in them particular beliefs about women's bodies, which, while perhaps erroneous and sexist, are highly engrained in medical culture. Sovereignty is about what medical ideology presents as good or necessary care; a doctor might then be worried about their patient's desire to have a 'natural' birth for purely clinical reasons. The logic behind those clinical reasons might be inherently advantageous to physicians, but that does not mean the doctor is lying in presenting them as honest concerns.

Analysts holding to this belief have emphasized medical education as a major producer of medical ideologies and subsequent medical dominance. Weitz (2007) identifies the following major "medical norms" instilled during medical education:

> ...doctors should value emotional detachment, trust clinical experience more than scientific evidence, master uncertainty,[5] adopt a mechanistic model of the body, trust intervention more than normal bodily processes, and prefer working with rare or acute illnesses rather than with typical or chronic diseases (p. 341).

[5] "Mastering uncertainty" refers to coping emotionally with uncertain clinical situations and aiming to reduce them whenever possible, even at the expense of patient well-being. One example might be performing an intrusive or painful test 'just to be safe.'

Many of these are also found in political economists' observations of how doctors co-opt scientific language and favour interventionist 'heroic' medicine. Some, however, constitute new insights. Emotional detachment is observed in so far as physicians-in-training can be subtly taught to use depersonalized language, engage in crass humour and treat their patients as 'cases' rather than people (Anspach, 1988; Hafferty, 1998; Mizrahi, 1986). While perhaps beneficial with respect to physicians' own aversion to psychological distress, such purposeful detachment contributes to how the "medical gaze" alienates the patient from their body as well as the contempt with which many physicians allegedly view their patients (Foucault, 2012[1963]; see also Weitz, 2007, pp. 341–343). Emphasizing medical education also exposes a contradiction between clinical autonomy and scientific medicine; while physicians are happy to use the language of science to tout the alleged superiority of their practice, they are personally taught to frequently defer to individual judgement rather than established best practice (Ludmerer, 1985; Millenson, 1997).

The second relevant aspect of this approach is its reconsideration of how gender is integrated into conceptions of medical dominance. Gender had indeed already been a topic of consideration for political economists, who frequently discussed the extent to which the healthcare division of labour should be seen along gendered lines as well as class divisions (Hearn, 1982; Willis, 1983; Witz, 1990). However, this debate is largely confined to how professionalization projects are impeded due to patriarchal societal beliefs and structures – for example, how gender affects nurses' struggle for professional recognition (see Willis, 1983). Its limits become apparent as demographics in healthcare provision shift. Today, as more and more women enter the medical profession, such

discussions are losing relevance. More recent feminist critics of healthcare provision increasingly focus their critiques on the nature of the profession itself rather than its demographics. Writes Duffin, "The pioneer women in medicine were thoroughly sensitized and motivated by feminist issues. But women who choose medicine today are said to become plain ordinary doctors, undifferentiated from and just as conservative as their male peers" (1999, p. 272; see also Bleakley, 2014; Malterud, 1999; Weitz, 2007).

Critical and feminist accounts often emphasize the relationship between doctors and patients rather than doctors and other providers. Regardless of the demographic makeup of medicine, medical ideology is said to perpetuate an image of an ideal patient who is male, white and monied. Weitz (2007) relates the emotional detachment encouraged among physicians to the observed relative prevalence of open emotional display amongst American women and certain ethnic groups; she argues that, as such, these demographics "are more likely to bear the brunt of doctors' disdain" (p. 347; see also Bleakley, 2014; Malterud, 1999). Moreover, critics have observed a startling level of misunderstanding of women's bodies among physicians and the medical establishment. For example, in 1991, an activist campaign in the *New York Tim*es proclaimed that "Women don't get AIDS. They just die from it," stressing how, since AIDS displays different symptoms in women than in men, cases were consistently failing to meet the standards of the Centres for Disease Control and remaining undiagnosed (Taylor-Brown, 1992; see also Bleakley, 2014; Malterud, 1999; Weitz, 2007). Finally, the medical profession 'medicalizes' natural female biological processes such as pregnancy and menopause, as they represent deviation from normal functions under a mechanistic, male-

centric model of the body (Biggs, 1983; McCrea, 1983; Weitz, 2007, p. 345). This mistrust of female bodies only increases doctors' impulse to intervene and minimize risk.

The three perspectives outlined here – functionalism, political economy and critical and feminist perspectives – build on one another through critique. Political economy criticizes the lack of power present in functionalist accounts of the physician-patient relationship. It also adds an element of dynamism to medical dominance, as well as an expanded explanation of the relationship between doctors and the state and doctors and their coworkers. Critical and feminist analysts then criticize political economy for focusing exclusively on those aspects of medical dominance that physicians wield over others – in fact, they argue, the ideology behind medical dominance shapes doctors' own beliefs before they even receive their credentials. As well, according to these perspectives, gendered aspects of medical dominance cannot be overcome by adding more women to the profession; rather, the ideology of medicine itself is patriarchal.

This literature constitutes a rich discourse around the nature and consequences of medical dominance. However, these approaches are limited in that they cannot be reliably used to draw inferences about organized medicine's political activity on the ground. They discuss only what dominance is, and not how organized medicine relates to it. As such, significant gaps exist in social scientists' understanding of how Canadian organized medicine exercises its political power, how medical dominance functions differently across jurisdictions and how Canadian physician colleges and associations engage with dominance. The next section outlines these gaps to set up how this research contributes to a richer understanding of organized medicine's political activity in Canada.

Gaps in the literature

This dissertation seeks to fill three important gaps in the literature on medical dominance, as applied to the Canadian context. First, despite the strong theoretical attention to medical dominance and despite the power and significance of Canadian doctors, there is an overall lack of scholarly interest in Canadian organized medicine as a political force. Second, while authors do frequently apply conceptions of medical dominance to particular jurisdictions (Coburn, 2006; Coburn et al., 1983; Weitz, 2007; Willis, 2006), it is rare for them to acknowledge how it functions differently across state or substate borders. Finally, the literature outlined above is tenuously connected to the actual political activity of Canadian medical colleges and associations, leaving analysts to assume a fairly straightforward relationship between medical organizations and medical dominance.

The literature on medical dominance has not been supplemented with dedicated, rigorous analysis of Canadian organized medicine. Contandriopoulos notes that physicians are not alone in being relatively ignored in this regard, as there are "few empirical studies on interest groups[6] in Canadian health care" (2011, p. 56). However, within social science organized medicine seems especially overlooked. While the medical profession is present to some degree in just about any discussion of Canadian health policy, it is almost never front and centre. Rather, the medical profession typically plays the role of an antagonist, standing in the way of reform. Commentators focus on the change-makers: be they midwives (Bourgeault, 2006; Bourgeault, Benoit, & Davis-

[6] While medical organizations engage in pressure politics, literature on the advocacy coalition framework is more appropriate to capturing the belief-driven politics of colleges and associations than would be literature on interest groups. The next chapter further discusses how the advocacy coalition framework is mobilized in this dissertation.

Floyd, 2004; Burtch, 1994), nurse practitioners (DiCenso et al., 2007; O'Reilly, 2000; Worster, Sarco, Thrasher, Fernandes, & Chemeris, 2005), women's movements (Barnett, White, & Horne, 2002; Basen, White, Bourrier-Lacroix, Boscoe, & Alleyne, 2004; Hankivsky, Varcoe, & Morrow, 2007), or any number of forces seeking to alter the state of Canadian healthcare policy and provision. In these stories, there might be some consideration of physicians' posture. However, the specific reasons behind their positioning are not systematically explored[7] – perhaps understandable, as the medical profession itself is not the subject of inquiry.

Organized medicine is an important political force in Canada. Within healthcare policy communities, doctors hold enormous sway; physician colleges and associations are highly institutionalized, represent a critical constituency with specialized knowledge and constitute 'peak' associations representing an entire profession (Canadian Medical Association, n.d.; Fierlbeck, 2011; O'Reilly, 2000; Pross, 1992; Smith, 2018, pp. 114–115; Tuohy, 1999). Medicine is also unusually loud for such an entrenched group,[8] frequently speaking out against policies and programs that doctors find threatening or undesirable (Arrowsmith, 2006; CBC, 2018; Meslin, 1987; Picard, 1989). Politically, Canadian doctors demand attention; nevertheless, academics appear reluctant to give them the spotlight, preferring to keep their analysis focused on those driving change rather than those resisting it.

The preceding section also reveals a gap in the medical dominance literature concerning dominance and jurisdictional context. This is perhaps surprising, as the state

[7] There are studies, however, on individual physicians' political beliefs (see Blais, Lambert, & Maheux, 1999; Stevenson, Williams, & Vayda, 1988).
[8] This tradition varies by province, as discussed in Chapter 3 (see Lomas, Charles, & Greb, 1992; Tuohy, 1999)

figures large in these theoretical debates, particularly within the political economy approach. Political economists place significant emphasis on state sponsorship of medicine and its withdrawal thereof (Coburn et al., 1983; Freidson, 1970; Willis, 2006), and there has been some discussion of how jurisdictional boundaries, even within Canada, impact how the medical profession engages with the state (Lomas et al., 1992; Tuohy, 1999). However, even within political economy there has been little consideration of how the healthcare division of labour affects dominance differently from jurisdiction to jurisdiction. In her seminal work *Accidental Logics* (1999), Carolyn Tuohy describes how structures of healthcare financing and delivery are the result of the 'accidental' timing of their emergence – as such, they cannot be separated from the circumstances surrounding their birth. The same insight can be applied to the healthcare division of labour, for which differences between jurisdictions are stark and at times seemingly random. For example, while Canada and the United States utilize optometrists to provide primary eye care, in Germany responsibility for these tasks is more formally split between ophthalmologists, opticians, and orthoptists, with ophthalmologists performing 'medical' procedures, opticians classified as 'craftspeople' who design corrective lenses and orthoptists assisting ophthalmologists (see Jahn, Thomas, Weegen, Wasem, & Walendzik, 2011).

Some of these jurisdictional particularities have significant implications for medical dominance, especially when applied to Canada. For example, while in most of the world midwives are more or less a fact of life for physicians, in Canada they had been marginalized for decades; as such, their re-emergence was seen as a significant threat. Complicating matters further, physicians move around the world fairly frequently; the

Canadian Institute for Health Information reports that, in 2017, 30.2% of general practitioners and 22.5% of specialists had earned their MDs outside of Canada (Canadian Institute for Health Information, 2019b). An additional portion of Canadian-trained doctors also spend time abroad during or following their training; there is an opportunity here to consider how jurisdictional context shapes not only the structure of medical dominance itself, but also how physicians perceive certain aspects of dominance as important or unimportant (Blais et al., 1999). While this dissertation is concerned with organizational positions rather than the beliefs of individual doctors, this is significant insofar as the prevailing beliefs of physician members might trickle up to the leadership of colleges and associations, leading to significant differences and shifts in the medical establishment's position on what were once key tenets of medical dominance.

The final gap in the literature concerns the activities of jurisdictionally-bound medical colleges and associations and how they connect back to medical dominance as a theoretical concept. When we consider medical dominance as a social and political phenomenon, we lack a bridge between the interests of 'medicine' as an overarching professional category and the activities of context-dependent medical organizations. As a result, these organizations become stand-ins for dominance itself. Commentators frequently point to the strength of colleges and associations as a sign of medical dominance; likewise, a decline in their influence has been equated with a decline in dominance (Coburn, 1993, 2006; Gidney & Millar, 1994; McKinlay & Marceau, 2002; Weitz, 2007). This is not entirely without justification, as analysts frequently cite high-profile instances of organizations fighting to maintain or expand medical dominance – most infamously, multiple Canadian medical associations fought tooth and nail against

the implementation of medicare and the subsequent *Canada Health Act* (Hacker, 1998; Meslin, 1987; Naylor, 1986; Tuohy, 1999).

However, little attention has been paid to instances in which these organizations might decide against defending medical dominance as it is typically understood. Most discussions of threats to medical dominance do not spend any time at all discussing medicine's reaction (see Bourgeault & Mulvale, 2006; Coburn, 1993, 2006; Navarro, 1988; Weitz, 2007; Willis, 2006; White & Willis, 2002). When they do, anything other than stanch protectionism is typically explained as a function of strategic resource allocation. Bourgeault (2006), for example, discusses how Ontario doctors shifted to a more accepting posture towards midwifery as the debate on regulation progressed in this province. However, while noting the importance of rank-and-file physician allies to the midwives' efforts, she connects organized medicine's posture to "lack or diffusion of interest," and "diffusion of resources" as medical organizations found themselves preoccupied with more salient issues and became "somewhat invisible" on the midwifery question (2006, p. 267–268). Following similar logic, Vadeboncoeur and her colleagues argue that Quebec medicine was able to take a more hardline position on midwifery thanks to the strong control that Quebec organized medicine exerts over the rank and file (Vadeboncoeur et al., 1996). In Alberta, drawing from Witz' (1992) discussion of patriarchal professional structures and relations, McKendry and Langford (2001) argue that physicians shifted away from full-on opposition to midwifery when regulation became seen as inevitable. By these accounts, changes in medicine's posture should not necessarily be seen as indicative of any ideological complexity within the medical establishment.

Canadian medicine's political activity on other issues has been explained in similar terms. For centuries doctors have struggled with pharmacists over the grey area between their two scopes of practice; while there are cases in which organized medicine has accepted a stronger role for pharmacy, these have been painted as horse trading or grudging acceptance (Coburn et al., 1983; see also Clark, 1991; Malleck, 2004). A similar explanation has been used for medicine's partial acceptance of certain elements of complementary and alternative medicine, most notably acupuncture; Kelner and her colleagues, drawing from Saks (1999), label this as strategically motivated "limited incorporation" rather than any sort of paradigm shift within medical ideology (Kelner et al., 2004). Finally, returning to the introduction of Canadian medicare, organized medicine's position has been described as fluctuating based on the perceived threat the new regime caused to physician incomes and professional autonomy, rather than a softening of the profession's position on the underlying issue of state involvement in the medical marketplace (Hacker, 1998; Naylor, 1986; Tuohy, 1999; see also Stevenson, Williams, & Vayda, 1988).

The chief objective of this dissertation is to nuance these portrayals. As the following two chapters will demonstrate, there is ample reason to reconsider them. First, strategic retreat is not the only kind of learning experienced by collective actors. While strategic imperatives are indeed important to explaining collective beliefs, one should not preclude the possibility of more fundamental shifts within organized medicine (Grin & Loeber, 2006; C. M. Hall, 2011; Heclo, 1974; May, 1992; Nilsson, 2005). Under the right circumstances, then, competing providers may actually be capable of pushing doctors to re-examine their core policy beliefs in ways that open the door for significant policy

change (Jenkins-Smith et al., 2017; Sabatier, 1988; Weible et al., 2009). In short, we need to consider the possibility that, instead of having to actually overcome medical resistance, competing providers might sometimes directly soften or even reverse that resistance by inciting a more fundamental kind of learning within organized medicine.

Second, Canadian organized medicine is marked by a long history of ideological diversity (Badgley & Wolfe, 1965, p. 470; Naylor, 1986; Stevenson et al., 1988), one that continues through the present day. Duffin (1999) notes how progressive factions within medicine have been successful in making their voices heard in policy debates in Canada (see also Ayers, 2017; Badgley & Wolfe, 1965; Tuohy, 1999). As will be discussed in Chapter 4, this is perhaps most visible in divisions in how the profession responded to the introduction of medicare and associated provincial-level interventions in healthcare provision (Badgley & Wolfe, 1965; Tuohy, 1999). Further, the profession's demographics and expressed values and priorities are changing in ways that might make this variability all the more likely in the future (Bleakley, 2014; Canadian Medical Association, 2018; Crossley et al., 2009). All of this points to a need and opportunity to re-examine how the Canadian medical profession engages with traditional conceptions of dominance.

Conclusion

This chapter has reviewed the literature on medical dominance, outlining the evolution from functionalism to political economy to critical and feminist discussions. It then discussed the gaps in the literature that this dissertation aims to address, which largely concern how considerations of medical dominance have been (or have not been) applied

to the Canadian context: there is little interest in studying Canadian organized medicine, the impact of jurisdictional context on dominance has not been considered, and analysts lack a bridge between medical dominance in theory and the day-to-day activities and political positions of colleges and associations. This last point is most significant, as it directly relates to the widespread assumption that Canadian medical organizations are essentially extensions of dominance itself.

In exploring why Canadian organized medicine sometimes supports threats to medical dominance, this dissertation can begin to address these three gaps. The analysis contributes to an improved understanding of Canadian organized medicine and how it engages in the healthcare policy community. It also contextualizes medical dominance by considering how it functions differently across borders, as well how Canadian physicians who spend time abroad might be influenced by other jurisdictions (Blais et al., 1999; Canadian Institute for Health Information, 2019b).[9] Finally, and most importantly, it bridges the theoretical literature on medical dominance to the Canadian reality by considering whether and how organized medicine can be pushed to reconsider its core policy beliefs on key tenets of traditional dominance.

This third contribution in particular requires close consideration of how medicine's shifting positions can be observed, traced and explained. As such, the following chapter outlines the theoretical and methodological choices that structure the inquiry presented in this dissertation. This includes identification of variables that prompt medicine to change its positions, how the research integrates different types of threats to

[9] This is particularly relevant to the midwifery case. In most of the world, midwives never disappeared, and birth attendance never became as critical a part of medical dominance (Bourgeault, 2006). In its treatment of midwifery, this dissertation acknowledges and integrates this by considering how internationally-trained physicians view midwives differently from those trained exclusively in Canada.

medical dominance, the appropriate methodology for distinguishing between different kinds of shifts in belief, and the specific methodological decisions made with respect to data collection and analysis.

3. Theory and method: Observing different kinds of learning

When physician organizations shift their posture to support or fall silent on threats to medical dominance, their position is typically explained in terms of strategic interests, as a political decision rather than one of 'genuine' support (Bourgeault, 2006; Coburn, 2006; Vadeboncoeur et al., 1996). However, there are theoretical reasons to question the importance of strategic calculus to understanding changes in medicine's positions. The literature on learning suggests that, at times, actors' expressed beliefs change not out of strategic considerations, but out of substantive change in opinion on the issue at hand (Grin & Loeber, 2006; C. M. Hall, 2011; Kübler, 2001; Larsen, Vrangbæk, & Traulsen, 2006; May, 1992; Nilsson, 2005; Sabatier, 1988). May labels this "social policy learning," or change in core policy beliefs (May, 1992; see also Jenkins-Smith et al., 2017; Sabatier, 1988). This chapter delves further into theoretical treatments of learning, drawing particularly from the advocacy coalition framework and its discussions of variables that facilitate learning across opposing coalitions (Ingold & Varone, 2011; Jenkins-Smith et al., 2017; Sabatier, 1988; Sabatier & Weible, 2007). These considerations then impact how I explore the extent to which social policy can account for changes in organized medicine's policy positions.

The question that this chapter seeks to answer is as follows: How do we know when organized medicine's support for a particular initiative is at least in part a product of social policy learning? To address this, the discussion proceeds in two parts. First, I outline the theoretical approach mobilized for this project, which draws from discussions of learning, including aspects of the advocacy coalition framework. The remainder of the

chapter then lays out the methodology employed to distinguish different kinds of learning across two policy cases. To address the research question, this dissertation considers how doctors have reacted in four provinces – Alberta, Ontario, Quebec and Nova Scotia – to two cases of policy change: the expansion of pharmacy scope and the re-introduction of midwifery. Methodological considerations range from selection of cases according to different kinds of medical dominance, to the process tracing methodology mobilized in the research, to specific decisions made in designing and carrying out this research, such as identification of interviewees and interview technique.

Learning: Theoretical perspectives

This research calls for a theoretical framework that will accomplish two objectives. First, the framework will need to capture the specific relationship between variables. In this analysis, the dependent variable is organized medicine's position on threats to medical dominance, while the independent variables are the causes of that change. The appropriate theoretical framework will need to address what kind of change this is – specifically, to what extent it represents a substantive change in opinion on a pillar of medical dominance. To accomplish this, I draw from the literature on learning, specifically distinctions between political and social policy learning (May, 1992; see also Grin & Loeber, 2006; C. M. Hall, 2011; Nilsson, 2005). These insights are valuable in that they allow the analysis to move from *why* to *how* change occurs, focusing not on specific independent variables but rather on the type of change that they prompt.

Second, in identifying independent variables that might lead to either type of change, this dissertation adopts a largely inductive approach. However, as Wong writes,

"taking an inductive approach does not mean that everything is, or should be, analytic fair game" (2001, p. 22). While it is neither necessary nor desirable to isolate a single independent variable in advance, an appropriate theoretical framework is necessary to suggest important explanatory factors in order to guide what kind of data are collected (see Falleti, 2016). Several factors have been shown to facilitate or impede substantive change in long-held beliefs; identifying them ahead of time is useful in that it allows me to select provinces that demonstrate the impact of potential key variables and frame my interviews with key informants accordingly. To this end, I leverage aspects of the advocacy coalition framework to suggest factors that might encourage change in beliefs (see Jenkins-Smith et al., 2017; Sabatier, 1988; Sabatier & Weible, 2007).

In asking how physician organizations sometimes come to change their expressed positions on a policy issue, I consider two options: medical organizations change their posture on a threat to medical dominance because they feel it is the best political option, while still remaining opposed in principle; or, medical organizations undergo a substantive change in organizational position on the policy question itself. Both of these options are examples of learning. Learning figures large in academic discussions of policy change and development (see C. J. Bennett & Howlett, 1992; Etheredge, 1981; C. M. Hall, 2011; P. A. Hall, 1993; Heclo, 1974; May, 1992; Rose, 1993; Sabatier, 1988). While its definition may appear self-evident, its scope and boundaries require careful and precise delineation. Drawing from Deustch's (1966) discussion of political communication, Heclo (1974) uses the concept of learning to examine changes in social policies. He defines it as follows:

> In its most general sense, learning can be taken to mean a relatively enduring alteration in behaviour that results from experience; usually this

> alteration is conceptualized as a change in response made in reaction to some perceived stimulus. Unfortunately, learning theory has concentrated almost exclusively on learning by individuals... To speak of learning by society or groups should not imply reifying society into a discrete organic mind responding to holistic stimuli. Social learning is created only by individuals, but alone and in interaction these individuals acquire and produce changed patterns of collective action (pp. 306–307).

While learning then occurs primarily at an individual level, Heclo suggests that, in instances where it affects policy change, its consequences are collectively experienced. As such, when considering learning it is important not only to cite instances of individual learning, but also to demonstrate that such instances translate into changes in collective position. For the purposes of this dissertation, the implication of this definition is that it does not matter if a particular doctor changes their beliefs with respect to traditional medical dominance; rather, they need to be part of a broader change in medical opinion that manifests as a shift in position by their representative and governing organizations.

May (1992) outlines three kinds of learning: instrumental policy learning, social policy learning and political learning (see also Grin & Loeber, 2006; Hall, 2011; Nilsson, 2005). Instrumental policy learning – policy elites re-evaluating specific policy instruments and implementation designs – is not relevant to the cases discussed in this dissertation. It concerns the technocratic details of policy design, and does not address reconsideration of policy goals themselves. Social policy learning, however, entails redefining problems or goals and changing beliefs about "fundamental aspects" of a policy (p. 337). In most cases this involves the state or society as a whole; as an example, May cites the broad shift in tax philosophy that occurred in the 1980s among the American political establishment and general public (ibid; see also Coyle & Wildavsky, 1987). However, social policy learning can also be discussed in reference to individual

organizations. May discusses how one advocacy group can prompt social policy learning in another. He writes, "As a given set of advocates become more sophisticated in their advocacy, they may be able to...bring about a change in opposing groups' construction of a policy or problem" (1992, p. 340). To look for instances of social policy learning, then, the analysis must seek out evidence that doctors are persuaded to change their core policy beliefs. Medical organizations would not only support the specific change being proposed, but also actually accept and take up the underlying logic driving the proposal in question. Such a change in fundamental belief would largely take place through exposure to the arguments being advanced by proponents of the change (see Jenkins-Smith et al., 2017; Sabatier & Weible, 2007).

In contrast, political learning, which is the third and final type of learning described by May (1992), is all about strategy. This is primarily relevant to the internal workings of advocacy groups and coalitions as they determine the best way to advance their interests. This mechanism assumes pre-defined, relatively stable beliefs and advocacy goals; for example, unions should consistently fight for maintaining or increasing benefits for their membership, and pro-choice movements should by definition support maintaining or expanding abortion rights. In many cases, political learning means nothing more than a shift in tactics; in the 1980s, for example, the Ontario Medical Association (OMA) launched a strike in protest of the *Canada Health Act.* Following this action, the Ontario public lost significant confidence in organized medicine (see Meslin, 1987); the OMA may well have learned from this experience and thought twice about similar disruptive action in subsequent years.

For the purposes of this project, the critical aspect of political learning is those instances when it results in retreat from a particular goal. In social science, the notion of strategic retreat was originally applied to policymaking itself (see Wildavsky, 1979), entailing backing away from objectives in light of evidence that they have become unattainable. This could be seen as resulting either from political learning (i.e. cases in which a policy goal becomes prohibitively costly politically) or social policy learning (i.e. when repeated policy failure results in fundamentally altered beliefs, see May, 1992; Wildavsky, 1979). However, the kind of strategic retreat of interest here concerns instances of medical organizations deciding to abandon a particular campaign in the face of evidence that their efforts are likely futile, a product of political learning (May, 1992). This does not mean they have abandoned their beliefs, but rather that organized medicine will no longer pursue them in that specific case. Moreover, medical organizations may trade certain beliefs for strategic interests if they are convinced that the threat they face is small enough in magnitude that it is worth their while to behave cooperatively (see Ingold & Varone, 2011; Sabatier & Weible, 2007) – for example, for the purposes of gaining favour with the government ahead of fee schedule negotiations. These situations present a risk of strategic miscalculation, as medical organizations might very well underestimate the final impact of a particular policy.

Regardless of cause, strategic retreat is important to this dissertation insofar as it allows the analysis to capture instances when physicians' formal position might change without any change vis-à-vis their underlying beliefs. This is a direct contrast to social policy learning, which represents a shift in the profession's view of medical dominance itself. Of these two kinds of learning, social policy learning is the more significant as it

contradicts the established consensus regarding organized medicine's protection of medical dominance (Bourgeault, 2006; Coburn et al., 1983; McKinlay & Marceau, 2002; Weitz, 2007). If instances of organized medicine's support a particular threat can be traced to social policy learning, then physician organizations can indeed change their position on core tenets of medical dominance. However, if such instances can only be traced to political learning and strategic retreat, then the traditional protectionist portrayal of medicine is validated.

May's (1992) conception of learning, in which political and social policy learning are clearly delineated, forms the theoretical basis of this dissertation. However, one aspect of May's definition needs to be nuanced for the purposes of this analysis. May writes, "learning implies improved understanding, as reflected by an ability to draw lessons about policy problems, objectives, or interventions" (May, 1992, p. 333); this is particularly relevant to instrumental and political learning, in which policy aims remain constant (see also Etheredge, 1981; Sabatier, 1988). Levy (1994) criticizes this impulse as an unnecessary and at times biased restriction of learning. In conducting this research, it is indeed important to consider how doctors sometimes learn bad lessons, as strategic blunder is an important consideration in explaining medicine's positioning in certain provinces. As such, I do not restrict learning to instances of improved or refined understanding, but consider it more broadly in terms of collective change in belief (see Heclo, 1974; Sabatier & Jenkins-Smith, 1999).

The inquiry is structured around identifying instances of social policy learning. In both policy cases selected, doctors' groups initially opposed the forthcoming reforms. In some provinces, they then moved to a position of support over time. The task of this

dissertation is to determine how they were brought to that new position – was it simply a function of political learning and strategic retreat, as some have suggested (Bourgeault, 2006; Vadeboncoeur et al., 1996)? Or, is there evidence that the change in position was at least partially due to social policy learning? Finally, as will be discussed further in the section on methodology, do threats to different aspects of medical dominance elicit different kinds of learning (see Willis, 1983, 2006)?

Before addressing these questions, I need to consider what causes learning in the first place – as well as, conversely, what can inhibit it. To this end, I turn now to the advocacy coalition framework. Sabatier and Jenkins-Smith introduced the ACF in the late 1980s, with a series of papers (see Sabatier, 1985, 1987; Sabatier & Jenkins-Smith, 1988) culminating in Sabatier's seminal piece in 1988 (Sabatier, 1988). The framework was created to explain policy change, under the guiding assumption that ideas matter. It begins with three guiding premises: Explaining policy change requires looking at a time period of at least a decade; it is policy subsystems (essentially all concerned parties, be they in or outside government), not government institutions, that are the basic unit of analysis for explaining change; and, policies and programs are reflections of belief systems in that they implicitly take up beliefs about desirable goals and how they might be achieved (ibid). Those with similar beliefs aggregate themselves into coalitions with some degree of coordinated action, thereby attempting to translate their shared belief system into policy (Jenkins-Smith et al., 2017; Sabatier, 1988; Sabatier & Weible, 2007). The "auxiliary belt" of the advocacy coalition framework has been modified on many occasions over the past thirty years (Jenkins-Smith et al., 2017), with new considerations

added to clarify the definition of subsystems, incorporate different political systems and elucidate new causes of policy and belief change (ibid; Sabatier & Weible, 2007).

Over the past three decades, many studies have sought to utilize and test the advocacy coalition framework as a means of explaining policy change (for overviews of this literature, see Jenkins-Smith et al., 2017; Pierce, Peterson, Jones, Garrard, & Vu, 2017; Weible, Sabatier, & McQueen, 2009). This project is not one of them. Instead, it takes up a piece of the framework – namely, learning – and applies it to medicine's reaction to threats to its traditional dominance. As previously mentioned, under the ACF, public policy is seen as a reflection of belief; as dominant beliefs change, so does policy. A major source of change is then policy-oriented learning, which Sabatier and Jenkins-Smith define as "enduring alternations of thought or behavioral intentions that result from experience and which are concerned with the attainment or revision of the precepts of the belief system of individuals or of collectives" (Sabatier & Jenkins-Smith, 1999, p. 42).[10] Critically, the ACF also acknowledges that opposing coalitions can learn from one another, prompting change in policy when one side shifts its posture (Jenkins-Smith et al., 2017; Sabatier & Jenkins-Smith, 1988; Weible et al., 2009). Cross-coalition learning is not the only possible cause of policy change; in fact, the ACF has traditionally emphasized shocks internal and external to the policy subsystem as far more important sources of change, and has more recently also incorporated negotiated agreements

[10] It has occasionally been argued that the ACF's conception of learning should be thought of as distinct from generational change, which is one of the chief causes of ideological shifts within the medical profession (Canadian Medical Association, 2018; Crossley, Hurley, & Jeon, 2009; Levy, 1994). However, as Levy (1994) argues, generational change only means that learning has occurred *before* a particular cohort has risen to power. It is still learning that ultimately impacts change; that learning has simply occurred earlier in the process, thereby delaying its impact on policy.

between coalitions into explanations (Sabatier & Jenkins-Smith, 1999; Sabatier & Weible, 2007; Zafonte & Sabatier, 2004).

Nevertheless, the ACF is most useful to this dissertation in that it suggests causes of different types of learning. For Sabatier and other adherents, political learning is more or less self-explanatory. It typically occurs entirely within coalitions; Sabatier writes, "members of an advocacy coalition are always seeking to improve their understanding of variable states and causal relationships which are consistent with their Policy Core" (1988, p. 155). There is an underlying assumption within the ACF that actors are boundedly rational, unsure of how exactly to achieve their objectives. As such, the framework assumes that coalitions actively work to improve their understanding of how to achieve their goals. This can include reassessing perceived chances of success in light of new information, or trading core beliefs for strategic interests as external circumstances change. Nohrstedt, for example, discusses how the Swedish Social Democrats compromised their positions on nuclear power and the use of referenda following the Three Mile Island accident, even as their underlying values remained constant (2005; see also Sabatier & Weible, 2007).

The ACF is far more interested in the causes of cross-coalition learning,[11] which entails alteration of beliefs closer to the policy core and requires actors to actually learn from their opponents – this is consistent with May's definition of social policy learning (Jenkins-Smith et al., 2017; May, 1992; Sabatier, 1988). Cross-coalition social policy learning is far rarer than political learning; however, the ACF pinpoints four conditions that can facilitate it. First, the level of conflict should be high enough to encourage

[11] In studying how medicine learns, this dissertation focuses on one side of the cross-coalition learning dynamic; however that is not to say that midwives and pharmacists do not also learn from their interactions with medicine.

participation in debate, but low enough that actors still consider the validity of information that might challenge their beliefs, avoiding the "devil shift"[12] (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017). When the ACF was initially put forward, Sabatier and others suggested that opposing coalitions could not easily change each other's core beliefs; instead, writes Sabatier, cross-coalition learning is most likely when "the conflict [is] between secondary aspects of one belief system and core elements of the other or, alternatively, between important secondary aspects of the two belief systems" (Sabatier, 1988, p. 155; see also Jenkins-Smith et al., 2017; Jenkins-Smith & Sabatier, 1993; Sabatier & Weible, 2007). However, subsequent empirical work has not consistently supported this hypothesis. In their review of the ACF research as of 2017, Jenkins-Smith and his colleagues find that many studies have identified cases of cross-coalition learning on both secondary and policy core levels of belief (Jenkins-Smith et al., 2017; see also P. A. Hall, 1993; Larsen et al., 2006).

Second, the ACF proposes that opposing coalitions are more likely to engage in cross-coalition learning when the forum in which they come together encourages productive dialogue (Jenkins-Smith et al., 2017; Jenkins-Smith & Sabatier, 1993; Sabatier, 1988). To this end, Jenkins-Smith writes that forums should ensure that participants "speak a common analytic language" and adhere to shared norms of conduct (Jenkins-Smith, 1990; see also Jenkins-Smith et al., 2017; Sabatier & Jenkins-Smith, 1988). In these ways, appropriate forums can mitigate the effects of higher levels of conflict between opposing belief systems and facilitate social policy learning (Jenkins-Smith, 1990). For the purposes of this dissertation, this is a particularly significant

[12] The 'devil shift' refers to a distorted understanding of the motivations and power of the opposing coalition (Ingold & Varone, 2011; Jenkins-Smith, Nohrstedt, Weible, & Ingold, 2017; Sabatier, Hunter, & McLaughlin, 1987; Weible, Sabatier, & McQueen, 2009).

enabler of social policy learning, as different provinces provided different opportunities for direct engagement between doctors and the competing profession in question.

Third, the attributes of the actors involved are significant in facilitating learning (Jenkins-Smith et al., 2017). 'Extremist' participants can push a coalition to a more obstinate stance. On the other hand, 'brokers' can serve as channels for learning between coalitions (Ingold & Varone, 2011; Jenkins-Smith et al., 2017). The Canadian medical community is not ideologically monolithic; as such, both 'extremists' and 'brokers' can come from inside the profession itself. This research then needs to pay particular attention to who specifically was at the table in each province.

Finally, actors are more likely to question their existing beliefs when the issue under consideration produces high-quality, 'objective' data that is less subject to interpretation (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Jenkins-Smith & Sabatier, 1993). This kind of evidence can be strategically employed by one side of the debate to either gain support from decision-makers; or, it can even prompt shifts in some of the beliefs of their opponents (ibid; see also Fafard, 2008). When dealing with physicians, the use of evidence can be particularly fruitful insofar as it can suggest the clinical benefits or drawbacks of a particular policy initiative as well as its potential consequences for the medical community.

If this kind of evidence is important, then so is the ability to draw lessons from other jurisdictions. Learning does not have to entail direct experience, as many have noted (see Kingdon, 1984; Rose, 1993; Schneider & Ingram, 1988); rather, lessons can be taken from elsewhere regarding the impact of particular programs and ideas, a phenomenon explored in the literature on policy diffusion (e.g. Berry & Berry, 2018;

Shipan & Volden, 2008; Simmons & Elkins, 2004). Studying mechanisms of policy diffusion between American cities, Shipan and Volden (2008) find that cities are more likely to adopt antismoking laws when residents in neighbouring cities are subject to similar rules (see also Berry & Berry, 2018). Collective actors within jurisdictions can also draw from experiences elsewhere, especially in a federal context. Canada is a federation, which enables substate jurisdictions to serve as 'laboratories' for new policy regimes (Shipan & Volden, 2008); as such, this kind of lesson-drawing is paramount to any consideration of learning. In healthcare, lesson-drawing is often deliberate, as provinces frequently share experiences and align policy (Benzie, 2012; Gerein, 2017). Professional groups are also often federalized, with a national body sharing the membership of provincial affiliates; such is the case for the provincial branches of the Canadian Medical Association. This structure promotes dialogue between provincial branches, and may facilitate common positions when relevant and necessary. Health is then a policy field in which it is extremely important to account for if and when policymakers, professional organizations and other interested groups and movements learn from their counterparts elsewhere in the country.

Drawing from the advocacy coalition framework, we can then identify three main causes of social policy learning: the features of forums for dialogue, the presence of brokers or extremists and the availability of evidence, particularly from other jurisdictions.[13] However, just because these are present in a jurisdiction in which medicine shifts its position does not mean that any social policy learning has occurred.

[13] As mentioned the analysis puts aside the question of level of conflict, as this is a) consistent across provinces, since they all consider the same policy cases, and b) only partially borne out in tests of ACF hypotheses (Jenkins-Smith et al., 2017; see also P. A. Hall, 1993; Larsen et al., 2006).

Studies of the ACF have suggested that, on their own, these conditions are not necessarily sufficient to prompt cross-coalition learning of this kind (see Weible et al., 2009). In some cases, they might simply prompt political learning and strategic retreat. For example, evidence from another jurisdiction might demonstrate to physicians the feasibility or unfeasibility of a particular advocacy goal; if one province institutes a dramatic increase in pharmacists' scope of practice, this might signal to doctors elsewhere that efforts to oppose it are likely futile. Even the presence of venues for dialogue between groups might simply reveal to the medical leadership that the government's mind is effectively made up, and that doctors should not risk any public backlash or expend any resources opposing a done deal.

To this end, the question shifts from *why* to *how* (see Falleti & Lynch, 2009). What is important is not the specific variables that prompt change in organized medicine's positions, but how that change unfolds and how those variables interact with one another within specific contexts. Independent variables are still observed and noted, but they do not address the central research question, which concerns how doctors come around to support threats to medical authority and medical sovereignty. To accomplish this, the dissertation requires a methodology that can discern the nature of the relationship between independent and dependent variables. This and other methodological considerations are discussed in the following section.

Methodology: Case selection, causal mechanisms and method of inquiry

The discussion now turns to how exactly this research has been structured to distinguish the kinds of learning denoted previously. We begin with the selection of policy cases.

The chief objective of this analysis is to determine if it is possible for medical organizations to engage in social policy learning and shift their core beliefs on threats to medical dominance. However, this dissertation also considers that doctors might react differently to threats to different levels of dominance, as discussed by Willis (1983, 2006). In particular, it seeks to integrate a key point of differentiation between autonomy and authority on one hand, and sovereignty on the other. While autonomy and authority are intrinsically connected to physicians' paycheques – autonomy allows doctors significant control over their own incomes, while authority limits competition from those providers under doctors' control (Freidson, 1970; Tuohy, 1999; Willis, 1983, 2006) – sovereignty concerns what they see as 'good care,' as internalized during their medical education (Lupton, 2012; Weitz, 2007).

This distinction between sovereignty and the other two levels is critical to this dissertation, as it ties into the mandates of medical colleges and associations. Associations are charged with advancing the interests of the medical profession while also advancing good care – the Canadian Medical Association's vision statement, accordingly, is "A vibrant profession and a healthy population" (Canadian Medical Association, n.d.). This means defending not only the 'material interest' levels of dominance – autonomy and authority – but also upholding medical sovereignty through defending medicine's vision of appropriate healthcare. Meanwhile, colleges only have an official responsibility to protect the public by advancing good care – however, they have in the past been accused of straying beyond that mandate and inappropriately protecting

the profession (see Boisvert, 1993).[14] As such, the difference between sovereignty and the other levels is critical to unpacking how medical colleges and associations engage with medical dominance. While authority and autonomy represent the material side of medical dominance, sovereignty presents a level of dominance that manifests as concern for patient welfare and desire for a well-functioning health system.

To capture this fundamental distinction, I need to consider sovereignty as well as either autonomy or authority, examining threats to each across the provinces selected. I focus on authority, as the empowerment of "paramedical" occupations in Canada (Freidson, 1970, p. 49) is a trend that has resulted in similar cases of reform between provinces. The levels of medical dominance do converge and reinforce one another; for example, medical sovereignty privileges the acute care provided by physicians over the chronic, long-term care typically provided by paramedical occupations. However, I propose that threats to each can be distinguished from one another. To threaten authority without threatening sovereignty, another professional would have to intrude upon physician territory while still accepting the basic tenets of medical sovereignty. Such a profession would lean toward interventionism, take up a medical model of the body and base itself on scientific education.

Pharmacy fits these criteria. The profession accepts medical sovereignty, and in fact has a history of capitalizing on the same assumptions that underlie medical dominance; for example, the pharmacy profession has a history of trumpeting its own scientific education and expertise in drug therapy, which contrasts with doctors' more general knowledge base (Clark, 1991; Malleck, 2004, 2006). For centuries, pharmacists

[14] Doctors have also often publicly framed threats to autonomy and authority in terms of patient care (see Metro, 2009; Picard, 2017); however, such strategic framing is distinct from how doctors have been argued to internalize medical sovereignty (Lupton, 2012; Weitz, 2007).

and physicians have fought over the 'grey area' between the two professions, with physicians seeking the right to sell medication and pharmacists seeking more power in primary care (ibid). However, recently Canadian pharmacists have struck into the heart of doctors' professional authority, seeking the power to assess patients and prescribe certain drugs independently. Freidson writes, "Legally and otherwise the physician's right to diagnose, cut and prescribe is the centre around which the work of many other occupations swings, and the physician's authority and responsibility in that constellation of work are primary" (1970, p. 69). Independent prescribing not only obviously intrudes on prescription, but also creeps awfully close to diagnosis. Moreover, easy prescriptions result in quick visits to the doctor's office that can be lucrative under fee-for-service (Kevin Chapman, interview, Halifax, Apr. 27, 2016). When pharmacists are given the authority to prescribe independently, medical dominance is then challenged at the level of authority but not sovereignty.

Identifying a policy threat to medical sovereignty is a little more difficult. Most challenges to sovereignty are long-term societal shifts, such as decreasing public confidence in medical expertise (see Coburn, 2006; Willis, 2006). There is no policy proposal here for physician organizations to resist. However, although it technically comes from a rival provider and not from the public, the re-emergence of midwifery constitutes such a threat to sovereignty. When doctors first began pursuing exclusive jurisdiction over birth attendance, their motivation was in large part economic, as performing deliveries was a convenient way for a young physician to develop a new base of patients (see Bourgeault, 2006). However, when midwives began seeking reintegration into the health system in the 1970s and 1980s, their numbers were far smaller, ranging

from single digits in Nova Scotia to dozens in the larger provinces. Moreover, physicians had been gradually losing interest in obstetrics as the practice comes with unpredictable hours, costly insurance and a high rate of litigation (Barrington, 1985).

Instead of authority, midwives threaten medical dominance at the level of sovereignty. The medicalization of birth has been frequently decried as anti-woman and counterproductive, resulting in an increase in unnecessary, invasive procedures (Biggs, 1983; Bourgeault, 2006; Duffin, 1999). Doctors defend this shift as a natural result of technological improvements that increase the safety of birth, which also happen to be beyond midwives' capabilities (Oxorn, 1994). However, it is a distinctly different approach to perinatal health than that coming from midwifery, which sees birth as a natural process (Biggs, 1983; Bourgeault, 2006; Duffin, 1999) The debate between physicians and midwives is then more concerned with the nature of care than doctors' material interests. This is a question of sovereignty, not authority.[15]

When considering these two cases, one key benefit of the ACF is that it can capture how organized medicine prioritizes different beliefs. Adherents to the framework typically put forward three levels of belief: deep core beliefs, or fundamental values; policy core beliefs, which include preferred outcomes, problem definition and basic causal beliefs; and secondary beliefs, or specific instruments by which a policy goal can be achieved (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988; Sabatier & Weible, 2007). The two policy cases chosen both concern doctors' policy core beliefs, calling into question principles near to the heart of medical dominance. For pharmacy and

[15] Appendix B provides data on the number of physicians, pharmacists and midwives practicing in each province as of 2013 – near the conclusion of the midwifery debate in Nova Scotia (the final province of the four to re-integrate midwives) and the implementation of pharmacy reforms in most provinces.

medical authority, this is doctors' control over diagnosis and prescription, which Freidson (1970) argues are among the core aspects of doctors' work around which the work of other professionals revolves. For midwifery and medical sovereignty, this is the medicalization of birth, which reflects the traditional medical view of what healthcare should look like by placing a natural biological process under medicine's purview and prioritizing interventionist care (Biggs, 1983; Bourgeault, 2006; Duffin, 1999). However, even these near-core beliefs will not supersede all other imperatives all the time. In particular, overarching clinical imperatives – such as access shortages – may be such that doctors have no choice but to support a policy with which they are uncomfortable in principle. This does not mean they changed their beliefs, but that they have deferred to a belief to which they attribute greater weight (Jenkins-Smith, 1990, p. 90).

This research is not simply tasked with determining if learning is or is not present, but needs to distinguish different *kinds* of learning. To this end, even if it were demonstrated that the presence or absence of a given variable caused doctors to shift their position on a given policy proposal, that would not address the matter of whether the medical profession's change in opinion simply came out of strategic calculus rather than re-evaluation of the proposal on its merits. As such, the inquiry needs to move beyond the presence or absence of particular independent variables and pay attention to the exact dynamics of interaction between variables. It is not just important that physician groups learn under the right conditions – after all, as previously discussed, the literature on medical dominance and Canadian organized medicine already allows for such changes when political conditions force physicians to allocate resources strategically (Bourgeault,

2006; Coburn, 1993, 2006; Vadeboncoeur et al., 1996). Rather, the objective here is to identify any instances of social policy learning on core tenets of medical dominance.

To accomplish this, the analysis employs a mechanistic understanding of causality. Statistical methods and qualitative methods of 'isolating' variables typically mobilize a Humean conception of causality, which assumes that we cannot understand the workings of causal relationships beyond the simple observation of regular interactions between variables. In contrast, the mechanistic view suggests we can indeed open the 'black box' of causality, observing how variables interact within a specific case (see Salmon, 1984). While this proposition might appear more positivist than a Humean perspective – it asserts our ability to view causal relationships at an even closer level, after all – critical realists have used it to question the theoretical significance of law-like, universal patterns of interaction between variables, the establishment and testing of which is the goal of most positivist analysis (Miles, Huberman, & Saldana, 1984; Sayer, 1992). In mechanistic causal analysis, explanations are naturally specific to the cases in which they are situated, as variables interact with contextual factors in such a way that exact dynamics are difficult to extrapolate and apply across contexts (see Falleti & Lynch, 2009; Maxwell, 2008). This feature conflicts with the traditional positivist pursuit of universal laws and generalizability.

Employing such an understanding of causality allows this research to ask *how* organized medicine learns, as it asserts that researchers can observe how variables interact and distinguish strategic change in position from fundamental reconsideration of beliefs and values. To accomplish this, the research employs process tracing, a method that involves closely scrutinizing the interaction between observed variables to establish

causality (George & Bennett, 2004; George & McKeown, 1985). Process tracing is typically used in single-case analysis; when touting the advantages of this kind of inquiry, social scientists most frequently point to the fact that, in directly observing causal processes, researchers overcome the need to isolate variables through controlled comparison (see Falleti, 2016; George & Bennett, 2004). This involves directly integrating intervening variables into the analysis, as well as context – that is, the stable features of a political arena in which causal mechanisms operate, which serve as the background against which the policy debate is situated (see Falleti & Lynch, 2009; Maxwell, 2008). Process tracing is then a popular tool for causal analysis in cases in which controlled comparison is not possible, as overcoming the particularities of a single case is not even desirable within this kind of analysis.

However, employing process tracing is about more than circumventing the need for controlled comparison or accounting for context and intervening variables. Critically for the purposes of this study, the method also allows researchers to discern the specific *type* of relationship that is observed, delineating different kinds of 'causal mechanisms' that characterize causal processes. Falleti and Lynch (2009) explain,

> Whereas variables are observable attributes of the units of analysis—with values (nominal, ordinal, or numerical) and with sample and population distributions—mechanisms are relational concepts. They reside above and outside the units in question, and they explain the link between inputs and outputs. Mechanisms describe the relationships or the actions among the units of analysis or in the cases of study. Mechanisms tell us how things happen: how actors relate, how individuals come to believe what they do or what they draw from past experiences, how policies and institutions endure or change, how outcomes that are inefficient become hard to reverse, and so on (p. 1147).

Given that the question of this study concerns *how* phenomena relate, identifying causal mechanisms via process tracing is appropriate. Independent variables, while still

important to describing events and determining what kind of data is collected, take an analytical backseat. As previously discussed, I still use theory to guide my inquiry by identifying important independent variables ahead of the analysis (see Falleti, 2016; Wong, 2001). However, what is most important is the causal mechanism that lies between variables and characterizes their relationship. To this end, political and social policy learning are understood as discrete (but not necessarily mutually exclusive) causal mechanisms, each representing a different kind of change in belief (see Falleti & Lynch, 2009).

This dissertation considers four provinces within each policy case – despite the fact that process tracing does not require comparison between cases to establish causality. To be clear, the analysis is not structured as a traditional controlled comparison or most similar systems design, as it does not control for context or intervening variables. However, there are three reasons why it is nevertheless methodologically useful to bring in a comparative aspect and include multiple provinces for each threat to medical dominance. First, this project asks why medical organizations *sometimes* come around to support threats to traditional dominance; as such, the analysis needs to take into account variation, including why medicine remained sceptical of threats to medical dominance in certain jurisdictions. Faletti writes that process tracing can be used comparatively to "identify different patterns and sequences and their related causes and consequences" (2016, p. 457). In shedding light on when and why change does *not* occur, such instances serve to highlight conditions for belief change elsewhere. Take, for example, the fact that organized medicine remains opposed to expanded pharmacy scope in Ontario. When contrasted with provinces in which change does occur, it might become apparent that

Ontario medical organizations have been emboldened to oppose this policy because of favourable political conditions such as sympathetic governments or a strongly engaged membership; this would suggest that a logic of political learning and strategic calculus drives the medical establishment's decision-making on this issue. On the other hand, it might be discovered that Ontario organized medicine remained opposed due to the influence of 'extremists' (see Ingold & Varone, 2011; Jenkins-Smith et al., 2017) and a lack of dialogue with pharmacy leaders; this would point to an underlying logic of social policy learning.

Second, using process tracing across multiple cases allows this analysis to directly integrate instances of equifinality, in which two or more cases arrive at the same result via divergent paths (Beach & Pedersen, 2019; A. Bennett & George, 1997; Kay & Baker, 2015) Bennett and George write "With more cases, the investigator can begin to chart out the repertoire of causal paths that lead to a given outcome and the conditions under which they obtain" (1997, p. 6). Integrating multiple cases then allows for a richer explanation of medicine's support for threats to dominance, one that can incorporate multiple paths that doctors might take to that support in different provinces.

Finally, this dissertation seeks to understand contextual differences between provinces and consider how change in one province affects another. While the research question is situated against broad understandings of 'Canadian' medical dominance, the cases themselves must be understood within the context of specific provincial dynamics. As will be further discussed with respect to the selection of provinces, within Canada provinces and territories can learn from one another's experiences, and policy trends can quickly spread across the country. Complicating matters further, there is so single model

of profession-state accommodation in Canada; rather, Canadian provinces and territories are home to dramatically different traditions when it comes to how medicine engages with the state, affecting how dominance is expressed in specific jurisdictions (Lomas et al., 1992; Tuohy, 1999). This how variables interact from province to province and ultimately the anticipated likelihood of different kinds of learning. As such, just as the two policy debates were selected as representative of attacks on different kinds of medical dominance, the four provinces were chosen to represent the ways in which these debates function in different Canadian jurisdictions.

The four provinces examined are Ontario, Alberta, Quebec and Nova Scotia.[16] In selecting these provinces, I expected that social policy learning would be more likely in some jurisdictions than in others. Provinces were selected according to two criteria, each of which interacts with the causes of social policy learning as per the advocacy coalition framework. Employing the ACF within process tracing in this way reflects what Faletti refers to as "Theory-Guided Process Tracing," in which theory is employed "to identify the relevant events that constitute the sequence or process of interest," but is not utilized to deductively test specific hypotheses (2016, p. 457). In this dissertation, the ACF is used to both justify the selection of provinces and guide the kind of data that are later collected.

First, my selection of provinces took into account the anticipated importance of timing. Grzymala-Busse (2011) outlines distinct aspects of temporality, each of which

[16] I selected the same provinces for the midwifery and pharmacy cases in hopes that some informants might be interviewed regarding both cases; ultimately, 7 of my 42 interviewees were able to discuss both pharmacy and midwifery to some extent. In these interviews I was able to directly address elements of the comparison in the conversation; for example, Kevin Chapman of Doctors Nova Scotia repeatedly contrasted the rank and file's significant concerns over pharmacy scope with their general apathy toward midwifery (Interview, April 27, 2016, Halifax).

exerts an effect on how mechanisms, including learning, can unfold. Tempo, for example, affects actors' ability to learn in that a quicker rate of change limits opportunities for deliberation and re-evaluation (p. 1269). Timing, in contrast, refers to an event's position relative to other events. For example, Hacker (1998), discusses how timing impacts the development of healthcare insurance in Canada, the US and the UK, noting that, for example, interventionist policies are more likely if the government is able to act before private insurance becomes ubiquitous.

As previously discussed, timing significantly impacts the availability of evidence, one of the facilitators of social policy learning suggested by the advocacy coalition framework (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017). In the Canadian context, evidence is more likely to be relevant to a policy discussion if another province has already instituted a comparable policy. This is lesson-drawing, an indirect form of learning that is extremely important to Canadian healthcare policy (see Rose, 1993). To account for the anticipated importance of lesson-drawing here, I chose the first province to implement each of the reforms: Ontario for midwifery, and Alberta for pharmacy scope. It is important to note here that policy debates in all provinces overlap, beginning before the first province had fully implemented the proposed change. This limits opportunities to learn from the trailblazer's example; nevertheless, these cases were selected in anticipation that physicians would be more hesitant to support a particular policy if they did not first see it implemented in another province. Shipan and Volden observe that, "policymakers cannot learn about policies that have not yet been tried" (2008, p. 842);[17] the same can be said of doctors in the Canadian context.

[17] See also literature on laboratories of democracy and the advantages and risks associated with first movers in federal states (Galle & Leahy, 2008; Rose-Ackerman, 1980).

It should again be noted that lesson-drawing can also prompt political learning. After all, if the Alberta Medical Association spends hundreds of thousands of dollars waging a divisive campaign against expanded pharmacy scope and comes away with nothing to show for it, why would the comparatively-tiny Doctors Nova Scotia bother opposing it in their own province afterwards? This speaks to the importance of utilizing process tracing to identify how learning occurs, rather than simply what prompts it.

Second, after Alberta and Ontario, the final two provinces were selected to capture a range of traditional physician-state relationships, which exert a significant effect on how medical dominance is institutionalized differently from jurisdiction to jurisdiction. The Canadian health policy literature has long been concerned with the idea of patterns of accommodation and debate that both structure the system itself and shape expectations for interactions between government and the medical profession (Hurley, Lomas, & Goldsmith, 1997; Hutchison, Levesque, Strumpf, & Coyle, 2011; Lomas et al., 1992; Tuohy, 1999). Specifically, it has been noted by Tuohy (1999), drawing from Lomas et al. (1992), that different provinces exhibit distinct patterns of fee schedule negotiation with organized medicine. These patterns reflect how medicine engages with the state, if and when it is acceptable for doctors to go public with their opposition, and what kinds of voices are likely to come to power within the medical establishment. Ontario and Alberta (but especially the former), for example, are known for an adversarial relationship between the state and the medical profession that frequently spills over into the public sphere (Tuohy, 1999, p. 208). In Ontario, this is particularly applicable to the Ontario Medical Association, which has a well-known history of high-profile clashes with the government (Meslin, 1987; Tuohy, 1999).

Meanwhile, in Nova Scotia, as elsewhere in the Atlantic region, Lomas et al. (1992) write that negotiations have historically been observed to be informal and away from the public eye. While this no longer quite captures the Nova Scotia dynamic, as tensions between the two parties have at times become public in more recent years (see Canadian Press, 2017), it remains relatively uncommon to see high-profile clashes between the province and organized medicine.[18] Nova Scotia also provides an example of a far smaller medical community than the other jurisdictions studied, with only 2,456 practicing doctors as of 2017, compared to 32,055 in Ontario, 10,680 in Alberta and 20,908 in Quebec (Canadian Institute for Health Information, 2019c).[19]

The final province added to the comparison is Quebec, in which the structure of the healthcare policy community does not conform at all to the mould set by the other nine provinces. The province has a tradition of neo-corporatism, or fixed procedures through which organized interests can affect and participate in policy formulation (Montpetit, 1999; Montpetit & Coleman, 1999). In this same vein, shortly after medicare's inception, Quebec adopted formal channels for complicated bargaining between the profession and the province, which Lomas et al. deem a 'Gallic' model of accommodation (1992; see also Tuohy, 1999, pp. 207–208). These more structured negotiations are also marked by separate associations for GPs and specialists, as well as greater stability of leadership – whereas elsewhere in the country medical associations turn over their leadership annually, in Quebec presidential terms are longer (two years for

[18] This dynamic was later confirmed by Nova Scotian informants, who frequently expressed surprise and dismay at the tenor of debates elsewhere in the country.
[19] Medicine in Atlantic Canada is also extremely understudied, and there is a dearth of academic discussion of the midwifery and pharmacy cases in the region. This is especially problematic regarding midwifery, a policy field in which the four Atlantic provinces lag significantly behind the rest of the country.

the specialists and four for the GPs) and incumbents frequently seek re-election. Finally, the environment in Quebec is one of more explicit interest protection, in which both medical associations (neither of which is an affiliate of the CMA) have traditionally fought strongly for their respective memberships in ways that have often spilled into the public eye (Lowry, 1994; Vadeboncoeur et al., 1996).

These patterns of accommodation were expected to impact two key facilitators of social policy learning as per the ACF: the presence and quality of forums for discussion, and the presence of brokers or extremists within organized medicine. In both cases, it was expected that social policy learning would be more likely to occur in jurisdictions with less confrontational dynamics. Prior to conducting my interviews, for example, it was anticipated that Quebec would be less likely to produce 'broker' voices within organized medicine than Nova Scotia, as Quebec's medical profession is known for strong defense of its beliefs and interests. The same was true with respect to the features of forums for dialogue, which should be more conducive to social policy learning in less confrontational environments. This is not to say that brokers and appropriate forums cannot emerge in provinces with more antagonistic patterns of debate. Rather, in selecting provinces along these lines, I recognize that these conditions for social policy learning are more likely to emerge in some jurisdictions than others.

As previously mentioned, in the analysis of each provincial case, I employed process tracing to seek out evidence of social policy learning. Bennett and George write "The general method of process tracing is to generate and analyze data on the causal mechanisms, or processes, events, actions, expectations, and other intervening variables, that link putative causes to observed effects" (1997, p. 5). For the purposes of this

project, process tracing was conducted by generating data on key conditions, events and actions in each policy case to determine whether and how they impacted medicine's positions. I identified facilitators of social policy learning by looking for examples of venues for cross-coalition dialogue and asking questions of interviewees regarding their interactions with opposing coalitions. In keeping with the previously-discussed importance of timing, I also asked interviewees what lessons they have learned from other jurisdictions across the country (see Appendix A). Again, this method reflects Falleti's (2016) description of how theory can be mobilized within process tracing analysis without employing a deductive approach. Generating and analyzing data in this way ultimately allowed me to pinpoint the level of belief on which learning took place within organized medicine, thereby distinguishing social policy learning from political learning and strategic retreat.

As a function of the mechanisms under consideration, this study relies mainly on primary sources. In his discussion of learning, May (1992) repeatedly comes back to the difficulty of measuring and observing changes in belief and perception, which are integral to the critical realist understanding of causality associated with causal mechanisms (see also Maxwell, 2008). Such phenomena are best observed directly, and need to be assessed via multiple witnesses whose accounts may conflict with one another. This study draws on two streams of primary sources. The first is archived news media, press releases and policy statements. Articles from journalistic sources are the best available resources for constructing a timeline and flagging relevant events for each policy case within each province, an important initial step in process tracing analysis.

They also provide direct quotations from important figures who are either unwilling to be interviewed or have since passed away.

Archived press releases are available via the same databases as news media, and serve as a particularly important primary source as they provide the voice of the groups or institution rather than a particular spokesperson. For example, when Augustin Roy, former president of the Quebec College of Physicians, gave an off-the-cuff remark comparing demand for midwives to demand for sex workers on a radio program, he was speaking as a representative of the College but his remarks were not necessarily subject to rigorous institutional filtering (see Canadian Press, 1989). We do not know the extent to which he had been prepared for the interview, or whether a particular quip was part of speaking notes drafted for him by staff. Indeed, given the rather offensive nature of Dr. Roy's comments, one doubts that the College was particularly successful in keeping him on script. In contrast, a prepared, edited and approved press release speaks unambiguously for the institution itself. The same can be said for official policy documents and statements, which are also mobilized throughout the project.

The second stream of primary evidence utilized is semi-structured interviews with key informants in each jurisdiction. Early discussions of process tracing focused more on the value of documentary research rather than obtaining firsthand accounts via purposefully selected interviewees (George & Bennett, 2004; Tansey, 2007). However, Tansey (2007) notes that interviews can be a valuable tool in that they can confirm or challenge information obtained elsewhere, provide insight into participants' perspectives and ultimately illuminate those "hidden elements of political action" that are so critical to understanding how variables interact (p. 767). In short, if archived news material and

policy statements establish what medical organizations said and did, interviews build on these and dive deeper into the reasons behind medicine's words and actions, ultimately allowing me distinguish social policy learning from political learning and strategic retreat. For the purposes of this project, interviewing was also a particularly appropriate method for strategically mobilizing theory within the process tracing analysis (see Falleti, 2016), as I was able to indirectly inquire about specific facilitators of cross-coalition learning as per the ACF (see Appendix A; see also Jenkins-Smith et al., 2017).

While medical organizations are the subject of inquiry, this project does not rely solely on medical interviewees. Many informants come from organized pharmacy and midwifery, as well as government, the not-for-profit sector and activist circles as needed.[20] This was not due to any lack of medical informants, but was an effort to ensure a broad array of perspectives. Kay and Baker (2015) describe the importance of considering bias when analysing primary evidence (see also Maxwell, 2008). In short, while it is always beneficial to get information straight from the horse's mouth, one must remain cognizant of the fact that the informant might be presenting the story in a particular way – especially when they are aware of how their past actions might be perceived in the cold light of the 21st century. It is one thing for a medical informant to say that they came around to believe in the benefits of midwifery and de-medicalized birth; it is another entirely for a midwife to say, "yes, I know this person, and I believe that they genuinely became an ally and pushed their organization accordingly."

[20] Given the scope of the research question, the analysis is tightly focused on medicine and its engagement with the pharmacy and midwifery. However, the experiences of nursing leaders, activists and other relevant players are brought in when they are shown to directly affect medicine's decision-making on the two policy cases under consideration.

Participants are spread roughly evenly across the four provinces, with two also coming from national organizations. I conducted a total of 42 on-the-record interviews, most of which lasted about an hour.[21] I identified interviewees using the initial media scan as well as other accounts of these policy debates. I also employed limited snowball sampling; at the end of each discussion, I asked participants to suggest other informants, many of whom I subsequently contacted. Discussions mostly took place at participants' workplaces, but when such accommodations were not possible participants were invited to suggest a preferred location. I conducted interviews in person whenever possible – however, due to the geographical distance between provinces I was only able to travel to Alberta once and Nova Scotia twice (in addition to multiple trips to Montreal and Toronto). As such, some interviews were conducted by phone or via Skype. Almost all interviews were recorded; in only two cases did technological failure result in my substituting note-taking for recording. Discussions unfolded in either French or English according to the respondent's preference, and only those citations from francophone interviews directly quoted in the project were translated into English.

Interviews followed a semi-structured format in order to provide the flexibility necessary to pursue unexpected trajectories and tailor the specific conversation to each informant. While I employed a broad interview guide (see Appendix A), this was adapted to each participant, and questions were frequently inserted regarding specific events and experiences. Interviews also strayed according to the direction taken by the conversation, especially where informants offered insights in areas that I had not anticipated. I often needed to overcome some initial suspicion from participants, particularly medical

[21] I obtained ethics approval prior to beginning the interview stage of the research (uOttawa ethics file #11-15-15).

informants and others sceptical of midwifery or the empowerment of pharmacists. Their suspicion is well-founded – ever since Freidson coined the 'medical dominance' thesis, discussions of this phenomenon have been overwhelmingly critical of doctors' power (Freidson, 1970; Lupton, 2012; Weitz, 2007; Willis, 2006). This is particularly relevant to the midwifery case, in which nobody wants to appear stodgy or anti-feminist, but is also relevant to a few of the pharmacy interviews.

In many cases, the identity of the informant is directly relevant to the data generated and provides additional weight to the comments. For example, when discussing Quebec's Pilot Project Assessment Board (PPAB) for the midwifery case, it makes for a more compelling case to refer directly to the former chair of that process rather than to an anonymous informant with knowledge of the case (see A. Poirier, interview, Montreal, Dec. 16, 2016). As such, subject to the consent of each participant, I refer to their full identities within this analysis. About half of the informants requested some level of anonymity, while others requested to verify quotations or avoid direct quotes altogether. All such requests are honoured in the presentation of my results. Some informants were able to discuss more than one province, while others were able to discuss both pharmacy and midwifery; I took advantage of such opportunities whenever possible. While most participants were interviewed primarily in their capacity as representatives of their respective organizations, they were also asked their personal views when appropriate. Interviews with participants who are retired or no longer involved in professional politics were far more focused on personal views and reflections, as were interviews with prominent individuals who are not formally affiliated with an organization.

Interviews took place over the course of a year, from early 2016 to early 2017. This longer timespan was largely a product of expediency – I wanted to conduct as many in person as possible, despite the significant travel required – but came with the added advantage of allowing significant overlap between the interviewing and analysis phases. Thanks to this overlap, I could use insights gleaned from early interviews to alter my approach in the future according to what prompts were successful in providing useful information. After transcribing these interviews, I did an initial close reading of each transcript to identify key points by highlighting references to themes relating to my research question – such as learning, perceived inevitability, resources, etc. This allowed me to quickly scan each interview for common threads or conflicting accounts as I drafted the chapters. As the purpose of these interviews was to ask direct questions in order to gain insight into events, this method was sufficient to surface and analyse the relevant data – it was not necessary to employ software to conduct a discourse analysis of the texts, for example. I then triangulated viewpoints between participants from different backgrounds, ensuring that the data generated from one interview were weighed against evidence from other sources. It should be noted that, despite the imperative to take conflicting beliefs and perspectives seriously in such analysis (see Maxwell, 2008), there was remarkable consensus between subjects, even on issues that placed subjects in opposing camps. When areas of explicit or implied disagreement did emerge, I acknowledged and incorporated this directly into my analysis.[22]

[22] The analysis I employ centres on how interviews can be used as evidence within process tracing analysis (George & Bennett, 2004; Tansey, 2007). For discussion of interview research techniques that can contribute to more interpretive analyses of beliefs and meanings, see resources on interpretive interview analysis (McCormack, 2000; Yanow, 1999; Yanow & Schwartz-Shea, 2015).

I made the methodological decisions outlined here with the intention of supporting the central research question and the theoretical assumptions that flow therefrom. To identify instances of social policy learning and distinguish them from political learning and strategic retreat, it is necessary to closely examine the interaction of variables and events within such a process, in order to identify not only what prompts a change in beliefs, but how exactly such learning unfolds. As learning is an all-but-invisible phenomenon, it then makes sense to rely on firsthand accounts to surface these otherwise-hidden aspects of the process (Tansey, 2007). It also makes sense to ensure that those firsthand accounts integrate diverging perspectives. And it makes sense to structure those discussions loosely so as to allow participants ample space to express their views.

Conclusion

This chapter has outlined the interconnected theoretical and methodological considerations that structure this research. First, it has established that the dissertation is concerned with determining the extent to which changes in organized medicine's positions are a function of social policy learning (see May, 1992). Specifically, distinguishing social policy learning from political learning captures the heart of the research question in allowing the analysis to differentiate shifts in the medical establishment's core beliefs from political calculus leading to strategic retreat. This question demands a mechanistic view of causality centred on *how* relationships unfold, as described in the literature on process tracing and causal mechanisms (Falleti, 2016; Falleti & Lynch, 2009; Maxwell, 2008).

Second, this chapter draws from the advocacy coalition framework to identify potential explanatory factors that can prompt social policy learning, including: the ability for coalitions to draw from objective evidence, the features of forums available for cross-coalition dialogue, and the presence of brokers or extremists (Jenkins-Smith et al., 2017; Sabatier, 1988). While the presence or absence of these factors is not sufficient to determine if social policy learning has occurred, identifying them ahead of time is useful to guide my data collection as I seek out evidence of social policy learning (see Falleti, 2016).

Third, this chapter provides justification for the selection of policy cases as well as the provinces in which they are studied. Policy cases are chosen to correspond as exclusively as possible to either medical authority or medical sovereignty. With respect to provinces, while this dissertation is not structured as a traditional controlled comparison, I include multiple provinces for each policy case to allow the analysis to consider provinces in which learning is either delayed or does not occur and to ensure that the project is able to go beyond the particularities of a single jurisdiction and speak to the political activity of organized medicine as a pan-Canadian force. As such, provinces were chosen according to criteria that were anticipated to affect the favourability of conditions for social policy learning. These include a) timing considerations, particularly insofar as they impact lesson-drawing (Grzymala-Busse, 2011; May, 1992), and b) the traditional physician-state accommodations in place in each province (Lomas et al., 1992; Tuohy, 1999).

Finally, while primary evidence is important to all discussions of causal mechanisms, it is especially crucial to understanding changes in beliefs and perceptions,

which are inherently subject to conflicting interpretation (Falleti & Lynch, 2009; Maxwell, 2008; May, 1992). As such, the project rests on semi-structured interviews with informants representing all sides of these policy debates, including midwifery, pharmacy, government, nursing, the not-for-profit sector, activist groups and, of course, medicine itself.

In the empirical portion of this dissertation, I examine medicine's response to the reintroduction of midwifery and the granting of independent prescribing rights to pharmacists, searching for evidence of social policy learning across the four provinces. Before delving into the empirical work, however, the next chapter considers the history of medicine, pharmacy and midwifery in Canada. The history of medicine demonstrates its past protectionism and its ideological variability, while the history of midwifery and pharmacy bolster the proposition here that each represents near-exclusive threats to authority and sovereignty respectively. This chapter also sets the stage for the policy debates at the heart of the project. The specific policy debates may appear new at the time of their emergence, but they carry with them the weight of centuries of inter-provider politics and conflicts. As such, the historical discussion provides critical context, allowing the analytical chapter to focus more sharply on the period of interest and the data collected.

4. History: Doctors, pharmacists and midwives in competition and conflict

The Canadian medical profession is a European import. While the history of healing in North America extends thousands of years and medicine is by no means rooted exclusively in western science, the roots of today's medical discipline can be traced through colonization. Initially, admission to the profession in British North America was only immediately open to those with degrees from prestigious European institutions, while other candidates (including those with American medical training) were required to pass an exam (Duffin, 1999, pp. 120–121). Domestically trained physicians did not enter the system until the advent of Canadian medical schools in the 1800s. At this point, the profession became more or less 'Canadianized;' afterward, all candidates educated abroad had to submit to an examination before they could receive permission to practice (ibid).

Once Canadian medicine established itself as a professional force, it did not take long for its political representation to take shape. The Canadian Medical Association (CMA), founded in 1867, is the national political organization representing physicians. It advocates on health-related issues under federal jurisdiction, such as the government's 2016 response to the Supreme Court ruling on assisted dying (*Carter v. Canada (Attorney General)*, 2012). However, Canadian healthcare delivery is constitutionally a provincial matter. While the specific lines between federal and provincial responsibility have frequently been disputed (see Boessenkool, 2013; Fierlbeck, 2011; Lazar, 2013; McIntosh, 2004; Tuohy, 1999), provinces bear legal responsibility for most nuts-and-bolts aspects of Canadian healthcare policy of particular interest to organized medicine,

including setting professional scopes of practice and negotiating payment arrangements with various providers.

As such, the CMA's provincial and territorial divisions are far more relevant to everyday issues facing Canadian doctors. While these divisions are not technically unions, they are the recognized bargaining agents for doctors in each province and territory. In addition to this role, CMA divisions often act as self-proclaimed 'patient advocates,' pushing for policy change in the name of protecting the public and strengthening the system. As a result, it is common from them to frame their claims in terms of helping their patients and protecting the system. In certain cases, physicians' assertions that their political activity is patient-focused are quite believable, such as the Alberta Medical Association's advocacy for improvements in mental health services (Ward, 2015). In other cases, however, the line between self-serving and patient-focused advocacy is blurred; it is common, for example, for physicians to argue that reductions (or insufficient increases) to their fee schedules constitute cuts to healthcare that would endanger patients (OMA, 2015). While this may be true in some cases, it downplays the direct financial interest physicians have in fee schedule funding.

While the Canadian Medical Association and its affiliates constitute the official advocacy branch of organized medicine,[23] we must be careful not to limit consideration of physicians' political activity to these explicitly political organizations. Doctors are also organized in the form of provincial and territorial colleges, which regulate the profession through maintaining standards of practice as well as investigating cases of misconduct and disciplining those found guilty. These organizations then also have to be considered as agents of political mobilization, as they have explicit mandates to protect what doctors

[23] Quebec is an exception, as neither the FMOQ nor the FMSQ is affiliated with the CMA.

see as good healthcare (i.e. medical sovereignty, see Willis, 1983), and have been at times criticized for defending the profession at the expense of the public (see Boisvert, 1993).

This chapter provides an historical overview of Canadian physicians' political activism. The benefits to this are threefold. First, the discussion provides historical justification for the tendency, common to theoretical and empirical discussions of doctors and paramedical providers (Bourgeault, 2006; Coburn, 2006; Weitz, 2007), to paint physician organizations as inherently protectionist and defensive of medical dominance. There is indeed strong historical base for such a characterization; however, as mentioned earlier, so too is there reason to believe that the profession is ideologically complex and evolving. Second, this chapter reinforces Chapter 3's assertion that expanded pharmacy scope threatens authority but not sovereignty, and that midwifery threatens sovereignty but not authority. Finally, this discussion sets the stage for the interprofessional disputes discussed in later chapters, providing necessary background information on how medicine, midwifery and pharmacy have evolved and come into conflict with one another.

This chapter begins with a brief recap of how Canadian doctors have responded to the foundational questions of Canadian medicare, from the creation of a public insurance system in Canada to the *Canada Health Act* of 1984. This demonstrates Canadian medicine's history of protectionism and explains how doctors are a particularly powerful political force in Canada compared with other countries. It also, however, notes a certain diversity in opinion within the profession and between provincial medical associations, and hints at doctors' willingness to change their minds on contentious issues. Moreover,

it suggests that the medical profession is only becoming more complicated as it changes in demographic and ideology. Subsequent sections then discuss the medical profession's historic relationships with pharmacy and midwifery, focusing on factors that shaped how doctors have approached these rival providers over the years. The discussion concludes with a look forward to the empirical chapters, which pick up where the respective historical discussions of midwifery and pharmacy leave off.

Doctors and their governments: Canadian medicare in the 20th century

Traditionally, social scientists have depicted medicine as a protectionist, conservative force, with an overwhelming tendency to defend medical dominance (Biggs, 1983; Bourgeault, 2006; Weitz, 2007; Willis, 1983). Commentators write that doctors have long fought to preserve their traditional power; physicians have resisted state intrusion into their autonomy, contested threats to their professional authority and fought to maintain and expand medical sovereignty (Biggs, 1983; Coburn et al., 1983; Duffin, 1999; Willis, 1983). Moreover, with respect to the major systemic questions of medicare that have arisen since the mid-20th century – the questions about which social scientists are perhaps most eager to write – Canadian physicians have often appeared downright politically conservative, their organizations advocating for the maintenance of free-market mechanisms within the system.

Canadian healthcare as we know it materialized near the apex of medical dominance. With the emergence of specialties and improvements in medical science in the late 19th century, doctors' popularity reached new heights (Duffin, 1999, p. 124). Gone were the days when physician care was an ineffective Hail Mary, equally likely to

harm or kill the patient as it was to improve their condition (p. 188). Diseases that were once death sentences were now curable with the help of a well-trained doctor (p. 123). 'Celebrity' physicians rose to prominence, and their prestige trickled down to regular practitioners who swore by their methods (ibid). The medical profession's new social stature endured long into the following century; it was in this environment, at the peak of western medical power in the 1950s, that Canada began its journey toward publicly funded medical insurance. Riding a century-long wave of public sympathy, organized medicine would naturally play a major role in the unfolding story.

While they may have been popular, even before the system we know came to fruition physicians were neither united nor consistent in their positions on publicly funded health insurance. In the 1930s, the CMA viewed government-funded healthcare as necessary and likely inevitable, a position they formalized in 1943 with their endorsement of provincial health programs (Taylor, 1987, p. 23). Three years later, the province of Saskatchewan passed a bill providing universal hospital insurance, the first of its kind in Canada (Hacker, 1998). Full state-funded coverage of medical services did not seem far away. By the 1950s, however, the CMA's posture had changed. The association released a new statement favouring private insurance with means-tested government support at the individual level (Taylor, 1987, p. 108). This shift in position, coming at the same time as governments were planning to ratchet up intervention in healthcare, positioned doctors as the main antagonists to reform.

In 1957, the Canadian government passed legislation to create cost-sharing arrangements for hospital insurance with provinces across the country (Tuohy, 1999, p. 57), a plan that all provinces took up by 1961. At the time, the medical profession

opposed public hospital insurance for fear that it would trigger a slippery slope toward public medical insurance (p. 52). Doctors' fears turned out to be well founded. The same CCF government that had introduced public hospital insurance in Saskatchewan brought forward legislation to fund public medical insurance that would cover comprehensive healthcare for all residents (Hacker, 1998, p. 100; Tuohy, 1999, p. 53). The policy was in essence a pre-emptive compromise with physicians: the government would maintain the fee-for-service method of remuneration, but replace private insurance with public insurance for services deemed medically necessary.

Still, doctors were not about to accept the new state of affairs without a fight. The moment the bill became law on July 1, 1962, they launched a bitter and divisive strike, claiming they were defending individual rights against unjustified state intrusion (Badgley & Wolfe, 1965). This strike remains the most infamous instance of physician job action in Canadian history. While participation was technically voluntary and there were many doctors in Saskatchewan who supported the proposed legislation, those who failed to toe the professional line faced consequences. British physicians who came to fill the gap in services saw their work impeded at every turn (p. 470). Of these 'heretic' doctors, Badgley and Wolfe write,

> British training was downgraded, even though over 500 such doctors had come to Saskatchewan in the preceding decade. Hospital privileges were refused certain doctors. Co-operation was denied the heretics and consultations were refused. And yet the same doctors who refused co-operation sat in judgment on the heretics in matters concerning their rights to practice. (Badgley & Wolfe, 1965, p. 470)

Badgley and Wolfe go on to quote one president of a district medical society who referred to these doctors as "scab labour" (ibid). Relations between medicare-supporting

doctors and the professional establishment deteriorated to the point where the provincial Health Minister's wife had to give birth at home because her physician was one of the many denied hospital-admitting privileges by their colleagues (Robertson, 2013). Other medicare-supporting physicians had to be accompanied on house calls for fear of physical attack (ibid).

This strike lasted 23 days and resulted in a key concession: physicians would be allowed to bill patients above and beyond what the government plan covered (Tuohy, 1999). This kept doctors in control of pricing and limited the extent to which the government could shape the medical marketplace. However, while this seemed like a massive setback for public health insurance at the time – patients would still have to pay out of pocket in some situations, after all – the long-term effect of this settlement was a drastic reduction in Canadian doctors' resistance to publicly-funded health insurance. Across the country, physicians and their political organizations watched closely through the early years of the Saskatchewan plan. They took note as physician incomes in Saskatchewan remained competitive with incomes elsewhere in the country (p. 54). So when, in 1966, the federal government voted to create a cost-sharing system to replicate the Saskatchewan program across the country (with only two nay votes in Parliament, no less), there was less resistance than may have been expected. As provinces one by one adopted the cost-sharing plan, Quebec was the only jurisdiction (other than Saskatchewan) to encounter a doctors' strike in protest (p. 207). This case demonstrates how a trailblazer province can spur nationwide change not only through providing ideal political conditions for innovation (Maioni, 1997), but also in demonstrating to hesitant actors that their worst fears may not become reality.

In many ways, passage of universal medical insurance signalled the beginning of a decline in medical dominance, as it drastically and enduringly reduced Canadian doctors' power and freedom from state intervention – their autonomy had been dramatically curtailed. However, the 1966 reforms also froze into place the fee-for-service system of remuneration and maintained organized medicine's control over resource allocation (i.e. the fees for specific procedures, see Tuohy, 1999, pp. 204–205). Furthermore, it constrained the growth of private insurance, preserving a political dynamic revolving around the relationship between the state and the medical profession. This stands in contrast to the United States, in which private insurance and Health Maintenance Organizations have grown in size and influence to the point where they overshadow physicians in many respects (Tuohy, 1999; Wilsford, 1991). Ironically, Canadian medicare may then be responsible for preserving some important aspects of physician power. While it was certainly a short-term blow to organized medicine, the compromise that the physician lobby secured appears extremely favourable in retrospect.

Following the 1966 legislation, provinces and territories continued to tinker with their respective systems, encountering varying degrees of opposition from doctors' groups when initiatives infringed on physicians' traditional powers and freedoms. For example, immediately upon adopting medicare in 1970, Quebec banned physicians from billing beyond what the government insurance plan would cover, a practice known as extra billing (M. G. Taylor, 1972; Tuohy, 1999). This resulted in the aforementioned strike in the province, as physicians tried to secure the same concession as had their counterparts in Saskatchewan nine years prior. However, only the Fédération des médecins spécialistes du Québec (FMSQ), which represents the specialists, actually went

on strike, and they were ultimately forced back to work through legislation[24] after two weeks (M. G. Taylor, 1972). For its part, in 1983 British Columbia became the first province to try to economically discourage physicians from practicing in 'overserviced' localities (thereby encouraging doctors to move to more remote areas), a policy that the British Columbia Medical Association successfully challenged in court (Tuohy, 1999, pp. 208–209).

At the federal level, the *Canada Health Act* of 1984 remains the most serious blow to physician autonomy since medicare itself. Before the bill was passed, six provinces still permitted extra billing (p. 94). This was a key concession to organized medicine when the Saskatchewan strike ended, and was of great symbolic importance to physicians despite only 10 per cent of doctors actually taking advantage of the option (ibid). Banning it was also of extreme symbolic importance to the beleaguered Trudeau government, which was eager to demonstrate its commitment to federal involvement in social programs (ibid). The CMA mobilized against the legislation, arguing that extra billing was symptomatic of underfunding and that banning it was intended to distract from government's failure (p. 95). While the legislation passed – once again, with all-party support – it required provincial implementation. Physicians in most provinces were content with securing some form of compensation for the loss of the extra billing option (ibid; pp. 207–211). However, the Ontario Medical Association (OMA) opted to protest implementation through a 25-day strike in 1986. By most accounts, this strike proved a public relations nightmare, resulting in a major loss of public confidence in organized medicine in the province (Meslin, 1987).

[24] This conflict, while significant to the evolution of Canadian healthcare, was overshadowed at the time by the October Crisis, which occurred over the same period (M. G. Taylor, 1972).

What can the story of Canadian medicare teach us about doctors' political action? First, organized medicine has been a powerful force for conservatism both in terms of protecting physicians' economic freedom and in terms of preserving traditional forms of healthcare provision. However, it should not be painted as a monolithic collection of interests. Even in Saskatchewan, home to the nastiest doctors' strike in Canadian history, renegade doctors spoke out in favour of medicare at great personal risk. Today, left-leaning advocacy groups such as Canadian Doctors for Medicare serve as the voice of the ideological descendants of these physicians. Furthermore, the OMA's unusually strong response to the *Canada Health Act*, contrasted with doctors' willingness elsewhere to accept the legislation on condition of compensation, demonstrates that the medical organizations across the country do not always react in the same way to initiatives that threaten their interests.

Additionally, the early days of medicare exhibit how doctors can shift their positions. When medicare in Saskatchewan did not lead to plummeting incomes, physicians elsewhere took note and their opposition to a similar plan nationwide softened considerably. Softening opposition can constitute either political learning or social policy learning (May, 1992). Such flexibility is by no means unique to the medical profession, but it is perhaps particularly important to organized medicine because of the tendency for provinces to move at different times on health policy change. Both of the phenomena explored in this project involve a trailblazer province: Ontario for midwifery, Alberta for pharmacists' scope of practice.

Since the early days of medicare, medicine has changed in ways that signal even more potential for variability in its political positions and action. To start,

demographically, it is far less male than it once was. In 2016 (Canadian Medical Association, 2018), 40% of Canada's doctors were women due to a massive influx of women graduates – as women dominate the younger generation of physicians, this percentage will only increase. Just 15 years prior, women made up less than 30% of the profession (Canadian Medical Association, 2001). Traditional authority structures aside, the country is quickly moving away from a time when the medical profession could be deemed a 'male' profession in total contrast to 'female' paramedical providers (Willis, 1983). Analysts debate the difference this makes with respect to medical politics – for some, medicine is patriarchal not because it is full of men, but because of how it treats women and their bodies (Duffin, 1999; Lupton, 2012; Weitz, 2007).[25]

Perhaps more significant, however, is that the demographic shift in medicine has coincided with a change in new doctors' priorities. The CMA reports that, between 1997 and 2014, the average number of hours doctors worked per week in Canada decreased from 53.2 to 48.2 (Canadian Medical Association, 2014). Female physicians, particularly younger female physicians, are more likely to work shorter hours than male physicians; however, male physicians are also reducing the number of hours they work, suggesting that demographic change alone cannot account for this trend (Crossley et al., 2009). While doctors are still working extremely long hours, they are purposefully stepping away from the amount of work they used to do. This new orientation disproportionately affects certain medical tasks, particularly more time-consuming, unpredictable practices such as birth attendance. Here, professional territory that was near and dear to older

[25] Moreover, while Canada's medical profession is making progress toward gender balance, the share of female physicians in Canada is still below the OECD average of 46.3% as of 2016 (OECD, 2017).

doctors has been increasingly shrugged off by newer generations, suggesting that medicine might weaken in its resolve to defend certain aspects of traditional dominance.

Physicians' professional associations have also changed, at least in image. Interviewees for this project repeatedly observed that medical advocacy groups have become more publicly concerned with improving the system than they once were, especially compared to the early days of medicare. This is perhaps expected of the Canadian Medical Association, which does not have an explicit mandate to negotiate with government on behalf of its members. However, even provincial-level CMA affiliates, which (with the exception of Quebec) act as recognized bargaining agents for physicians, have increased their public emphasis on patient advocacy and system improvement; for example, the Alberta Medical Association has registered "Patients First" as a trademark, speaking out often on matters of public health that go beyond the strict scope of physician advocacy (Alberta Medical Association, n.d.). This has meant occasionally adopting policy or behaving in a way that is contrary to the strict interests of the profession. To take another example, in an interview for this project former Nova Scotia Health Minister Maureen MacDonald described how Doctors Nova Scotia's decision to reopen its contract was a show of good faith in the face of a budgetary squeeze (Interview, Nova Scotia, May 2, 2016).

These shifts in organized medicine have occurred as doctors have increasingly found themselves under attack by cost-cutting governments. As medical technology has progressed, new treatments have emerged that are far more costly than past methods, driving up costs in prescription drugs and hospital spending across the country (Marchildon, 2012). This is bad for doctors; budget-wise, they are easy targets.

Compared to other publicly-funded professionals, physicians are quite wealthy, an attribute that governments are quick to point out when they come into conflict over pay (Csanady, 2016). An ever-tightening fiscal situation has not only pushed provinces to reduce physician fees at times, but also to adopt measures to constrain professional autonomy and ultimately reduce doctors' power. For example, beginning in Quebec in the 1970s, provincial governments moved to adopt global budget caps, with varying degrees of flexibility, for physician services (Tuohy, 1999, pp. 213–214). For the first time, there would be a limit on what provincial governments would pay for physician services, fundamentally altering the original profession-state accommodation. From there, provinces across the country began to push for alternative payment plans, moving away from the fee-for-service system of remuneration that had defined physician autonomy at the outset of medicare (p. 222). These plans vary by jurisdiction, and many provinces still hold to the original fee-for-service arrangement (see CIHI 2013). However, the trend away from the original fiscal accommodation secured in the 1960s is clear, signalling a significant reduction in physician autonomy.

This section has demonstrated physicians' history of protectionism when faced with the introduction and expansion of universal health insurance. These developments reduced medical dominance primarily at the 'autonomy' level, placing restrictions on what doctors can and cannot do within the system. However, it has also demonstrated that medicine's political positions can vary between organizations and change over time. Moreover, the profession itself has changed over the past 30 years in ways that suggest increasing political complexity. We cannot assume that protectionism will always prevail

within the medical establishment; rather, doctors might sometimes learn and substantively change their positions on threats to medical dominance.

This discussion now turns to doctors' relationships with two other healthcare providers: pharmacists and midwives. The legal definition of what both professions are permitted to do has changed dramatically on multiple occasions. For doctors, asserting their place at the top of the healthcare hierarchy meant that competing professions would have to be either eliminated (as with midwifery) or placed in a decidedly subordinate role (as with pharmacy). The following sections outline doctors' efforts to constrain these professions' roles in Canadian healthcare provision, efforts that have again generated mixed results.

Canadian pharmacy: A professional grey area

There has been little academic discussion of the history of Canadian pharmacy, particularly with respect to pharmacists' relationship with physicians (Beales & Austin, 2006). Nevertheless, medicine has an extensive history of conflict with pharmacy, as the two professions have for centuries grappled for control over the grey area where their respective competencies overlap. For pharmacists, this boils down to a struggle to practice to their 'full scope:' the true extent of what those trained in pharmacy are able to do, given their education and experience. However, what pharmacists see as their scope has regularly shifted. Technology and the drug marketplace shape and constrain what pharmacists can and desire to do, placing the meaning of pharmacy in a near-constant state of renegotiation. Naturally, the medical profession has a lot to say whenever swings in pharmacy's perceived full scope engender legislative and regulatory change.

Pharmacy's fluidity is perhaps its greatest threat to medical dominance, as it poses a perpetual challenge to the stability of the medical hierarchy. As there is no stable definition of what pharmacy even is, there are no permanent agreed-upon borders between it and medicine. Furthermore, this presents an opportunity for differences in competency between jurisdictions; within reason, pharmacy can be whatever the government wants it to be, depending on the specific needs of the province or territory.

All this being said, physicians do not have the same kind of basic philosophical divergence with pharmacists as they do with midwives. While, as will be discussed in the next section, midwifery poses a fundamental challenge to medical sovereignty, pharmacists accept and draw from the same medical logic as doctors – including interventionism, scientific rationality and the medicalization of biological processes. In their struggle for legitimacy, they speak physicians' language by using similar scientific rhetoric employed by the medical profession (Malleck, 2004). Conflict between the two professional groups resembles a classic battle of interests, in which each set of professionals fights for control over pieces of the healthcare pie without really disputing what that pie should look like.

Like medicine, the roots of pharmacy extend further than recorded history. Humanity's initial survival depended on knowledge of the effects of ingesting particular herbs and roots, be they beneficial or deadly (Zebroski, 2015). Engravings dating back 80,000 years suggest that early humans were concerned with transmitting this lifesaving knowledge to one another (ibid). Madge (1987) notes that the formal practice of pharmacy as an occupation developed in three clusters around the world: the Mediterranean, Southeast Asia and China. The Canadian pharmacy profession originates

from the Mediterranean – more specifically, from Egypt via Greece and eventually Western Europe.

As medicine became more sophisticated and respected, so too did pharmacy – even before it was known by that title. Pharmacists' precursors were known in English as apothecaries. In Britain, these apothecaries earned the admiration of the lower classes in particular, especially when contrasted with physicians. When the plague hit, doctors fled along with the upper class, while apothecaries stayed to treat those who remained (Beales & Austin, 2006; Madge, 1987). While this was ultimately a simple matter of following their income (as physicians already had virtually exclusive domain over the monied elite) it led to a change in attitude in which the common people considered the apothecary to be their *de facto* family physician, calling local doctors only in special cases (Madge, 1987).

While British apothecaries were legally permitted to advise patients on health matters at this time, the House of Lords eventually ruled that they could only demand payment for dispensing medicine. As a result of this discrepancy between what they were paid for and what they actually did, apothecaries gradually left the practice and took up medicine, which they found far more lucrative (ibid). This left a void that informally-trained druggists, who had long competed for the drug dispensing market, were happy to fill (ibid). Druggists gradually became more and more organized and ultimately replaced apothecaries as the chief providers of pharmaceutical services. While the profession nominally changed, the demand for an immediately accessible drug dispenser never went away.

In France, pharmacy evolved quite differently. At the beginning of the 19th century – long before they gained recognition in Britain or Canada – pharmacists gained

the right to self-regulate, including the establishment of a professional college (Collin, 2010). This divide between the France and Britain impacted how pharmacy would evolve in Canada. Most of Canada naturally took up the British model. The francophone parts of the country initially held to a modified version of the French model, with apothecaries serving as a distinct profession from both pharmacists and physicians (ibid). However, in the mid-19th century the British model began to slowly take over. By the time pharmacy had crystalized as a distinct occupation in Quebec, it had taken on most of the characteristics of the British and American practice (ibid). This shift occurred just in time for the Canadian medical profession to make its push to put pharmacy under its own regulatory thumb.

In the mid-19th century – once again, the height of medical dominance – Canadian physicians were consolidating their power by cracking down on unlicensed practitioners, including druggists. The medical establishment's overarching goal was to eliminate competition by eradicating certain practices and placing others firmly under the control of physicians' own regulatory bodies. Given the aforementioned constant demand for an accessible drug dispenser, eliminating pharmacy altogether was never in the cards. Rather, physicians worked to convince policymakers that the best way to ensure high-quality (and therefore safe) pharmaceutical services was to oblige pharmacists to obtain licensure through the medical profession's own colleges, which would require appropriate education as determined by the medical establishment (Malleck, 2006). Physicians' argument here was grounded not only in the newfound public respect for scientific knowledge and formal education, but also in the increase in dangerous drugs available on the market (Malleck, 2006).

Physicians believed that pharmacists required formal, standardized education to ensure not only competence but also moral character. This is an argument that hints at pharmacists' other identity: that of a merchant. Unlike other healthcare professionals, pharmacists make their money off of selling things, including non-medical products. In fact, even in the mid-1800s, the bulk of pharmacists' income came not from activities that required professional expertise (namely the distribution of so-called 'poisons') but rather from the sale of pre-packaged drugs and non-medicinal wares (Clark, 1991, pp. 44–45). This placed their professional identity in question, and allowed doctors to raise questions about whether pharmacists could be trusted to avoid pressures of the free market that could compromise the quality of their work (Malleck, 2004, p. 180).

Pharmacists were well aware of the accusations levelled against them by the medical profession, and had the organizational capacity to resist and strike back. Interestingly, they did not deny many of the claims physicians made about the need for scientific expertise and strong moral character. They accepted that the status quo was insupportable and that some form of licensure was critical for insuring the integrity of their profession (Clark, 1991; Malleck, 2004, 2006). However, they did not believe that this implied a need for medical control over their work. They instead argued for self-regulation via the creation of Pharmacy Colleges that would govern their profession, much in the same way that Colleges of Physicians and Surgeons govern medicine (Clark, 1991; Malleck, 2004, 2006, pp. 103–104).

In making this case, pharmacists turned physicians' arguments against them. Pharmacists agreed that capitalist competition could corrupt some in their ranks – that is why full legal and regulatory recognition of pharmacists through a self-regulating

professional body was absolutely necessary (Malleck, 2004, p. 185). A professional body would empower pharmacists to discipline those who strayed from the ethical boundaries of their profession and fully control the education that would-be pharmacists received in accordance with standards that they themselves set. Pharmacists also exploited the scientific language that characterized doctors' claims to professional supremacy by touting their own specialized expertise in drug therapy in contrast to doctors more general medical education (Clark, 1991; Malleck, 2004, p. 178). At times, they would even attack physicians' knowledge of drugs, framing themselves as the true protectors of ethical and competent medical practice and arguing that some doctors were prescribing dangerous drugs unnecessarily (Beales & Austin, 2006; Malleck, 2004). In this way, pharmacists staked out their own professional territory while challenging the medical profession's claims of all-encompassing and superior medical knowledge. Pharmacy had taken the scientific rhetoric of the medical profession and twisted it against them, a remarkable feat in the era of medicine's rise.

Pharmacists' eventual victory was not totally clean. In 1845 and 1846, doctors presented formal proposals putting pharmacy under their purview (Malleck, 2004, p. 179). Pharmacists initially fought off this threat, but two decades later the government of what would become Ontario and Quebec finally acquiesced to physicians' request (Collin, 2010; Malleck, 2004). However, medicine's victory was short-lived. Ontario became the first province to incorporate pharmacists through a legislative act in 1871; this was the first time the role of 'pharmacist' was legally defined in the province (Paterson, 1969). Quebec was not far behind, passing legislation to place pharmacists' education in the profession's own hands in 1875 (Malleck, 2004, p. 178). Other provinces

took until the end of the century to fully recognize pharmacy as an autonomous profession (ibid), but the end result was always some form of incorporation and self-regulation. Pharmacists won where many other unlicensed professionals had lost: They secured a legally-recognized, self-governing place in the healthcare system, one that would endure through to the present day. As the next section will demonstrate, this presents a stark contrast with midwifery.

It should be noted that throughout this period, the actual work pharmacists performed did not remain entirely consistent. Industrialization meant that compounding gradually became a less important component of the druggist's skillset (Beales & Austin, 2006; Clark, 1991). This change happened at the same time that doctors were reducing their reliance on drug therapy and increasing their adherence to standardized doses (Clark, 1991), posing a clear threat to pharmacists' professional work. Pharmacists responded in part by adding a new weapon to their arsenal: chemical analysis, by which they could provide some form of quality control (ibid). In this case pharmacists displayed flexibility with respect to the scope of their profession; when demand for one service fell, they began to provide another. Pharmacy's desire to adjust its scope in response to shifts in healthcare practice has been a consistent attribute since these early days.

Such flexibility in the role of the pharmacist could have perhaps served as a warning sign for physicians, who were generally unconcerned about direct competition from pharmacists even after the profession incorporated across the country (Beales & Austin, 2006; Clark, 1991). After pharmacists gained professional recognition, it quickly became apparent that the line between their professional jurisdiction and that of the medical profession was not as sharp as either side may have anticipated. Pharmacists and

doctors engaged in a series of professional skirmishes regarding what specifically both professions could do. Clark (1991) discusses a few high-profile examples of such disputes in Ontario, noting that physicians were particularly annoyed by the extent to which pharmacists regularly engaged in counter-prescribing. For their part, pharmacists defended counter-prescribing as a necessary safeguard against physician incompetence, again touting their own specialized expertise. They specifically targeted physicians' infamous handwriting, claiming that such lazy prescribing work can harm patients if not for pharmacists' vigilance (ibid). The result was that, while physicians would occasionally take counter-prescribing pharmacists to court, their efforts were rarely successful, and the medical profession failed to end the practice (Clark, 1991; Coburn et al., 1983). The public was unreceptive to doctors' claim to exclusivity over the activities in the grey area between physician and pharmacist competency, proving once again the success of pharmacists' efforts to build a reputation as a knowledgeable, science-based profession (Beales & Austin, 2006; Clark, 1991).

Pharmacists did not just play defense following incorporation. They also fought to constrain physicians in new ways. Initially, doctors had retained the right to own their own drugstores and dispense medication in direct competition with pharmacists (Clark, 1991). While the competitive impact of this right is debatable, it reinforced the perception of pharmacy as a profession wholly derivative of medicine, and denied pharmacy any *de jure* exclusive domain whatsoever. Physician-owned drugstores remained unregistered in Ontario until 1889, and pharmacists' efforts to obtain exclusive jurisdiction over dispensation were thwarted altogether (ibid). Eventually, pharmacy struck what Coburn et al. describe as a "tacit bargain" with medicine, essentially trading counter-prescribing

for drug dispensing; pharmacists would respect physicians' authority in prescribing, while physicians would back off of directly selling medications (Coburn et al., 1983, p. 413). This bargain nicely characterizes pharmacy's relationship with medicine, which is essentially one of mutual accommodation punctuated by discrete conflicts over the border between the two practices. While occasional skirmishes do occur, the two have no choice but to tolerate one another, and have a mutual interest in establishing clear professional boundaries.

One must be careful not to overgeneralize pharmacists' relationship with the medical profession. The two groups shared a perspective on regulating drugs, which often put them on the same side of policy debates in the early 20th century (Malleck, 2004, p. 197). Physicians would recognize and appeal to pharmacists' authority in these debates (ibid). However, the rocky period following incorporation demonstrates a longstanding grey area where pharmacy and medicine overlap. This engenders conflict particularly when pharmacists' definition of their work changes (Beales & Austin, 2006; Clark, 1991).

Physicians' historic relationship with pharmacists sheds light on several relevant aspects of both professions. First, doctors attempted to use scientific knowledge to their advantage in order to secure dominance over the healthcare hierarchy; however, unlike in the midwifery case discussed in the next section, pharmacists could throw the same rhetoric right back at them. Where physicians claimed ultimate authority over medicine as a whole, pharmacists claimed exclusive, in-depth expertise in a smaller area. Doctors were not able to dismiss this claim from pharmacists, and following incorporation found themselves defending their right to even share certain competencies with pharmacy.

While scientific expertise was a go-to weapon in physicians' arsenal against virtually all other unlicensed practitioners, they tailored one argument to pharmacists in particular: their double-identity as professionals and merchants. Morality plays a particularly strong role in the medical profession's attacks on pharmacy. Pharmacists, they have argued, are bound to become corrupted by the capitalist system and must be subjected to oversight from a true professional. Pharmacists would occasionally throw this argument back at physicians, citing the structure of doctors' own pay incentives under fee-for-service (Beales & Austin, 2006; Malleck, 2004). This argument was quite effective; Malleck cites one letter to the Halifax *Reporter and Times,* submitted anonymously under the pen name 'Medicus,' in which the writer argued that the real danger was not pharmacists but "the grabbing and grasping rapacity of the medical profession...most of them like to, and do, demand and take a fat fee whenever and wherever it can be got" (Halifax Reporter and Times, 1874; as originally cited in Malleck, 2004). Doctors may not sell granola bars and toilet paper, but their payment structure still might prompt them to 'sell' unnecessary services to patients. Nevertheless, this represents an historic vulnerability for pharmacists, one that they have had to work to overcome.

Today, the dominance of large chains has created two kinds of pharmacists. In Quebec, pharmacies are typically franchises, owned and operated by licensed pharmacists (Association québécoise des pharmaciens propriétaires, 2013a). Outside Quebec, it is common for pharmacists to work as employees of large chains such as Rexall or Shoppers Drug Mart (although owner-pharmacists still exist as well). These are more defined by their professional role. The interviewees cited in later chapters often

referenced these two kinds of pharmacists, arguing that the former are more subject to the pressures of the capitalist marketplace.[26] Pharmacists' merchant identity must now be nuanced when considering the arguments doctors make; however, as we will see in later chapters, allusions to pharmacists as merchants have not disappeared entirely from political discourse.

The historic relationship between medicine and pharmacy is very different from doctors' relationship with midwives. There has never been an essential disagreement over what counts as legitimate knowledge between pharmacists and medicine; rather, pharmacy has asserted its right to function as an independent profession based on the same assumptions about medical care advanced by physicians. As such, medicine did not challenge pharmacy's right to exist. Eventually, doctors even grudgingly accepted that pharmacists have specialized knowledge in their field rather than treating them as practitioners of a small slice of the medical pie, the entirety of which physicians have ostensibly mastered.

The arguments for an increased role for pharmacists represent a continuation of a longstanding battle of interests, a fight for control of the ever-shifting grey area between pharmacy and medicine. Toward the end of the 20th century, pharmacy found itself within an advantageous ideological context, as the idea of exclusive scopes of practice had lost favour in the eyes of the public and governments (see O'Reilly, 2000). Rigidity in roles had become unpalatable, leading many provinces to re-examine the rules governing what various health professions could and could not do. Doctors are expensive, and empowering lower-paid providers could allow governments to increase efficiency within

[26] A recent *Toronto Star/Global News* has also found evidence of significant fraud and overbilling in Ontario pharmacies (Chown Oved & Jarvis, 2019).

the system without dramatically cutting services. This came with a whole host of consequences for traditional medical authority, presenting an opportunity for the emergence of new professions such as nurse practitioners, as well as the dramatic empowerment of and already-existing providers (ibid). Pharmacy, with its history of challenging the medical profession for authority, was poised to capitalize.

The next section concerns a provider with a very different history of conflict with medicine. Pharmacists and physicians tolerate one another and share similar views of how healthcare should be provided. There is no threat to medical sovereignty here. However, pharmacists have a long history of challenging doctors' authority, one that continues in Canada to the present day. In contrast, midwifery poses a diminishing threat to medical authority, but presents a fundamental challenge to sovereignty. Midwives have incurred not only competition from physicians, but also their moral disdain, leading to a decades-long campaign to all but eliminate the practice.

Canadian midwives: A profession in (brief) exile

Historically, midwifery has been the demographic and philosophical inverse of the medical profession. The latter has been dominated by medical men accused of perpetuating male-centric images of the body, while the former is a female-dominated profession that specializes in serving women (Duffin, 1999; Lupton, 2012; Weitz, 2007). Gender has been central to understanding midwifery's relationship with Canadian medicine, from the days when the medical profession shunned birth attendance, to doctors' aggressive crusade to delegitimize midwives, to midwifery's (mostly) successful campaign for reintegration into mainstream healthcare. For centuries, doctors kept their

distance from childbirth in the name of modesty, relegating such care to the category of 'women's work' (Duffin, 1999, p. 244). Later, when they started taking an interest in attending birth, physicians derided midwives as dirty, illiterate and dangerously unqualified, delegitimizing the forms of experiential knowledge held by these women at the time (Biggs, 1983). These same themes would reappear when midwifery made its comeback toward the end of the 20th century.

Connor (1994) calls midwifery "probably...the oldest, most traditional, and culturally widespread health care activity" (p. 103). Indeed, in what would become Canada the practice was once ubiquitous in both Indigenous and settler communities (Bourgeault, 2006; Olson & Couchie, 2013). Bourgeault notes that, in the early years of North American colonization, midwifery services were a point of interaction between settler and Indigenous women, as Indigenous midwives often delivered babies for newcomers (2006, p. 43). Midwifery was not typically a full-time occupation and did not require a license; as such, it is difficult to know how many midwives were even practicing during this period (Biggs, 1983; Bourgeault, 2006, p. 44; J. T. H. Connor, 1994, pp. 105–106). Unlike pharmacists, midwives were not politically organized and made no effort to protect or legitimize their work, as any need for such protection was inconceivable.[27] However, there was perhaps in retrospect one warning sign of midwives' eventual displacement. Even as they shunned birth attendance itself, physicians were still interested in birth in an academic sense; since antiquity there have been treatises and handbooks written about pregnancy and childbirth aimed at physicians and the educated

[27] Our understanding of midwifery during this time period is admittedly quite blurry, as there are no accounts written by the midwives themselves (J. T. H. Connor, 1994, p. 105).

elite rather than midwives, who were typically illiterate (Duffin, 1999). While birth was considered women's work, the medical gaze kept an eye on it from a distance.

Doctors first began to take interest in attending childbirth in what would become Canada in the late 1700s (Bourgeault, 2006, p. 44). However, due to low physician numbers, any steps taken at this time to limit midwifery services were utterly unenforceable (ibid). It was only in the following century, when the medical profession was more numerous and organized, that doctors' efforts to constrain midwives began to bear fruit. In this period, physicians were consolidating their power as a professional bloc (J. T. H. Connor, 1994; Plummer, 2000). Birth attendance was seen as an easy way for a new physician to both build his skills and establish a client base; as such, reducing competition in this domain would benefit doctors at a time when they were aiming to make their services synonymous with medical care (Bourgeault, 2006, p. 44). In essence, taking over birth attendance was not just a matter of extending medical sovereignty, but also a substantive and profitable extension of professional authority. Midwives were not the only unlicensed, unorganized professional group drawing physicians' attention – indeed, they were not even particularly high on organized medicine's list of foes (Biggs, 1983; Bourgeault, 2006, p. 44; J. T. H. Connor, 1994) – but repression of midwifery nevertheless emerged as a key step in establishing the medical monopoly that would come to characterize Canadian healthcare provision.

Doctors were not acting in a vacuum. By the mid-1800s, advancements in medical technology allowed them to make a convincing case that their services were superior to those offered by midwives. Biggs (1983) writes that this was a time when the public was "enamoured with the rationality of science" (p. 31); physicians' appeals to their own

medical expertise and ability to provide more 'sophisticated' services were more resonant than ever before (Oxorn, 1994). The line between intervening in childbirth (hastening the delivery, previously done almost exclusively for reasons of absolute medical necessity) and attending birth began to blur, as women increasingly preferred the use of medical instruments and drugs even in 'normal' deliveries (Biggs, 1983; Duffin, 1999, p. 245). Medical sovereignty was on the rise; demand swelled for interventionist procedures such as the use of forceps, C-sections, anaesthesia, and antiseptics. Doctors capitalized not only on their exclusive ability to provide most of these services, but also on the increasing acceptance of birth as a medical, scientific domain.

For midwives, the most consequential of these changes may have been the increasing use of forceps – ironically, the oldest and least technologically sophisticated of the aforementioned 'advancements.' While Duffin writes that forceps might have been in use in antiquity (1999, p. 245), they fell out of use for hundreds of years, finally re-emerging in Britain in the 1600s (Biggs, 1983). However, their use was legally restricted to male practitioners. This, coupled with other precautions such as "modesty blankets" contributed to the popularity of male midwives among the upper classes, a development that began chipping away at the notion that birth was exclusively women's domain (see also Duffin, 1999, p. 250). However, forceps were still widely considered unnecessarily dangerous until the mid to late 1800s, when demand for more interventionist methods skyrocketed in Europe and North America as women became less comfortable giving birth without medical assistance (Biggs, 1983; Bourgeault, 2006; Plummer, 2000). As female midwives were still not authorized to use forceps – or any other of the new

instruments and medications becoming popular at this time – they were unable to respond to this demand (ibid).

It was in this environment that Canadian physicians made their public case against midwifery and in favour of restricting birth attendance to licensed medical professionals. Not all physicians were particularly invested in this crusade. Just as some were concerned about the unnecessary use of instruments such as forceps in childbirth (Biggs, 1983), there were many doctors who were perfectly comfortable keeping birth attendance in the hands of midwives – and some even actively supported the practice (J. T. H. Connor, 1994, p. 104). Bourgeault notes that only a small group of physicians was dedicated to discrediting midwifery, helped along by an awkward alliance with some in the nursing profession (2006, pp. 47–48). Nurses' opposition to midwifery, coming at a time when they were struggling to gain a foothold as an established healthcare profession, was born out of their desire to avoid alienating physicians and eliminate competition from a potential rival profession (ibid; see also Plummer, 2000). Bourgeault writes that nurses took on the role of "propagandist" in the struggle for medicalized, hospital-based birth, all the while fighting to normalize their place as physician assistants in these births (2006, pp. 47–48).

Biggs (1983) argues that in their quest to delegitimize midwives, doctors conflated illiteracy with stupidity, essentially arguing that since most midwives could not read or write, patients could not be confident in their competence. In doing so, they also dismissed knowledge gained through means other than professional education, their own scientific training over midwives' firsthand understanding of birth (ibid). Doctors capitalized on midwives' inability to provide scientific explanations for infant and

maternal deaths, contrasted with physicians' ability to explain how they were not at fault when a birth went awry. Myths and stereotypes about midwives' hygiene also contributed to the belief that midwifery was dangerously inferior to physician care (Biggs, 1983; Bourgeault, 2006; Plummer, 2000). Tales of botched deliveries served as grisly illustrations of the supposed consequences of unqualified birth attendants – although Connor (1994) argues that these could oftentimes be read as a condemnation of specific midwives rather than the profession writ large. Nevertheless, all of these efforts reinforced doctors' drive to medicalize birth through normalizing an interventionist, clinical approach.

Doctors' initial target market was upper-class women. The medical establishment believed that, if the upper classes began expressing disdain for midwifery, these attitudes would trickle down to the lower classes (Biggs, 1983, pp. 25–26; Bourgeault, 2006). Male physicians framed themselves as simply the higher quality option, chosen by those with the most discerning taste. This strategy bore fruit, contributing to the decline of consumer confidence in midwives and, eventually, the near-disappearance of midwifery from the Canadian landscape (Biggs, 1983; Bourgeault, 2006; Plummer, 2000).

Making midwifery entirely illegal was never in the cards in Canada. From the very beginning, doctors recognized this option as unenforceable and feared a massive public backlash, as criminalization could potentially block women from seeking unpaid help in delivery from their neighbours (Bourgeault, 2006, pp. 44–45). Instead, what emerged was a dynamic of so-called 'alegality,' in which midwifery services were not illegal per se, but they were not a part of the officially recognized healthcare system. Not only did this mean that recipients of midwifery services had to pay out of pocket, but also

that in some cases midwives could face prosecution for practicing medicine without a license.[28] Alegality would also serve as a major deterrent to those considering entering midwifery practice, to the point where attrition posed a significant threat to the profession's continued existence (ibid; see also J. T. H. Connor, 1994).

Midwifery became alegal at different points in time in different Canadian provinces, but generally occurred near the height of medical dominance, from the mid-1800s to the emergence of medicare. Most analyses of the profession's demise focus on Ontario, which at the time of legislation was united with Quebec in a single Province of Canada. Here, birth attendance was officially placed under the exclusive purview of licensed practitioners in 1865. However, the effects of this *de jure* change were quite gradual, as the medical profession in practice continued to tolerate midwives while working to convince women of the superiority of physician-attended births (J. T. H. Connor, 1994; Relyea, 1992). Once Quebec became a separate province, midwifery became legal there again until after the First World War, when it again lost recognition. Nova Scotia also took until after the War to legally restrict birth attendance (Relyea, 1992). Newfoundland and Labrador was the final holdout, continuing to issue midwifery licenses until 1961 (Plummer, 2000). Little by little, the practice lost legal recognition across the country. How big a role that ultimately played in the profession's demise is debatable, as alegality would have been untenable without the public shift toward preferring medicalized birth (see J. T. H. Connor, 1994). Nevertheless, both of these changes were preceded and helped along by a concerted effort from anti-midwifery

[28] Such prosecution would eventually play a major role in the fight to re-integrate midwifery into the modern healthcare system, as discussed in Chapter 6.

physicians to delegitimize the practice and promote physician-attended, hospital-based, interventionist birth.

Even as it lost legal recognition, Canada's geography prevented midwifery's total disappearance. The idea of eradicating midwifery in a country where significant portions of the population live in sparsely populated areas is impractical and highly undesirable to anybody who values ability to access healthcare services in remote regions. For all intents and purposes midwives could practice with total impunity in some areas, often with the approval (or at least tolerance) of local physicians (J. T. H. Connor, 1994, p. 121). As well, even during alegality, cases occasionally popped up of official, albeit contained, midwifery programs across the country. Throughout the mid-twentieth century, Alberta maintained a 'district nurses' program in isolated areas (Plummer, 2000). District nurses were nurses deemed qualified to practice midwifery; at first this title was confined to those with some form of foreign training, but during the Second World War a training program for these nurses was set up at the University of Alberta (ibid). District nurses attended birth until the 1960s (when demand decreased upon the introduction of medicare), while the program at University of Alberta continued until 1984 (ibid). The university then set up a certificate of midwifery program three years later, when it was becoming increasingly apparent that midwifery would soon be making a legal comeback (ibid).

Midwifery also persisted in the far north. In the aftermath of WWII, high infant mortality rates led Northern Health Services to recruit non-Indigenous midwives as part of a push to get Inuit women to give birth in nursing stations and hospitals (ibid; see also Bourgeault 2006). Eventually, this evolved into a program to fly women south long

before their due dates to give birth in hospitals, a practice that conflicted with many aspects of Inuit culture and proved traumatic for women and families (Plummer, 2000). Following backlash, in 1986 a birthing centre was created in northern Quebec that included both Inuit and non-Indigenous midwives. Crucially, this initiative included training midwives to help women give birth in their communities (ibid). Bourgeault notes that 20th-century efforts to create midwifery programs in Indigenous communities generally encountered little opposition, as they were limited in scope and targeted towards specific populations (Bourgeault, 2006, pp. 53–54). As significant as these programs were to the communities they served, in the vast majority of Canadian jurisdictions midwifery remained unrecognized, unfunded and untrusted. The medicalization of birth was all but complete; interventionism in deliveries was now the norm, representing an extension of medical sovereignty.

The decline of midwifery reveals several qualities of the Canadian medical profession's political activism and its relationship with other professionals. First, as mentioned at the outset of this section, it demonstrates that gender dynamics persistently colour the medical establishment's relationship with midwives (Willis, 1983). Differences between physicians and midwives, which doctors exploited in their drive to take over birth attendance, were (and still are) unavoidably gendered. Physicians touted their scientific knowledge while downplaying the value of knowledge coming from experience, which characterized female occupations (Biggs, 1983).

Midwifery's near-death experience also demonstrates one of the first high-profile incidents of doctors appealing to public opinion to advance their cause. There were two stages to this. First, physicians had to get women onside with medicalized birth, or else

their appeals to government to change legislation would go unheeded. Second, they needed public opinion to remain in their corner in order for the new legislation to be at all effective. Marginalizing midwifery through legislation alone in a country as geographically massive as Canada was simply not feasible (J. T. H. Connor, 1994). Shifting public opinion and demand for midwifery services would once again prove important upon the practice's re-emergence, as physicians both reacted to and attempted to shape how women viewed childbirth.

Midwifery began its unofficial Canadian renaissance in the 1970s, through an increased demand for alegal services provided by lay midwives (Bourgeault, 2006, p. 56). How this demand translated into legislative change from province to province will mostly be discussed in Chapter 6, insofar as the practice's comeback occurred in different ways in different jurisdictions. However, a few overarching trends should be discussed here in connection with the profession's initial decline. The midwifery that re-emerged was very different from the midwifery that had gone into decline earlier in the century, and the threat it posed to medical dominance was very different from the one they had successfully marginalized decades prior.

Midwife-assisted birth was once simply a fact of life, tacitly sustained in part due to ideas of modesty and 'women's work' (Biggs, 1983; Duffin, 1999, p. 244). When it re-emerged, women had not suddenly decided that they were uncomfortable with male healthcare providers delivering their babies. Rather, the practice's resurgence was connected to ideals new to western medicine, particularly natural childbirth and choice in

maternal healthcare. These ideals are tightly connected to patient empowerment.[29] Much has been made of how today, the internet has ushered in the age of the 'informed patient,' as websites offer easily-accessible information that would have otherwise been transmitted primarily via a medical professional directly (see Erdem & Harrison-Walker, 2006; Kivits, 2006; Lee & Hornik, 2009). However, even before the so-called IT revolution, the counter-culture movement was challenging traditional medical sovereignty and preaching patient empowerment through de-medicalization. While this is not necessarily anti-scientific, it brought forth the idea of 'natural' childbirth, which rests far less on formal scientific education and technological sophistication (see Johnson, 2008). Proponents of de-medicalizing birth were alarmed by the high rate of C-sections and other invasive interventions in hospital deliveries (Bourgeault, 2006; Duffin, 1999). This backlash shook the initial justification for doctors' control over birth attendance, opening the door for midwifery's re-emergence (see Plummer, 2000).

At the time of its demise, the midwifery profession was also unorganized. This was due to the informal nature of the work, as many midwives delivered babies on a part-time or casual basis (Biggs, 1983; J. T. H. Connor, 1994, pp. 105–106). Lack of organization meant they had no formal voice with which to promote and defend their work. This would no longer be the case upon the profession's renaissance; by the 1980s, Canadian midwives would become far more organized than they ever were back when they held a virtual monopoly on birth attendance. Associations emerged of midwives and their allies, serving not only as the voice of the profession but also the constituency that

[29] Johnson (2008) points out the inequity of this empowerment, discussing how, just as medicalized childbirth began as a luxury afforded only to the upper classes, so too has refusal of medical intervention in birth emerged as a mark of privilege in contemporary society.

was demanding it. However, midwifery in some provinces would be more organized than in others, affecting how different jurisdictions would go about regulation as well as how physicians perceived the profession and the threat it posed to their own work.

Finally, when doctors first marginalized midwifery they were aiming to extend their professional authority along with medical sovereignty. As mentioned, birth attendance was initially a valuable way for new physicians to reach out to potential clients (Bourgeault, 2006, p. 44). However, by the time of midwifery's re-emergence, doctors were losing interest in attending normal births. Beginning in the 1980s, medical graduates began shying away from obstetrics as a specialty (Bartlett, 2004; Cohen, 1991). At the same time, general practitioners were opting out of birth attendance at an increasing rate, citing time constraints and the increasing complexity of medical birth (Bourgeault, 2006, p. 57; Williams, 1994). Even obstetricians/gynaecologists were increasingly finding the gynaecology side of their work to be far more lucrative, treating obstetrics as a sort of "loss leader" in order to attract and keep patients (Barrington, 1985, p. 156). One major factor in physicians' move away from obstetrics has been the increased value they place on leisure time. Obstetrics is time-consuming, unpredictable work – you never know what time the baby will arrive, but you can be sure it will be inconvenient. The effect of all this is that midwives have become less of a source of competition to physicians and more of an opportunity to download work that doctors do not want to do anyway.

As with medicare, physicians' push to marginalize midwifery once again constitutes an instance of prevailing protectionism in a profession characterized by diverse political views. While many doctors either tolerated or supported midwifery

services, a group of particularly loud voices was able to dominate the conversation around medicalized birth (Bourgeault, 2006, p. 47; J. T. H. Connor, 1994, p. 121). Biggs (1983) describes the ideology espoused by these voices as "patriarchal" (p. 21). It represented far more than an effort to gain financial advantage by restricting competition; by attacking midwifery, these doctors were advancing a view of medical care that pushed away outsider forms of knowledge, medicalized natural female biological processes and privileged interventionism. This represents a direct extension of medical sovereignty. By the time of the practice's re-emergence, the threat to sovereignty was the only real element of concern to organized medicine, as the reality of the Canadian medical landscape has changed such that the direct threat it poses to their livelihood has significantly diminished. As such, midwifery's re-emergence posed a significant threat to sovereignty, but authority was left largely unscathed.

Conclusion

In delineating the history of medicine, pharmacy and midwifery in Canada, this chapter has advanced the objectives of this thesis in three ways. First, it has discussed Canadian organized medicine's history of protectionism; with respect to the emergence and expansion of medicare, physicians' marginalization of midwifery and the long history of competition between doctors and pharmacists, medical organizations have implicated themselves to protect and expand medical dominance. However, this discussion has also noted the emergence of dissenting voices within the profession (Badgley & Wolfe, 1965; J. T. H. Connor, 1994). Moreover, this chapter has discussed significant changes in the profession itself and the political environment surrounding it, most of which began

between the 1970s and 1990s. Medicine is changing as a profession not only in terms of demographics, but also in terms of values and priorities (Canadian Medical Association, 2014, 2018; Crossley et al., 2009). As a result, midwifery no longer poses a particularly significant threat to physician authority (Barrington, 1985; Bartlett, 2004; Bourgeault, 2006). Further, changing political environments leave authority and sovereignty vulnerable to challenge (Csanady, 2016; Marchildon, 2012; Tuohy, 1999). As such, the time is ripe for re-evaluation of whether and when medical organizations protect traditional medical dominance.

Second, this chapter has supported up the proposition put forward in the methodological discussion that midwifery uniquely threatens sovereignty and that pharmacists' prescribing uniquely threatens authority. Two observations support this. For midwifery, the medical profession no longer has a strong economic stake in preserving its monopoly over normal birth attendance, nor do new graduates express an interest in entering this field (Barrington, 1985; Bartlett, 2004; Bourgeault, 2006). For doctors, maintaining jurisdiction over birth attendance is a natural consequence of technological innovation into the field (Oxorn, 1994). Supposedly, it is simply good care to a) minimize risk through a medicalized, interventionist approach, and b) ensure the birth is attended to by somebody formally qualified to perform such interventions. Meanwhile, pharmacists challenge authority by competing for significant shares of traditional medical territory, but they base their claims on the assumptions of medical sovereignty. The two cases are then well-suited to capturing this divide within medical dominance.

Finally, this chapter has laid the empirical groundwork for Chapters 4 and 5, which tackle the substance of my project. Both the pharmacy and midwifery sections

have ended with the global context in which the relevant policy debates took place. Following this discussion, the analysis can move to specific provincial proposals to empower pharmacy and reintegrate midwifery. Neither of these happened simultaneously in all Canadian jurisdictions, and neither is fully realized across the country. Alberta was the first province to dramatically expand pharmacists' scope of practice in 2007, although it had been also talked about in other jurisdictions for many years prior. Many other provinces quickly followed, but thus far none have expanded pharmacists' responsibilities as widely as Alberta. In the case of midwifery, the timeline of re-integration has been even more inconsistent across the country. In 1986, Ontario became the first jurisdiction to announce the profession would be fully legally recognized. Nova Scotia, the most recent province to officially bring midwifery back, did not do the same until thirty years later, and implementation since has been plagued with problems. Other Atlantic Provinces have yet to move on this issue at all.

From here, the real analytical work of the project can begin. Across the four selected provinces, there have been massive differences in how organized medicine has responded to threats from pharmacy and midwifery as they arose. The contrast is striking, and challenges past depictions of medicine's defensiveness. I begin with pharmacy; here, we see that, despite opportunities for cross-coalition learning in some provinces, medicine's core policy beliefs remained intact. The learning that does occur is political, leading to strategic retreat rather than any fundamental reconsideration of medical dominance.

5. Defending diagnosis: Physicians' reactions to expanded pharmacy scope

Discussions of debates around medical dominance typically chalk up any flexibility in medical opinion to political calculus rather than substantive change of core policy beliefs (Bourgeault, 2006; Coburn, 1993; Kelner et al., 2004; Vadeboncoeur et al., 1996). Variation between provinces in the position of organized medicine is thought to occur exclusively out of political learning and strategic retreat, a causal mechanism by which actors back away from policy positions for political reasons; this is in contrast to social policy learning, a mechanism through which actors reconsider their policy goals and beliefs (May, 1992; see also Grin & Loeber, 2006; Hall, 2011; Nilsson, 2005). In these next two chapters, I examine the extent to which this assumption is accurate. I also consider whether organized medicine might respond differently to different kinds of threats to medical dominance, as have been understood by social scientists considering different sources and manifestations of medical power. In my review of the literature, I drew from Willis (1983) to identify three kinds of dominance – autonomy, authority and sovereignty – and threats associated with each. Independent prescribing by pharmacists does not pose a threat to medical sovereignty, as pharmacists adhere to the same medical belief system as doctors (Clark, 1991; Malleck, 2004, 2006). However, it represents a significant threat to medical authority, as it creeps up against a particularly sensitive area of medical competency: the doctor's right to diagnose (Freidson, 1970).

Critical to understanding the pharmacy case is the purported difference between diagnosis and assessment.[30] Interviewees explained that conditions are assessed rather

[30] Assessment is also occasionally referred to as evaluation in interviews and elsewhere.

than diagnosed when they can be chalked up to self-evident symptoms; in contrast, a diagnosis is about identifying and treating an underlying cause (Interview, telephone, Apr. 6, 2017; J-B Trudeau, interview, Montreal, Feb. 8, 2017). Informants identified head lice and common rashes as among the conditions that do not typically require a diagnosis. Whenever pharmacists have been given the power to initiate prescriptions, this power has been ostensibly limited to conditions that require only an assessment and not a full diagnosis. However, some informants argued that even relatively straightforward ailments, such as common rashes, could be presenting as symptoms of something deeper, which a pharmacist would not be qualified to identify (Interview, Edmonton, Oct. 24, 2016; Interview, telephone, Apr. 6, 2017). Moreover, it is not always clear which conditions require assessments and which require diagnoses. For example, Kevin Chapman, Doctors Nova Scotia's Director of Partnerships and Finance and past-Director of Health Policy and Economics, cited haemorrhoids as a minor point of contention, explaining, "I might question how you diagnose haemorrhoids in a pharmacy, but it's on the list [of conditions that can be assessed]" (Interview, Halifax, Apr. 27, 2016). The distinction between assessment and diagnosis is fuzzy; even medical informants who are on balance supportive of expanded pharmacy scope see this as a problem (ibid; Interview, Edmonton, Oct. 24, 2016).

Expanded pharmacy scope also poses a particularly significant threat to medical authority as it directly affects a large number of physicians. Just about every general practitioner's work is affected by what pharmacists can and cannot do. Meanwhile, as we will see in the next chapter, one of the key attributes of the midwifery case is that, even as the medical establishment considered 'natural' birth to be inappropriate care, the rank and

file were increasingly losing interest in obstetrics. While midwifery may be a greater affront to traditional medical philosophy, then, individual physicians are more likely to feel the pinch of expanded pharmacy scope in their everyday work.

This chapter examines organized medicine's reaction to proposals to allow pharmacists to prescribe independently across four provinces: Alberta, Nova Scotia, Ontario and Quebec. Contextual data on the provision of care in each of these four provinces as of 2013 (the closest date to the implementation of these reforms for which data is readily available) can be found in Appendix B, and is referred to occasionally throughout this chapter. Of these four provinces, Alberta and Ontario's physician organizations consistently opposed independent prescribing by pharmacists, whereas medicine in Nova Scotia and Quebec came around to positions of support. However, this chapter finds that these surface-level differences mask substantive agreement on the issue underlying expanded pharmacy scope, as the variation between provinces largely hinges on how closely specific reforms impinge on physicians' diagnostic turf, as well as shifting strategic imperatives. Across the cases examined, organized medicine never actually shifted its opinion on diagnosis; as such, these changes are not a function of social policy learning within the medical leadership, but occur through political learning and strategic retreat.

This chapter begins with Alberta, the 'first mover' province. It is important to note that, in all provinces discussed here, pharmacists began preparing their push for an expanded role many years prior. The events subsequently explored in Nova Scotia, Ontario and Quebec began before anything was finalized in Alberta, limiting opportunities to learn from the trailblazing province. Nevertheless, interviewees

repeatedly bring up evidence from other provinces' experiences with expanding pharmacy scope, demonstrating that order still matters to a certain extent. The chapter concludes with a discussion of what, specifically, explains why medical organizations across these jurisdictions took such disparate positions on independent pharmacist prescribing.

Alberta

Alberta provides a story of a very public clash between organized medicine and organized pharmacy. Here, pharmacists brought forward an ambitious proposal to expand their scope deep into traditional physician territory. Medicine responded in kind, raising significant concerns about pharmacists' ability to take on these new responsibilities. The following paragraphs trace the evolution of the Alberta debate around pharmacy scope from the late 90s to the mid-2000s, drawing from interviews with key informants to elucidate why organized medicine took such a hostile posture to independent prescribing by pharmacists.

In 1999, Alberta passed the latest iteration of its *Health Professions Act,* uniting regulated health professionals under a single piece of legislation and kicking off protracted negotiations about what each profession would now be permitted to do under subsequent regulations (Ruttan, 2005). After years of quiet preparation, in 2002, Barry Cavanaugh of the Pharmacists' Association of Alberta (colloquially known as RxA) made the official public 'ask:' Alberta's pharmacists would seek regulatory authority to prescribe drugs independently, as the organization believed that this would be the logical

consequence of practicing to the full extent of pharmacy training (Canadian Press, 2002; Sinnema, 2006).

Within the pharmacy profession, the most prominent rallying cries for this expansion came not from RxA or the College but from the profession's academic leaders. This is not seen in the other provinces discussed here. An interviewee familiar with the Alberta debate identified Ross Tsuyuki of the University of Alberta as among the chief proponents of a sort of "damn the torpedoes" approach (Interview, Edmonton, Oct. 29, 2016), by which academics turned their attention not only to evaluating policy but also to recommending strategies for how pharmacists might pursue and manage change. Tsuyuki, working with Theresa Schindel, another University of Alberta-based academic, wrote extensively on strategies for reforming pharmacy practice based on Kotter's principles of leading change (Tsuyuki & Schindel, 2008). While the final paper from this effort was published after the Alberta debate had concluded, Drs. Tsuyuki and Schindel had been advocating for this general approach for some time (Tsuyuki & Schindel, 2005). The steps for leading change they outline are strategic rather than research-oriented, essentially resting on the notion that the change itself is already by definition a good idea. The posture from pharmacy was then less open to critical input than some sceptical parties wanted to see (Interview, Edmonton, Oct. 29, 2016; Interview, telephone, Jan. 6, 2017). Indeed, when asked about strategies for convincing physician groups of their objectives, one pharmacy leader involved in the push replied: "We weren't seeking permission...we were seeking to be collaborative, to get their feedback, understand their concerns, see if there could be opportunities to strengthen the process. But we weren't asking if we could do it or not" (Interview, Edmonton, Oct. 27b, 2016).

Looking strictly at the policy that came forward, the pharmacists' confidence paid off. Iris Evans was sworn in as health minister in 2004; the aforementioned interviewee described her as "exceptionally supportive," despite the proposal's relative obscurity (ibid). The regulatory changes announced in 2006, which followed additional legislative amendments to the *Health Professions Act* (Mitzel, 2006), were ambitious; under the new regime, pharmacists would administer vaccines and other injected treatments, refill prescriptions for chronic conditions and, most importantly, independently prescribe for any Schedule 1 medication following additional training (Canadian Pharmacists' Association, 2016; Sinnema, 2006).[31] To this day, no other province in the country has granted the profession such extensive prescription rights (Canadian Pharmacists' Association, 2016).

The College of Physicians and Surgeons and the Alberta Medical Association had two main problems with the proposal, expressed in presidents' letters, a resolution submitted to the Canadian Medical Association and quotes provided to media outlets.[32] Interviewees from organized medicine confirmed these positions in discussions for this project. First, physician leaders publicly doubted pharmacists' ability to diagnose, which they believed was not adequately excluded from the proposed new scope; one physician

[31] This term refers to any medication that requires a prescription (Alberta College of Pharmacy, 2018).

[32] It took the media a few weeks to get a handle on organized medicine's position. Initially, physicians' objections were reported as small and conditional. Kelly Eby of the College said at the time that doctors were "cautiously supportive" of the move, but had concerns over pharmacists becoming "primary prescribers" (Sinnema, 2006). This was not surprising, as the College had adopted a policy against pharmacist prescribing the previous year (Smolkin, 2006). Nevertheless, their position was initially reported by Sinnema as cautious support rather than outright opposition, as there were aspects of the new regime (such as renewals and vaccinations) with which they had no problem at all (ibid). While organized medicine's position did not change, as the debate drew out it became clearer to onlookers that the objection over prescription initiation was not a minor quibble at all, but rather a fundamental disagreement over the centrepiece of pharmacists' new role.

interviewee explained (while admitting he was using hyperbole) that "the medical profession is the emperor of diagnosis" (Interview, Edmonton, Oct. 24, 2016). In an interview, Dr. Lyle Mittelsteadt, who handled this file for the AMA, pointed out perceived holes in pharmacists' training around diagnosis – unsurprising, as diagnosis is at the centre of physicians' own training, and any additional education for pharmacists is unlikely to compare to what physicians undergo in medical school. While technically the new regulations permitted pharmacists to assess and not diagnose, interviewees from all sides – pharmacy included – questioned the distinction between the two concepts (Interview, Edmonton, Oct. 24, 2016; Interview, Edmonton, Oct. 27b, 2016; L. Mittelsteadt, interview, telephone, Jan. 26, 2017).

Alberta physicians were also anxious about the alleged conflict of interest that occurs when a pharmacist sells what they prescribe, as a pharmacist might be inclined to act in their own financial interest rather than in the interest of the patient.[33] Unlike most other healthcare professionals, pharmacists sell products rather than services and work in heavily market-oriented environments. As discussed in Chapter 4, this attribute has been a subject of contention between the professions for over a century (see Malleck, 2004). Here, it once again contributed to physicians' overall negative assessment of independent pharmacist prescribing (Lang, 2006; T.-K. Lee, 2006). Pharmacists brushed off the idea that such qualms outweigh the benefits of greater scope. One pharmacy interviewee remarked, "[the conflict of interest] question's been asked and answered. Now, [critics] may not like the answer, and that's fine, but it's been asked and answered, so stop asking...Any professional that recommends a service, be they an accountant, a dentist, a

[33] The medical profession has its own well-documented history of ethical problems concerning pharmaceuticals (see Chren, Landefeld, & Murray, 1989; Lexchin, 1987).

lawyer or whomever, and then delivers that service, is in a conflict of interest" (Interview, Edmonton, Oct. 27b, 2016). In short, there is little perceived difference between what pharmacists were seeking to do and what a whole swath of other professionals already did. The informant later emphasized that pharmacists would of course be subject to disciplinary processes if they engaged in shady prescribing practices (ibid)

Both the AMA and the College of Physicians and Surgeons were opposed to the proposed new regime (Arrowsmith, 2006; Lang, 2006; T.-K. Lee, 2006). In the summer of 2006, before the new rules were to come into force, they came together to submit the following resolution to the Canadian Medical Association general council:

> The Canadian Medical Association, in conjunction with its divisions and affiliates, without endorsing pharmacist independent prescribing strongly urges the Government of Alberta to require pharmacists who are given independent prescribing authority to:
>
> a) require explicit, informed consent from a patient;
> b) maintain a patient's record;
> c) provide 24-hour availability to the patient;
> d) carry appropriate coverage for legal liability;
> e) disclose any potential conflict of interest as both a prescriber and dispenser of medication; and,
> f) if the pharmacist changes a physician's prescription, advise the physician of the change(s). (Canadian Medical Association, 2006) [34]

The resolution did not initially include the line "without endorsing pharmacist independent prescribing" – that was added in by convention delegates on the floor before they passed it (Smolkin, 2006).

The joint resolution demonstrates the extent to which the AMA and the College were on the same page on the issue. It is hard to find any distinction at all between their

[34] An interviewee familiar with the case recounted that it was too divisive of a motion for the CMA to actually turn into official policy; they could not create the necessary consensus to move it any further (Interview, Ottawa, June 28, 2016).

respective positions throughout the pharmacy debate, even after speaking with medical informants. The only difference in posture was that, according to one interviewee from pharmacy, the College was more resigned to the inevitability of the reforms and was therefore more willing to work to shape how they might be implemented (Interview, telephone, Jan. 6, 2017).

Physician opposition did not lighten up as the debate wore on through 2006 and 2007. Trevor Theman, president of the College, continued to raise concerns regarding diagnosis (Arrowsmith, 2006). The AMA was equally tenacious in its opposition. Even on the eve of the regulation's implementation, AMA president Gerry Kiefer told the *Calgary Herald* that "Physicians remain unconvinced that pharmacists have the education and training for clinical assessment, diagnosis and treatment" (Lang, 2007). Pharmacists continued to give their reasons why they felt the reforms were warranted, and they did not feel that physician support was necessary to move forward. Physicians were not the only ones opposed, however; they had an unexpected ally in the Consumers' Association of Alberta, which shared their concerns around conflict of interest (Sinnema, 2006; Weeks, 2006). While the Consumers' Association did not formally work with physician groups on this file, its interjections added to the debate's confrontational tone, helped physicians avoid being the only dissident voice in the discussion and granted organized medicine an added air of credibility as it was harder to dismiss their criticisms as mere turf protection. In all other provinces explored here, consumer associations had weakened significantly long before pharmacists' scope was on the policy agenda and were totally absent from public discussions.

On April 1st, 2007, the new regulations were eased in over objections from the AMA and the College. Dr. Mittelsteadt believes that fallout has harmed the dynamic between the two professions since – both in terms of the occasional "adversarial approach" that has been taken to discussions at the organizational level, and in terms of individual pharmacists not communicating adequately with physicians when prescribing for their patients (Interview, telephone, Jan. 26, 2017). Physicians have not worked to undo the new regime – with the adoption of the regulations, the debate over the principle of independent pharmacist prescribing essentially ended. However, there was another bout of resistance from doctors in 2012, when the government began to pay pharmacists for these services. The AMA President (Dr. Linda Slocombe at that time) together with the President of the organization's Section of General Practice wrote a piece in the Association's periodical (also submitted to several provincial newspapers), in which they speculated about possible unforeseen costs to the system if pharmacists are unable to spot issues that would have been caught by a physician (Slocombe & Vaida, 2012).

Alberta organized medicine was consistently opposed to granting pharmacists' independent prescribing powers for several reasons, as indicated by interviewees. First, of all provinces studied, Alberta went the furthest with its reforms, opting to allow pharmacists to prescribe any Schedule 1 drug without restriction to certain ailments or conditions. Dr. Mittelsteadt argued that this was in part due to the Progressive Conservative government holding power for so long and feeling they could get away with a more aggressive stance (L. Mittelsteadt, interview, telephone, Jan. 26, 2017). Furthermore, a deeper examination reveals that the proposal was even more ambitious than it might initially appear – not as a result of anything in the regulation itself, but

rather the legal context in which it was and is still situated.[35] Alberta is unique in not listing diagnosis among the restricted activities set out in its *Government Organization Act* (RSA 2000 CH G-10, Sched. 7.1). Prescription initiation is listed, but not the act that it is often regarded as an essential prerequisite for prescribing in more complicated cases (ibid). Interviewees pointed this out as a unique aspect of the Alberta context that gave physicians and other critics extra cause for concern (Interview, Edmonton, Oct. 29, 2016; Interview, telephone, Jan. 6, 2017). Physicians are already inclined to believe that the line between assessment and diagnosis is ether fuzzy or non-existent. In this case, the ambiguity in the overarching legislation meant that using the word 'assessment' to describe how pharmacists treat patients was all but meaningless, more a matter of political expediency than legal necessity. Unlike any other province surveyed here, pharmacy informants in Alberta readily expressed that the line between assessment and diagnosis it not clear, and admitted that they only shied away from the word 'diagnosis' because it was not politically correct or acceptable (Interview, Edmonton, Oct. 27b, 2016; Interview, telephone, Jan. 6, 2017).

Second, Alberta went first. While other provinces were having similar discussions, on the eve of implementation there were no Canadian sources of assurance that the sky would not fall. One interviewee from the federal scene pointed out the surprising lack of research that had been done on this issue before it started being put into practice (Interview, telephone, July 1, 2016). Dr. Mittelsteadt explained that this hindered the medical profession's ability to actually assess the proposal (Interview, telephone, Jan. 26, 2017). Interviewees from the Alberta medical profession, even as they defended their past positions as still valid, admitted that the new regime has not gone as poorly as it

[35] See also the literature on policy layering (Béland, 2007; Thelen, 2004).

could have (ibid; Interview, Edmonton, Oct. 24, 2016). While their initial worries have not entirely abated, the urgency of those worries has somewhat subsided. However, one new criticism has crept up. Physicians now point to what they perceive as the failed promise of collaboration, as independent prescribing has allegedly resulted in a siloed approach to prescribing rather than encouraging teamwork (Interview, Edmonton, Oct. 24, 2016; L. Mittelsteadt, interview, telephone, Jan. 26, 2017). Pharmacists' new role, organized medicine now claims, has not accomplished what it set out to do. This criticism was echoed in some of the jurisdictions discussed later.

Organized medicine's response to pharmacists' claims can also be traced to the latter's initial 'full steam ahead' attitude when it came to pushing for the change, leading to a confrontational environment that was not conducive to cross-coalition dialogue. Interviewees from both parties gave the impression that pharmacists were not as accommodating of physician concerns as we see elsewhere (Interview, Edmonton, Oct. 27b, 2016; Interview, telephone, Jan. 6, 2017) – in Nova Scotia, which will be discussed in more detail in the next section, one pharmacy informant explained that they went to great lengths to ensure that physicians were fully on board with the new regime, and believed that such support was essential to their success going forward (Interview, Halifax, Apr. 28, 2016). Alberta pharmacists' more aggressive posture led to the AMA and the College responding in kind.

Another reason for organized medicine's scepticism, brought up particularly by Dr. Mittelsteadt, is the perceived disconnect between the alleged motivation behind the scope of practice expansions and the Albertan reality. While pharmacists claimed at the time – and interviewees from the profession reiterated in our discussions – that the

reforms were necessary to improve patient access to primary care (Interview, Edmonton, Oct. 27b, 2016), physician informants dismissed that argument, claiming it was more about convenience than anything else. Albertans, they argued, simply were not having trouble accessing drug therapy (Interview, Edmonton, Oct. 27a, 2016; L. Mittelsteadt, interview, telephone, Jan. 26, 2017; see also Appendix B). At the time, Wendy Armstrong of the Consumers' Association argued that pharmacists' claims of access shortages were in fact totally backward, as prescribing of drugs had in fact gotten "out of control" (in Weeks, 2006). For his part, Dr. Mittelsteadt argued that physician supply was not a problem at the time, and that Alberta has since developed an oversupply of doctors. Other commentators, even some not affiliated with pharmacy, disagreed on all counts (Noseworthy & Moulton, 2006). However, later in this chapter other jurisdictions will be presented in which access problems were totally undeniable; as such, the mere fact that they could be up for debate in Alberta weakened pharmacists' argument and granted physician organizations latitude to protect their traditional role.

Those four factors – scope and legislative context of the reforms, timing, pharmacists' attitude and questionable access problems – all pushed physician organizations to oppose prescription initiation by pharmacists.[36] These impacted whether or not physicians believed that the reforms would infringe on their near-exclusive power to diagnose and whether they felt it was necessary to bolster access to drug therapy. This confirms the centrality of diagnosis to medical authority and the dominant medical belief system, but does suggest that physicians elsewhere might support a specific regime to

[36] There is no evidence from these interviews that organized medicine actively coordinated with the Consumers' Association in responding to the prospect of expanded pharmacy scope, or that the Association emboldened physicians in any way. However, the literature on political opportunity would suggest that the presence of such an ally should have also been encouraging to organized medicine (Meyer & Minkoff, 2004; Tarrow, 1998).

allow pharmacists to prescribe so long as it was seen as a) clinically necessary, and b) separate and distinct from diagnosis. Of the four provinces examined, the province that went next chronologically also happens to be the one that provides the most dramatic contrast to the Alberta experience. Doctors in Nova Scotia were by far the most amenable to prescription initiation by pharmacists; the reasons why are explored in the following section.

Nova Scotia

The Nova Scotia debate over pharmacy scope of practice was far quieter than in Alberta, and lacked any major public pushback from organized medicine. As previously discussed, physicians in the Atlantic region have a tradition of behind-the-scenes negotiations with government around fee schedules (Lomas et al., 1992), a tradition that has bled into doctors' general relationship with government. As such, few of the arguments presented by government, physicians or pharmacists received media attention. The analysis of interviews is then particularly important to this case, as it fills critical gaps in the public narrative. Fortunately, informants from all sides were eager to shed light on some of the conversations that took place away from the public eye.

Once again, the push for greater scope of practice started long before the debate became particularly politically prominent. According to a Nova Scotia pharmacist familiar with the discussions, the debate kicked off with the PC government's changes to the *Pharmacy Act* in 2001, which gave pharmacists the legislative authority to prescribe (Interview, Halifax, Apr. 28, 2016; Canadian Press, 1999, 2001; Muir, 2001). However, legislative authority is all but meaningless if it is not accompanied or followed by

regulatory changes. Halfway through the decade, pharmacists' push for such regulations began in earnest, along with legislative amendments to the Act that would allow them to immunize, as well as order and interpret tests (Interview, Halifax, Apr. 28, 2016). Pharmacists worked not only with the bureaucracy, but also with nursing and medicine to ensure that the plan was as non-controversial as possible by the time it reached the public eye (ibid).

When asked about the College of Physicians and Surgeons' initial impression of pharmacy's push, the aforementioned informant admitted, "When they first heard about it, they were uncomfortable...I don't think they thought we would pursue it recklessly, but there was still a lot of discomfort" (ibid). As in Alberta, medical discomfort was particularly strong around the issue of assessing and initiating prescriptions. However, in Nova Scotia, pharmacists actively alleviated these fears and strategically downplayed the significance of the proposed changes. Pharmacy leaders embraced the term 'minor ailments' – a term that pharmacists in Alberta still reject, according to one interviewee (Interview, telephone, Jan. 6, 2017) – and argued that pharmacists already assess patients for certain conditions, but just have to stick to recommending over-the-counter solutions. Interviewees from both sides recall these arguments being quite effective (ibid; Kevin Chapman, interview, Halifax, Apr. 27, 2016).

The association, Doctors Nova Scotia, was also extremely supportive in the end. Generally speaking, DNS does not have a strong tradition of issuing formal policy statements, as Kevin Chapman, Doctors Nova Scotia's Director of Partnerships and Finance and past-Director of Health Policy and Economics, explained (Kevin Chapman, interview, Halifax, Apr. 27, 2016). However, Mr. Chapman indicated that support for

expanded pharmacy scope has been the "implicit if not explicit position of the association" (ibid). While he admitted DNS might question some of the specific minor ailments for which pharmacists would eventually be permitted to prescribe, the association agreed that there was a strong argument to allow for this sort of limited prescription initiation (Kevin Chapman, interview, Halifax, Apr. 27, 2016). Moreover, Dr. Jane Brooks, President of Doctors Nova Scotia in 2010-11, expressed trust that pharmacists recognized the limits of their own scope (J. Brooks, interview, telephone, May 1, 2017).

In early 2010, then-Minister of Health and Wellness Maureen MacDonald unveiled her government's proposal to expand pharmacy practice, which was to include prescription rights, immunization as well as the ordering and interpreting of tests (Canwest, 2010). While legislative authority for the prescription piece had been introduced in 2001 by a different government, the other elements required a new amendment to the *Pharmacy Act* (RSNS 2010, ch. 67). In Nova Scotia, civil society groups and members of the public can speak or submit written comments on proposed legislation to the Law Amendments Committee, a popular venue for groups to publicly air concerns over legislation. Had a similar process taken place in Alberta, it is hard to imagine organized medicine opting out. However, the only submissions on record for the proposed amendments came from the College of Pharmacists and the Pharmacy Association (Nova Scotia Legislature, 2010).

All aspects were approved and/or passed with little controversy at an organizational level.[37] In fact, interviewees recalled that Doctors Nova Scotia took on the

[37] Rollout was slowed down somewhat by rules obliging pharmacies to have private counseling rooms before being allowed to initiate prescriptions (Huras, 2013).

role of selling the changes to members who might be more sceptical (Kevin Chapman, interview, Halifax, Apr. 27, 2016; Interview, Halifax, Apr. 28, 2016; Interview, Halifax, May 2, 2016). For Mr. Chapman, a major part of "trying to stave off physician hysteria" involved bringing up experiences elsewhere in the country to demonstrate that "the sky doesn't fall in" (ibid). He recounted how many physicians approached him with their concerns, but because the medical community in Nova Scotia is so small, they know him well enough to trust him when he says everything is going to be ok; one pharmacy interviewee mentioned him by name as a major help in calming down concerned doctors (Interview, Halifax, Apr. 28, 2016).

Concurrent to the pharmacy debate of 2010 was a significant shift in the relationship between medicine and the government. Maureen MacDonald was the first Health Minister in the province's first NDP government, and recounted a shaky relationship with physicians at the outset. At the time, the President of Doctors Nova Scotia was Ross Leighton, an orthopedic surgeon who Min. MacDonald claimed "didn't have a lot of time for an NDP government." However, by the time the new regulations came down, Dr. Leighton had been replaced by Dr. Jane Brooks, a family physician long active within DNS on policy issues, who also was a major proponent of collaborative care (M. MacDonald, interview, Halifax, May 2, 2016; J. Brooks, interview, telephone, May 1, 2017). Both the former Minister and Dr. Brooks recalled that, at this point, the relationship between the association and the government improved dramatically. The two set up monthly agenda-free meetings where they were accompanied by minimal staff, which went a long way to establishing a trusting relationship (M. MacDonald, interview, Halifax, May 2, 2016; J. Brooks, interview, telephone, May 1, 2017). In our interview,

Minister MacDonald was categorical that in these meetings she heard no opposition to the proposed pharmacy scope expansions, including the independent prescribing piece.

By the following year, the new independent prescribing regulations were fully put into place with little fanfare (J. G. Taylor & Joubert, 2016). For those following the state of Nova Scotia pharmacy, any remaining discussion had been overshadowed by the brouhaha surrounding the *Fair Drug Pricing Act*, a debate that had begun while scope of practice was still being discussed (Canadian Press, 2010; MacDonald, 2011). The attempt to impose a cap on generic drug pricing incensed organized pharmacy; one pharmacy interviewee believes that the NDP government was tainted by their view of pharmacists as "greedy capitalists," although the same interviewee admitted that pharmacies did not particularly help with that impression (Interview, Halifax, May 2, 2016). Minister MacDonald recalled that scope of practice reform was intended to be the "carrot" to get pharmacists onside with the cap, but it was ultimately unsuccessful. The fight quickly became nasty, as pharmacy broke with the typical Nova Scotia practice of going through the bureaucracy to attack the Minister politically (M. MacDonald, interview, Halifax, May 2, 2016).

At the same time, the relationship between organized medicine and the government was better than ever. In a time of severe fiscal crunch, Doctors Nova Scotia voluntarily opened up their contract to stretch scheduled pay increases over a longer period of time (M. MacDonald, interview, Halifax, May 2, 2016; J. Brooks, interview, telephone, May 1, 2017; Canadian Press, 2011a). Dr. Brooks recalled that the government was planning to legislate away some of those increases anyway; however, it was still a tough sell to the DNS membership. Minister MacDonald now feels quite

warmly toward physicians in Nova Scotia, as evidenced by the following excerpt from our conversation:

> My understanding of it is that they're reasonable people, they're very well-educated people, and they're very much committed not only to the healthcare system and what they do but to the province. They're very engaged citizens. A lot of doctors are very civic minded and civically oriented, and I gained a new appreciation and a new respect for physicians as a health minister. It's one of the things that I wouldn't have predicted. (M. MacDonald, interview, Halifax, May 2, 2016)

The most recent development in pharmacy scope in Nova Scotia occurred after the election of the Liberal government that replaced the NDP. In 2015, a pilot project was launched that would see pharmacists paid by the province for certain patient assessments. Despite once again hearing pushback from individual physicians, neither the College nor DNS opposed the initiative (CBC, 2015a, 2015b). Gus Grant of the College acknowledged trepidations about conflict of interest, but felt that such an initiative was "on balance" worth the risk (in CBC, 2015b).

All the way through this policy debate, we see a far more supportive posture from Nova Scotia physicians than we saw from their Alberta counterparts. At first glance, this appears to be a prime example of social policy learning, as the three main facilitators of cross-coalition learning identified in Chapter 2 (Jenkins-Smith et al., 2017; Sabatier, 1988) – the availability of evidence, the presence of brokers and respectful, productive dialogue between actors – are all present here (Jenkins-Smith et al., 2017; May, 1992; Sabatier, 1988). First, with respect to evidence from other jurisdictions, Alberta had already instituted even more dramatic reforms; pharmacists used this experience to alleviate some physician fears about the worst possible consequences of independent

prescribing. Explained Chapman, "Will we see thousands and thousands and thousands of people going to pharmacists for minor ailment prescribing? No, we won't. At least that's not been the experience in other jurisdictions. And interestingly, the pharmacy association...tells us that" (Interview, Halifax, Apr. 27, 2016).

Second, there are two 'brokers' visible in this case. Kevin Chapman is one; one pharmacy interviewee credited him with helping to calm down concerned doctors (Interview, Halifax, Apr. 28, 2016). Dr. Brooks represents another broker. At the time, the leadership of DNS was concerned about its faltering relationship with the government; as such, while Dr. Brooks did not direct DNS policy, she recalled that she had assumed the presidency in 2010 with a mandate to rebuild relationships that had previously deteriorated (J. Brooks, interview, telephone, May 1, 2017). Her relationship with the Minister was a crucial component of this particular policy debate. It is impossible to argue definitively that things would have been different with another president; tellingly, however, Minister MacDonald contrasted Dr. Brooks' overall attitude towards government with her predecessor, who had apparently had a "spectacular row" with the Chief Medical Officer of Health over who was responsible for delivering H1N1 vaccinations (M. MacDonald, interview, Halifax, May 2, 2016).

Finally, the traditional behind-the-scenes policy dynamic of Nova Scotia shone through in this case (see Lomas et al., 1992), facilitating productive dialogue between parties. When asked about goings-on in Alberta or Ontario, subjects from all parties expressed shock that such public clashing was even possible (Interview, Halifax, Apr. 28, 2016; Interview, Halifax, May 2, 2016; J. Brooks, interview, telephone, May 1, 2017). Dr. Brooks argued, "we often hear from Ontario and BC and Alberta, and they have a

much different attitude [than] we do to many things. And it's often honestly taken with a little bit of a grain of salt. We understand where their thinking comes from sometimes but it often doesn't translate to what happens in our province, to be honest...I'm not sure why, it just seems to be a bit of a different culture here" (J. Brooks, interview, telephone, May 1, 2017).

The consequences of this difference in tone are immediately visible. Recall the Alberta pharmacy informant's assertion that they "weren't asking" physicians for their approval, and always planned to press ahead regardless of what the medical establishment thought (Interview, Edmonton, Oct. 27b, 2016). Unsolicited, a Nova Scotia pharmacist expressed the opposite sentiment, saying:

> We really wanted them to be on board, we didn't want them just to grudgingly say "ok," because we knew that if physicians weren't on board when pharmacists actually got the authority and started prescribing there'd be so much pushback it wouldn't be worthwhile. So we really wanted to have them really solidly on board with us, sort of hearts and souls and not just minds (Interview, Halifax, Apr. 28, 2016).

Later in the interview, they elaborated further:

> If it had come to the point where physicians were absolutely dead set against pharmacists prescribing, I just don't think we would have pursued it. Well, we would have kept pursuing it I guess, but it just wouldn't work out there in the real world. I mean, you'd be asking pharmacists to be pissing physicians off every time they prescribe (ibid). [38]

While the interviewee did not suggest that Nova Scotia pharmacists asked doctors' "permission" (to use the Alberta informant's terminology), there was a strong belief expressed here that it would not have been worthwhile to attempt the change without

[38] This sentiment appears particularly prescient in light of Dr. Mittelsteadt's comments about the Alberta debate harming the grassroots physician-pharmacist relationship (L. Mittelsteadt, interview, telephone, Jan. 26, 2017).

organized medicine on board. This is a starting point far more amenable to dialogue than we see in Alberta. It paid dividends for the pharmacists; not only did DNS support their efforts after a long behind-the-scenes discussion, the association actually worked to convince its own membership of the initiative's merits (Kevin Chapman, interview, Halifax, Apr. 27, 2016). As for the College of Physicians and Surgeons, one pharmacy informant recalled that eventually they were actually suggesting new ailments be added to the regulation (Interview, Halifax, Apr. 28, 2016).

However, one should not overstate the amenability of Nova Scotia organized medicine to granting prescription initiation to pharmacists. While we see many of the prerequisites for social policy learning – the availability of evidence from other jurisdictions, the presence of 'broker' figures in Dr. Brooks and Mr. Chapman and the predominance of respectful, constructive dialogue between the parties (see Jenkins-Smith, Nohrstedt, Weible, & Ingold, 2017; Sabatier, 1988) – there is no evidence that doctors actually changed their core policy beliefs on the underlying core policy belief. Specifically, diagnosis again emerges as a line in the sand for doctors; this time, however, organized medicine was satisfied that pharmacy scope would not intrude on this area of traditional medical practice. Dr. Brooks explained, "Is it a slippery slope for pharmacists diagnosing and treating? It doesn't seem to have been. I don't think the pharmacists want that responsibility" (Interview, telephone, May 1, 2017). Dr. Brooks also echoed criticisms that this model is not necessarily "collaborative" and risks further siloing care (ibid). However, on balance she and DNS supported pharmacists' claims.

To be sure, the traditional facilitators of cross-coalition learning matter to this case. However, the type of learning they prompted concerned beliefs not directly

impacting the policy core. For example, even though Alberta's experience demonstrated to Nova Scotia physicians that "the sky doesn't fall in" when prescription rights are conferred to pharmacists (Kevin Chapman, interview, Halifax, Apr. 27, 2016), this is more about the degree of the threat than actually reconsidering medical dominance. Physicians were reassured that their pocketbooks would not be dramatically affected, and were, unlike in Alberta, sufficiently convinced that the expansion would not creep into diagnosis (ibid; J. Brooks, telephone, May 1, 2017). The Alberta reforms also contributed to a certain sense of inevitability around pharmacy scope of practice expansions. Mr. Chapman explained "This is a trend, it's not localized here...We're not lemmings to all go off the cliff, but...other jurisdictions have done this, this is the new model of primary care. We can ignore it, or we can try and understand how it works and then say 'how do we make this work?'" (Kevin Chapman, interview, Halifax, Apr. 27, 2016).

Similarly, while Nova Scotia's policy tradition and culture set 'rules of engagement' favourable for compromise, pharmacists' discourse was focused on strategically framing their proposed changes in such a way that physicians could find palatable. Interviewees argue that, in their conversations with doctors, Nova Scotia pharmacists used terms such as 'minor ailments' and played down the significance of prescription initiation to allay medical fears (Interview, Halifax, Apr. 28, 2016; J. Brooks, interview, telephone, May 1, 2017). This was not a matter of convincing doctors that pharmacists could diagnose; it was a matter of making it crystal clear to physicians that this is *not* what they were aiming to do, and that the change they were proposing would not result in sudden, massive competition from pharmacists (Kevin Chapman, interview, Halifax, Apr. 27, 2016; Interview, Halifax, Apr. 28, 2016).

Informants also point to lack of access to primary care as the 'elephant in the room' throughout discussions on pharmacists' expanded role. This directly affected how physician groups perceived the issue in multiple ways. First, recall how critics of pharmacist prescribing in Alberta brushed off claims of access problems, with Dr. Mittelsteadt even arguing that there is now an overabundance of physicians in his province (L. Mittelsteadt, interview, telephone, Jan. 26, 2017). One cannot say the same thing in Nova Scotia, in which lack of access to primary care, particularly in rural areas, is a major part of public discourse (Doctors Nova Scotia, 2017; Doucette, 2018),[39] which nullifies a major justification for physician opposition. Second, access problems created a situation in which physicians in low-serviced areas, for lack of another option, were instructing pharmacists to take care of their patients while they were out of town. One pharmacy informant explained,

> I think [medical leaders] all recognized that when physicians go on vacation or whatever they always call the pharmacy up and say, "I'm gonna be gone for 3 weeks, can you look after my patients?" It was happening all the time (Interview, Halifax, Apr. 28, 2016).

Another pharmacy informant backed this up, explaining, "Particularly in smaller communities physicians and pharmacists have to work together. They'd both be dead in the water without each other" (Interview, Halifax, May 2, 2016).

Nova Scotia's rural access problems also meant that pharmacist competition was less likely to threaten doctors' pocketbooks. The aforementioned interviewee argued, "[elsewhere in the country], family doctors are feeling a bit under siege, where here

[39] As of 2013, Nova Scotia actually had a relatively high number of practicing physicians, with 133 family physicians and 128 specialists per 100,000 residents in 2017, compared to the national rate of 112 family physicians and 109 specialists per 100,000 residents (see Appendix B; Canadian Institute for Health Information, 2019a). However, this figure is somewhat inflated as the province provides tertiary care to residents of other provinces in the region, and doctors are distributed inequitably across the province (ibid; see also Doctors Nova Scotia, 2017).

there's more than enough work for everybody." Minister MacDonald repeated this sentiment almost verbatim, saying the DNS leadership of the time understood that "there's more than enough work to go around." Doctors were going to be busy anyway; while Mr. Chapman argued that the reforms meant that physicians would give up some of their "loss leaders," he believes that is a problem better solved by changing the pay model than trying to resist something like expanded scope for pharmacists. As such, not only was there little clinical justification for opposing pharmacist prescribing in this context, but the monetary consequences for physicians were less significant than elsewhere.

While Nova Scotia physicians represent the supportive side of the spectrum in this case, there is no evidence of social policy learning within the medical establishment. Rather, physicians were brought around to support pharmacists' expanded scope because a) they felt the new role was still adequately far from diagnosis and would not constitute significant competition to physicians, and b) they saw that the change was coming anyway and opposition would be clinically irresponsible, so it was imperative to get on side. Neither of these constitutes social policy learning. The latter is a textbook example of strategic retreat; doctors saw that the change was imminent and Nova Scotia was experiencing access shortages in rural areas, so it was best to avoid contesting a lost cause (see May, 1992). The former is not necessarily strategic retreat – it constitutes change in how physicians perceived the new regime – but nor does it signal a change in medicine's core policy beliefs. Rather, medicine's shift in beliefs concerned whether pharmacists' limited prescribing would constitute a significant threat to authority in the first place (Kevin Chapman, interview, Halifax, Apr. 27, 2016; Interview, Halifax, Apr. 28, 2016).

In Nova Scotia, the conditions for social policy learning were present; however, pharmacists did not actually push physicians to reconsider their core beliefs. In the end, the medical establishment's position moved out of political learning and strategic retreat, not social policy learning. This stands in contrast to Alberta, in which the change represented a far more direct and explicit attack on physicians' exclusive right to diagnose and medicine stood firm in its opposition (RSA 2000 CH G-10, Sched. 7.1; Interview, Edmonton, Oct. 27b, 2016; Interview, Edmonton, Oct. 29, 2016; Interview, telephone, Jan. 6, 2017). The next two provinces provide additional cases of opposition and support, respectively. We begin with Ontario, a province in which, unlike Alberta, medical opposition has thus far successfully held off significant expansions of pharmacy scope into the realm of prescribing.

Ontario

Ontario organized medicine has a well-earned reputation for adversarial advocacy, with a long history of public clashes with the state (Lomas et al., 1992; Meslin, 1987; Tuohy, 1999). When faced with pharmacists' claims for greater scope of practice, this reputation held true. Organized medicine's statements and reasoning are often reminiscent of what the Alberta medical establishment put forward prior; however, the Ontarian medical leadership took a distinct path to this opposition, one that reflects the internal politics of the rather large and unwieldy Ontario Medical Association.

As was the case across the country, broad discussions around an expanded role for Ontario pharmacists began long before any new legislation or regulations came down. According to one pharmacy interviewee, when they began talking with physician

organizations behind the scenes in the mid-90s they were met with a rather hostile reception (Interview, telephone, Apr. 6, 2017). With time, the medical establishment's posture softened; however, there remained a line in the sand around independent prescription initiation. When the governing Liberals publicly floated the idea of expanding pharmacy scope in 2008 (after the Alberta reforms had already been implemented), prescription initiation figured prominently in media discourse (J. Hall, 2008; Puxley, 2008). This piece of the debate provoked particularly strong ire from physician leaders. The president of the Canadian Medical Association at the time was Dr. Brian Day, a notoriously outspoken advocate for private practice with strong traditionalist opinions on a wide range of medical issues – including professional roles. Stressing pharmacists' alleged inability to diagnose, he argued bluntly "To say this is an answer to the doctor shortage is ludicrous. The answer to a shortage of doctors is to produce more doctors" (in Puxley, 2008). Dr. Ken Arnold, president of the OMA at the time, concurred, claiming that to allow "corner-store" pharmacists to prescribe would be akin to setting up "lesser levels of health care" (in Hall, 2008).

The Ontario Pharmacists' Association was eager to demonstrate that the medical establishment was out of step with the public, sponsoring a poll which suggested a large majority of Ontarians supported an expanded role for pharmacists (Ontario Pharmacists' Association, 2009a). Specifically, 86% of those surveyed said that they would personally visit a pharmacist to assess and advise on medication for a minor ailment (ibid). However, the medical leadership held firm, voicing the now-familiar concerns about diagnosis and siloed care that physicians find so troublesome (J. Hall, 2008; Puzic, 2009). While Dr. Arnold stressed the need for sufficient training with respect to diagnosis, he

suggested that even that would not be enough to change his opinion, telling the Windsor Star, "I suppose our feeling would be, if you're going to do all that training, you might as well do it all and become a doctor" (in Puzic, 2009). Before legislation had even been brought forward, then, the respective positions of organized medicine and organized pharmacy were all but incompatible. Moreover, physicians expressed their views publicly, a stark contrast to the Nova Scotia case that is well in line with the traditional confrontational dynamics of Ontario medical politics (Lomas et al., 1992; Tuohy, 1999).

Legislative authority for expanded pharmacy scope came in May of 2009, in the form of the *Regulated Health Professions Statute Amendment Act* (Government of Ontario, 2009). This was a massive piece of omnibus legislation that affected numerous other professions, all in the name of addressing an alleged physician shortage (Toronto Star, 2009a). For pharmacists, it granted the authority to prescribe any drug set out in the still-to-come regulations, along with ordering tests and extending, adapting or adjusting prescriptions (ibid; see also Ontario Pharmacists' Association, 2009b). However, from the beginning the government's plan was to initially limit subsequent regulations for prescription initiation to smoking cessation drugs (Ontario Pharmacists' Association, 2009b). This was a far cry from the dramatic authority granted to pharmacists in Alberta, or even the more limited 'minor ailment' prescribing we see in Nova Scotia. As well, the Act represented a bit of give-and-take for pharmacists, as it granted nurses the legislative authority to dispense medication, an intrusion on pharmacists' traditional territory (ibid). One pharmacy interviewee points out that, as a result of this trade off, some pharmacists were quite unhappy with what came forward (Interview, telephone, Apr. 6, 2017). That being said, the OPA publicly expressed measured approval. In a press release, OPA CEO

Dennis Darby commented, "this legislation would bring Ontario one step closer to using pharmacists to the best of their abilities" (ibid) – while pharmacists may not have gained everything they would have hoped for, the plan represented an historic breakthrough and laid the foundation for potential further regulatory expansions.

The OMA's response to the legislation was unenthusiastic, if not actively hostile. The association acknowledged the problems Ontarians were having accessing physician services, particularly GPs, but believed that any scope of practice reforms should go hand in hand with hiring more doctors (Toronto Star, 2009b). In a press release, then-president Dr. Mark MacLeod argued that, prescription initiation aside, even the authority to extend, adjust and adapt prescriptions could fragment care rather than foster true collaboration (Ontario Medical Association, 2009). Nevertheless, the association did not officially oppose the proposed changes on balance, instead publicly voicing concerns about certain aspects – perhaps unsurprising, as prescription initiation for anything other than smoking cessation drugs had been taken off the table.

While the OMA's official position was measured, the Association's size and complexity bred a certain inconsistency in tone. Its right hand did not always know what its left was doing. The OMA is composed of several sections, each representing a different subset of physicians that operate autonomously and are large enough to have significant resources at their disposal. One of those, the Section on General and Family Practice (which represents GPs, a huge chunk of the OMA membership), has a reputation for combative political activism. In late 2009, its chair, Dr. David Bridgeo, lashed out at the proposed legislation, saying, "Having these roles filled by non-medical personnel is like having a member of a flight crew fly an airplane... How many people would be

comfortable with having someone with less education, training and experience replacing pilots?" (Metro, 2009). The Section followed up these comments with an ad in *Maclean's*, which featured a sketch of a person's face peering fearfully through their fingertips.[40] The ad proclaimed,

> "Doctors, and doctors alone, have years of education in both diagnosis and treatment...Allowing pharmacists to prescribe certain medications may seem convenient, but do they have the training in diagnosis and examination to do this properly? By both prescribing and selling medications, isn't there a risk of conflict of interest and a potential risk to patient safety? Wouldn't you be more comfortable with a doctor overseeing your care?" (Section on General and Family Practice, 2009)

The SGFP's campaign ultimately undermined the OMA's approach, resulting in significant public backlash and harming the association's relationship with government and other professional groups. One interviewee from organized medicine acknowledged, "[the ad] was actually a disaster...It was very bad for the OMA's credibility" (Interview, Toronto, May 19, 2016). Mr. Darby, in an interview for this project, reflected on his organization's response to the ad, saying, "We met with the OMA at that time and they said that section is allowed to do its own PR...They're members of OMA but [the OMA doesn't] control them, so they were able to do their own thing" (Interview, Toronto, May 19, 2016). However, public confusion about the Section's autonomy tied the OMA to its rhetoric – for example, one headline attributed the "fly a plane" comment to the OMA as a whole (Metro, 2009).

Following this blowup, the debate simmered for just over two years while regulations were drafted – a significant undertaking given the breadth of the Act. In early 2012, before regulations were announced, the Commission on the Reform of Ontario's

[40] A copy of this advertisement is available in Annex A.

Public Services released a report with 105 wide-ranging recommendations on the organization and delivery of healthcare in Ontario (Commission on the Reform of Ontario's Public Services, 2009; Talaga, 2012). Section 5-94 recommended that pharmacists be permitted to initiate prescriptions for select minor ailments, a step that the government had not initially intended to take (Commission on the Reform of Ontario's Public Services, 2009). The OPA highlighted this recommendation, saying in a press release,

> Ontarians would also benefit greatly if pharmacists were enabled to prescribe for select minor ailments, as recommended in section 5-94 of the report. In many circumstances patients seek advice, assistance and treatment of self-limiting ailments like skin rashes or eye infections. The report recognizes the triaging role that pharmacists can play in assessing such conditions, and if still unresolved, in referring patients to a physician or nurse practitioner (Ontario Pharmacists' Association, 2012a).

However, when new regulations were finally proclaimed the following October, the government stuck to its OMA-friendly plan to exclude minor ailment prescribing and restrict prescription initiation to smoking cessation drugs. While the OPA welcomed the expansion, the organization was quick to make known that the conversation around pharmacists' role had only just begun, and that they would continue pushing for independent prescribing rights for minor ailments despite medical opposition (Ontario Pharmacists' Association, 2012b). Mr. Darby leaned on other provinces' experiences when making this argument, explaining, "In Saskatchewan and Nova Scotia for example, pharmacists provide counseling and prescriptions for minor ailments... it could be cold sores, or it could be a yeast infection, it could be poison ivy...We're not there yet but we're on the way" (in Artuso, 2012). Meanwhile, France Gélinas, an NDP MPP and

prominent critic of the OMA, took a harder line, alleging that "pharmacists will continue to be on the margins" under the new regulations (in Leslie, 2012). For its part, the OMA reiterated its stance of cautious support, with then-president Dr. Doug Weir commenting, "It is important that when health care professionals take on new roles and responsibilities, we also improve lines of communications between providers, training opportunities and monitoring practices to ensure that the quality of care, patient safety and continuity of care are all enhanced" (in Adam, 2012).

A pharmacy interviewee noted that, unlike elsewhere in the country, Ontario's College of Pharmacists did not really push for independent pharmacist prescribing, that charge being instead led by the OPA (Interview, telephone, Apr. 6, 2017). Professional colleges and associations normally interact on their own distinct 'planes;' whenever I asked about relationships with other professions, interviewees from associations tended to refer more to their association counterparts, and interviewees from colleges spoke more about the other regulatory bodies. As such, it is little surprise that, since the Ontario College of Pharmacists was not particularly involved in any push, the College of Physicians and Surgeons of Ontario was not particularly active in organized medicine's response.

Ontario still has not approved independent pharmacist prescribing beyond drugs for smoking cessation, nor has the OMA changed its policy on the matter. One informant explained that this sort of OMA policy is responsive rather than generative; the association does not re-examine positions like this until events in the province prompt such a reconsideration (Interview, Toronto, May 19, 2016). As such, the association's *de jure* position is unlikely to change until there is another proposal on the table.

The reasons behind this posture are diverse. First, as was the case in Nova Scotia and Alberta, medical concerns about diagnosis and siloed care came up in interviews. Argued one medical informant, "if you're making it sort of less and less necessary for a patient to see a primary care provider, then aren't you really just siloing care more, so that [patients] just go to their pharmacist now?" (Interview, Toronto, May 19, 2016; see also interview, May 4, 2016). In the same discussion, regarding diagnosis, they explained,

> "Technically in legislation the controlled act is communicating a diagnosis. It's kind of semantics, but physicians feel that that is a specific set of skills that obviously you get through medical training... [Physicians' concern is] that if you skip that step and allow an individual to treat a minor ailment, then you run into concerns. Then you run into trouble." (Interview, Toronto, May 19, 2016)

As in Alberta, Ontario physicians also engaged in arguments over how serious 'access issues' really were at the time. Access, specifically access to primary care services, was a major component of how the Ontario government framed its *Regulated Health Professions Statute Amendment Act* (Government of Ontario, 2009; Toronto Star, 2009a). The same argument was employed by the pharmacists to push for independent prescription initiation. Mr. Darby explained that they tried it directly with physicians in an attempt to convince them that pharmacists were not about to steal their business, saying, "If they're overworked and their office is full all the time anyway, wouldn't it be better to deal with the more complex or the harder-to-deal-with patients?" (D. Darby, interview, Toronto, May 19, 2016). However, informants contended that physicians and other resistant parties remained unconvinced that there really was such a need (Interview, Toronto, May 19, 2016; Interview, telephone, Apr. 6, 2017). One pharmacy interviewee,

personally sceptical of independent prescription initiation, speculated that they might see the value in jurisdictions with physician shortages, but that this was not the situation in Ontario (Interview, telephone, Apr. 6, 2017; see also Appendix B).

The other factors brought up by Ontario interviewees are unique to the province. Even though the outcome (medical opposition) was broadly the same as we saw in Alberta, many of the circumstances leading up to it were quite different – confirming, as indicated in the methodological discussion, that similar outcomes might be produced by different factors, a phenomenon called equifinality. First, unlike in Alberta, Ontario medical organizations did have the ability to look to other jurisdictions' experiences in evaluating independent prescribing by pharmacists. Indeed, their resistance on this issue continues to this day, even as their colleagues across the country have long given up the fight. This is not unusual – Ontario medical politics have long been marked by a certain insularity from other medical groups across the country. Mr. Darby refers to a general "wall around Ontario," one that prevents policymakers in the largest province from learning from others' experiences (D. Darby, interview, Toronto, May 19, 2016). When asked about the influence of other medical organizations on OMA policy, one medical informant responded, "the OMA is a bit bigger, it has a very large staff, it has a lot of resources, so I think there's a feeling that it can take a deeper dive on these issues" (Interview, Toronto, May 19, 2016). This is essentially the inverse of strategic retreat – the OMA was emboldened by its strategic position and resources to take a more hard-line position.

This insularity is, in part, a function of the OMA's broader culture and tradition of adversarial engagement with the state (see Meslin, 1987; Tuohy, 1999), which affected

how interviewees perceived and described its political action. For some, this meant freely using the word 'union' in a way that interviewees in Nova Scotia and Alberta did not (F. Gélinas, interview, Toronto, May 19, 2016; D. Darby, interview, Toronto, May 19, 2016; Interview, May 4, 2016). Mr. Darby, while quite diplomatic in his criticism overall, said of the OMA's opposition to pharmacist prescribing, "they pushed back on us, but partially because as a union that's what their members expect them to do, right? To protect their scope of practice" (D. Darby, interview, Toronto, May 19, 2016). An informant from organized medicine explained further, "[The OMA is] very aware and conscious of the fact that it represents every single physician in the province...So I think that there's definitely a drive to make sure that members know their association is advocating for them" (Interview, Toronto, May 19, 2016). This is accomplished in large part through advertisements, which are as much aimed at physician members as they are at the public in a bid to keep the membership aware of and happy with the organization's advocacy work (ibid).

The confrontational dynamic described above was exacerbated by the OMA's tendency to fracture; as described by one physician the organization has historically been a little unwieldy (Interview, telephone, July 7, 2016). Whether fending off attempted leadership coups (K. Connor, 2017) or dealing with splinter groups (Doctors Ontario, 2013), the OMA has long felt the fallout of a large, diverse and politically-active membership. Indeed, even as she criticizes the OMA, France Gélinas was quick to say that the organization should not be confused with the broader, more ideologically varied medical profession (F. Gélinas, interview, Toronto, May 19, 2016). In this case, the OMA was itself undermined by its more traditionalist wings. One medical interviewee,

describing the SGFP ad, commented, "it's as much of, I think, a failure on the part of the OMA as it is anybody, the fact that [the Section] clearly didn't feel that they were being heard sufficiently" (Interview, Toronto, May 19, 2016). The same informant noted that this opposition from the SGFP "muted everybody else," effectively replacing the OMA's position as the most immediately visible comment from organized medicine on the matter (Interview, Toronto, May 19, 2016).

In Ontario, the same concerns about pharmacists' prescribing emerged as seen in Nova Scotia and Alberta. In Nova Scotia, we saw a case in which local conditions overrode those fears. Nova Scotia's doctors also began to see the change as a trend emerging across the country, as a result of the experience of provinces that had acted prior (Kevin Chapman, interview, Halifax, Apr. 27, 2016). Ontario physicians had access to the same information as did their colleagues in Nova Scotia and all other provinces who followed Alberta's example on pharmacy scope. However, the association's size and adversarial history encouraged it to continue resisting, even as the efforts of their colleagues elsewhere failed. Thus far, Ontario medicine has been successful in its efforts to ward off this threat to their authority.

It is also notable that the forcefulness of Ontario doctors' opposition stemmed in part from internal discontent and lack of communication over how to proceed. While Ontario's doctors were ultimately successful in stopping pharmacists from prescribing anything other than smoking cessation drugs, their advocacy was not without hiccups. The SGFP's ad in particular backfired on the profession, with one medical informant describing it as a "disaster" (Interview, Toronto, May 19, 2016; see also Interview,

Halifax, Apr. 28, 2016). While the OMA has won this particular fight, the informant explained that the association has not emerged entirely unscathed.

We turn now to Quebec, the final province examined for this policy case. Given Quebec's reputation as a site of strong mobilization from organized medicine (Lomas et al., 1992; Lowry, 1994; Tuohy, 1999), we might expect another story of forceful, public opposition. However, in this case Quebec doctors found themselves at the opposite end of the spectrum, expressing support for expanded pharmacy scope.

Quebec

In Quebec, commentators have repeatedly observed that all associations, including those representing physicians, openly stand up for their members' financial interests in a way not seen elsewhere across the country (Lowry, 1994; Vadeboncoeur et al., 1996; Interview, Ottawa, Oct. 18, 2016; Interview, Laval, Nov. 15, 2016; Interview, Montreal, Nov. 17, 2016). However, that does not mean we can automatically expect doctors' groups here to oppose independent pharmacist prescribing. Within such a dynamic, compromises and strategic mistakes can temper how organized medicine responds to perceived threats. This is precisely what happened in the case of expanded pharmacy scope, as the Quebec dynamic produced a more nominally amenable medical profession than its reputation may have forecasted.

Who exactly is 'organized medicine' in this case? Quebec is home to a more formally fractured medical profession than elsewhere in Canada, seen most clearly in the separation between the FMOQ and the FMSQ. It is the Fédération des médecins omnipraticiens du Québec that is important to this case, as pharmacy scope infringes

almost exclusively on GPs' traditional territory and is of little concern to the specialists. A federation of regional associations, the FMOQ is the recognized bargaining agent for the province's general practitioners, gaining the Rand formula before any other medical organization in Canada (M. Martin, 1992). A few distinguishing features of the FMOQ should be noted here. First, Quebec is the only province in which the recognized medical bargaining agent is not the provincial CMA affiliate – as a result, as one informant at the federal level described, the CMA has an embarrassing lack of representation in Quebec (Interview, telephone, July 1, 2016; Lowry, 1994; Martin, 1992). The FMOQ also has never had an aversion to the word 'union.' While this is partially due to the more palatable sound of 'syndicat professionel' in French (Lowry, 1994), it also represents an acknowledgement from the get-go that the FMOQ protects physicians, one that we do not see expressed by any other medical association studied here. Finally, unlike in other provincial medical associations where the president turns over annually, the presidency of the FMOQ is a longer-term position, allowing the incumbent to put their own stamp on the organization (ibid). The current president, Dr. Louis Godin, has held the position since 2007, spanning the entirety of the formal debate around pharmacy scope.

The Association québécoise des pharmaciens propriétaires is another unique piece of the Quebec professional landscape. In Quebec, only pharmacists may own individual pharmacies, even if those pharmacies are tied to a chain (Association québécoise des pharmaciens propriétaires, 2013a). Pharmacists' political representation is then divided between the AQPP, which represents owner-pharmacists and the Association des pharmaciens des établissements de santé, which represents hospital pharmacists. The scope of practice expansions discussed here were mostly of concern to the AQPP.

The story of expanded pharmacy scope in Quebec begins with *loi 90*, which was introduced in 2002 to expand the scope of practice of several health professionals (Gouvernement du Québec, 2002). The law, which came fully into force in 2003, allowed pharmacists to adjust drug therapy, evaluate patients and prescribe emergency oral contraceptives (Pharmacy Post, 2003). Diagnosis, however, would legally remain the sole right of the physician (ibid). Given the frenzy that surrounded the legislation and the major changes won by other professional groups, one nursing informant expressed surprise that the pharmacists did not take this opportunity to push for more, saying "We got nurse practitioners, but they did not negotiate for anything. Instead, they began to negotiate ten years too late" (Interview, Ottawa, Oct. 18, 2016, translation mine). Even four years later, when the debate was heating up in Alberta, Quebec's pharmacists held off on pushing for these powers, preferring to focus their efforts on other matters (Weeks & Carroll, 2006).

When legislation further expanding pharmacists' prescribing abilities was finally announced, pharmacy scope was alone under the microscope. *Loi 41*, which was unveiled in November 2011, granted pharmacists prescribing rights in cases where a diagnosis has already been provided (Gouvernement du Québec, 2011). The bill also allowed pharmacists to renew prescriptions; however, it withheld the power of vaccination, which had been a fixture of similar legislative projects elsewhere in the country (Fédération des Médecins Omnipraticiens du Québec, 2011; Canadian Press, 2011b). Unlike the other provinces studied here, in Quebec interviewees recalled that the biggest opponents of this bill were nurses, represented by the Ordre des infirmières et infirmiers du Québec (Interview, Ottawa, Oct. 18, 2016; Interview, Laval, Nov. 15, 2016). In a press release,

the Ordre said that properly integrating pharmacists' new powers was "incomprehensible," and that government's focus should instead be on enhancing nurses' prescribing powers (Ordre des infirmières et infirmiers du Québec, 2011, translation mine). One nursing informant explained that the relationship between the two professions at the time was strained (Interview, Ottawa, Oct. 18, 2016). The OIIQ was upset that pharmacists had previously opposed expanded prescribing rights for nurse practitioners, as nurses believed they had a more legitimate claim to prescribing than did pharmacists (ibid).

The nursing profession did not, however, have a reliable ally in organized medicine. The Collège des médecins, through a joint committee with the Ordre des pharmaciens, had been intimately involved in crafting the legislation. Dianne Lamarre, president of the OPQ, extolled the bill as the "fruit of a unique and unprecedented collaboration between pharmacists and doctors" (in Leduc, 2011, translation mine).[41] The FMOQ was also on board; even before the nurses had issued their statement, the organization declared that it was essentially comfortable with *loi 41*, saying "We are satisfied that the government has essentially taken into account our legitimate concerns in drafting the legislation in that the pharmacists will not be given the power to vaccinate and will only be allowed to prescribe for patients not requiring a new diagnosis" (Fédération des Médecins Omnipraticiens du Québec, 2011, translation mine; see also L'Actualité Pharmaceutique, 2012). The first point here is only tangentially important to the research question, but nevertheless speaks to the nature of the FMOQ. No other medical association studied here, not even the infamously confrontational OMA, drew a line in the sand around injecting vaccines. For Kevin Chapman in Nova Scotia, physician

[41] The Office des professions was also involved in the creation of the legislation (Richer, 2011).

concerns around vaccination were mostly traceable to potential lost income, and, while certainly worth addressing via payment reform, should not override the public health imperative of increasing immunization rates (Interview, Halifax, Apr. 27, 2016).

The FMOQ's views on pharmacists' purported conflict of interest, as expressed by one medical interviewee, also reflect a more explicit protection of interests than seen elsewhere in the country. Rather than comment on any danger to patients, the informant expressed that GPs in Quebec would also like the legal right to sell what they prescribe – "why does [the pharmacist] not have a conflict of interest, when I have one?" the informant mused (Interview, Montreal, Nov. 17, 2016, translation mine). Indeed, shortly following the expansion of pharmacy scope, the FMOQ began pushing for this right as well (Papin & Leduc, 2013).

The FMOQ's apprehension regarding diagnosis is more in line with what came up elsewhere in the country. However, the Quebec legislation is unique in making explicit reference to the exclusion of diagnosis, which, as the association confirmed in its statement, helped overcome those initial concerns (Fédération des Médecins Omnipraticiens du Québec, 2011). The FMOQ's rhetoric here does not come off as particularly enthusiastic; the GP association simply pronounced itself "satisfied" while emphasizing that only doctors could diagnose (ibid, translation mine). It gives an air of cautious approval, all the while reiterating the associations' disapproval of some of the arguments made by the Ordre des pharmaciens in the past. Interviewees recalled that there were indeed serious reservations within the medical community about the bill – but, in the end, the FMOQ statement declared (and informants confirmed) that its relatively scaled-back nature, especially compared to what some pharmacists might have preferred,

proved adequately convincing (ibid; Interview, Laval, Nov. 15, 2016; Interview, Montreal, Nov. 17, 2016; J-B Trudeau, interview, Montreal, Feb. 8, 2017).

With the strong support of the opposition in the National Assembly (Aile parlementaire du PQ, 2011), *loi 41* easily passed less than two months after it was introduced. However, the road forward was not as smooth as the consensus over the initial bill might have us believe. Unlike the other jurisdictions studied here, compensation for pharmacists in Quebec was discussed concurrently with the regulatory framework. With the continued collaboration of the Collège des médecins, the regulations were finished in 2012 (Cabinet du ministre de la santé et des services sociaux et ministre responsable des aînés, 2012; Leduc, 2012); however, they would not enter into force until a final agreement on payment had been reached with the AQPP. These negotiations dragged on, as the government, regardless of political stripe, did not want to pay pharmacists for every individual act allowed under the regulations (Association québécoise des pharmaciens propriétaires, 2012, 2013b; Canadian Press, 2013).

While this was mostly a debate between the government and the AQPP, the FMOQ did comment in 2014 that if pharmacists were going to be paid for prescription-related activities, physicians should be similarly compensated (Rémillard, 2014). Indeed, a government informant indicated that a major contributor to the province's concern about paying pharmacists for these powers was that Quebec might be obligated to similarly compensate physicians (Interview, Montreal, Nov. 16, 2016). However, one medical informant revealed (and informants from government and pharmacy corroborate) that this was not exactly a priority for the GP association (Interview, Laval, Nov. 15, 2016; Interview, Montreal, Nov. 16, 2016; Interview, Montreal, Nov. 17, 2016). While

the negotiations dragged on until 2015, the culprit was not medical opposition but repeated changes in government, as the debate spanned over the short-lived PQ minority of 2012-14. A government informant expressed their "firm" belief that the pharmacists were essentially hedging their bets during the 2014 election campaign, holding out on finalizing a deal with the PQ to see if they might get a better one if the Liberals were elected (Interview, Montreal, Nov. 16, 2016, translation mine). This period of political instability also brought two key players from the health professions into government; Diane Lamarre, who had been president of the Ordre des pharmaciens, was elected as a PQ MNA in 2014, while Gaëtan Barrette, who had headed up the FMSQ, was elected that same year and became the new Liberal government's Health Minister.[42]

After an agreement on payment with the Liberal government was finally reached, pharmacists began using their new powers in mid-2015 (Ordre des pharmaciens du Québec, 2015). While a long and sometimes difficult process, the Quebec government had successfully introduced independent pharmacist prescribing without pushback from either the Collège des médecins or the FMOQ. The lack of overt resistance in Quebec is perhaps unexpected given that the dynamic of the health professions policy community is more confrontational than what we saw in Alberta or even Ontario. As mentioned at the outset of this discussion, the FMOQ has always served as an unabashed union for GPs. Today, with the proliferation of the Rand formula among most CMA affiliates (see Archibald & Jeffs, 2004), the FMOQ is no longer an exception in this regard; however, we still see a greater comfort with the label among all Quebec interviewees.

[42] The Premier following that election, Philippe Couillard, was also a physician, having moved into politics in 2003.

Commentators have frequently observed that organized medicine in Quebec tends toward more explicit interest protection than seen elsewhere in the country (see Lomas et al., 1992; Lowry, 1994; Montpetit & Coleman, 1999; Tuohy, 1999). Informants for this project also indicated that, while regulatory colleges now typically work well together in the province, professional associations often clash due to competing interests (Interview, Laval, Nov. 15, 2016; Interview, Montreal, Nov. 17, 2016; J-B Trudeau, interview, Montreal, Feb. 8, 2017). One medical interviewee argued that the strong "political project" of Diane Lamarre at the pharmacy college also strained relationships on that front for a time (Interview, Montreal, Nov. 17, 2016). So why then did both the CMQ and the FMOQ support *loi 41*? The most obvious reason is the categorical exclusion of diagnosis from pharmacists' new role, which significantly lessened the threat to authority. Dr. Jean-Bernard Trudeau of the CMQ recalled how pharmacists assured him that they were not interested in diagnosing (J-B Trudeau, interview, Montreal, Feb. 8, 2017). However, this was not done simply to please physicians. Recall how in Alberta diagnosis was absent from the province's list of restricted activities, fuelling cynicism about the practical difference between diagnosis and assessment. Quebec represents the opposite extreme. After expressing his personal trust that the diagnosis-assessment distinction is clear in Quebec, Dr. Trudeau explained:

> The sole person who can deliver a diagnosis in Quebec is the physician[43] ...Why? Because the way in which we have defined diagnosis in Quebec is such that the person who delivers a medical diagnosis must be able to perform a differential diagnosis.[44] To

[43] A more limited 'nursing diagnosis' also exists, but is treated as a distinct concept. The Collège des médecins has recently approved expansions in nurse practitioners' power to diagnose in Quebec, but the previous Minister of Health speculated that the only way the Collège would approve such a move is if the Minister had threatened to legislate (Valiante, 2019).
[44] That is, a diagnosis that distinguishes between two ailments presenting similar signs or symptoms.

> perform a differential diagnosis, one must be capable of evaluating all systems of the human body (J-B Trudeau, interview, Montreal, Feb. 8, 2017, translation mine).

For Trudeau and the Collège, this provided a far thicker barrier between medical and pharmacy professional scope than what was present elsewhere in the country, particularly Alberta. The relative comfort of physicians with *loi 41* then stemmed in part from the already-existing legislation in which the bill was situated.

The language of *loi 41* alone was not enough to overcome physician anxiety, however. Dr. Trudeau recalled how, after being named secrétaire adjoint in September of 2011 (before the bill was formally announced), he was immediately asked to take on the pharmacy file as there was a lot of tension on that front. Pharmacists had been pushing for an expanded role, and doctors knew that change was imminent. Dr. Trudeau recounted that, after holding meetings between the professional colleges and gradually establishing a relationship of mutual trust, the Collège became convinced that pharmacists could indeed do more (ibid). He himself had experience with the Canadian Medical Association, and was familiar with other provinces' experiences on this front. He knew that Quebec was lagging behind (see also Labrie, 2015; Weeks & Carroll, 2006). Dr. Trudeau also recalled how, at this point, the Quebec government had decided to bring in a broader pharmacy scope regardless of what doctors thought; the CMQ then felt that it would be better to show support in order to get a seat at the table in shaping the new regime (ibid). All of this brought the Collège to a position where they felt comfortable collaborating with the OPQ to develop the new regime.[45] In the end, the organization not only was intimately involved in the crafting of the legislation and regulations, but also

[45] The shift within the Collège to a more collaborative approach had been characterized as a "new guard" (Leduc, 2011a)

helped create guidelines for the new activities and secured representation on a watchdog committee set up to monitor the regime (Whittom, 2013).

The FMOQ by all accounts was much more reluctant. Recalls Dr. Trudeau, "with the [FMOQ], we tried to make them understand that it would be better to negotiate, but they found that difficult" (translation mine). The FMOQ did eventually get onside and, according to Dr. Trudeau, had a representative for negotiating the regulations following *loi 41*. However, whether or not this was a strategically astute decision is controversial. One medical informant revealed that the FMOQ leadership was unhappy with the final result. Calling the legislation itself a "smokescreen," they argued that some of the concurrent modifications to the *Loi médicale* placed in pharmacists' hands the right to prescribe in cases that, "for the FMOQ, appeared to require a diagnosis" (Interview, Montreal, Nov. 17, 2016, translation mine; *Loi médicale* chapter M - 9, a. 19, 1er al., par. b, 2013). Even if the legislation states that no pharmacy diagnosis shall be permitted, what exactly that entails is open to interpretation. The informant described the FMOQ as "completely against" the more liberal interpretation of what can be prescribed without a new diagnosis (ibid). The same interviewee also expressed dismay that immediately after the law passed, pharmacists started advertising that they could prescribe – this revealed, in the informant's opinion, the true intent behind *loi 41*, one that had been hidden from physicians (ibid).

The final piece to consider in the Quebec context is the population's access to primary care. As in Nova Scotia, Quebec pharmacists put forward the argument that physicians would not lose patients under the new regime because there is plenty of work to go around (Interview, Laval, Nov. 15, 2016); indeed, while Quebec is around the

Canadian average with respect to doctors per capita, physicians are inequitably distributed across the province, and as of 2013 15% of the population reported having no regular doctor or place of care – a rate far exceeding the Canadian average (see Appendix B). However, this was perhaps less important to physicians' eventual support than was how their hypothetical opposition might have been perceived by the public. Calling access to primary care a "major problem," one informant argued that the pressing need for improvement on that front precluded any significant physician resistance to *loi 41* when it was introduced in 2011, saying,

> "We see in other provinces where there is not this phenomenon of primary care access problems, that physicians are able to oppose such an expansion by saying that prescribing is their prerogative. In Quebec it would have been indefensible." (Interview, Montreal, Nov. 16, 2016, translation mine).

The same informant described how these problems created a media environment that was extremely favourable to pharmacists and a virtual landmine for organized medicine (Interview, Montreal, Nov. 16, 2016). A physician interviewee agreed that perceived access problems have shaped how the media and the broader public view issues like this, arguing that they allow lower-paid professions to claim that they can dramatically improve access while saving massive amounts of money – even if such claims amount to nothing but "pure demagogy" (Interview, Montreal, Nov. 17, 2016, translation mine).

The Quebec case is particularly interesting because it is a confrontational policy environment that nevertheless resulted in compromise – albeit a reluctant compromise that some in organized medicine now regret. The above analysis suggests that this came from political learning and strategic retreat rather than social policy learning. Once again the prevailing medical opinion regarding diagnosis remained unchanged; indeed, Quebec

informants discussed how the legislative context in which *loi 41* was situated placated many in the medical community by placing a barrier between pharmacists and diagnosis. They also suggested that the FMOQ's initial support of the legislation was perhaps a mistake, as what followed made the association extremely uncomfortable. Finally, the access problems faced in Quebec were described as contributing to a political climate in which physician opposition to scope of practice reform would prove toxic to the medical profession's image.

Conclusions

The jurisdictions presented here display four very different dynamics. Even when physician organizations in different provinces have taken similar positions, they followed different routes to get there, a phenomenon known as equifinality (see A. Bennett & George, 1997). Below, Table 1 outlines the independent variables surfaced from the ACF – evidence, brokers and venues for cross-coalition dialogue – that were found across these four provinces, along with other explanatory factors that were identified inductively through the interview analysis.

Table 1: Medicine's reaction to expanded pharmacy scope:

	Independent variables (ACF)	Other explanatory factors	Learning mechanism(s)	Medical posture
AB	• Lack of evidence • Confrontational dynamic	• Proposal perceived to impinge on diagnosis • Perceived lack of access issues	• None	• Opposed

NS	• Evidence from elsewhere • Broker participants • Venues for dialogue	• Proposal perceived as distinct from diagnosis • Clinical imperatives	• Strategic retreat	• Moved to support
ON	• Isolated medical community inhibited evidence • Confrontational dynamic	• Perceived lack of access issues • Unwieldiness of OMA	• None	• Opposed
QC	• Evidence from elsewhere • Confrontational dynamic	• Proposal perceived as distinct from diagnosis • Clinical imperatives • Strategic miscalculation	• Strategic retreat	• Moved to support

As demonstrated above, not every independent variable identified by the ACF proved important in every province. Provinces were selected based on the likelihood of factors emerging that foster cross-coalition learning as per the ACF. However, that does not guarantee they will emerge according to each province's history or reputation – for example, just because Nova Scotia tends to encourage venues for cross-coalition dialogue (see Lomas et al., 1992; Tuohy, 1999) does not mean that will necessarily prove true in every case. Nevertheless, we do see evidence of all three of these variables across the provinces studied. Evidence from elsewhere (or lack thereof) was significant in all four provinces. Brokers and venues for productive dialogue emerged in Nova Scotia, while the other three provinces demonstrated more confrontational dynamics stemming from either their policy traditions (as was the case in Ontario and Quebec) or the posture communicated by pharmacists (as in Alberta).

However, in these provinces the most important explanatory factor was how closely doctors perceived each proposal to approach diagnosis. This is not even a matter of learning; rather, it suggests that physicians will be more likely to oppose policies that appear more threatening to what has traditionally been understood as core medical competencies, activities that are central to medical authority. In all four provinces studied, regardless of whether physicians ultimately supported or opposed the reforms under consideration, the medical profession consistently opposed extending the power of diagnosis to pharmacists. Supportive medical organizations ultimately held the same underlying concerns as more sceptical organizations. However, the details of each proposal mattered to physicians, as some were seen as closer to diagnosis than others. The Alberta reforms were far more extensive than what eventually emerged in Nova Scotia and Quebec, allowing pharmacists to initiate prescription of any Schedule 1 medication. Moreover, the legislative context in which each proposal was situated impacted how close they were perceived to creep toward diagnosis. In Alberta, diagnosis is not a restricted activity – as such, there lacked the sort of legal bulwark between assessment and diagnosis that we see elsewhere, giving physician organizations additional cause for concern. Meanwhile, in Quebec, medical diagnosis is strictly defined in such a way that it is restricted to physicians. This provided additional reassurance that pharmacists would not stray over the boundary between their practice and physicians' traditional role – even as one informant felt that the new regulations ended up infringing on diagnosis regardless (Interview, Montreal, Nov. 17, 2016).

In all provinces studied, organized medicine's core policy belief on diagnosis – that pharmacists should not be permitted to do it – remained remarkably consistent.

Accordingly, we see that all explanatory factors – including those surfaced from the ACF – prompted political learning and strategic retreat rather than social policy learning. With respect to evidence from other jurisdictions, in Quebec and Nova Scotia organized medicine began to see a shift towards expanded scope as inevitable. Experiences such as Alberta's suggested that the country was moving in a particular direction, and physicians would need to get on board if they wanted to play a role in shaping the emerging regime. While parts of Alberta's experience demonstrated that expanding pharmacy scope would not be disastrous for physicians' financial well-being, such evidence did not lead to any reconsideration of the underlying question of diagnosis.

Even brokers and venues for cross-coalition dialogue prompted political learning and strategic retreat rather than social policy learning. In Alberta and Ontario, confrontational policy dynamics impeded dialogue between physicians and pharmacists. In contrast, in Nova Scotia, pharmacists believed that it was absolutely imperative that the medical community be fully on board before pressing forward, and two key brokers worked to maintain positive organizational relationships (Interview, Halifax, Apr. 28, 2016; J. Brooks, Interview, telephone, May 1, 2017; Interview, Halifax, Apr. 27, 2016). The advocacy coalition framework suggests that these are conditions amenable to cross-coalition learning, which can encourage actors to reconsider beliefs closer to their policy core (Jenkins-Smith et al., 2017; Sabatier, 1988; Weible et al., 2009). However, for Nova Scotia medicine these underlying beliefs remained constant, as pharmacists focused their efforts on convincing doctors that their new role would not significantly threaten medical authority after all (J. Brooks, Interview, telephone, May 1, 2017; Kevin Chapman,

interview, Halifax, Apr. 27, 2016; Interview, Halifax, Apr. 28, 2016; Interview, Halifax, Apr. 27, 2016)

Problems of access faced in each province also mattered to structuring medicine's strategic considerations. In Alberta and Ontario, medical interviewees questioned the need for pharmacist prescribing, arguing that it was really more a matter of convenience for patients not to have to make a doctor's appointment. Meanwhile, in Quebec, perceived issues of access contributed to a climate in which physicians could not realistically be seen to oppose expansion of pharmacy scope (Interview, Montreal, Nov. 17, 2016). In Nova Scotia, access problems were also relevant, as pharmacy informants spoke to how physicians and pharmacists were already working together by necessity, particularly in rural communities where there might only be one or two local physicians (Interview, Halifax, Apr. 28, 2016; Interview, Halifax, May 2, 2016). Again, this is not social policy learning – rather, specific local conditions in Nova Scotia and Quebec impacted how stringently doctors could defend their traditional professional territory without egregiously compromising public health. Quebec informants explained that this created a state of affairs in which they could not be seen to oppose efforts to expand access (Interview, Montreal, Nov. 16, 2016; Interview, Montreal, Nov. 17. 2016).

Organized medicine has responded sharply to local conditions when assessing independent prescribing by pharmacists. Some of these can even be traced to the facilitators of cross-coalition learning as outlined in discussions of the advocacy coalition framework (Jenkins-Smith et al., 2017; Sabatier, 1988; Weible et al., 2009). However, as previously discussed, these three facilitators can sometimes prompt political learning and strategic retreat rather than social policy learning. In this case, as there remained strong

underlying consensus on the issue of diagnosis, we see that medicine's core policy beliefs have remained unchanged. There is no significant current of belief within organized medicine that pharmacists should be permitted to diagnose – in fact, the agreement on diagnosis is so strong that one national-level informant asserted that there is no real controversy here at all (Interview, telephone, July 1, 2016).

As such, shifts in medicine's position here cannot be traced to any evidence of social policy learning. The pharmacy case then supports the prevailing wisdom about organized medicine's relationship with medical dominance. Even when conditions were favourable for cross-coalition learning and the profession supported a specific incursion into its dominance, this was the result of political learning and strategic retreat rather than a more fundamental reconsideration of dominance itself. However, as previously discussed, pharmacy scope only threatens medical dominance at the 'authority' level. The next chapter discusses midwifery's re-emergence, which represents a threat to another level of dominance: medical sovereignty. We see that this case proves far more challenging to traditional depictions of organized medicine, revealing more flexibility in how the medical establishment views and engages with medical dominance.

6. Back from the margins: Medicine's reaction to midwifery reintegration

If pharmacists are untrustworthy, midwives are unqualified. If pharmacists are too embedded in the healthcare marketplace, midwives are too removed from dominant medical structures. While both professions' clashes with medicine are typically spun as 'turf wars,' their attributes – and alleged deficiencies – could not be more distinct. As a result, while pharmacy scope challenged medical authority but not sovereignty, the re-emergence of midwifery represents an attack on medical sovereignty but not on authority. By the late 20th century, midwives no longer posed a particularly salient threat to the average doctor's income or professional territory, as they practiced in an area in which medical interest had been waning (Barrington, 1985; Cohen, 1991; Williams, 1994). Midwives then left medical authority almost entirely unscathed. However, in requesting access to mainstream healthcare provision, midwives challenged medical sovereignty by placing in question critical assumptions that underlie doctors' dominance within the system, namely that birth is a medical phenomenon and that intervention is warranted to minimize risk (Weitz, 2007).

In the preceding pharmacy discussion, differences between provinces in organized medicine's posture were immediately visible; medicine became supportive in Nova Scotia and Quebec, but remained opposed in Ontario and Alberta. This time, all medical organizations were supportive in the end; however, differences in their positions can be delineated by the distinction between incorporation (total opposition to midwife-attended birth) and deskilling (support under conditions that bring midwifery closer to the dominant medical model of birth attendance, see McKendry & Langford, 2001; Witz,

1992). In all provinces considered here, medicine started from a position of incorporation. However, differences between provinces can be observed according to whether, when and how medical organizations moved from incorporation to deskilling (and occasionally back again).[46] As variation is identified across Ontario, Quebec, Alberta and Nova Scotia, so too are the causal mechanisms underlying shifts in medical positions on midwifery in each province. If all shifts can be traced to strategic retreat, then the prevailing wisdom about medicine's motivations is again confirmed. However, if some shifts can be traced to social policy learning, then the medical establishment is not as closely tied to medical sovereignty as has been depicted in both empirical and theoretical considerations of its dominance (Bourgeault, 2006; Vadeboncoeur, 2004; Weitz, 2007; Willis, 1983, 2006). This analysis finds that there is indeed a strong current of social policy learning underlying organized medicine's changing positions on midwifery.

The discussion again proceeds in five parts, considering each province on its own before discussing findings in a concluding section. It begins with the 'first mover' province: this time, Ontario. However, as was the case with pharmacists pushing for expanded scope, there is significant overlap between provinces. In all jurisdictions studied the midwifery question first gained prominence in the 1970s, well before the profession was formally brought back in Ontario. Indeed, one Quebec midwife noted that their province actually had a head start on Ontario before allowing itself to be overtaken (I. Brabant, interview, Montreal, Jan. 10, 2017). Regardless, Ontario's shadow looms large over the other jurisdictions examined here. Interviewees from other provinces

[46] Data demonstrating the number of practicing midwives in each province as of 2013 – once the pilot sites were fully established in Nova Scotia – is available in Appendix B.

repeatedly referred to Ontario as the standard against which other Canadian midwifery professional 'projects'[47] are judged.

Ontario

Ontario's experience legalizing midwifery is a compelling story of social mobilization resulting in significant policy change. Within this narrative, consideration has often been given to physician involvement in the debate, as multiple accounts have highlighted how, despite Ontario organized medicine's aforementioned reputation for confrontation, doctors' opposition here was weak, contributing to the pro-midwifery movement's success (Bourgeault, 2006; Vadeboncoeur et al., 1996). Indeed, Ontario physicians moved from incorporation to deskilling relatively early, cooperating with the implementation process while still trying to advance their own priorities. However, describing opposition as weak suggests a difference in degree rather than kind between Ontario and other provinces, implying that strategic retreat is the sole mechanism by which doctors' opposition softened. The interviews conducted for this project suggest that medicine shifted its beliefs in a deeper, more substantive way in this province than has previously been assumed.

Before midwifery officially caught the Ontario government's eye, the practice was enjoying an unofficial renaissance as consumer demand grew for a more natural approach to normal childbirth (see Plummer, 2000). Organized medicine's initial response to this trend was not positive, as doctors sought to protect their incorporation of birth attendance. In 1982, the Ontario College of Physicians and Surgeons made a

[47] This term was coined by Larson (1977) to describe instances when an occupation or profession attempts upward mobility (see also Bourgeault, 2006).

statement discouraging births out of hospital (Gadd, 1983), asserting that it would constitute "professional misconduct" for a physician to assist an unlicensed attendant in a home birth (in Bourgeault, 2006, p. 73). The College's effort to dissuade physicians from attending home births was an astute move, as allied doctors had developed into a crucial resource for the pro-midwifery movement (Vadeboncoeur et al., 1996, p. 231). Often these doctors had been trained outside Canada, and were familiar with midwifery as a normal part of maternity care (see Bourgeault, 2006, p. 68). Such physicians would frequently work with midwives under the table, bringing them on as 'additional attendants' to aid in home births (ibid).

In 1983, Ontario's Health Professions Legislation Review (HPLR) invited midwives to make a submission for regulation. The HPLR was a massive undertaking, involving reconsideration of the rights and responsibilities of a wide range of practitioners (see O'Reilly, 2000). As part of the process, relevant professional groups were invited to comment on the midwives' submission. For their part, the Ontario Medical Association and the College of Physicians and Surgeons argued that, while they accepted midwifery in principle, it should only be permitted under physician supervision (Bourgeault, 2006, pp. 95–96) – ironic, considering the CPSO's past action to discourage physicians from supervising midwives. This shift in position, coming as the Ontario government made its first move to seriously consider midwifery reintegration, represents a distinct shift to a strategy of deskilling. Bourgeault links medicine's softer positioning to a "lack or diffusion of interest" and an associated "diffusion of resources" (p. 267–268); in short, the sheer volume of issues to deal with under the HPLR had doctors spread thin, and midwives were not particularly high on their list of priorities. As such, the

medical establishment did not campaign as vigorously against midwives' claims as it otherwise might have.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) also played an important role in this process, as the debate provided its first opportunity to formally weigh in on midwifery reintegration in Canada. From 1982 to 1987, Dr. Patrick Mohide was secretary of the Society. In an interview for this project, he described how he was able, working with midwives and others in the movement, to bring the Society to a position of non-opposition (P. Mohide, interview, telephone, Nov. 8, 2016; see also Kaufman, 1991). Officially, the SOGC remained opposed to home birth (Oxorn, 1994, pp. 84–85); however, this was more of a compromise than a firm belief about the nature of obstetric care (P. Mohide, interview, telephone, Nov. 8, 2016). Dr. Mohide described the overall debate as follows:

> Support for the concept and need for midwifery was not universal during the 1980s among the members of the Council. Representatives from the West and from Quebec expressed their concerns and sometimes their opposition... However, some members of Council had a different point of view regarding midwifery: 'Why not?' (in Oxorn, 1994, p. 83)

For its relatively moderate position on midwifery, the SOGC was rewarded with backlash from those believing that midwives undermined the role of family doctors, who shared midwifery's emphasis on 'normal' birth – family doctors had also long struggled for representation within the Society and were concerned about having their concerns overlooked (Oxorn, 1994, pp. 22, 147).

While the HPLR was ongoing, doctors did have one opportunity to amplify their views on midwifery: a 1985 coroner's inquest into the death of a baby, born on Toronto Island with the help of two midwives, Sue Rose and Vicki Van Wagner. The case

involved an instance of normal labour; however, once born it became clear that the baby needed to be immediately transferred to a hospital downtown. The infant died two days later. Expert witnesses from physician organizations representing OB/GYNs, paediatricians, family doctors as well as the Ontario Medical Association (OMA) itself weighed in on the case, using it as a platform to criticize midwifery and promote medicalized, in-hospital birth (Bourgeault, 2006, pp. 107–115; Sweet, 1985). As a result, the inquest quickly shifted from an examination of a single tragic incident to a general debate on midwife-assisted birth.

The shift in tone did not come solely from the medical profession. The midwives enlisted Dr. Marsden Wagner, a well-known paediatrician and perinatal epidemiologist from the World Health Organization, to testify on their behalf; however, instead of focusing on the decision-making of the two midwives at the centre of the case, they had him present arguments on the importance of bringing their practice inside the formal healthcare system (V. Van Wagner, interview, telephone, Apr. 29, 2016; Bourgeault, 2006). This strategy bore fruit, as cracks in the medical establishment's position began to show throughout this process. Most tellingly, Dr. James Milligan, chair of the OMA committee on reproductive care, commented, "We may indeed need individuals other than physicians practicing midwifery...but for the sake of safety, they need to be trained and adhere to very high standards" (quoted in Sweet, 1985). While this was not yet OMA policy, the logical consequences of Dr. Milligan's statement were unavoidable. Recalled Dr. Van Wagner: [48] "We were sitting there saying, look, we're only working outside the system because we are forced to. We want to be regulated. We want formal training" (Interview, telephone, Apr. 29, 2016). While prosecution lawyers had initially framed

[48] Vicki Van Wagner is referred to here as "Dr." to denote her PhD.

their case as a denunciation of midwifery practice itself, at the inquest's conclusion even they argued for the regulation of midwives as a professional group – albeit under the umbrella of nursing (Tedesco, 1985; Weir, 2006). The jury eventually ruled that the baby's death was avoidable, but nevertheless recommended the establishment of a self-regulated midwifery profession (Bourgeault, 2006; Marier, Paterson, & Angus, 2014).

In 1986, following recommendations coming out of the HPLR, Ontario made the decision to regulate midwifery. However, there was still a lot of debate left to be had, as decisions were still needed on how it would be integrated into the system; to this end, the province launched the Task Force on the Implementation of Midwifery in Ontario (TFIMO). Perhaps counterintuitively, the OMA's official line actually hardened somewhat at this point. During the HPLR process, the Association had claimed to support the principle of midwifery (Bourgeault, 2006, p. 96). However, in its submission to the TFIMO, the OMA walked back that position and explicitly pushed incorporation, arguing that the deficiencies that regulated midwifery would ostensibly fix would be better addressed through increasing the capacity of existing resources (Task Force on the Implementation of Midwifery in Ontario, 1987, p. 238). This was a departure from other medical bodies, including the College of Physicians and Surgeons of Ontario, the Ontario Chapter of the College of Family Physicians of Canada and the Society of Obstetricians and Gynaecologists of Canada, all of which either supported or cautiously accepted midwifery on certain conditions consistent with a deskilling strategy (ibid; see also

College of Physicians and Surgeons of Ontario, 1986; Morrison, 1991; Ontario Chapter – College of Family Physicians of Canada, 1986).[49]

Perhaps more important than organized medicine's expressed positions, however, was its willingness to cooperate with the process. Successful implementation requires medical cooperation, if not enthusiastic support; we will see in discussions of other provinces what can happen when doctors hinder the process either at an institutional or individual level. In Ontario, even the most sceptical of physician organizations contributed productively to the implementation process, the result of several factors to be discussed later in this section (see Vadeboncoeur et al., 1996, p. 231). This is despite the fact that the Canadian Medical Association was still in 1987 officially urging provinces to abandon any plans to regulate midwifery (LeBourdais, 1988; see also Sullivan, 1988). While midwives and their allies might still lament medical scepticism in Ontario (B. Soderstrom, interview, Ottawa, Sept. 8, 2016; M. Kaufman, interview, telephone, Nov. 7, 2016), when contrasted with the other provinces to be discussed here Ontario doctors appear far more collegial in their approach.

The TFIMO (1987) eventually endorsed a model of midwifery care that included home birth, self-regulation and public funding. The Minister then acted on those recommendations, with midwifery formally integrated in 1994. During implementation, the OMA broke with the Canadian Medical Association's continued official opposition to midwifery. At the CMA annual meeting in 1990, Dr. Ted Boadway, the OMA's health policy director, explained, "we're living with the introduction of midwifery in Ontario

[49] For their part, nursing organizations all argued that midwifery was essentially a specialty of nursing, and that midwives should be required to obtain a nursing education (Bourgeault, 2006; Task Force on the Implementation of Midwifery in Ontario, 1987).

and it's not a horror story...In Ontario, we are quietly ignoring the CMA policy and introducing midwifery without confrontation" (in Sullivan, 1990).

How can we explain medicine's shifting posture in Ontario? While the observed flexibility might be counterintuitive given the novelty of Canadian midwifery at the time, it does not defy explanation. Through analysis of the interviews conducted for this project, several factors emerge that incited both strategic retreat and social policy learning. With respect to strategic retreat, an unfavourable political climate and the perceived inevitability of midwifery regulation inclined medicine toward softening its opposition. With respect to social policy learning, the influence of pro-midwifery physicians and the existence of venues for cross-coalition dialogue led to more substantive shifts in organized medicine's positioning.

Informants cited the political climate as a major independent variable that prompted a mechanism of political learning and strategic retreat within organized medicine. The midwifery debate came at the same time as perhaps the worst public relations episode in Ontario medicine's history. In 1986, upon hearing that the new Liberal government (which had replaced a four-decade PC dynasty) would ban extra billing, doctors lashed out. The OMA launched a strike that saw over half of the province's physicians close their offices (Meslin, 1987). Rotating strikes were launched thereafter, culminating the disbanding of an abortion committee in Sarnia – an action which rendered abortion access impossible in the region (York, 1987) – and the withdrawal of select emergency room services. With this action, the medical profession as a political force was viewed as unquestionably compromising the public good over an issue of payment. Meslin writes, "The OMA's threat to close ERs sent a strong message

to the Ontario public about the priorities of the medical profession. Many physicians were not particularly proud of the message, nor should they have been" (1987, p. 14). Not only did this strike exacerbate the "diffusion of resources" that Bourgeault describes (2006, p. 267), but it also dealt a serious ego blow to physicians by the time it ended. Their relationship with the public was tenuous at best; prominent midwife Dr. Karyn Kaufman speculated that, "the leadership was probably sensitized enough to be aware that they couldn't be seen to be in opposition to everything that was going on" (K. Kaufman, interview, Skype, Apr. 4, 2016).

This was also a time in which the abortion debate was raging, creating a climate in which the Ontario government was eager to tackle a less-controversial feminist cause. Recounted Dr. Van Wagner, "it was a moment when Henry Morgentaler had people on the streets, both the right-to-life and the women's movement. Midwifery looked like an easy problem. We looked like motherhood and apple pie... if the government needed to look good on a woman's issue, maybe there's less political cost to pushing forward midwifery" (V. Van Wagner, interview, telephone, Apr. 29, 2016). In addition to a favourable contrast with abortion, the climate of Ontario's feminist movement provided the midwives with a particularly strong group of consumer allies. Bobbi Soderstrom recounted how the consumer movement could be "in your face" in a way that the midwives themselves could not (Interview, Ottawa, Sept. 8, 2016).

Second, as previous discussions of the advocacy coalition framework had highlighted the importance of evidence to fostering learning, I had anticipated that the first province to bring back midwifery would face particularly strong opposition, while doctors in 'late moving' jurisdictions would see the change as inevitable and/or less

threatening after seeing it in action elsewhere (see Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988). In fact, Ontario demonstrates that the opposite can occur. The TFIMO caught physician groups off guard, conveying a sort of inevitability more common to late movers (B. Soderstrom, interview, Ottawa, Sept. 8, 2016; Taylor & Nesdoly, 1994). In essence, the decision was made before organized medicine could formulate any sort of coherent opposition. As well, Dr. Van Wagner argued that the uncertainty caused by going first caused doctors' groups to make a key misjudgement around insurance. She recalled, "I remember sitting there in one of the Toronto hearings when the OMA was testifying...they said 'we really think it's a moot point anyway because there's no way that midwives are going to get malpractice insurance'" (Interview, telephone, Apr. 29, 2016). In fact, midwives were already negotiating with insurers, who, according to Dr. Van Wagner, felt they might be less of a risk to insure than the physicians given their focus on normal, uncomplicated birth (ibid).

Both the political environment and the timing of the TFIMO are independent variables that prompted a mechanism of strategic retreat. As Bourgeault (2006) and Vadeboncoeur and her colleagues (1996) discuss, much of Ontario doctors' relatively amenable posture toward midwifery can then indeed be explained by strategic considerations. However, the interviews conducted for this project uncovered a significant current of social policy learning as well, prompted by the facilitators of cross-coalition learning as noted in discussions of the advocacy coalition framework (see Jenkins-Smith, Nohrstedt, Weible, & Ingold, 2017; Sabatier, 1988).

First, prominent allied physicians served as brokers for midwifery, not only by influencing public discourse in a way that undermined traditional medical views, but also

by actually pushing their organizations in particular directions. While it is difficult to pinpoint what exactly turned individual doctors into allies of midwifery, one major point of commonality has been repeatedly cited: doctors who have some kind of previous experience working in countries where – to use Dr. Van Wagner words – the practice is "common, normal and uncontroversial" tended to be more supportive of the profession (Interview, telephone, Apr. 29, 2016). Practicing abroad was indeed a common part of many Ontario OB/GYNs' training (Oxorn, 1994, p. 83).[50] The structure of medical organizations in Ontario also provided such physicians with the opportunity to make their views known. At the time, while the OMA had a reputation for strong political action, it was still a voluntary association, lacking the authority to speak on behalf of the entire medical profession (see Archibald & Jeffs, 2004; Vadeboncoeur et al., 1996).[51] As such, individual allied physicians spoke out with relatively little fear of retribution, with several making favourable submissions to the TFIMO (1987, p. 241).

Social policy learning is concerned with shifts in *institutional* positions; the presence of individual brokers is then ultimately important only in so far as they can push medical groups in particular directions. That certainly happened in this case. Ontario is big, as is its medical community. In the preceding pharmacy discussion, we saw that traditionalist wings undermined the overall OMA position. However, in this case the opposite occurred, as pockets of support were concentrated in particular institutions and regions. Two are particularly important to this case. The first is the SOGC, which was pushed to a position of neutrality through Dr. Mohide and other supportive figures, in consultation with midwives and pro-midwifery activists (P. Mohide, interview,

[50] As will be discussed in the next section, this is an important point of difference between Ontario and Quebec.
[51] The association would gain the Rand formula by the time of the pharmacy debate.

telephone, Nov. 8, 2016). While a national-level organization, the SOGC was a major player throughout the Ontario debate. More recently, Dr. Van Wagner described some of the SOGC's positions on midwifery as "exemplary" (Interview, telephone, Apr. 29, 2016), and the Society now counts midwives among its membership, alongside nurses and other allied professionals (Society of Obstetricians and Gynaecologists of Canada, 2003, n.d.). For a once notoriously exclusive organization (Oxorn, 1994), this represents significant evolution. Even on critical matters of medical sovereignty – such as their position on 'natural' deliveries and choice in birth location (Hutton, 2016; Payne, 2011; Roome, Hartz, Tracy, & Welsh, 2016) – the SOGC has moved away from protecting medical dominance.

Medical support was also concentrated at McMaster University in Hamilton, which would later house a midwifery baccalaureate program. This school was home to Dr. Mohide as well as Dr. Murray Enkin, perhaps the most prominent medical ally to midwives. While interviewees differed on the extent to which the teaching hospital at McMaster can be called 'progressive' (K. Kaufman, interview, Skype, Apr. 4, 2016, M. Kaufman, interview, telephone, Nov. 7, 2016, P. Mohide, interview, telephone, Nov. 8, 2016), it did provide a relatively positive environment from midwives and their allies throughout the debate. Karen Kaufman described how midwives in Waterloo attending home births who needed to transfer their client would often want to bring them to McMaster, as that is where midwives would not be "thrown out the front door" (K. Kaufman, interview, telephone, Apr. 4, 2016). McMaster, in collaboration with local physicians, was also permitted to set up a nurse-midwifery site while the HPLR process was ongoing (Kaufman & McDonald, 1988). The cultural contrast between McMaster

and other provincial learning and hospital environments is conspicuous; following the decision to regulate, Dr. Mohide recounts how, when a fast-track midwifery training program was set up at the Michener Institute in Toronto, they were unable to find local doctors willing to teach (Interview, telephone, Nov. 8, 2016). The institute ultimately had to ask Hamilton physicians, himself and Dr. Enkin included, to commute (ibid).

While the decisions to a) invite midwives to submit to the HPLR, and b) launch the TFIMO were in themselves rather sudden, they each constituted lengthy, deliberative processes, which interviewees also claimed helped to substantively shift medicine's attitude. Bourgeault (2006, p. 267) describes how the multitude of issues taken on under the HPLR process rendered midwifery little more than an afterthought for doctors and other professionals who might normally be more concerned about the profession's entry. This is certainly important in understanding why midwives generally had an easier time in Ontario than elsewhere. However, the advantages of the HPLR went beyond distracting the opposition. As previously discussed, doctors who spend time with midwives tend to become more comfortable with their practice; the long march toward regulation in Ontario provided several venues in which sceptics' logic could be challenged and medical comfort could increase one doctor at a time. Indeed, Ontario MPP France Gélinas described how midwives were able to focus their efforts on convincing physicians on the ground (Interview, Toronto, May 19, 2016).

With respect to bringing around the medical profession, perhaps the most important event was the aforementioned Toronto Island inquest, in which Dr. Milligan of the OMA decried midwives' lack of training (Sweet, 1985). The idea of 'focusing events' has been explored extensively in public policy literature: that is, that a particular event

can capture the attention of policymakers and the public in such a way that shifts the agenda and creates an opportunity for change (see Birkland, 1997, 1998; Thompson & Wallner, 2011). We might expect an event like this to lead to further demonization of midwifery practice and result in a consolidation of medical power. However, even as they were on the defensive, midwives successfully used the inquest as a venue to force doctors to embrace the basic logic of their position. Explained Dr. Miriam Kaufman, then a medical ally to the midwives, "I thought the midwives were brilliant...they didn't want something [like the death of an infant] to happen, but they knew that if something happened that there would be an inquest and that they needed that inquest to actually move things forward for them in terms of legalization" (M. Kaufman, interview, telephone, Nov. 7, 2016). The TFIMO hearings provided similar venues for cross-coalition dialogue, according to informants from midwifery (V. Van Wagner, interview, telephone, Apr. 29, 2016, B. Soderstrom, interview, Ottawa, Sept. 8, 2016). Dr. Van Wagner recalled how, at one hearing, the OMA representative was asked whether or not women who choose to give birth at home should be attended by a well-trained midwife. "Very simple question," she recounted, "and there's only one appropriate answer...There were many little moments like that that were just critical to moving out of that oppositional place. Expecting medicine to be professional, to be scientific and to be rational was always a really good strategy" (Interview, telephone, Apr. 29, 2016).

In Ontario, several aspects of the debate inclined medicine away from opposition to midwifery. Some of these operated simply by inciting strategic retreat (May, 1992). The overall political climate was not favourable to doctors, discouraging them from engaging in risky political activity and dividing their attention and resources among

multiple issues (Bourgeault, 2006; Meyer & Minkoff, 2004; Tarrow, 1998). The TFIMO also signalled that midwifery regulation was inevitable, further dissuading organized medicine from expending resources opposing it. And doctors mistakenly thought midwives would have trouble meeting the insurance requirements for regulation.

However, other aspects of the Ontario debate reveal a current of social policy learning within medicine's shifting posture. Pro-midwifery physicians, who had often received training abroad, were able to act as brokers and push medicine toward a more amenable position – this is in part due to the size of the Ontario medical community, which allowed allied doctors to concentrate themselves in particular institutions or regions. As well, the HPLR and TFIMO processes – and even the Toronto Island inquest – served as venues through which midwives could directly present their arguments to sceptical physicians. These not only allowed midwives to publicly dismantle opposing arguments, but also provided them with opportunities to convince doctors of midwifery's merits.

Quebec provides the clearest contrast to the Ontario case, and the perhaps the most extreme example of medical protectionism examined in this dissertation. Indeed, what medical resistance took place in Ontario appears near-insignificant compared to the total meltdown that occurred in Quebec, as organized medicine publicly demonized midwifery practice and obstructed the process at nearly every turn. This exceptionally confrontational dynamic is outlined in the following section.

Quebec

Prior to the Quebec government considering midwifery regulation, the practice was enjoying the same rebirth as elsewhere in the country (see Vadeboncoeur, 2004). Even at this time, however, it was rarer for individual doctors in Quebec to publicly support midwifery than their Ontario counterparts. Vadeboncoeur et al. (1996) chalk this up in part to the profession's organization. As previously mentioned, Quebec is the only Canadian province with separate bargaining agents for GPs and specialists. While at times this has led to visible divisions within Quebec medicine (see Martin, 1992; C. H. Tuohy, 1999), these associations have exerted remarkable control over their respective memberships. This power is due in large part to the features and culture they shared with traditional unions, including an early adherence to the Rand formula, by which practicing physicians are obligated to pay dues to the organizations (Vadeboncoeur et al., 1996, p. 235). Comparatively, they were then extremely capable of preventing midwifery-supporting doctors from speaking out (ibid). Compounding matters, the province also has a distinct OB/GYN society, the Association des obstétriciens et gynocologues du Québec (AOGQ), which has not been shy about breaking with the anglophone-dominated SOGC (see Oxorn, 1994, pp. 68–69).

Quebec's midwives formally organized in the mid-1980s and began pushing for regulation. Unlike in Ontario, midwifery in Quebec was treated as a distinct issue apart from an all-encompassing process such as the HPLR, resulting in a far less formal political debate. When a government report came out recommending midwifery regulation in 1989 (Ministère de la santé et des services sociaux, 1989), organized medicine's reaction was swift, severe, and united. The most passionate defender of

medical dominance was Augustin Roy, outspoken president of Quebec's Collège des médecins. In an interview, he infamously compared the proposal to "[making] prostitution legal," as "more people are asking for prostitutes than midwives" (in Picard, 1989). Hélène Cornellier, then the President of the Quebec Alliance of Practicing Midwives, described the comments as "insipid and insulting," explaining, "it really shows how little respect the medical establishment has for women" (ibid). Dr. Roy was the most prominent medical opponent to the government's proposal, but he was far from alone in his propensity for demeaning comparisons; Dr. Clément Richer, his counterpart in the FMOQ, likened midwifery to "letting an apprentice pilot take charge of a Boeing 747" (ibid).

Doctors stood alone in their opposition; while the nursing association wanted midwives to be brought under the broader tent of their own practice, they did not ally themselves with physicians (Interview, Ottawa, Oct. 18, 2016), and did not insist that aspiring midwives should first be trained as nurses – in contrast, in Ontario nurses had argued that midwifery was essentially a specialty of nursing (Bourgeault, 2006; Fauteux, 1988; Laughlin, 1987; Task Force on the Implementation of Midwifery in Ontario, 1987). Despite physicians' isolation, *loi 4*, the legislation that Quebec eventually put forward, represented a concession to organized medicine, launching an extended period of experimentation with pilot sites across the province. Vadeboncoeur (2004) paints this as a pre-emptive compromise and an attempt to defuse opposition coming from medicine. It did not work. Physician organizations were furious, with Dr. Roy blasting the bill as a "still-born monster" (in Canadian Press, 1989). "It's to show feminists that the government is ready to stand up to the big, bad doctors," he opined (in Peritz, 1989). To

the disappointment of the Minister, the Collège refused to give any support to the pilot projects, claiming they were little more than a phased implementation of full midwifery (Dunn, 1989). Dr. Roy continued to benefit from the support of his Quebec medical colleagues. For its part, the AOGQ was clashing with the SOGC over the latter's more conciliatory posture toward Canadian midwifery. Oxorn (1994, p. 67) notes that, at the time, francophone OB/GYNs in Quebec identified with the AOGQ rather than the SOGC, which they did not see as a true "national" body. The midwifery debate exacerbated this divide, with many francophone physicians, for lack of reliable translation, interpreting the SOGC's neutrality on midwifery as support for *loi 4* (pp. 68–69). This disconnect mirrors Quebec physicians' posture towards the CMA, which suffers from a major lack of representation in the province (Interview, telephone, Jul. 1, 2016; see also Cameron & Simeon, 2010 on linguistic divides in Canadian voluntary associations).[52]

Mirroring what took place in Ontario, in Quebec the government's plans were briefly slowed during an inquest into the death of an infant following a home birth (Aubin, 1989; Kuitenbrouwer, 1989; McLaren, 1990). The midwife at the centre of the inquest was Isabelle Brabant, who was one of the pioneering midwives at the time and, by her own account, among the most outspoken within the pro-midwifery movement (I. Brabant, interview, Montreal, Jan. 10, 2017). In our discussion, she recalled, "[the doctors], they just sat there and waited for the inevitable to happen. And they were so lucky that the inevitable happened to me" (ibid). Critically, this case did not provide the same opportunity for midwives to discuss regulation as we saw in Ontario. While Ontario's inquest broadened in scope to become a discussion about midwifery more

[52] This is despite the fact that, on the subject of midwifery, the Quebec medical community was more in line with official CMA policy opposing midwifery than their counterparts in Ontario (see Sullivan, 1990).

generally, in Quebec the inquest stayed focused on Ms. Brabant and the specifics of the case (Vadeboncoeur, 2004). Moreover, Ms. Brabant recalled that media coverage of this story was extremely unfavourable to the midwives, sensationalized in newspapers and on television in such a way that did not contribute to productive discussion about the merits of midwifery-assisted birth (ibid). As a result, far from serving as the critical venue for dialogue seen in Ontario, Quebec's inquest contributed further to the combative tone of the debate and caused further mistrust between midwives and physicians (Aubin, 1989; Kuitenbrouwer, 1989; McLaren, 1990).

Loi 4 eventually passed in 1990, launching an experimentation process that one informant argued signalled an effective end to any meaningful debate over midwifery (Interview, Ottawa, Oct. 18, 2016). Doctors must have missed this memo, however, as instead of moderating their position in anticipation of regulated midwifery they moved from opposition to overt obstructionism. First, organized medicine criticized the experimentation and assessment structure – which was composed of a team of researchers and a government appointed evaluation committee called the Pilot Project Assessment Board (PPAB) – as biased in favour of midwifery (Interview, Montreal, Dec. 6, 2016).[53] Meanwhile, midwives were upset that the study was to be conducted out of a faculty of medicine (A. Poirier, interview, Montreal, Dec. 16, 2016). Once the research design for the assessment cleared independent review, both of these criticisms were effectively neutralised (ibid); nevertheless, medical mistrust persisted. At the encouragement of the AOGQ, physicians successfully blocked all attempts to set up midwifery pilot projects in hospitals, significantly delaying the start of the program (Fannin, 2007, p. 182). Both the

[53] Interviewees suggested that the government was indeed strategic in choosing midwifery-friendly physicians to serve on the committee (Interview, Montreal, Dec. 6, 2016; A. Poirier, interview, Montreal, Dec. 16, 2016).

FMOQ and the FMSQ had also written to their members urging them not to participate in the projects (Dunn, 1990). In 1993, the Deputy Minister threatened outright legalization in response (Canadian Press, 1993); doctors were not swayed, however, and the government backed down on that threat just days later (Seguin, 1993). Medical groups continued their obstructionism, forcing the pilot sites out of hospitals altogether (see Fannin, 2007).

Organized medicine's interference did not stop there. In early 1997, before the experimentation process ended, the Collège submitted public recommendations to the Office des professions du Québec, a body, unique to Quebec, which oversees all regulated professionals in the province. These recommendations indicated what the Collège wanted midwifery to look like, including a prohibition on births outside of hospitals (Conseil d'évaluation des projets-pilotes, 1997, pp. 105–107). Their attempt to undermine the process prompted a sharp rebuke from Dr. Alain Poirier, then-chair of the PPAB, who, while noting that this (likely accidentally) implied openness to midwifery in principle, called the recommendations "inappropriate, premature and incomplete" (Conseil d'évaluation des projets-pilotes, 1997, p. 105, translation mine; see also A. Poirier, interview, Montreal, Dec. 16, 2016; Interview, telephone, Feb. 1, 2017).

Following the results of the study, the PPAB's final report recommended self-regulated midwifery with provisions for home birth (Conseil d'évaluation des projets-pilotes, 1997). The Collège had appointed a representative to the PPAB – Dr. Gilles Bernier – who ultimately dissented from these recommendations (p. 138). However, Dr. Poirier noted that by this time Dr. Roy had left the Collège, and the new leadership was on balance more amenable than the representative appointed under Dr. Roy (A. Poirier,

interview, Montreal, Dec. 16, 2016). Vadeboncoeur (2004) concurs, noting that the Collège at this time finally shifted to a posture of conditional support that mirrored what had occurred far earlier in Ontario. While Dr. Bernier's dissent was indeed problematic for the PPAB, it reflected more a holdover from the Roy era than the contemporary position of the Collège. Meanwhile, the FMOQ reiterated its position that midwives were simply not necessary at this time (ibid). By this point, Quebec was far behind Ontario, Alberta, and several other Canadian jurisdictions in legalizing midwifery (A. Poirier, interview, Montreal, Dec. 16, 2016). The government reacted favourably to the PPAB recommendations, and midwifery was formally legalized in Quebec in 1999 (ibid).

Quebec's medical community was markedly more resistant to midwifery than were Ontario's doctors. Organized medicine in Quebec maintained a position of incorporation throughout the experimentation period, until the decision to regulate was absolutely final; in contrast, most Ontario medical organizations pushed a deskilling agenda during the HPLR and TFIMO. Resistance to midwifery in Quebec was also punctuated with instances of obstructionism; in contrast, in Ontario medicine generally cooperated with the HPLR, TFIMO and implementation processes.

This observation is not new. Past discussions on Quebec and Ontario's experiences legalizing midwifery have noted the difference between the two in physician resistance (Bourgeault, 2006; Fannin, 2007; Klein, 1994; Vadeboncoeur, 2004; Vadeboncoeur et al., 1996). Usually, the reasons given are not particularly sympathetic to the medical profession, treating it as inherently inclined to oppose midwifery – an understandable instinct given doctors' systematic incorporation of the practice mere decades prior and the stark ideological and demographic differences between the two

professions. As mentioned in the preceding Ontario discussion, for example, Bourgeault (2006) discusses a "diffusion of resources" in Ontario thanks to the length and scope of the HPLR (p. 268), a phenomenon that left doctors stretched too thin to effectively oppose or obstruct. Similarly, Vadeboncoeur and her colleagues (1996) discuss a union-like culture among Quebec physicians, including an adherence to the Rand formula, that discouraged dissenting voices within the organization. The implication of such arguments is that Ontario associations would have acted similarly had they benefitted from similar institutional levers or opportune moments, consistent with a mechanism of political learning and strategic retreat (May, 1992). In benefitting from resources not available to their Ontario colleagues, Quebec's physicians were allegedly emboldened to put up a stronger (and longer) fight. However, while it is indeed important to look at these kinds of resources and opportunities, the unique elements of Quebec's landscape go beyond traditional resources identified in accounts of strategic retreat.

To explain this, we first need to consider the Augustin Roy factor. Much of the Quebec midwifery debate was shaped by the bombastic leader of the CMQ. Despite leading a nominally apolitical organization, Dr. Roy never shied away from contentious debates, becoming well known for his abortion rights advocacy (Marin, 2016). His belief in choice did not extend to midwifery services, however, to which he remained staunchly opposed. Ms. Cornellier described how, as *loi 4* was being debated, Dr. Roy would show up every day to listen despite its limited impact on the medical profession writ large (Interview, Montreal, Nov. 17, 2016). Other informants confirmed his personal interest in keeping midwifery alegal, which ultimately shifted the CMQ's role to one more

appropriate to an association or other political organization (Interview, Montreal, Dec. 6, 2016; Interview, telephone, Feb. 1, 2017).

Dr. Roy's tenure did not last long enough for him to see the midwifery file through to the end. In 1993, the Office des professions accused him of misconduct related to sexual abuse by physicians, specifically alleging that he favoured doctors over the public, personally intervened to cover up physicians' actions and failed to uphold the confidentiality of a complainant (McKenzie, 1993). Dr. Roy had even been caught on tape calling one complainant a "crackpot" to a room full of laughing doctors (ibid). He was ultimately censured and left the presidency the following year. Throughout the midwifery debate, Dr. Roy was instrumental in whipping up opposition and imbuing medical opposition with a particularly aggressive flavour (Interview, telephone, Feb. 1, 2017). In no other province do we see midwives compared to sex workers or hear proposals described as "still-born monster[s]" (in Canadian Press, 1989). From the perspective of proponents of the advocacy coalition framework, Dr. Roy would be labelled an 'extremist,' a hindrance to cross-coalition learning (see Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988). This particular extremist went on to dominate public discourse entirely, drowning out any more moderate positions within organized medicine that may have otherwise proved influential.

There were many other factors at play in Quebec that inclined medical organizations toward opposition. For one, Quebec doctors lacked access to the sort of direct evidence about midwifery's merits that was available to physicians in other provinces. As in Ontario, Quebec physicians have typically been more open to midwifery if they have worked with midwives in the past and completed pre-medical education

outside Quebec (Blais, Lambert, & Maheux, 1999). One interviewee explained, "When we don't know what something is, we doubt it, we are resistant," and referred to their own experience overseas providing formative encounters with midwifery practice. (Interview, Montreal, Dec. 6, 2016. translation mine). This echoed Dr. Van Wagner's point about physicians training in jurisdictions where midwifery is "common, normal and uncontroversial" (Interview, telephone, Apr. 29, 2016). The informant argued that Quebec physicians tend to be trained solely in Quebec, limiting their opportunities to see midwifery in action elsewhere, whereas Ontario doctors are more likely to go abroad to other anglophone countries (Interview, Montreal, Dec. 6, 2016). Other interviewees from both Quebec and Ontario also referred to this difference as a critical contrast between the two provinces, trickling up to the medical leadership (A. Poirier, interview, Montreal, Dec. 16, 2016, P. Mohide, interview, telephone, Nov. 8, 2016; see also Klein, 1994; Vadeboncoeur et al., 1996).

In addition, in contrast to the Ontario experience, Quebec lacked the context of a 'mega-bill' modifying healthcare professional boundaries, which, in addition to isolating the midwifery case, denied doctors the usual venues through which they could voice their concerns and become exposed to pro-midwifery arguments. As a result, Vadeboncoeur and her colleagues note that physician groups felt shut out and angry (1996, p. 237). Their reaction to *loi 4* can be read as an objection to the process as well as an objection to midwifery itself. Moreover, in Ontario the formal hearings and debates surrounding the HPLR and the TFIMO had allowed physician leaders the opportunity to learn about midwifery and become convinced of its merits; such opportunities did not exist in Quebec, compounding the already-existing problem of unfamiliarity with the practice.

As in Ontario, there was an inquest into the death of an infant in Quebec. However, Vadeboncoeur (2004) argues that this inquest was handled very differently from that concerning Dr. Van Wagner in Ontario, focusing on the defense of Ms. Brabant's actions rather than an argument for legal midwifery. It did not serve a venue for convincing physicians – or anybody else for that matter – of midwifery's merits, in contrast to the Ontario experience (Sweet, 1985). According to Ms. Brabant, this was also the first time she felt that the media had turned on her profession (Interview, Montreal, Jan. 10, 2017). Looking back, she discussed how this hurt the midwives' cause in Quebec; in contrast, the inquest that unfolded in Ontario is often regarded as a paradoxical watershed moment in the profession's march to regulation and a focusing event for wider discussions about the importance of regulating midwifery practice (ibid; see also M. Kaufman, interview, telephone, Nov. 7, 2016; Birkland, 1997, 1998; Thompson & Wallner, 2011; Vadeboncoeur et al., 1996). These two factors – the more limited scope of the case and the negative media coverage – meant that Quebec midwives were not able to use this moment in the same way as their counterparts in Ontario.

Throughout this process, many midwives were also extremely resistant to working with physicians. To be sure, this hesitancy exists in all jurisdictions; however, it was especially salient in Quebec. This is a bit of a vicious cycle: doctors do not trust midwives, who avoid working with them because of this mistrust, which then denies physicians the opportunity to learn that midwives are quite competent. One informant referred to the establishment of the initial certification program for midwives at Trois-Rivières, far away from any medical school (Interview, Dec. 6, 2016). Quebec midwives have also been less likely to work in hospitals than Ontario midwives (CTV Montreal,

2018; Vadeboncoeur, 2004; Vadeboncoeur et al., 1996). All of this has created a culture of separation, which, while more consistent with the traditional midwifery philosophy of demedicalization, prevented the medical establishment from becoming comfortable with the profession (Interview, Montreal, Dec. 6, 2016; interview, telephone, Feb. 1, 2017). While a desire to avoid working with a hostile profession is understandable, one informant from the government side argued that these midwives "did not help their cause" (Interview, Montreal, Dec. 6, 2016, translation mine).

By the end of the experimentation and evaluation process, midwifery's professional project had reached the point of inevitability. Ms. Brabant recalled the moment where the Minister of Health said that the doctors no longer had an ear on this particular issue, and that the evidence was now clearly stacked in favour of the midwives (Interview, Montreal, Jan. 10, 2017). Dr. Poirier recounted that, when they presented their findings to the Minister, "I thought I was about to have a scientific discussion with a colleague, but to my surprise...he immediately switched into political mode...who would resist it, who would be allies, [etc.]" (Interview, Montreal, Dec. 16, 2016, translation mine). In fact, once the decision was effectively made, doctors had no choice but to strategically shift to a strategy of deskilling (Interview, Ottawa, Oct. 18, 2016; Interview, Montreal, Dec. 6, 2016).

In Quebec, the three facilitators of cross-coalition learning are notable by their absence (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988). The case features a classic example of an 'extremist' participant in Dr. Roy. Quebec did not provide the necessary venues for productive dialogue between midwives and the medical profession that we saw in Ontario. And, Quebec physicians lacked the direct experience

with midwives that had inclined their Ontario counterparts toward more supportive postures. As a result, the social policy learning visible in the Ontario case did not occur here. Doctors' groups moved in near-lockstep with one another, obstructed a process of which they felt shut out and only switched nominal positions on midwifery when it became an absolute strategic imperative to do so. This underlines the importance of changing individual hearts and minds to this particular case and challenges resource-driven accounts of physician resistance in these provinces (see Bourgeault, 2006; Vadeboncoeur et al., 1996).

The analysis now turns to Alberta, a story of a unique path to regulated midwifery that features some counterintuitive behaviour from physician organizations. While Quebec and Ontario showcase a relatively straightforward between cooperation and obstructionism, the Alberta experience hinges more on a critical strategic misjudgement from organized medicine. This case, which concerns a very different path to regulated midwifery than observed in Quebec and Ontario, is described over the following pages.

Alberta

Looking at the state of Alberta healthcare in the late 1970s, the province appeared to be a prime candidate for drama-free midwifery reintegration. Wild rose country had a more recent history of legal midwifery than elsewhere in Canada, with limited nurse-midwifery programs persisting in sparsely-populated areas until the 1960s (Plummer, 2000) – the concept was then already quite familiar to many physicians and healthcare administrators. The province also technically still permitted unlicensed midwifery in rural areas, a unique

legal quirk in the Canadian context (Williams & Levy, 1992).[54] As well, the structure of organized medicine reflected that of Ontario rather than Quebec's union-like environment (Archibald & Jeffs, 2004; Sullivan, 1988).

As in Ontario, Alberta organized medicine began from a position of incorporation. In fact, while Ontario's College of Physicians and Surgeons only discouraged physicians from home birth attendance, Alberta's banned the practice entirely in 1981 (Canadian Press, 1981). Commented College president Dr. Roy le Riche, "We don't care if these women choose to have their babies on top of a manure pile, as long as they leave the medical profession out of their bad decisions" (in Goulet & Botting, 1999). The ban came despite outcry from pro-midwifery physicians, who were prominent in Alberta as in Ontario (Canadian Press, 1982, 1988; Health Disciplines Board, 1991, p. 57). It quickly backfired, galvanizing midwives and their supporters (James & Bourgeault, 2004; McKendry & Langford, 2001); looking back, Dr. Ben Toane, the most prominent pro-midwifery physician in Alberta, commented "we can credit Dr. le Riche with the establishment of midwifery as a profession in this province, because he single-handedly convinced physicians to prohibit their colleagues from attending home births...thereby leaving the door open for the venerable profession of midwifery to find its rightful place" (in Michaels, 2009).

The next year, the province's domiciliary midwives submitted an unsuccessful proposal to the Health Disciplines Board for regulation. Unlike in Ontario, they did not first form a united front with nurse-midwives (McKendry & Langford, 2001). As domiciliary midwives – whose discipline was purposefully distinct from nursing and

[54] This stemmed from a 1903 ruling from the Supreme Court of the Northwest Territories (which at the time included Alberta), which determined that midwifery was not medicine (Moysa & Aikenhead, 1991).

emphasized community practice, including home birth – were the less compatible of the two groups with traditional medical sovereignty (ibid), it is little surprise that doctors' groups opposed this proposal altogether. However, the same year, the College of Physicians and Surgeons set up a task force to examine hospital midwifery (ibid). The re-emergence of the midwifery program at University of Alberta in 1987 also signalled an expectation that the practice would soon see an official renaissance (Canadian Press, 1986; Plummer, 2000).

In 1988 the province's Advisory Council on Women's Issues put forward a discussion paper on midwifery, outlining the arguments for and against introducing the practice to Alberta maternity care (Alberta Advisory Council on Women's Issues, 1988).[55] The paper described how physician groups in Alberta denied the need or demand for midwifery services (Alberta Advisory Council on Women's Issues, 1988). Laurie Blakeman, former Liberal MLA and long-time advocate for midwifery and other feminist causes, served as executive director of the Council. In an interview for this project, she recounted how this council served as an intermediary between activists and the government; as they could "move between these worlds," they were able to set the stage for another debate on midwifery reintegration (Interview, telephone, Jan. 25, 2017).

Midwives applied again for regulation again in 1989, this time as a unified Alberta Association of Midwives (McKendry & Langford, 2001). According to Dan Charlton, who worked on this file through the Health Disciplines Board as director of the Health Disciplines Act, the midwives already had a friendly ear with the Alberta bureaucracy (Interview, Edmonton, Oct. 28, 2016). He recounted,

[55] The Advisory Council had been established by Legislative Act in 1986 to "advise and report to the Alberta Government, and to develop recommendations on any matter relating to women" (Alberta Advisory Council on Women's Issues, 1988, p. 1).

> "I think the feeling we had right from the beginning, to be frank about it, is we've got to figure out a way to get them regulated. We've got to get them recognized as a legitimate profession, get standards in place and establish a scope for them so that we at least avoid some of those legal problems and also respond positively to the pressure from the consumer community and from the midwifery group" (ibid).

The problem, according to Mr. Charlton, was to convince the Minister that this "political hot potato" (ibid) was worth taking on. As Alberta was dominated politically by the Progressive Conservative Party, the midwives and their allies knew that their home province might not be as amenable to the same sort of social movement-driven pressure that was working in Ontario and Quebec. They responded by hiring Ken Chapman, a lawyer and prominent PC insider, to be their 'Tory whisperer.' In our interview, Mr. Chapman explained that, aside from a general interest in social justice issues, he did not have much in the way of knowledge about the case. He recalled,

> "They thought I'd get my phone calls returned...When they first called me I said 'Why me?' And they talked about the political connections and the influence and capacity to maybe advance a cause. But I said sardonically to them, 'Look, I'm an only child and an adoptive father so what I don't know about childbirth is pretty much everything!' And they said, 'Well that's really good, we'll teach you!'" (Interview, Edmonton, Oct. 27, 2016).

Mimicking the formal processes that took place in Ontario, the Health Disciplines Board then invited submission from groups and individuals who wished to weigh in on the matter. At this point, physician groups declared that they would accept hospital-based midwives working as part of interdisciplinary teams (Health Disciplines Board, 1991; McKendry & Langford, 2001, p. 536). However, they nevertheless raised concerns about the safety of midwifery care (Health Disciplines Board, 1991, append. II). The College also maintained that introducing a new practitioner into the system was at this time unnecessary, and

that the practice should be confined to specially trained nurses (ibid). Both the Alberta Medical Association and the College remained opposed to home birth (Health Disciplines Board, 1991). When asked to give a simple yes or no answer to designating a new midwifery profession under the *Health Disciplines Act*, the College of Physicians and Surgeons, the College of Family Physicians and the Alberta Society of OB/GYNs said no, while the Association abstained (Health Disciplines Board, 1991, append. I).

We might nevertheless describe doctors as inching toward deskilling, since as organizations had expressed openness to midwifery in principle. However, such a strategy of deskilling came with a major asterisk. Before the Health Disciplines Board released its recommendations, physician groups took the familiar step of pursuing legal action against a midwife assisting in a home birth, accusing Noreen Walker of practicing medicine without a license (Mickleburgh, 1990). This case was prompted by a complaint from Dr. William Young, who had previously been the obstetrician to the mother in question and was also president of the Society of Obstetricians and Gynaecologists (Moysa & Aikenhead, 1991; Williams, 1991). The mother, Kathy Charpentier, told the court that she decided to pursue a home birth after Dr. Young stripped her membranes without her permission – Dr. Young in turn said he felt "betrayed" by her decision (in Kent, 1991; Moysa & Aikenhead, 1991).

At this time, Alberta officially permitted unlicensed midwifery in rural areas; however, the prosecution argued that, as the birth was a vaginal birth after

Caesarean (VBAC), [56] it went beyond the accepted scope of lay midwifery (Williams, 1991). However, unlike in Ontario and Quebec, this birth was free of complication, its only distinguishing feature being that it was a VBAC (Mickleburgh, 1990; Williams & Levy, 1992). McKendry and Langford deem this charge a "final, desperate attempt to maintain its legal incorporation of midwifery skills" (2001, p. 537). While they formally stuck to their nominal position of deskilling, the College's action here demonstrates a view of midwifery care as inherently illegitimate and dangerous.

The trial was high profile, galvanizing supporters of midwifery across the province (Kraus, 1990; Mickleburgh, 1990; Williams, 1991). As in Ontario, Noreen Walker and the midwifery movement framed the case around the broader midwifery question, with Ms. Walker arguing "I think I've been charged because doctors want to keep total control of medical care in this country" (in Mickleburgh, 1990; see also Ramondt, 1991). The case ultimately resulted in a directed acquittal; the judge concluded, "nowhere can I find evidence in this case that Ms. Walker was practising medicine...This was a normal, natural and uncomplicated birth" (in Moysa & Aikenhead, 1991; see also Burtch, 1994). Noreen Walker did not even have to testify. The implications of the verdict were significant; it confirmed that lay midwifery was not a crime in Alberta under the existing legislation, reinforced that midwifery was not medicine and characterized VBACs as potentially "safe" and "uncomplicated" (Moysa & Aikenhead, 1991).

[56] VBACs are being increasingly recognized as safe and legitimate options in most cases (HealthLinkBC, 2017).

Recalled Noreen Walker in an article she authored several years later, "we felt like David must have felt after he slew Goliath" (1999).

The Health Disciplines Board had in fact already decided to accept midwives' bid for regulation, but waited until after the court case had concluded to make its recommendations public (Health Disciplines Board, 1991; McKendry & Langford, 2001; Midwifery Services Review Committee, 1992). At this point, doctors' groups continued to pursue deskilling while regulations were developed, only dropping their opposition to home birth after the practice was fully legalized (McKendry & Langford, 2001; Moysa, 1991). Mr. Charlton recalled that the Alberta Medical Association was a bit more reluctant than the College, but that both got onside by the very end (Interview, Edmonton, Oct. 28, 2016).

The matter of financing was much more difficult in Alberta than elsewhere, as midwifery services went without government funding until 2009 (Berenyi, 2011). [57] Doctors' role in this delay is debatable. James and Bourgeault (2004) write that the financial issue was a sore spot for physicians, who were struggling to protect their own piece of the healthcare funding pie. However, McKendry and Langford (2001) argue that the initial lack of financing was more a result of the rightward shift as Alberta entered the Klein era than sustained opposition from physicians. Laurie Blakeman recalled how she tried for years to convince successive ministers to fund the service, only to be successful with Ron Liepert, a conservative lawmaker (and now a Conservative MP) who she described as "the last person on earth anyone expected to get it from" (ibid). Looking back, she described the government's action on midwifery as motivated largely by

[57] It took even longer – until 2013 – before midwives were finally allowed to set up an independent professional college (Pratt, 2012).

"whimsy" rather than any consistent logic, as ministers make policy decisions based on spur-of-the-moment reactions to proposals (ibid).

Ms. Blakeman also discussed how the financing issue was compounded by the government's initial refusal to cover insurance for midwives (L. Blakeman, interview, telephone, Jan. 25, 2017). "Doctors can charge enough that they can get that insurance paid, and if you work in a hospital the hospital pays it. If you're working in a clinic, the clinic pays it. But these were women on their own," she explained. "We did lose the first group of midwives as a result of that" (ibid). I encountered this phenomenon firsthand when attempting to track down interviewees for this project, as many of the midwives I had hoped to reach while visiting Alberta had long since moved away.

To sum up, Alberta organized medicine falls in between Quebec and Ontario in terms of its shifting position on midwifery. In Alberta, medical organizations did not obstruct to the degree seen in Quebec, but largely declined to give a simple endorsement to midwifery in their submissions to the HDB. Nevertheless, they were gradually moving toward deskilling as the debate wore on; however, they then suddenly decided to prosecute a midwife who had delivered a healthy baby at the eleventh hour. This is not a recipe for successful public relations. In the end, the Alberta midwifery debate saw a rather disorganized medical profession, responding in a way Mr. Charlton described as "clumsy" (Interview, Edmonton, Oct. 28, 2016).

Alberta then presents an unusual pattern of behaviour from physician organizations. Doctors had been slowly coming around to midwifery; however, at the last minute, they switched back to a posture of incorporation. The reasons behind their initial shift toward deskilling are similar to those seen in Ontario. There were several

opportunities throughout the process for midwives to incite social policy learning within the medical establishment, as well as formal submission processes laid out in the HDB. Moreover, the structure of organized medicine in Alberta is more similar to Ontario than Quebec. While the AMA was the recognized bargaining agent for physicians, it did not benefit from the Rand formula, a dynamic which persists to this day (see Archibald & Jeffs, 2004). The culture of solidarity that we see in Quebec, in which individual physicians are strongly discouraged from publicly disagreeing with their associations, is also absent in Alberta.

Indeed, pro-midwifery physicians were some of the loudest critics of the College's decision to ban home birth in 1981 (Canadian Press, 1982). Among them was Dr. Ben Toane, who would go on to become the midwifery movement's most prominent medical ally, and whose persistence in assisting home birth was one of the reasons behind the College's action (Michaels, 2009). One midwifery informant described how, as in Ontario, physicians trained in locations where midwifery was already in place were more amenable to the practice (Interview, telephone, Feb. 14, 2017). This had an impact on the posture of the College and association; indeed, this same informant recognized that there were "threads of support" for midwifery within organized medicine. For his part, Mr. Charlton discussed how the College lacked unity on midwifery (Interview, Edmonton, Oct. 28, 2016). He argued that more moderate members were active within the debate and helped to move the College away from incorporation and credits organized medicine with "honestly engaging with the process," similar to what was observed in Ontario (ibid). Indeed, as in Ontario, interviewees here describe how resistant doctors can be turned into supporters – one midwifery informant even indicated that Dr. Young, the

obstetrician behind the complaint against Noreen Walker, has become a supporter in recent years (Interview, telephone, Feb. 14, 2017).

If Alberta medicine was moving toward support in a similar way seen in Ontario, how can we understand its late shift back to a strong defense of incorporation? Pursuing the case against Noreen Walker was counterintuitive and counterproductive, undermining the College's own conciliatory posture during the Health Disciplines Board negotiations, and turning into a significant public relations problem for the medical profession. To understand how doctors got to this point, we must consider the difficulty of pushing for midwifery in Alberta at the beginning of the 1990s. In our interview, Ms. Blakeman described some of the challenges she faced as a feminist activist in Alberta. For one, they lacked the raw number of activists that could mobilize in support of midwifery in places like Ontario and Quebec. She explained, "[Edmonton] was a city of half a million people then...We're not Detroit, we don't have thousands and thousands of women who would step out and self-identify. We had dozens and dozens, or maybe a hundred and a hundred" (Interview, telephone, Jan. 25, 2017). James and Bourgeault (2004) also point out that, in Ontario, the pro-midwifery lobby benefitted from a rosy financial situation in the 1980s as well as a progressive shift in government ideology. Meanwhile, Alberta midwives faced an unfavourable fiscal climate and a government that was not exactly feminist-friendly to begin with.

While it is surely an oversimplification to refer to Alberta as an inherently conservative place, the reticence of this particular government toward midwifery came up again and again with interviewees, which in turn affected how doctors were able to control the narrative even as they moved to deskilling. While Mr. Charlton recalled that

the bureaucrats were never met with any explicit resistance from the political side, there was little enthusiasm for the file (Interview, Edmonton, Oct. 28, 2016); meanwhile, informants in Ontario and Quebec referred to numerous specific political allies who were willing to directly confront medical opposition (V. Van Wagner, interview, telephone, Apr. 29, 2016; I. Brabant, interview, Montreal, Jan. 10, 2017). Mr. Chapman also discussed politicians' discomfort and lack of familiarity with this issue. He recounted one incident in particular in which, after being given a presentation on how midwifery works, a female MLA interjected, exclaiming, "my idea of childbirth is give me the epidural and wake me up when the hairdresser arrives!" (Interview, Edmonton, Oct. 27, 2016). He recalled that the men on the committee would repeatedly refer to the midwives as "girls" or "dear" (ibid). Even when they tried to tailor their pitch to a conservative government by highlighting consumer choice, this did not resonate as well as the midwives had hoped (ibid).

Faced with such an unfavourable government, Alberta's midwives found themselves in a bind at the turn of the decade. While doctors had backed away somewhat from incorporation, they were still pursuing a fairly aggressive deskilling strategy (Health Disciplines Board, 1991; McKendry & Langford, 2001, p. 536). At the same time, as in Ontario, the province's nurses were pushing for midwives to be incorporated under their legislation (D. Charlton, interview, Edmonton, Oct. 28, 2016). Faced with these two arguments and an unsympathetic cabinet, the chances of midwives achieving full self-regulatory status, the right to perform home births and public funding appeared slimmer by the day. Mr. Chapman described interactions with organized medicine during this time as "polite conversations that were pointless," as "[doctors] held all the cards" (Interview,

Edmonton, Oct. 27, 2016). While organized medicine had moved from incorporation to deskilling, they appeared able to hold that line without making further significant concessions.

When the College pursued charges against Noreen Walker, it provided the midwives with an opportunity to change the debate. Mr. Chapman recalled,

> "I remember the core group of the midwives coming to me in tears and saying isn't this terrible, but my legal mind said this is wonderful! This is now a test beyond a reasonable doubt.... Babies are born in taxicabs, babies are born on riverbanks, babies are born all over the place all over the world. If they think this is criminal, we have them." (Interview, Edmonton, Oct. 27, 2016)

The case proved to be a turning point in midwives' public relations as well. Continuing, Mr. Chapman explained, "what happened is that we just became such a *cause célèbre* amongst women that they rose up against this and the doctors looked really bad. They wanted to withdraw the charge, but we wouldn't let them" (Interview, Edmonton, Oct. 27, 2016; see also Michaels, 2009).

While one midwifery informant described the case as an opportunity to persuade doctors of midwifery's merits (Interview, Edmonton, Feb. 14, 2017), it does not appear to have facilitated the kind of broad discussions about professional regulation that occurred in Ontario. Rather, according to Mr. Chapman, the case was "leverage" in a "pure political play" (Interview, Edmonton, Oct. 27, 2016). He now believes the charge was laid in a "procedural error" (Ken Chapman, interview, Edmonton, Oct. 27, 2016); however, the College had turned itself into a political strawman, making physicians look radical and unreasonable. Through Noreen Walker's trial, midwives could galvanize public opinion and overcome medicine's deskilling efforts.

In Alberta, we can again see instances of strategic retreat and social policy learning. As usual, medicine engaged in strategic retreat from incorporation to deskilling as the debate wore on. As for social policy learning, Mr. Charlton explained how the College was not united on midwifery from the beginning, with more moderate members working as brokers to soften resistance (Interview, Edmonton, Oct. 28, 2016). Further supporting the ability of physicians to grow and evolve on midwifery, another informant described how Dr. Young, the doctor who initially issued the complaint against Noreen Walker, has turned into a supporter (Interview, telephone, Feb. 14, 2017). However, neither strategic retreat nor social policy learning explains doctors' shift back to incorporation with the case against Ms. Walker. While this may have been a mistake on the part of organized medicine, one must consider that midwives might not have always *wanted* a more amenable medical profession. In this case, doctors had moderated somewhat, but their arguments were proving quite effective with the government. To overcome them, the midwives and their allies seized the chance to paint doctors as unreasonable.

Alberta then adds a new dimension to the analysis. In Ontario, midwives benefitted from formal structures and processes that allowed them to incite social learning within the medical profession. In Quebec, the lack of a formal process denied midwives this opportunity. Now, in Alberta, we see a case where the midwives had successfully moved doctors to a position of deskilling, in part through inciting the same kind of social policy learning seen in Ontario. However, Alberta doctors then moved back to incorporation. This was to the midwives' benefit; In Alberta, it was not enough to

try and bring physicians onside; they had to set doctors up as a political foil in order to complete their push for a recognized, independent, self-regulated midwifery profession.

The three provinces explored thus far are among the four largest in the country, and all legalized midwifery before the turn of the century. For a more complete picture of debates over midwifery regulation in Canada, we now turn our attention to a small province with a more recent experience. Nova Scotia presents a distinct dynamic from the other provinces explored in this case, with a more ambiguous posture coming from the medical profession throughout the debate.

Nova Scotia

Of all the cases considered here, Nova Scotia has attracted by far the least academic attention. There are a few plausible reasons for this omission. First, Nova Scotia is a small jurisdiction with limited political stature, and events there often go unnoticed by the rest of the country. Second, the province lacks the high-profile clashes with doctors that have historically characterized physician-state relations in Ontario, Quebec and British Columbia, as in Atlantic Canada doctors traditionally settle disputes with government informally and behind closed doors (Tuohy, 1999, p. 210). Drama attracts more attention than quiet, restrained disagreement. Finally, the Nova Scotia midwifery story is still not settled. The province is technically still in an 'experimentation' period – albeit one without a fixed end date that appears more and more permanent every day. There was never a definitive moment in Nova Scotia when the dust settled and academics could begin analysing the midwifery experience, secure in the confidence that the policy debate over regulation had concluded and that their findings would not be rendered obsolete.

Analysing the Nova Scotia case is somewhat challenging, as physicians' posture is often ambiguous. One medical informant explained that the physician association never really had a formal policy on midwifery regulation (Interview, Nova Scotia, Apr. 28, 2016). This is not uncommon; as mentioned in the pharmacy discussion, organized medicine in Nova Scotia does not have a strong tradition of issuing formal policy statements (Kevin Chapman, interview, Halifax, Apr. 27, 2016). As a result, there is far less stringent of a 'party line' for individual physicians to either toe or challenge. Media are often also left to rely on the personal musings of whoever happens to be in charge at any given moment. More than any other province studied here, then, Nova Scotia organized medicine's policy positions can be essentially captured by whoever happens to be in charge, resulting in significant shifts in posture when leadership changes. This potentially allows either 'brokers' or 'extremists' significant sway over each of the debates studied in this dissertation (see Jenkins-Smith et al., 2017; Sabatier, 1988; Weible et al., 2009).

Before the province decided to integrate midwifery, figures from the Medical Society of Nova Scotia (MSNS, later Doctors NS) occasionally spoke to media outlets on the issue as midwives were gaining recognition elsewhere across the country. In 1992, its president denied any need for a new provider despite the exodus of physicians from obstetrics that had only worsened since the previous decade (Barrington, 1985; Lethbridge, 1992). In 1996, a report from the chief of obstetrics in Yarmouth supported hospital midwifery but castigated home birth (Medical Post, 1996b). Later that same year, a government-appointed committee began a review of the reproductive care system (Moulton, 1999). MSNS, now led by Dr. Cynthia Forbes, took the unusual step of issuing

a position paper on midwifery, giving it a "conditional thumbs-up" due in large part to a worsening physician shortage and declining interest in obstetrics (Medical Post, 1996a). The document even recommended self-regulation, but expressed a preference for pilot projects before full integration into the system (ibid).

The next year, following recommendations from that committee, the Minister announced the government's intent to regulate midwifery, fund the practice and investigate alternatives to hospital birth after consultation with physicians and other affected practitioners (Thorne, 1997). Despite the Society's past support, the new MSNS president expressed concern, saying the plan would have to ensure that Nova Scotia maintained its high standards for infant health (Moulton, 1997). In 1999, the society again had a new president – Dr. Robert Mullan – who took an even harsher stance against midwifery, calling the service impractical and expensive (Moulton, 1999).

The government then struck a Working Group, which included physician representation, to discuss how to implement midwifery services in Nova Scotia. The Working Group released its report in May of 1999, recommending that the government recognize midwifery as a self-regulating profession in Nova Scotia, governed by a College of Midwives, and that it include midwifery care among its insured health services. The principles articulated in the report emphasized consumer choice in childbirth as well as the distinct philosophy of midwifery practice (Interdisciplinary Working Group on Midwifery Regulation, 1999). Despite Dr. Mullan's objections expressed only four months earlier, representatives from MSNS and the College of Physicians and Surgeons endorsed the report, with the exception of one provision that they saw as implying support for home birth (ibid). However, even on this point both

organizations reiterated their support for freedom of choice in birth location – their objection was based on their perception that rapid transportation to a hospital would not be consistently available in case of emergency.

Despite this support from physician organizations, the following year the province's new Progressive Conservative government scrapped the midwifery plan on the grounds that there were not enough midwives for self-regulation to be feasible (Moulton, 2000). Louise McDonald, a practising midwife in Nova Scotia at the time, remarked that "the new government is too busy slashing essential services to really do anything about looking at midwives" (in Klager, 2000). The debate would remain on the back burner until 2006, when the same government suddenly announced that it would finally regulate the profession (Doucette, 2006). However, due to a low number of midwives, the service would only initially be offered in three pilot sites (Benjamin, 2010). This time, doctors were extremely quiet in response – Maureen MacDonald, who became Health Minister shortly after the new regime came into effect in 2009, recalled that she "didn't hear a peep" from doctors about midwifery (Interview, Halifax, May 2, 2016).

The structure of the pilot projects just so happened to be fairly in line with some of physicians' demands elsewhere in the country. In lieu of self-regulation, the plan that emerged involved a regulatory council including members from midwifery, nursing, medicine and the public (Midwifery Regulatory Council of Nova Scotia, n.d.). However, interviewees explained that this decision was made due to the prohibitively low number of midwives more so than any physician pressure (Interview, telephone, Sept. 19, 2016; interview, Halifax, Jan. 19, 2017). Explained one midwife, "employee/employer models seemed to make sense...there were so few people and there just wasn't enough money,

quite frankly, to support an independent contracting arrangement" (Interview, Skype, Mar. 25, 2016). While many in the midwifery community would still like to someday see self-regulation (Interview, telephone, Sept. 19, 2016; Interview, Halifax, Jan. 19, 2017), it would first require a significant influx of new midwives.

Organized medicine's amenable position was undermined by what one interviewee described as a passive-aggressive posture from individual physicians, particularly those in charge of the obstetrics program at the IWK children's hospital in Halifax, one of the three pilot sites (Interview, telephone, Sept. 19, 2016, see also Interview, Halifax, Jan. 19, 2017; K. Kaufman, interview, telephone, Apr. 4, 2016). Another interviewee further argued that the obstetrics department used any argument they could think of to keep the fledgling program within the hospital itself, where midwives would be "handmaids to the obstetricians" (Interview, Halifax, Jan. 19, 2017). By 2010 – the year after midwifery was officially regulated – all midwives in Halifax had quit the program, placing its future in jeopardy (Moore, 2010). One of those midwives, Karen Robb, blamed a "clash of belief systems" for creating a toxic work environment (in Moore, 2010; see also K. Kaufman, Robinson, Buhler, & Hazlit, 2011; K. Kaufman, interview, Apr. 4, 2016). However, even at the height of this crisis in 2011, the president of Doctors Nova Scotia expressed strong support for the pilot program, affirming that midwives could provide women with a uniquely positive birthing experience (Cardwell, 2011). In this tumultuous time, the association could have fought against the experimentation with probably more success than its Quebec counterparts, but it did not – in fact, its president took an even more supportive posture than the organization had in the past.

Today, the pilot projects are looking more and more permanent. The NDP and Liberal governments that followed the PCs have repeatedly declined to expand the program, much to the consternation of midwives and their allies (see Appendix B). Minister MacDonald, responding to such criticisms in our interview, recalled,

> I met with two people and I said to them, 'What do you want me to do? I don't have a midwife in this bottom drawer I can just haul out and dust off and send over to the IWK. [58] This is a problem. I realize this is a problem. But you know, it's not a problem that can be solved just like that.' (M. MacDonald, interview, Halifax, May 2, 2016)

The problem is not just one of political ambivalence, but also public ambivalence. One interviewee from the pro-midwifery community described their frustration convincing the wider Nova Scotian public that an expanded midwifery program would be beneficial, as many are self-conscious about anything that might seem old-fashioned (Interview, telephone, Sept. 19, 2016). The story of midwifery in Nova Scotia, according to interviewees, is one of perpetual frustration and setback.

The most noticeable feature of the Nova Scotia experience is the importance of the association's president in setting organized medicine's *de facto* position. MSNS, later DNS, lacks a strong tradition of official public policy statements, which empowers the president to effectively drive the organization's positioning through their public statements. This position turns over annually, resulting in significant variability in MSNS/DNS's posture. Compounding matters, the College of Physicians and Surgeons was not particularly visible within the public debate on midwifery, although it did have representation on various committees throughout the process. The result is a mess of mixed signals from various figures within organized medicine that sometimes make it hard to pin down any position at all.

[58] IWK refers to the Izaak Walton Killam Health Centre, a children's hospital in Halifax.

However, there is a distinct pattern of ambivalence from Nova Scotia's medical establishment on the topic, one that stands in contrast to the righteous fury seen in Quebec and the relatively constructive contributions of medicine in Ontario. Mr. Chapman discussed mild concerns among the DNS membership regarding return on investment and relative costs of midwifery services compared to medical obstetrics – a common concern for Canadian physicians (Interview, Halifax, Apr. 27, 2016; see also Interview, Nova Scotia, Apr. 28, 2016). However, he painted these concerns as relatively minor. Even among grassroots opponents to midwifery in Nova Scotia, there was not a particularly strong effort to push their association to combat the changes – instead, according to pro-midwifery interviewees, they quietly undermined midwives' work once the pilot project was underway (Interview, telephone, Sept. 19, 2016; Interview, Halifax, Jan. 19, 2017).

In Nova Scotia, language around incorporation and deskilling then becomes almost obsolete, as there is very little to work with in terms of official statements and comments. DNS changed its position over time, but shifts were the result of changes in the organization's political leadership. Some Nova Scotia doctors did obstruct the implementation process, but this took the form of grassroots resistance rather than organized attempts to stop midwifery regulation.

What explains this posture of ambivalence from Nova Scotia physicians? In this case, the elephant in the room is the structure of the pilot projects that eventually emerged. This is not the self-regulated autonomous profession that we see elsewhere, but is much more in line with what we would expect doctors to prefer. There is even a doctor on the regulatory council. As was the case with respect to pharmacists' prescribing for

'minor ailments,' it might be intuitive to trace doctors' support for midwifery in Nova Scotia to the restrained nature of the new regime. However, this time there is not much evidence to support such a conclusion. Even back in 1996, Nova Scotia doctors anticipated and accepted some form of self-regulation for midwives, as discussed in their "conditional thumbs-up" – there is no indication that they would have drawn a line in the sand around regulation (Medical Post, 1996a). The connection between the structure of the pilot projects and doctors' posture is then tenuous. However, the two phenomena do share a common cause: The process from the beginning was highly bureaucratized, treated as a technical challenge for public servants rather than a response to a social movement, which both prevented any public pushback from medicine and hindered midwives from gaining the sort of model found elsewhere in the country.

Midwifery activists lament the lack of a political "champion" in Nova Scotia (Interview, Halifax, Jan. 19, 2017) – as in Alberta, there was no obvious ally in the Nova Scotia legislature on whom midwives could count. For her part, Minister MacDonald – who is not herself opposed to midwifery – does not believe the public push was particularly strong. She explained,

> My perception is that midwifery appeals to a very small segment of the public. I tended to hear from crunchy granola type people, I tended to hear from hipsters in the city... I didn't hear from one other living, breathing soul who wouldn't fall into that category. (M. MacDonald, interview, Halifax, May 2, 2016)

Indeed, even the Midwifery Coalition of Nova Scotia – the voice of the consumer movement supporting midwifery – has recently been "losing steam" according to one interviewee (Interview, Skype, Mar. 25, 2016), and many of its members have become "burnt out and jaded," according to another (Interview, Halifax, Jan. 19, 2017). All of this

had the effect of depoliticizing midwifery as an issue, to the disappointment of advocates such as the pro-midwifery physician quoted earlier. However, one midwife believes this was on balance a positive development. They explained,

> I really need to applaud the leadership of the department in NS at the time, who rather than buying into the trappings of all the hype around midwives, and trying to do what everybody else was doing, moved it through a process that they would have for any other healthcare provider...[Meanwhile], every other province has added midwives or implemented midwives on the sole basis of political pressure. (Interview, Skype, Mar. 25, 2016)

While there is substantial disagreement between interviewees on the relative merits of this model – it is an unusual position for a midwife to hold – the bureaucratized approach that generated it appears to have pre-empted any kind of concerted political opposition from doctors. In Nova Scotia midwifery was dealt with relatively quietly as a technocratic problem rather than as a public clash of ideologies.

As discussed in the literature on physician-state relations in Canada (Lomas et al., 1992; Tuohy, 1999), Nova Scotia, along with the rest of the Atlantic Provinces, has a reputation for avoiding the sorts of public confrontations with medicine seen in other provinces. In the midwifery case this already-existing tendency was reinforced by several other circumstantial factors. Nova Scotia was a very late adopter of midwifery; informants described how this created a sense of inevitability around the practice, as it is difficult for such a small province to resist national trends (Interview, Skype, Mar. 25, 2016; Interview, Nova Scotia, Apr. 28, 2016). It also meant that the medical community was not totally unfamiliar with the idea. According to one medical informant, "the fact that Ontario had an established program probably gave physicians more comfort" (Interview, Nova Scotia, Apr. 28, 2016).

Ontario, Alberta and Quebec midwives should not, however, look upon the Nova Scotian experience with too much envy. While the informality of the debate negated any sustained opposition from the province's doctors, it also engendered a less predictable medical establishment. Without official, strong, formal public statements from either MSNS/DNS or the College, the accepted position of organized medicine was left up to whoever happened to be in charge of the medical association at any given time. While in other provinces the president of the medical association is often likened to a spokesperson with relatively little autonomy (Interview, telephone, Jul. 7, 2016, L. Mittelsteadt, interview, Edmonton, Jan. 26, 2017), in Nova Scotia they serve as a much more independent voice. As previously mentioned, Minister MacDonald recalled that her relationship with DNS changed significantly depending upon who happened to be in charge (M. MacDonald, interview, Halifax, May 2, 2016). While Nova Scotia was then amenable to brokers emerging at the highest levels of DNS, midwives could never be sure if the next president would be an ally or an adversary.

Even more importantly, while Nova Scotia appears to have offered a venue conducive to cross-coalition learning in discouraging all-out clashes between midwives and medicine, the informality of the process also allowed unaddressed questions to fester behind the scenes. There were no grand 'a-ha' moments as we saw in in Ontario, and there were few opportunities for midwives to engage publicly with the medical establishment. The result was an unhealthy working environment at the IWK, in which doctors were clearly unprepared for the entrance of midwives into the system. While one midwifery informant praised Nova Scotia for fostering "integration" rather than a separate profession (Interview, Skype, Mar. 25, 2016), this integration was not preceded

by any major shift in grassroots physician attitudes, and, as such, quickly imploded. Without a high-profile public process through which the two sides could hash out their differences, many medical sceptics remained sceptics. While DNS supports midwifery today, discontent in the rank and file may have been better alleviated by a more public discussion rather than behind-the-scenes dialogue.

As in the other three provinces, certain elements of the Nova Scotia experience suggest organized medicine became more supportive of midwifery out of strategic retreat rather than social policy learning. Midwifery poses less of a threat to medical sovereignty in Nova Scotia than elsewhere, and the province did not integrate midwifery until its re-emergence had already grown into a national trend. However, other important factors point to a deeper kind of learning that does not hinge on strategic considerations or imperatives. First, the power and independence of the MSNS/DNS president allowed incumbents to speak with relative freedom on this issue without needing to change formal policy. While we do not see the evidence of broker participants observed in Ontario and Alberta, some presidents were clearly more amenable to midwifery than others, which caused the posture of the association to shift according to who happened to be in charge (Cardwell, 2011; Medical Post, 1996a; Moulton, 1999). Second, the behind-the-scenes nature of Nova Scotia medical politics and the bureaucratization of this debate in particular provided venues and forums suitable for cross-coalition dialogue and learning (Lomas et al., 1992; Tuohy, 1999; Interview, Skype, Mar. 25, 2016; J. Brooks, interview, telephone, May 1, 2017). Finally, in regulating midwifery relatively late, there was ample evidence to which Nova Scotia midwives could point to support their claims (Interview, Nova Scotia, Apr. 28, 2016). All of these align with what adherents to the ACF put

forward as facilitators of cross-coalition learning on core policy beliefs (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988).

Indeed, there is evidence to support the idea that medicine's support of midwifery was more than reluctant, surface-level tolerance, signalling that threads of social policy learning did exist within organized medicine. For one, MSNS/DNS had endorsed self-regulation in the 1990s, which suggests that the employer/employee model that eventually emerged was not critical to securing doctors' support. Rather, medicine signalled its willingness to support a more independent midwifery profession, as seen elsewhere in the country. Moreover, the association declined to use the problems of implementation at the IWK to reinforce medical sovereignty, instead expressing continued support for the pilot projects (Cardwell, 2011). It is hard to imagine Augustin Roy's Collège in Quebec declining to use such an opportunity to attack the emerging practice; however, not only did Nova Scotia organized medicine opt not to advocate for the end of the midwifery program at this time, it actually reiterated its support. This suggests a stronger acceptance of midwifery, one more in line with social policy learning than strategic retreat.

However, this is clearly not the same social policy learning we observed in Ontario. In Ontario, medicine's shift involved a slow shift in the establishment's posture leading to a clear end state of acceptance of midwives. In contrast, Nova Scotia medicine shifted back and forth repeatedly on the question of midwifery, and interviewees discussed how tensions between the two professions have persisted to an extent not seen in the other provinces studied here (Interview, telephone, Sept. 19, 2016; Interview, Halifax, Jan. 19, 2017). Organized medicine shifted its core policy beliefs, but not in a

way that granted midwives the sort of clear, long-lasting victory they achieved in Ontario.

Conclusions

Discussions of midwifery – especially those isolated to a single province – tend to frame the medical establishment as inherently opposed to the practice (Bourgeault, 2006; McKendry & Langford, 2001; Vadeboncoeur et al., 1996). This is not entirely unfair, as in all provinces physicians were by and large the most resistant individual party. There is always a statement or two from medical leaders that appears protectionist when divorced from the larger Canadian context. However, in the four provinces outlined here, organized medicine displays a range of reactions to midwifery. While in all jurisdictions doctors stopped opposing midwifery in principle by the time it was legal, in some provinces they took much longer than in others and actively obstructed processes in place to consider midwifery reintegration. For example, in Quebec medicine was still pursuing a strategy of incorporation through the 'experimentation' phase; moreover, it regularly undermined efforts to consider and test midwifery throughout the process. Medicine's posture in each province is outlined in in Table 2, along with the independent variables for cross-coalition learning surfaced from the ACF and the learning mechanisms observed. As in the pharmacy case, other explanatory factors are also noted that were identified through the interview process.

Table 2: Medicine's reaction to midwifery reintegration

	Independent variables (ACF)	Other explanatory factors	Learning mechanism(s)	Medical posture
ON	• Lack of evidence from other jurisdictions • Venues for cross-coalition dialogue • Broker participants	• Political climate unfavourable to doctors • Diffusion of resources and interest	• Both social policy learning and strategic retreat	• Collaborative engagement • Early shift to deskilling
QC	• Lack of direct international experience • Lack of venues dialogue • Extremist participant/ confrontational dynamic		• Limited strategic retreat	• Obstructionism • Late shift to deskilling
AB	• Venues for dialogue • Broker participants	• Political climate unfavourable to midwives • Strategic misjudgements	• Both social policy learning and strategic retreat	• Increasing acceptance of midwifery, but late shift back to incorporation
NS	• Evidence from other provinces • Behind-the-scenes venues for dialogue	• Model of midwifery less threatening to doctors • Independent DNS presidency	• Both social policy learning and strategic retreat	• General ambivalence • Multiple shifts within DNS

Strategic retreat played a role in pushing medicine to more amenable positions in all four provinces. In all jurisdictions it became apparent that the debate over whether to legalize had ended and that future efforts to maintain incorporation would be futile. In Ontario, public perception had turned against doctors following an ill-fated strike; any obstinacy on midwifery would likely have further damaged physicians' reputation. In Nova Scotia, where the debate occurred after the practice had been legalized in many other provinces, opposing midwifery out of principle would have likely proven difficult.

However, there is a strong current of social policy learning visible across these jurisdictions as well. In past studies, it has been demonstrated that individual medical opinions on midwifery can vary based in part on exposure to the practice (see Blais et al., 1999). In the provinces studied here, it was observed once again that doctors can take evidence from their experiences working directly with midwifery and shift their core policy beliefs on birth attendance. This has jurisdiction-level implications when, as is the case for Quebec, one province sees fewer of its physicians training abroad in areas where midwifery is common. The advocacy coalition framework suggests that objective evidence and hard data are important to facilitating cross-coalition learning (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988); while this kind of first-hand experience is not necessarily 'objective' evidence as per discussions of the ACF, it nevertheless serves to challenge the pre-existing beliefs of coalition members in important ways that can contribute to social policy learning at an organizational level.

Furthermore, this discussion demonstrates that individual participants matter in fostering or inhibiting social policy learning (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988). In Ontario and Alberta, we see the emergence and influence of 'broker' participants within organized medicine, a key facilitator of cross-coalition learning as per the ACF (D. Charlton, interview, Edmonton, Oct. 28, 2016, P. Mohide, interview, telephone, Nov. 8, 2016). In Nova Scotia, the medical association shies away from formal policy, allowing the personal opinions of the president to dominate. This resulted in near-annual shifts in organized medicine's *de facto* position, with some presidents demonstrating more amenability to midwifery than others (Cardwell, 2011; Medical Post, 1996a; Moulton, 1999). Finally, in Quebec, we see a classic case of an

'extremist' participant blocking cross-coalition learning by organized medicine. This resulted in persistent opposition and a far more obstructionist posture than seen elsewhere.

Lastly, the four provinces discussed demonstrate the importance of venues and processes in which medicine can be persuaded of midwifery's merits. This again supports an explanation based at least in part on cross-coalition social policy learning (ibid). The legacy of the past hundred years of birth attendance meant that many medical leaders had to be convinced to support midwifery. In Ontario, the formal processes by which this could happen were amenable to social policy learning; they did not solely serve to signal inevitability, but also fostered to shifts in doctors' core policy beliefs. Midwives even successfully used the Toronto Island inquest as such a venue. Meanwhile, the informality in Quebec proved extremely unhelpful for the midwives. Not only was doctors' attention focused solely on midwifery, but their reaction was in part a function of feeling excluded from the debate (Vadeboncoeur et al., 1996, p. 237). Finally, in Nova Scotia the bureaucratization of the process was a double-edged sword. While it pre-empted any public opposition from medicine and encouraged a relatively technocratic, de-politicised debate, it also prevented traditionalist views from being publicly challenged like they were in Ontario. By the time the pilot sites were created, physicians were unprepared for integration and their working relationships with midwives were poor (Moore, 2010; see also K. Kaufman, Robinson, Buhler, & Hazlit, 2011; K. Kaufman, interview, Apr. 4, 2016; Interview, Halifax, Jan. 19, 2017).

These findings suggest that social policy learning is important to doctors' shifting positions on midwifery regulation. However, this conclusion needs to be qualified

somewhat. While advocates might celebrate doctors reversing their position on such a historically important element of Canadian medical sovereignty, creating such social policy learning among the medical establishment might not always be among midwives' top priorities. In Quebec, a sizeable cohort of midwives was extremely resistant to working with physicians, preventing doctors from becoming familiar with their practice. While some interviewees lament this phenomenon (Interview, Montreal, Dec. 16, 2016; Interview, telephone, Feb. 1, 2017), midwives' suspicion of doctors has ample historical grounding and should not be condemned outright. In Alberta, midwives also did not always want to keep doctors formally onside. Frustrated in their attempts to overcome doctors' deskilling arguments, the midwives used the College's alleged overreach in the charges against Ms. Walker to set them up as a foil (Ken Chapman, interview, Edmonton, Oct. 27, 2016). Mr. Chapman explained that Alberta midwives did not want a collegial College in that moment, but a lightning rod for public opinion (ibid).

Midwifery's challenge to medical dominance comes at the level of sovereignty. Midwives came into the system as outsiders, seeking to change how birth attendance services are provided. However, I have found that, despite the enthusiasm and vitriol with which doctors had initially discredited midwives, upon the practice's re-emergence there was a significant thread of social policy learning that pushed medical organizations to shift their positions on midwifery regulation. Unlike in the pharmacy case, in which change was traced to political learning and strategic retreat, in some provinces Canadian organized medicine actually shifted its core beliefs on midwifery practice.

The analysis has uncovered a significant difference between how Canadian organized medicine has responded to a threat to medical sovereignty and how it

responded to a threat to authority. On sovereignty, medicine has demonstrated flexibility on core policy beliefs, and can be substantively swayed by pro-midwifery arguments. On pharmacy, however, I found no similar dynamic. This suggests that, while medical organizations can be substantively brought around to support threats to medical dominance, the specific type of threat has significant implications for how amenable medicine will prove. Specifically, the centrality of diagnosis to medical authority meant that defending this particular aspect of physician turf was of overriding importance to medical organizations. In contrast, doctors' shift away from obstetrics appears to have allowed for more flexibility with respect to midwifery regulation. This and other conclusions and implications of the study are discussed in the following, final chapter.

7. Conclusion

Organized medicine has a more flexible and complex relationship with medical dominance than social scientists have assumed. This is the chief finding from the two preceding chapters, which have drawn on 42 semi-structured interviews with informants from medicine, pharmacy, midwifery, government and other relevant backgrounds to explore why and how organized medicine shifts it positions on threats to medical dominance. In the pharmacy case, variation between provinces was largely due to differences between reforms with respect to diagnosis, combined with elements of strategic retreat. However, in the midwifery case, I identified a significant thread of social policy alongside the elements of strategic retreat that Bourgeault (2006), Vadeboncoeur (2004) and others emphasize (see Coburn, et al., 1983; Kelner, Wellman, Boon, & Welsh, 2004; Vadeboncoeur et al., 1996).

This final chapter outlines in further detail the conclusions of this project and their implications for the gaps in the literature noted in Chapter 2. From here, the discussion turns to the limitations of the project; while such limitations do not detract from the significance of the findings, they suggest a need for more research and analysis in select areas. The chapter ends with a discussion of future avenues for study with respect to the Canadian medical profession, its political activity and its relationship with medical dominance.

Findings and implications

This dissertation has demonstrated that it is possible for organized medicine to engage in social policy learning on questions of medical sovereignty. On the question of re-introducing midwifery into the formal healthcare system, medicine's core policy beliefs shifted in three provinces: Ontario, Alberta and Nova Scotia. Ontario presents the most straightforward case, as organized medicine's learning resulted in a clear formal shift in position. Alberta was a surprising example of social policy learning, as I had initially perceived it as a province in which medicine was more resistant to midwifery (see McKendry & Langford, 2001). However, there was nevertheless some evidence in Alberta of social policy learning, even as this was obscured by a last-minute shift back to incorporation from organized medicine – a shift that was effectively exploited by the pro-midwifery activists to further their own cause (ibid; Ken Chapman, interview, Edmonton, Oct. 27, 2016). Nova Scotia provides another case of social policy learning. In this province, however, the shift in medicine's posture was undermined by resistance from individual doctors once midwives began practicing (Interview, telephone, Sept. 19, 2016, see also Interview, Halifax, Jan. 19, 2017; K. Kaufman, interview, telephone, Apr. 4, 2016). This was due to a combination of the bureaucratisation of the process, which prevented rank-and-file doctors from having their beliefs challenged, and Doctors Nova Scotia's avoidance of formal policy statements, which allowed for the personal positions of the president to dominate public discourse (Interview, Halifax, Jan. 19, 2017; Interview, Nova Scotia, Apr. 28, 2016).

In Quebec, organized medicine presents no sign of such social policy learning on the midwifery question, due in large part to the presence of an 'extremist' participant in

Dr. Roy. The advocacy coalition framework puts forward that extremist participants can indeed inhibit cross-coalition learning, as they effectively poison the well and prevent dialogue between parties (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988). Indeed, with incendiary statements comparing the government's proposal to a "still-born monster" (in Canadian Press, 1989) and likening midwives to sex workers (Picard, 1989), it is little wonder that Dr. Roy did not exactly invite productive discussion between pro-midwifery activists and the medical profession. Rather than challenging this conclusion, then, when contrasted with the other provinces the Quebec case is well in line with the idea that a logic of social policy learning underlies medicine's political positioning on midwifery.

It should be noted that, in all cases of social policy learning, the decision to support the proposed reform was not free of strategic considerations, or what I have referred to throughout this dissertation as strategic retreat. Rather, social policy learning was consistently observed in concert with political learning. In Ontario, medicine was preoccupied with other competing providers during the Health Professions Legislation Review, and began to see midwifery regulation as a) inevitable, and b) a relatively minor concern (Bourgeault, 2006; V. Van Wagner, interview, telephone, Apr. 29, 2016, B. Soderstrom, interview, Ottawa, Sept. 8, 2016). Meanwhile, Alberta doctors moved from a position of incorporation to deskilling as the debate wore on and it became clear that midwives would be regulated in some form (D. Charlton, interview, Edmonton, Oct. 28, 2016; Health Disciplines Board, 1991; McKendry & Langford, 2001, p. 536). In Nova Scotia, midwifery was seen as even more inevitable, given how established the practice was in most of Canada at this point (Interview, Skype, Mar. 25, 2016; Interview, Nova

Scotia, Apr. 28, 2016). Social policy learning and strategic retreat are then not mutually exclusive mechanisms, but can work together to move a resistant party from one position to another.

The pharmacy case does not demonstrate this same level of complexity. Indeed, even the variation that I had initially observed proved shallower upon closer examination, as doctors' resistance to pharmacists engaging in diagnosis proved remarkably consistent across the four provinces studied. This was sometimes simply a function of the proposal under consideration; critically, in Alberta, the province moved to allow pharmacists to prescribe any Schedule 1 drug (Canadian Pharmacists' Association, 2016; Sinnema, 2006). However, the institutional context in which each province's proposal was situated also had an impact on the perceived severity of each threat to diagnosis. In Quebec, for example, diagnosis is tightly restricted (J-B Trudeau, interview, Montreal, Feb. 8, 2017); meanwhile, in Alberta, the word diagnosis does not even appear in the province's list of controlled acts (Interview, Edmonton, Oct. 29, 2016; Interview, telephone, Jan. 6, 2017).

Other differences between provinces in this case can be chalked up to strategic retreat. In Alberta and Ontario, doctors were emboldened by various factors, including the lack of precedent in Alberta and the perceived exceptionalism of the Ontario Medical Association (L. Mittelsteadt, interview, telephone, Jan. 26, 2017; Interview, Toronto, May 19, 2016). While medicine failed in Alberta, Ontario doctors were successful in limiting expansions to pharmacy scope, although the medical coalition splintered in the process as one faction of the OMA overplayed its hand (Interview, Toronto, May 19, 2016; Metro, 2009). Meanwhile, in Nova Scotia and Quebec, doctors accepted the inevitability of the proposed reforms and cooperated with the process in hopes of

influencing the outcome (J-B Trudeau, interview, Montreal, Feb. 8, 2017; Kevin Chapman, interview, Halifax, Apr. 27, 2016). Some in Quebec later came to regret this initial conciliatory posture, feeling that pharmacists had used the original legislation as a "smokescreen" for a more dramatic expansion of their professional scope than had been anticipated (Interview, Montreal, Nov. 17, 2016, translation mine).

The midwifery case raises the question of why medicine only underwent political learning and strategic retreat on the question of pharmacy scope. In the pharmacy case, conditions favourable to cross-coalition learning were again present in certain provinces; however, this time they did not produce social policy learning. The advocacy coalition framework indicates that beliefs closer to the core of one's belief system are more difficult to change (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988; Sabatier & Weible, 2007) – and indeed, the question of diagnosis appears to constitute an aspect of medical dominance that is too fundamental to be altered through cross-coalition learning. Informants repeatedly signalled that diagnosis is particularly central to the medical belief system, suggesting that this is an absolutely critical difference between doctors and other providers (Puzic, 2009; Interview, Edmonton, Oct. 24, 2016; Interview, Montreal, Nov. 17, 2016). It should also be noted that in no province did pharmacists actually *try* to shift medicine's thinking on diagnosis. Informants suggested that this was a matter of political correctness or strategic framing (Interview, Edmonton, Oct. 27b, 2016; Interview, Halifax, Apr. 28, 2016); pharmacists believed that doctors would hold fast to this particular belief, and chose to avoid framing their claims along these lines. Even when evidence, cross-coalition dialogue and brokers were present, pharmacists avoided directly confronting medicine's beliefs on diagnosis.

These findings challenge past depictions of organized medicine and its relationship with medical dominance. Traditionally, medicine's political arms have been understood as extensions of medical dominance, with a deep-seated tendency to protect autonomy, authority and sovereignty (Bourgeault, 2006; Coburn et al., 1983; Kelner et al., 2004; Vadeboncoeur, 2004; Vadeboncoeur et al., 1996; Weitz, 2007). However, this study has found that, on midwifery, medicine's core policy beliefs have substantively shifted in response to evidence from and engagement with midwives and their allies. Following this study, it is then apparent that medicine's political organization and activity are more nuanced than traditional portrayals suggest, and need to be recognized as complex political phenomena that warrant exploration and study. Medicine's core policy beliefs *can* evolve, leading to fundamental shifts in position. However, this dissertation has also found that there are limits to medicine's openness to change in belief. While the profession proved flexible on the medicalization of birth, it demonstrated more consistency in posture with respect to independent prescribing by pharmacists. The medicalization of birth is a matter of medical sovereignty – in short, what western doctors have traditionally seen as good care. In contrast, pharmacy scope is a matter of authority, as diagnosis and prescription are core medical competencies, central to doctors' privileged position in the healthcare marketplace (see Freidson, 1970).

Three gaps in the literature were outlined in Chapter 2 of this dissertation, each of which these findings address. First, in shining a spotlight directly on doctors, this research represents a step forward into an area which social scientists have been reluctant to study. Social scientists have typically shied away from studying pressure politics in Canadian health policy (Contandriopoulos, 2011). When they do study cases of political

mobilization, they tend to focus on the change-makers rather than resistant parties (see Barnett, White, & Horne, 2002; Bourgeault, Benoit, & Davis-Floyd, 2004; O'Reilly, 2000). As such, while doctors are historically extremely important to Canadian healthcare policy and politics (Hacker, 1998; Tuohy, 1999), they have rarely commanded the centre of attention. This research and these conclusions serve to deepen social science's understanding of a set of actors that has traditionally been understudied.

Second, this dissertation has applied medical dominance to the Canadian context and demonstrated how sub-national and international borders shape how physicians perceive and engage with dominance. In the midwifery case, it was found repeatedly that physicians were less resistant to midwifery if they had spent time abroad in areas where midwifery was already integrated into the mainstream health system (V. Van Wagner, interview, telephone, Apr. 29, 2016; Blais, Lambert, & Maheux, 1999; Oxorn, 1994). Physicians in Quebec were less likely to have had these experiences than physicians practicing elsewhere in Canada, contributing to medicine's overall stronger resistance in this province (Interview, Montreal, Dec. 6, 2016; A. Poirier, interview, Montreal, Dec. 16, 2016, P. Mohide, interview, telephone, Nov. 8, 2016; see also Klein, 1994; Vadeboncoeur et al., 1996). Ideas about what healthcare should be, even among physicians, are then shaped by doctors' experiences with the system, which in Canada vary significantly by province. In impacting how they see 'normal' or 'ideal' care, then, this has a significant impact on how doctors perceive and engage with elements of traditional medical dominance. While this dissertation takes organizations and not individual physicians as its units of analysis, the leaders within these organizations were shaped by their own personal experiences, and informants referenced the need for

associations to demonstrate responsiveness to their respective memberships (Interview, Toronto, May 19, 2016; Kevin Chapman, interview, Halifax, Apr. 27, 2016; Interview, Ottawa, June 28, 2016).

Finally, and most importantly, these conclusions deepen our understanding of organized medicine's relationship with medical dominance. Medical organizations can undergo substantive shifts on important elements of medical dominance. Across the cases studied for this project, however, social policy learning only occurred with respect to one level of dominance: medical sovereignty. Sovereignty is not a matter of economics; indeed, by the time midwifery re-emerged in Canada, midwives did not pose particularly serious competition to physicians, who had been moving away from obstetrics for some time (Barrington, 1985; Bartlett, 2004; Cohen, 1991). Instead, sovereignty concerns what doctors see as good or proper care, according to the ideals instilled in them during their training (Lupton, 2012; Weitz, 2007; Willis, 1983, 2006). Meanwhile, authority, along with autonomy, represents the material side of medical dominance, impacting how and when doctors get paid and the degree of competition they face from other providers (Freidson, 1970; Willis, 1983, 2006). Across these two cases, then, authority proved nearer and dearer to the heart of medicine's political activity. While this is perhaps unsurprising with respect to medical associations, who have often been likened to unions with a mandate to defend their membership, it is important to consider that colleges do not even have an explicit mandate to protect doctors' material interests. Nevertheless, this dissertation found that colleges demonstrated more flexibility on midwifery – and the incursion into medical dominance this represented – than on pharmacy scope.

In addition to addressing the gaps in the literature noted above, these conclusions also contribute to discourse around the advocacy coalition framework. While this dissertation uses the ACF to guide its analysis, its findings serve to challenge and push the framework in two important ways. First, the ACF emphasizes how 'objective' evidence can be used strategically to advance objectives (Fafard, 2008; Jenkins-Smith et al., 2017; Sabatier, 1988; Weible et al., 2009). The right evidence can even prompt actors in opposing coalitions to shift some of their beliefs; as such debates are more conducive to cross-coalition learning when the issue at hand comes with objective, falsifiable data (Jenkins-Smith et al., 2017; Sabatier, 1988). In contrast, the midwifery case demonstrates that the firsthand experience of coalition members can shift core beliefs in the same way (P. Mohide, interview, telephone, Nov. 8, 2016; V. Van Wagner, interview, telephone, Apr. 29, 2016; Interview, Montreal, Dec. 6, 2016). 'Evidence' is then not just about proving to somebody that their previously-held beliefs were somehow incorrect, but can also be about increasing comfort with practices with which that person had been unfamiliar.

Second, this dissertation also serves to highlight how leadership matters to both strategic retreat and social policy learning. Discussions of the ACF consider how extremists and brokers can inhibit or facilitate social policy learning (Jenkins-Smith, 1990; Jenkins-Smith et al., 2017; Sabatier, 1988); this discussion takes that a step further by considering how medical leaders' personal opinions can come to dominate public discourse entirely, leading to significant shifts in medicine's posture when turnover occurs. This is not uniformly applicable across all organizations; while Nova Scotia informants attested to the independence of the MSNS/DNS president (Interview, Nova

Scotia, Apr. 28, 2016; Kevin Chapman, interview, Halifax, Apr. 27, 2016), Ontario and Alberta informants likened the role of their respective association presidents more to a spokesperson (Interview, telephone, Jul. 7, 2016, L. Mittelsteadt, interview, Edmonton, Jan. 26, 2017). The critical difference between these organizations is policy capacity; MSNS/DNS has not historically tended towards formal policy statements, allowing the president's personal views to effectively serve as organizational positions (Kevin Chapman, interview, Halifax, Apr. 27, 2016). However, as occurred in Quebec with Dr. Roy, sometimes a particularly opinionated leader rises to prominence and is able to impose their views regardless of the size and policy capacity of the organization (Interview, Montreal, Dec. 6, 2016; Interview, telephone, Feb. 1, 2017; H. Cornellier, Interview, Montreal, Nov. 17, 2016).

These findings then make an important contribution to the literature on organized medicine and medical dominance in the Canadian context. They demonstrate that medicine is not only an important political force in Canada, but also a complicated one, its positions conditioned by a wide range of factors that do not solely concern strategic calculus. Organized medicine can be pushed to unconventional positions via cross-coalition social policy learning, leading to significant shifts in how the profession perceives and engages with traditional medical dominance. In arriving at these conclusions, this project has drawn from key insights from the advocacy coalition framework, but has also pushed and challenged that framework in important ways.

As is the case with any project of this scale, this research also produced several other findings of empirical and theoretical significance, which, while not necessarily directly related to the research question, are nevertheless important insights that warrant

mention. First, as mentioned at the outset of this dissertation, I chose to examine both associations, which constitute the political voice of the profession, and colleges, which are accountable to the public but are nevertheless the *de facto* enforcers of medical sovereignty. Their mandates, while distinct, are both bound up in traditional conceptions of medical dominance. Nevertheless, it is notable that, while colleges frequently came around to proposed reforms earlier than associations (perhaps unsurprising, as they have a stronger mandate to promote what is best for the health system and are not explicitly 'political' organizations), their positions tended to eventually converge. When asked about the relationships between colleges and associations, interviewees pointed to the fact that these organizations engage with each other regularly, and indicated that they can shape one another's approaches on contentious issues (Interview, Edmonton, Oct. 24, 2016; see also J-B Trudeau, interview, Montreal, Feb. 8, 2017). In Quebec, for example, Dr. Trudeau discussed the Collège's efforts to bring the FMOQ out of a place of opposition to expanded pharmacy scope (Interview, Montreal, Feb. 8, 2017). This is consistent with a logic of within-coalition political learning, by which actors within the same coalition seek out improved understandings of how to achieve their overarching goals (see Sabatier, 1988).

As well, it warrants mention that the Canadian Medical Association played a surprisingly minor role in the two policy cases examined here. In setting out to conduct this research, I had anticipated that the CMA would try to smooth over differences between provincial affiliates to create a sort of pan-Canadian united medical front on important policy questions, much in the way that colleges and associations within individual jurisdictions tended to converge in position. In fact, the CMA did not view

divergences in policy between its provincial affiliates as a problem – when asked about this phenomenon, one interviewee at the national level simply shrugged and explained, "Well, that's Canada!" (Interview, Ottawa, June 28, 2016). The nature of the country is such that it is not reasonable to expect every affiliate of a federated body to agree on every issue. National-level interviewees agreed that the CMA generally tries to stay out of areas of provincial competence (Interview, Ottawa, June 28, 2016; Interview, telephone, July 1, 2016). In large part, this is out of respect for its provincial affiliates rather than any sort of apathy, as one informant argued that the provincial wings would likely push back if the CMA started involving itself in their affairs (Interview, telephone, July 1, 2016). Still, it is notable that the association has not attempted to foster some kind of common position between its affiliates on these questions. As has been observed by many others (see Lomas, Charles, & Greb, 1992; Tuohy, 1999), provinces have their own traditional dynamics in place between the state and the medical profession, which have endured and continue to shape how these debates unfold.

At the same time, provincial boundaries are not totally predictive of medicine's posture. In Ontario, for example, we saw a province that was known for a confrontational profession instead produce collaboration between doctors and midwives, leading to a significant thread of social policy learning within the profession (P. Mohide, interview, telephone, Nov. 8, 2016; V. Van Wagner, interview, telephone, Apr. 29, 2016). In contrast, the province's experience with pharmacy was a more typical example of the type of posture for which Ontario organized medicine is known, with the OMA resisting even more restrained expansions of pharmacists' scope of practice (Ontario Medical Association, 2009; Section on General and Family Practice, 2009). Meanwhile, in

Quebec, a province also known for inter-professional confrontation, it was the pharmacy case that sparked compromise between the professions – albeit a reluctant compromise that some now regret – while medicine actively obstructed the province's efforts to regulate midwifery (Interview, Montreal, Nov. 17, 2016, translation mine; H. Cornellier, interview, Montreal, Nov. 17, 2016).

This dissertation has also demonstrated that mistakes matter in discussions of learning. This is not solely a matter of learning from failure, which has been discussed at length elsewhere (C. M. Hall, 2011; May, 1992). Rather, strategic error can complicate actors' experiences of learning and needs to be considered in empirical discussions thereof. This is visible in both the midwifery and the pharmacy cases. With respect to midwifery, the TFIMO caught Ontario doctors off guard, leading to a misjudgement around insurers' willingness to cover midwifery practice (V. Van Wagner, interview, telephone, Apr. 29, 2016). Alberta doctors made the mistake of switching back to a strategy of incorporation through the pursuit of charges against a midwife who assisted a healthy birth (McKendry & Langford, 2001). This concealed the social policy learning that did occur, forcing medicine into a position where they could be used as a political foil for the midwives and their allies (Ken Chapman, interview, Edmonton, Oct. 27, 2016). Quebec provides an inverse example of strategic error with respect to pharmacy; here, some within medicine now think they were *too* trusting of the pharmacists, as their new scope allegedly crept closer to diagnosis than doctors had initially anticipated (Interview, Montreal, Nov. 17, 2016).

Limitations

The conclusions presented here demonstrate that it is possible for organized medicine to shift its core beliefs on a key tenet of medical sovereignty, while demonstrating the profession's tendency to protect medical authority. However, these findings are limited in some important ways. First, they have not demonstrated that social policy learning *alone* can prompt shits in organized medicine's positions, as in each of Ontario, Nova Scotia and Alberta, social policy learning occurred in concert with strategic retreat. While this is an important finding in its own right, it still leaves open the possibility that strategic retreat is in practice a necessary condition for organized medicine to support threats to medical dominance. Social policy learning may be possible, but that does not mean it is sufficient.

In fact, in two of the provinces in which social policy learning did occur – Nova Scotia and Alberta – the overall effect of that learning was somewhat masked by persistent elements of resistance within the medical coalition. In Alberta, this was seen through the aforementioned court case, which McKendry and Langford deem a "final, desperate move to maintain [medicine's] legal incorporation of midwifery skills" (McKendry & Langford, 2001, p. 537). In Nova Scotia, this manifested in grassroots resistance to midwifery practice, leading to a "toxic environment" and poor working relationships at the clinical level (Moore, 2010). Even in conjunction with strategic retreat, then, social policy learning does not guarantee that elements of medicine will not continue to oppose and obstruct changes that threaten traditional dominance.

Finally, in focusing on jurisdictional context and using theoretical insights to guide the data rather than testing a theory (see Falleti, 2006, 2016), these conclusions are

limited in their generalizability in two important ways. First, it is unclear how they might be applied beyond the medical profession to other powerful and well-organized collective actors. The work has demonstrated that doctors' groups can be convinced to re-examine some of their deeply-held beliefs – however, we do not know if this is something unique to the medical profession, or if it might apply more broadly to other well-established groups who benefit from the status quo in healthcare and elsewhere. Second, the implications of the pharmacy conclusions are somewhat ambiguous. I have demonstrated that social policy learning is possible within the medical profession on threats to medical sovereignty, which is sufficient to challenge prevailing assumptions about organized medicine and how it engages with medical dominance. On medical authority, however, I have only found evidence of strategic retreat across these four provinces, along with a strong uniformity of belief with respect to diagnosis. While prescription was selected as an 'ideal' threat to authority, I cannot conclusively argue that social policy learning on matters of authority is impossible in all circumstances, given a) the potential for other threats to authority to prompt less stringent resistance from organized medicine, and b) the importance of jurisdictional context to the explanation. In short, while finding evidence of social policy in the midwifery case demonstrates that it is possible for medicine to learn in this way on medical sovereignty, lack of similar evidence with respect to medical authority is not sufficient to prove that it is totally impossible.

Future research

The research presented here concerns an area that has not garnered much academic attention; there has not been much interest in studying pressure politics in Canadian

healthcare or in connecting medical dominance to Canadian doctors' on-the-ground political action. The limitations outlined above then relate to potential avenues for future research, which can further expand our understanding of modern Canadian medicine and the beliefs and behaviour of other powerful, entrenched organizations.

Most importantly, additional study is warranted with respect to how Canadian organized medicine functions on the ground. In demonstrating that medicine can undergo social policy learning on a key threat to medical sovereignty, the conclusions presented here represent a significant foray into a deeper understanding of how Canadian organized medicine engages with medical dominance as it is commonly understood. It also suggests, however, that diagnosis is particularly important to Canadian organized medicine, representing a line in the sand with respect to threats to authority. This suggests that there would be value in further exploring another significant threat to doctors' authority: the nurse practitioner. While their exact role varies by province, nurse practitioners blend nursing competencies with traditional 'medical' primary care functions, including limited diagnosis (DiCenso et al., 2007; Hass, 2006; K. Martin, 1995; Worster et al., 2005). Even in Quebec, where diagnosis is especially closely controlled, a "nursing diagnosis" exists that has recently been expanded with the nominal approval of the province's physicians (Valiante, 2019). It would then be valuable to explore how organized medicine has responded and adapted to nurse practitioners' entry into the health system.

Further research is also warranted into other well-organized, 'elite' organizations that benefit from the Canadian status quo. Studies of Canadian interest group and social movement behaviour tend to focus on insurgents who push for change, rather than those

in positions of power who are inclined to resist it (Smith, 2014, 2018). In turning its attention to doctors, this dissertation has highlighted how such resistant groups can be overcome or swayed. As such, they are valuable and interesting subjects not only in their own right, but also insofar as they impact the success or failure of those seeking change. The conclusions then demonstrate the value of examining the complexity of those groups that govern or represent the powerful. Future avenues for study could include lawyers, engineers, dentists or any other established, well-compensated Canadian profession.

This research also invites further discussion of what medical dominance is, exactly. The introduction put forward that this thesis was to test the relationship of organized medicine to medical dominance. Accordingly, the dissertation has revealed a certain malleability in medicine's view of medical sovereignty, malleability that was not seen with respect to authority. This suggests that medicine is indeed flexible in its relationship with at least one level of medical dominance. However, one might also interpret this finding as evidence that medical dominance itself is in flux. This thesis took traditional conceptions of medical dominance – specifically Willis' (1983) understanding of three levels of dominance – as its starting point. That being said, dominance is only meaningful insofar as it is important to physicians. If medical organizations no longer actually defend a particular aspect of dominance, can that aspect still be considered dominance at all? The purpose of this thesis was to engage with widely-accepted depictions of dominance and discuss how they relate to the day-to-day political activities of medicine on the ground. The dissertation is then positioned as an empirical exploration of organized medicine; however, the results of this examination suggest that social scientists' theoretical understanding of medical dominance needs to adapt to changes in

the beliefs and ideology of organized medicine. As such, as medicine itself changes and evolves, so too must social scientists reconsider and periodically revise medical dominance as a theoretical construct.

Conclusion

When conducting interviews for this research, I gained insight into some remarkable stories on how advocates push for change in healthcare provision. Especially in the midwifery case, many informants had overcome long odds and accepted great personal risk and sacrifice in order to effect change. Their experiences speak to the ways in which traditional power structures can be upended through persistent, well-executed political action, ultimately reshaping how we provide healthcare in Canada.

But this dissertation is also about taking a closer look at the antagonists in these stories. If we are going to understand instances of policy change, we need to understand why resistance to that change either fails or softens. This means paying attention to those who resist: that is, actors who either directly benefit from the status quo or otherwise hold a strong belief that the existing order should be upheld. It means exploring the motivations of these players to understand why, exactly, certain beliefs are so important to their political action. And it means understanding why and how these beliefs can shift, providing an opening for the protagonists to implement their desired changes.

The role of antagonist is one that Canadian doctors are accustomed to playing – after all, organized medicine was the single greatest obstacle to the emergence of the most iconic social program in the country (Hacker, 1998; Robertson, 2013; Tuohy, 1999). Even following the introduction of medicare, medicine remained relatively autonomous

and exercised significant control over the healthcare division of labour, meaning that those seeking to reform the system would have to overcome resistance from doctors first (Coburn, 2006; Coburn et al., 1983; O'Reilly, 2000). Within social science, the profession has also become strongly identified with patriarchy, the embodiment of how western healthcare routinely fails, marginalizes and alienates women (Biggs, 1983; Duffin, 1999; Lupton, 2012; Weitz, 2007). The medical profession is often understood as wealthy, powerful and traditionalist in all the wrong ways. It is, in a word, dominant – and physician organizations are widely seen as tools to protect that dominance.

This thesis has challenged this common understanding, revealing that, on midwifery, organized medicine has learned in ways that we might not have expected. However, medicine did not do this unprompted; physician organizations only shifted their beliefs once proponents began pushing for change. Forums for cross-coalition dialogue, broker participants and evidence from other jurisdictions all mean very little if there is nobody to leverage them. Nevertheless, it is important to recognize that even when organized medicine plays the role of the antagonist, it is not necessarily a lost cause. The profession's ties to traditional medical dominance can loosen under the right circumstances, contributing to significant shifts in medicine's positions and dramatic policy change.

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Appendix A: Sample Interview Guide

1. What role did you play in the provincial policy debate surrounding either expanding pharmacists' scope of practice and/or integrating midwifery into health care provision?

2. What were your interactions like with other stakeholders?

3. Was there disagreement within your professional group/department on how to handle the situation?

4. What are your impressions of how you counterparts in other provinces have handled this issue?

5. How much attention did your organization pay to how the debate unfolded in other provinces? Did that influence you?

6. How do you feel this issue was treated in the media? Was it covered adequately? Fairly?

7. Do you feel that the public was supportive of your position? Why or why not?

8. Did your organization have the resources necessary to advance its position?

9. How favourable was the government at the time to your position? Would it have been different with a different government?

10. Regardless of party in power, how would you describe the general relationship between the provincial government and your group? (If gov. rep, ask about all groups)

11. Was there ever an instance where your organization decided against a particular course of action because you felt it would fail?

12. Would you say that the current state of affairs is accepted by your professional group? If not, what needs to change?

13. Are there other people involved in these debates that you think I should interview?

Appendix B: Provision of care in provinces studied, 2013

Table 3: Provider numbers and satisfaction with healthcare system, by jurisdiction

	AB	ON	QC	NS	CA
Family physicians	4,630	13,973	9,500	1,255	**39,392**
per 100,000 residents	116	103	116	133	**112**
% female	40.4%	41.6%	51.4%	41.9%	**43.1%**
Specialists	4,394	14,449	9,862	1,206	**38,282**
per 100,000 residents	110	107	121	128	**109**
% female	31.2%	32.1%	38.5%	31.6%	**33.2%**
Midwives	73	608	168	11	**1,173**
per 100,000 residents	2	4	2	1	**3**
% female	100%	99.8%	100%	100%	**99.9%**
Pharmacists	4,383	13,233	8,428	1,275	**36,568**
per 100,000 residents	110	98	103	135	**104**
% female	63.3%	57.6%	n.d.	72.7%	**59.8%**
% Agreeing that "on the whole, the system works pretty well and only minor changes are necessary to make it work better"	43	50	23	39	**42**
% Reporting no regular doctor / No regular place of care	6	4	15	7	**7**

Data sources: Canadian Institute for Health Information, 2019a; Health Council of Canada, 2014

Annex A: SGFP advertisement

With today's healthcare, is an apple a day your best bet?

(Section on General and Family Practice, 2009)

With today's healthcare, is an apple a day your safest bet?

Patient safety is of vital importance to every healthcare professional. A critical component to patient safety is proper diagnosis. Doctors, and doctors alone, have years of education in both diagnosis and treatment. It's complex. That is why it takes years of study to learn.

Certainly, changes to our healthcare system are necessary to improve access for everyone in Ontario. Yet some changes raise questions. Nurse Practitioners provide a valuable service. But shouldn't their diagnosis and treatments be regularly reviewed by a physician? Allowing pharmacists to prescribe certain medications may seem convenient, but do they have the training in diagnosis and examination to do this properly? By both prescribing and selling medications, isn't there a risk of conflict of interest and a potential risk to patient safety? Wouldn't you be more comfortable with a doctor overseeing your care?

When making changes to healthcare, would it not be prudent for the government to consult and listen to the most educated frontline healthcare providers: doctors? We think so. And we think you do, too. Ask a doctor what you can do to help ensure that increasing access to your healthcare does not compromise your safety.

Funded by the members of the Section on General and Family Practice of the OMA, your Ontario family doctors.

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