

The Loosening of Professional Boundaries and Restructuring: The Implications for Nursing and Medicine in Ontario, Canada*

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This paper suggests that the combination of health care restructuring, legislation expanding, and redefining a regulated health profession in Ontario, Canada, has reduced medical dominance and increased managerial dominance of health care professionals. The paper focuses on nurses and doctors, and examines the effects of the Regulated Health Professions Act and the changes occurring within the health care system on their political, clinical, and economic autonomy. It argues that there has been a redistribution of power in the health care sector and suggests that the present autonomy of health care professionals is limited, and may be limited even further as the technical side of health care is prioritized over the indeterminate side.

[T]he *Regulated Health Professions Act, 1991* (RHPA) . . . has restructured the governance of health professions, entrenched and expanded the involvement of the public, and established the public interests as its foundation.

(Health Professions Regulatory Advisory Council 1994:2)

I. INTRODUCTION

Canada was a relative latecomer to state involvement in health care compared to most countries in the Western world. In the latter half of the twentieth century, Canada has developed a publicly funded medical insurance system, which covers hospital care and the provision of most medical and some other health care services, but concomitant with this development has been the gradual growth of administrative supervision of health care professions by the provincial level of the Canadian state, and

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more recently the gradual imposition of managerial power over the form and content of professional work.

In Canada, health care is ultimately a provincial responsibility with partial funding (in return for the observation of five principles) by the federal government. The federal amount of cash funds and the funding mechanisms have changed over the years, encouraging provincial governments to seek ways to reorganize their health care systems; they have reduced funding to hospitals, closed hospitals, increased the emphasis on community care, and introduced some privatization, such as the delisting of services so that they are not covered by provincial insurance and the encouragement of for-profit home care services. Paralleling this reorganization has been the development of new methods of regulation of health care professionals, a change in the roles of health care professionals, and an expansion in the number of regulated health professions. These changes in the health care system and the regulation of health care professions have resulted in a redistribution of power among health care professionals, and a transfer of some professional power to health care managers and the state/public.¹

This paper will discuss the redistribution of power between health professionals and the state, and within the health care system, in the province of Ontario. It will argue that this redistribution has been reinforced by the passage of the Regulated Health Professions Act in 1991. Through this act, the Ontario government ostensibly uncoupled health care professions from their subordination to medicine, but contradictorily this decreased their autonomy. Furthermore, this paper will suggest that the pursuit of the professional project² is an illusion that the state has seized (in this case the province) to reduce the power of all health professions and to attack the core of professionalism. When combined with a process of the restructuring³ of the health care system, health care professionals face further constraints on their autonomy because of pressures for cost containment and pressures to institute new ways to provide health care. In Ontario, this has entailed a reorganization of the health care system, which has included a reduction in hospital beds, the closure and mergers of hospitals, the reduction in length of stay, a reduction in the number of nurses employed by hospitals, the intensification of work for health care workers, and a transfer of care from the hospital to the community, among other things.

This paper will focus on the professions of nursing and medicine and their relationship with each other and with the Ontario provincial government. As medicine has been the most powerful profession in the health care sector, and other health care professions have attempted to escape from its umbrella, none of the health care professions can be discussed without some examination of their relationship to medicine. Nursing dominates the health care system in numerical terms, yet it has been subordinate to medicine and has pursued a policy of attempting to escape this subordination through the acquisition of professional traits.

II. A RESTRUCTURING OF POWER RELATIONS

Canada has developed a publicly funded medical insurance system, which is called "medicare," and covers hospital care and the provision of most medical, and some other, health care services. The provinces are responsible for the provision of health care, and each province has its own insurance system which must cover all medically necessary services. In Ontario, this is called the Ontario Health Insurance Plan (OHIP), and it covers what the Ministry of Health defines as medically necessary services.

Hospital insurance was first introduced in Canada in the province of Saskatchewan in 1947 and it was followed in 1962 by the Saskatchewan Medicare Act which introduced provincial medical insurance. This act received immense opposition from the medical profession, which withdrew its services because of the threat to its economic and clinical autonomy (Boase 1994: 180).

The first initiative at the federal level occurred with the passage of the Hospital Insurance and Diagnostic Services Act in 1958, which provided for a number of medical services associated with hospitalization and medical testing and entailed the federal government paying 50 percent of the average provincial costs. Coverage was broadened by the Medical Care Act of 1968, which was implemented in 1972; it included services such as physicians' fees that had not been covered under the earlier act. This was followed by the Canada Health Act in 1985, which reinforced the policy that medical care was to be financed out of the public purse. These acts established the five principles of medicare, which are accessibility, universality, portability, comprehensiveness, and a nonprofit administration. Thus, everyone has access without financial barriers, all residents are eligible on equal terms, coverage is portable from province to province, all necessary medical services are covered, and the plan is run on a nonprofit basis.

With the introduction of medicare, there has been a gradual erosion of medical power. Some of the fears of the Saskatchewan doctors were realized with the passage of the Canada Health Act, which restricted the provinces' rights to permit extra billing as well as the imposition of hospital user fees.⁴ Failure of provinces to comply within three years would have resulted in the federal government withholding an amount equivalent to that extra billed or charged in user fees from transfer payments to the province concerned. In response to this act, the Ontario government passed the Health Care Accessibility Act in 1986, which removed the right of physicians to opt out of the medical insurance plan and to extra-bill their patients. This encroachment on medical power was subject to immense opposition by the medical profession. The Canadian Medical Association filed a lawsuit against the federal government claiming that the act went beyond the constitutional authority of the federal government and that it contravened the Canadian Charter of Rights and Freedoms as it prohibited doctors from establishing private contracts with their patients. The Ontario Medical Association also

challenged the act in court and following the passage of the Ontario act it staged a twenty-five-day strike, but found that it faced an intractable government and an unsympathetic public. A less noticed amendment to the act permitted recognition of a health care practitioner for purposes of insurance outside an institutional setting. While this did not lead to any immediate changes, it did open the possibility for a challenge to medical dominance by other health care professions.

Since the introduction of medicare, provincial governments have encountered a change in the fiscal arrangement between themselves and the federal government, and this has encouraged them to seek ways to rationalize health care. Prior to 1977, the federal government of Canada paid half of the expenditures in the appropriate categories provided that the five principles were met. In 1977, it introduced a new formula that limited federal spending but transferred tax points, and thus granted the provincial government the right to raise more revenue from taxation. Since then the federal government has gradually reduced its health care expenditures while increasing tax point transfers.⁵ Changes in funding have encouraged provincial governments to seek ways to control health care. In Ontario, the passage of the Independent Health Facilities Act of 1989 transferred the power to determine what were medically necessary services (and therefore covered by insurance), from the Ontario Medical Association to the Ministry of Health. This was part of the goal to streamline the provision of public services to achieve greater efficiency. Also in Ontario these changes in funding encouraged the passage of the omnibus Savings and Restructuring Act of 1996, which, in conjunction with amendments to the Public Hospitals Act, laid the basis for massive changes in Ontario's health care system. The minister was granted the power to terminate, reduce, or suspend grants or loans or financial assistance to hospitals if it should be in the public interest to do so. In addition, the minister could close, amalgamate, or merge hospitals. This was achieved through the creation of the Health Services Restructuring Commission, which functioned at arm's length from the ministry. These changes and reductions in budgets have put pressure on hospital administrators to attempt to become more efficient and to reduce costs through bed closures, early discharge, contracting out of services, downsizing, and the reorganization of work.

The history of medicare, therefore, has been the imposition of principles by a national level of government with the provincial level of government being responsible for their implementation. It also has involved a gradual transfer of funding responsibilities from the national government to the provincial governments. This has occurred not only in an environment in which the ideological climate opposes tax increases, but also one of difficult economic conditions, escalating health care costs, and pressures from health care occupations to obtain professional status, and alternative care givers to be granted legitimacy. These conditions encouraged provincial governments not only to examine their health care systems but also the roles of their

health care professions. In Ontario, bureaucrats began to emphasize efficiency and outcomes and to restructure the health care system, but one of the impediments to this process of rationalization was the presence of professional monopolies in the health care sector.

III. PROVINCIAL REGULATION

Self-regulation is granted by the state to a health care profession on the basis that members of the profession possess a body of esoteric knowledge that others external to the profession cannot assess, and their clients trust them to use this specialized knowledge on behalf of their clients. A professional organization regulates the members on behalf of the state to protect the public, but the state can always change the conditions of self-regulation. In Ontario, the licensing and regulatory functions to protect the public are located in the colleges, and the interests of the profession are served by professional associations, whereas in other provinces they may be the same body. Self-regulation is a bargain between the state and the health profession in that it confers legitimacy and consequent socio-economic status in exchange for regulation to protect the public interest.

Following public insurance of health care, Canadian provinces attempted to rationalize the rapidly expanding sector of health professions. They conducted various studies and passed legislation that attempted to reconcile self-regulation with government funding and to address the problems of monopolies, the need to protect the public through lay representation and disciplinary processes, and the concerns that were being expressed in the newspapers and by patient organizations that professions sought legislation and imposed regulations that were in the interest of the profession and not of the client (Boase 1994).⁶ For example, Alberta passed the Health Occupations Act in 1980, establishing a health occupations board that included representatives of the medical profession and was to advise the government regarding the regulation of health care professions based on the need to protect the public from potential harm (*ibid.*).

Quebec was one of the first provinces to attempt to place stringent controls on its professions through the passage of the Professional Code in 1973, which had been meant to cover all professions, although the majority were health professions. Contandriopoulos, Laurier, and Trottier (1989) and Dussault (1989) consider this attempt to be a failure. Nevertheless, many of the elements of the Quebec legislation can be detected in the Ontario legislation twenty years later. The Quebec legislation established the protection of the public as the main reason for the legal recognition of professions and as the main goal of the various regulatory bodies (Dussault 1989:325). The other goal of the Quebec government was to rationalize professional work through professional regulation. To this end, it created an independent regulatory body, l'Office des Professions du Quebec, which had

the power to propose new professions, and to evaluate, amalgamate, or dissolve existing ones (Boase 1994:124). It also had the right to grant "an exclusive right to practice" (a license) or "a reserve of title" (a certification). However, this attempt at regulation did not address the basis of professional power, because the major professions were permitted to define delegated acts, which resulted in a broad definition of their fields of practice and their delegation of acts that already had been performed by other professions (Dussault 1989:326).

The roots of the Ontario legislation can be traced to the Report of the Committee on the Healing Arts in 1970. Many of its recommendations were ignored by the Ontario government, and the consequent Health Disciplines Act of 1973 was limited to the five "traditional" health care professions of medicine, pharmacy, dentistry, optometry, and nursing, leaving coverage of many of the other professions to a confusing Drugless Practitioners Act of 1925. However, the Health Disciplines Act did require lay representation on the councils of the colleges, prior review of regulations of the councils by the minister, the removal of the power to specify minimum admission and curriculum requirements, and required registration by licensure, except for nurses who were to be registered by certification.

In the 1980s, health care costs were increasing within the context of a policy of government restraint of expenditures. At the same time, several health care occupations were claiming professional status, alternative health care practitioners were becoming popular with the public, various professions continually lobbied the minister regarding turf wars and issues, and "concern was being expressed that the traditional professions were governing themselves in the interest of the profession and not the public" (Gignac 1998).⁷ Ontario took a unique approach, in attempting to rationalize its health care system, to reduce the influence of interest groups, especially the medical profession, and the conflicts among the various health care professions (Boase 1994: xx, 172). The minister established the Health Professions Legislation Review Commission, whose purpose was to examine the regulation of all health disciplines in Ontario. The review was conducted by a neutral third party, who controlled the input from the various groups and thus limited the influence of the traditional professions in the policymaking process. The commission made no final report. However, it made confidential recommendations to the Ministry of Health which made periodic announcements (ibid.:172). The head of the commission, Alan Schwartz, was given a mandate to devise draft legislation and he produced a report, *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions*, which was made public in January 1989. The result was an omnibus bill that included twenty-one acts that regulated twenty-four professions. The legislation was passed in 1991 and eventually promulgated in 1993.

In the attempt to assert control over the health care professions, the Ontario government did not make the same mistake as the Quebec

government. It challenged the basis of professional power and thus reduced medical dominance and limited the autonomy of all health care professionals. This was done by stipulating which acts were limited to which professions, and what constituted a controlled act using the criteria of the potential to do harm. In addition, the government isolated the process of the determination of professional power from the political process not only during the creation of the blueprint for the act but also through the creation of the Health Professions Regulatory Advisory Council (HPRAC), a lay body, which was to make recommendations to the minister concerning the regulation of health professions. This body can advise the minister on various professional issues, such as whether a profession should become a regulated profession or should no longer be considered a regulated profession, and who should be allowed to perform any of the controlled acts.

IV. AUTONOMY

The core of professionalism is considered to be autonomy, which is the legitimated control over the organization, terms, and content of a profession's work (Nettleton 1995:198). However, some authors (Elston 1991:61; Friedson 1970) distinguish between different aspects of autonomy: economic, political, and clinical or technical autonomy. In this paper, economic autonomy is defined as the ability of professionals to determine their remuneration. Political autonomy is regarded as having two aspects: an organizational autonomy and a policy autonomy. Thus, to possess political autonomy means that a profession has the right to self-governance and the right to make policy decisions as the legitimate experts on health matters in the area of work claimed by the profession. Clinical autonomy is the right to set standards and to control clinical performance and thus it incorporates control over an area of work and the context of that work.

Related to autonomy is the concept of dominance. Dominance is concerned with authority over other occupations in the workplace as well as influence over the policy process that affects other professions. Several authors (Coburn 1988; Friedson 1970; Hafferty & Wolinsky 1991; Haugh 1988) have discussed medical dominance and the power of medicine over other health professions and its potential decline. There is little, if any, work that considers the less obvious dominance of nursing: the disputed dominance of registered nurses (RNs) over registered practical nurses (RPNs) and the authority of both RNs and RPNs over generic workers. Yet, the implications of such dominance or authority over other workers is qualitatively different for nurses than for physicians because it entails responsibility for others' work and reduced job opportunities. The utilization of less-qualified workers has resulted in an increased supervisory workload for registered nurses and the replacement of RNs and RPNs with unregulated health care workers (*Nursing Week* 1998). Thus, dominance for

nurses has meant responsibility for the supervision of unregulated workers performing nursing work and little control over who performs which nursing act; dominance for medicine has entailed giving orders to nurses without the burden of supervision, as nurses are accountable to their own college. However, the dominance of medicine may change to include responsibility for the acts of other occupations, as the RHPA includes the ability to delegate medical acts.

V. THE DEVELOPMENT OF MEDICAL DOMINANCE

Allopathic medicine rose to dominance during the development of the professions in the particular social, political, and economic climate that existed in the nineteenth century. Socially, the claim to professional status provided opportunities for the expansion of the upper and middle classes into the ownership of knowledge and the exclusion of those who did not have access to a privileged education, such as women (Blisshen 1991). Politically, medicine's monopoly was the result of an alliance between that middle class and the political classes in the state (Clarke 1996; Torrance 1987). Economically, it met the needs of capitalism by ensuring that the health of the laboring classes was of sufficient quality that they could provide adequate labor (Brown 1979; Coburn, Torrance & Kaufert 1983) and later it would provide opportunities for the expansion of capitalism (Lexchin 1994; Relman 1990). Ideologically, not only did it fit in with the growing hegemony of science, but by focussing on laboratory medicine it also deflected attention from social medicine, which supported a change in the present power relations of society (Brown 1979; Larson 1977; Navarro 1988).⁸

One strategy practiced by allopathic medicine to attain dominance was to exclude, limit, and subordinate other healers (Willis 1983). Exclusion strategies included the absorption of homeopaths and eclectics and the suppression of midwives. Limitation of the pharmacy profession was achieved through an agreement that pharmacists would not counter-prescribe and doctors would not dispense drugs. Subordination of nurses was realized through the Nightingale philosophy of absolute obedience and through the transfer of the focus of training and health care to the hospital; and the subordination of paramedical professions was achieved because these professions developed in the hospital under medical control (Torrance 1987).

The essential factor in obtaining dominance was that medicine was able to persuade Canadian elites and their representatives in the legislatures to grant it monopoly powers of practice and the "strategic accessories" to enforce this monopoly, such as mandatory medical signatures on death certificates, sole access to hospital admitting privileges, and the exclusive right to prescribe drugs (*ibid.*:7). It maintained this dominance in Ontario

through the growth of a powerful organization, the College of Physicians and Surgeons of Ontario (CPSO), which disciplined its members and attempted to influence policymaking through briefs and the presence of its members in the government (Coburn, Torrance & Kaufert 1983).

Medicine thus possessed organizational autonomy. It regulated its members, and its organization granted it political influence as members of the profession were included in the government and were involved in policy-making (Blishen 1991; Coburn 1993). Also, medicine enjoyed economic autonomy as it set its own fees, and this fee-for-service method of payment was retained with the introduction of medicare. The profession possessed clinical autonomy as it had the right to set standards and to control clinical performance, and these decisions were not challenged. In addition, it maintained some measure of control over other professions, partly because it was able to practice strategies of subordination, limitation, and exclusion, and also because it achieved its monopoly prior to the development of the health care system, so that many of the newer health professions were developed in the hospital under the aegis of medicine (Coburn, Torrance & Kaufert 1983).

VI. NURSING

The achievement of medical dominance was intrinsically related to the subordination of other health professionals, especially nurses. This subordination was possible because provincial medical acts gave the College of Physicians and Surgeons the right to define services that constituted medical acts and practice and therefore what other health occupations could do (Blishen 1991:15).

Nursing developed as a profession that would be subordinate to medicine and to the hospital (Coburn 1987). It began as a divided profession with upper-class women as administrators and instructors, and lower-class women seeking "respect and upward mobility in this new women's 'profession'" (ibid.:448). The history of nursing in the twentieth century is that of attempts to escape its subordination to medicine by establishing itself as a profession separate from medicine. The pursuit of this goal has involved the acquisition of various professional traits, such as credentials, the development of a body of knowledge separate from medicine, and the creation of professional organizations. In Canada, nursing has sought the upgrading of the profession's credentials with the goal of all registered nurses obtaining a degree by the year 2000 (Wotherspoon 1994).

Nursing, unlike medicine, has only obtained limited political autonomy. It achieved some organizational autonomy with the establishment of the College of Nurses of Ontario (CNO) in 1962 when it successfully resisted the pressure to have physicians on the College Council. However, it failed to obtain the provision of licensing of nurses, which might have given it greater

economic and clinical autonomy. It “asked for licensing of all who ‘nurse for hire’ but the politicians were not convinced that such legislation was in the public interest.” The politicians argued that employers could impose “sufficient restrictions to ensure the provision of safe care by non-registered personnel without jeopardizing their employment in the way that licensing would” (Ford 1988:14). Thus, although the legislation granted nursing autonomy of organization and control over registration, nursing failed to obtain a monopoly and thereby autonomy and control over nursing work. Every registered nurse and registered practical nurse had to be a member of the college, but employers could hire non-registered workers to perform much of the work of nursing. This helped to reinforce the subordination of nurses to their employer.

Nursing did obtain limited clinical autonomy. The college can control the profession but not the context of nursing work. It controls the establishment of standards of practice and the imposition of disciplinary procedures. Thus, it can specify that its registrants must meet certain standards of practice, and it can discipline those members who do not meet them to the extent of revoking their certificates to practice.

Graduate nurses did possess economic autonomy at the turn of the century. Coburn (1987) notes that an estimated 85 percent of all graduate nurses were private nurses in 1909, and 60 percent in 1929. This was not because private nursing was an attractive proposition but because hospitals employed mainly student nurses. Private-duty nurses were often unemployed and poorly paid and competing in a highly competitive labor market. With the expansion of hospital care, the number of nurses in private-duty nursing declined from 60 percent of all graduate nurses in 1930 to 9 percent in 1960 (Blishen 1991:107).

VII. THE REGULATED HEALTH PROFESSIONS ACT

The power of the provincial level of the state over health professions became manifest with the passage of the Regulated Health Professions Act (RHPA) in 1991. Under the act, the Ontario Minister of Health can inquire into the state of practice of a health profession in a locality or institution. He or she can review a college council’s activities, require a council to provide reports and information to the ministry, require a council to make, amend, or revoke a regulation under a health act, and require a council to do anything that is considered advisable to carry out the intent of health legislation.

The RHPA signalled that the province had changed the terms of its monopoly agreement with the health care professions and that it had restructured the power relations in the health care sector. There had been earlier incursions into restricting the monopolies of health professions. In 1973, the Ontario Health Disciplines Act introduced revised regulations that governed medicine, dentistry, nursing, pharmacy, and optometry (Coburn

1993:134). These forced the colleges to include approximately 25 percent lay representatives on their councils, complaint committees, and disciplinary committees. In addition, appeals could be made to the Health Disciplines Board, a solely lay panel.

The RHPA was more comprehensive as it addressed the whole terrain of professionalism in the health care system. The legislation and its associated acts admitted many previously excluded health care occupations into the schema of regulated health professions. This conferred legitimacy and status upon excluded professions, such as midwifery. It also granted greater independence to the traditional, but previously subordinate and limited, non-medical professions, such as nursing and physiotherapy.⁹ The act listed twenty-four self-governing health professions, which were to be governed by twenty-one colleges, and laid down a specific procedural for all of them.¹⁰

This independence of health care professionals from medical dominance came at a price. The act reduced the autonomy of all health professions in several ways. It reduced organizational autonomy by introducing or increasing the presence of a third party – the state/public – in the college committees and thus into the governance of the professions. The political influence of the medical profession in the policymaking process concerning health professions was lessened by the creation of a lay advisory council to scrutinize the colleges' structures and to advise on matters of regulation and policies. The RHPA also decreased professional clinical autonomy by loosening professional boundaries so that professions became less distinctive despite their clear but limited claims to areas of practice. The effect of this reduction in these aspects of autonomy was an increase in the power of management, as it facilitated its introduction of cost-containment strategies and organizational changes in the health care system to cope with its reduction of funding in the case of hospitals, and with its increase in patient load resulting from early discharge in the case of visiting nursing agencies. These changes had some implications for the economic autonomy of some health professionals.

VIII. REDUCED ORGANIZATIONAL AUTONOMY

Health professionals have sought to attain professional status and to escape their subordination to medicine through the acquisition of credentials and through attempts to obtain organizational autonomy on the basis of these higher qualifications. However, the designation of "regulated health professional" entails giving up some of the powers of self-regulation to the state. Those professions regulated under the RHPA were required to create the same organizational structures with the same committees and to achieve similar goals. The five traditional professions had created some of these structures, such as complaints and discipline committees, following the Health Disciplines Act, but even they had to develop some new committees.

Each college has to have complaints and discipline committees, and a summary of the disciplinary proceedings has to be made public – physicians publish their proceedings in their newsletter, the *Members Dialogue*, and nurses in the college *Communiqué*. In addition, the provincial government required the colleges to set up patient-relations programs and quality-assurance programs to be reviewed five years after the passage of the act.

The Ontario government not only imposed a specific organizational form on the colleges but also limited their self regulatory power by enforcing 40 percent representation of the public, who were appointed by the government, on the internal college committees. Thus, the dominance of medicine over other health professions has been usurped by the state/public. Additionally, the autonomy of all professions has been reduced as forces external to the professions are placed at the very heart of their decision-making process.

The RHPA may have reinforced or increased the intra-professional divisions within health professions. By definition the different professional organizations represent different interests. The professional organizations, such as the Ontario Medical Association and the Registered Nurses Association of Ontario, are voluntary associations that represent their specific professions. The colleges, the College of Nurses and the College of Physicians and Surgeons, control registration to practice and represent the government and the public. They are responsible for standards, and this responsibility has increased under the act, but this overlaps with the role of the professional institution.

IX. REDUCED POLICY AUTONOMY

The RHPA has also increased the power of the public in policymaking concerning the regulation of the professions through the creation of a Health Professions Regulatory Advisory Council (HPRAC). This body is composed of lay people who advise the minister on the regulation and deregulation of health care professions and suggest amendments and regulations for any health acts. In addition, the council has a mandate to advise the Minister about the internal structures of the colleges, such as the effectiveness of the colleges' quality assurance, patient relations, and complaints and discipline procedures.

The public is now a presence within the regulation process of the health professions, but they are representatives of the government. Although the RHPA "is designed to maximize choice of safe options for the consumer and to place the consumer at the centre of the picture" (HPRAC 1994:2), consumers or users do not mean the same thing as public. Consumers or users of the health care system do not necessarily have the same interests as the public representatives on the various committees and boards of the colleges or on the HPRAC. There is no requirement that the public on these committees represent the various patient groups.

Medicine's influence over policies affecting other health care professions has been reduced, as the state/public now has political influence through the HPRAC, and medicine no longer sits on the boards or college councils of other professions. However, this reduction in power should not be overstated. Medicine is still the peak health care profession and still has considerable leverage in the policy arena. For example, in a climate of cutbacks of C\$800 million to hospitals, closure of hospitals, lay-offs of 5,000 Ontario nurses, and lay-offs of thousands of other hospital workers, the Ontario Minister of Health agreed to an increase of C\$594 million for doctors, to abolish clawbacks on doctors' incomes, and, should total billings exceed the new provincial "target," to rely on the input of a new committee controlled by doctors (Olsen 1997).

This leverage is complex. The formation of a Joint Management Committee of the Ministry of Health and the Ontario Medical Association in 1991 for ongoing policy development implied that the OMA would influence medical policy and maintain clinical autonomy. However, the consequent establishment of the Institute for Clinical Evaluative Sciences (ICES), which evaluates medical practices and patterns of utilization, has resulted in fears by some physicians that guidelines will be constructed to fit in with the economic restraint policies of the government (Rappolt 1997).

X. REDUCED CLINICAL AUTONOMY

The RHPA curtailed the power of health care monopolies by limiting their control to designated acts, which decreased their professional clinical autonomy and reduced the boundaries between the various health care occupations. Under this legislation, professions have a description of their scope of practice, which states what the profession does, what methods it uses, and why.¹¹ This scope of practice is not restrictive and can overlap with those of other professions. For example, midwives and physicians each can deliver babies, and most professions assess and treat patients. In addition, there are thirteen controlled acts that have been designated as potentially harmful to the public if they are performed by persons without adequate knowledge and training. Several of these acts may be performed by more than one profession. Medicine may perform twelve of them, nurses may perform three. For example, nurses may perform a prescribed procedure below the dermis or a mucous membrane, and they can administer a substance by injection or inhalation. Nurse practitioners will have the three nursing acts expanded to include the communication of a diagnosis, the prescribing of some drugs, the ordering of some laboratory tests, and the ordering of certain diagnostic ultrasounds and certain X-rays (CNO 1997). Some professions, such as occupational therapists, dieticians, and speech-language pathologists, have no controlled acts.

This legislation has not abolished hierarchies in the health care sector, but it has rearranged them according to the type of practice. By the substitution of controlled acts for broad monopolies, it has developed a new, more rigid hierarchy with the health care professions ordered according to their degrees of power. Medicine has lost some of its dominance over other professions with respect to their governance, and it is no longer the gatekeeper to the other health professions. However, it is still the peak profession as it can perform twelve of the thirteen controlled acts – the exception being the fitting of a dental prosthesis. Next are professions that may perform some controlled acts, such as nurses and physiotherapists, and they are followed by those who are not approved to perform any controlled acts, such as occupational therapists and dieticians.

The creation of controlled acts has not only reduced the power of all health care professions but also has enhanced and created friction within and between professions. For example, registered nurses (RNs) may initiate three controlled acts, but this ability was not granted to registered practical nurses (RPNs), who must receive orders from a physician, dentist, chiropodist, midwife, or RN (HPRAC 1996a). This has encouraged RPNs to continue to seek to escape their subordination to RNs by requesting a separate college and emphasizing that their practice is different from that of RNs.¹²

Paradoxically, on the one hand, there is a hierarchy according to ability to perform controlled acts, and on the other hand, boundaries have become more flexible. The potential to extend the controlled acts of one profession to other professionals heightens the permeability of boundaries. Thus, medicine is under threat from other professions, especially nursing. Nurses offer a cheaper alternative to the provision of many aspects of medical care that are provided by a physician. This is particularly the case with nurse practitioners who have been recommended by HPRAC to be allowed to perform, within limitations, the controlled acts of diagnosis and the prescription of drugs, and to order specified laboratory tests (HPRAC 1996b).¹³

As much of the work of nurses does not come under the designation of a controlled act, employers can hire generic workers to perform many facets of nursing work. Additionally, nurses can find their work extended to include actions previously performed by other professionals, such as occupational therapists and social workers, which not only increases their workload but threatens their professional identity. A controlled act also can be performed by a non-professional or any other professional under the supervision of a professional designated to perform that act (HPRAC 1996c; RHPA 1991; Sky 1995). Thus, nurses can be required to supervise several less-qualified personnel to perform controlled acts.

Hospital management have also been given other tools to exert some form of control over medical clinical practice. The Institute for Clinical Evaluative Sciences (ICES) in Ontario publishes guidelines and *Patterns*

of *Health Care in Ontario*, (the *Practice Atlas* series), which documents provincewide variations in medical and surgical care. This has embarrassed members of the profession, but hospital managers are enthusiastic about this research, which they use to increase the efficiency of their medical and surgical services (Rappolt 1997). Rappolt (ibid.) reports that some bureaucrats, practitioners, and academics suggest that ICES is a mechanism for the systematic surveillance of medical practices, and that, in the eyes of some practitioners, its purpose is to control physicians' practices and their incomes.

XI. ECONOMIC AUTONOMY

The RHPA's effect on economic autonomy is related to policies of restructuring and is mainly speculative for physicians and apparent for nurses. The act has created the potential for increased competition for employment among health professions, within professions, and between health professions and less skilled workers by limiting monopolies to certain acts. Within a climate of cost containment and restructuring, this has implications for the economic autonomy of physicians and nurses.

The government policies of restructuring may have some economic ramifications for doctors. Salaried physicians attached to hospitals may face unemployment as a result of hospital closures or may be hired as independent consultants by the hospital when necessary (Baer 1996; Gray 1997; Sullivan 1997). Independent physicians face the possibility of a restriction on their abilities to maintain or increase their incomes. Most physicians have limited economic autonomy through a fee-for-service method of payment whereby the state pays for each billable service that doctors provide. However, some services have been deinsured and are no longer billable. For example, physicians can no longer bill the government for physiotherapy services that they provide. Physicians can only increase their incomes by seeing more patients, performing more services, or charging for uninsured services. Furthermore, in attempts to reduce the costs of health care, the government has favored a reduction in the number of patients and the number of tests and procedures ordered. In addition, it has pursued policies of capitation and clawbacks of income.

The government has made other efforts to change the economic autonomy of doctors. It has formed a joint committee with the Ontario Medical Association to examine billing practices and ways to cut health care costs, although a new agreement in 1997 granted doctors increased control over remuneration. If total billings exceeded the provincial target, the government could not act without the permission of a committee controlled by doctors (Olsen 1997). However, in May 1998, in conjunction with the OMA, the Ministry of Health launched a pilot primary care model, which groups family doctors in a network to provide twenty-four-hour services

and pays the doctor on a capitation basis with the option of a reformed fee-for-service payment or a global monthly payment. This has several effects. It should provide some relief to overcrowded emergency departments which have been one of the results of hospital closures. It encourages physicians to opt for a payment basis other than fee-for-service. It also incorporates other health professionals more fully into primary care, and through the provision of enhanced services supports health promotion and provides linkages to community services.

Most nurses are employees in the hospital sector,¹⁴ and until the 1970s they were grossly underpaid. Unionization and a shortage of nurses granted them some influence over their salaries and helped to increase nurses' earnings (Day 1993). However, restructuring has resulted in lay-offs of nurses in Ontario, an increase in part-time work, contract and temporary positions, and competition with cheaper, less-qualified personnel.¹⁵ Also, the RHPA has granted management the ability to substitute less qualified workers for nurses, so their unions have little bargaining power and do not wield the same amount of power as they previously had. However, the Canada Health Act does enable provincial governments to reimburse health care practitioners under the health insurance system, although no provincial government has chosen to implement it on a broad basis (CNA 1998). Thus, the CNA claims that patients could choose nurses as their main health care providers.

XII. THE CONTROL OF PROFESSIONAL WORK

The changes in the organizational autonomy of professions has implications for their clinical autonomy. The state now faces multiple, weak health professions with overlapping boundaries instead of a powerful, dominant medical profession that was ostensibly representing some health professionals. Medicine is still at the peak of the hierarchy but its power has been reduced.

State bureaucrats have interests of their own (Skocpol 1985), but in the case of the health care sector they face contradictory interests. They want to cut health care costs, but they do not want to antagonize the public, which views the provision of medicare as a distinguishing feature of Canada. Changes in organizational structures were designed to ameliorate public dissatisfaction with changes in the provision of health care by incorporating the public into the core of the professional organization. Cutting costs in the core health care sector requires a restructuring of that sector and the development of a managerial elite with the power to manage the reduced budgets of hospitals with the managerial tools of the private sector. To achieve a rationalization of the health care sector, the government requires greater flexibility of health care personnel, the replacement of professional goals with administrative goals, and the ability to control personnel to achieve these goals. The RHPA gave administrators some of the tools

necessary to rationalize health care and the ability to exert greater pressures on clinical autonomy and also constraints on economic autonomy. At the same time, technology offered other means of controlling and standardizing professional work.

A. THE INDETERMINACY/TECHNICALITY RATIO

In the 1970s it was argued that the higher a profession's indeterminacy/technicality ratio was, the greater was the social distance between the health professional and the patient. Thus, if a profession had a high degree of indeterminacy (that is, more intuitive and non-routinized intelligence than codified, openly accessible knowledge), it could define the needs of the consumer and how they should be met (Jamous & Peloille 1970; Nettleton 1995:198). Today, the more knowledge can be codified, the more likely it can be computerized and the more likely that practice can be measured and controlled. The emphasis on controlled acts, which can be measured, diminishes the importance of the indeterminacy side of the ratio. Thus, it is only by emphasizing indeterminacy that professions can claim a specific type of knowledge as the basis of a monopoly.

It is in the interests of management that work becomes more technical and measurable because then it can be performed by machines or divided into discrete parts that can be performed by less qualified, cheaper personnel. The new managerial methods of the private sector emphasize specification and the achievement of measurable objectives; the continuous evaluation of performance against defined objectives, outputs, and standards; the rationing of resources by effectiveness criteria; and the surveillance of health professionals (Campbell 1994; Choiniere 1993; Kelly 1991; Nettleton 1995). Such practices threaten not only clinical autonomy but also the whole area of professional health expertise.

While it is less apparent that this will affect medicine as much as nursing, there are signs that the indeterminacy side of medical knowledge is being reduced. More diagnostic testing is being transferred outside of the hospital to multiple, divided, specialized sites, and it is based on technology rather than on intuitive specialized knowledge (Stoeckle 1988:80). This has occurred more in the United States than in Canada, but there are examples in Canada, such as mammography and rehabilitation centers, and with the closure of more hospitals this trend is likely to increase.

A greater threat to the clinical autonomy of medicine may be the trend toward evaluative medicine. Information technologies can assess the effectiveness of particular procedures rather than the physician operating at the level of micro uncertainty. Thus, the technicality side of the ratio is increased as the physician is no longer dependent on the skills and knowledge learned in medical school and in training and practice, but the procedures that he must follow are prescribed for him. Consequently, information systems can be used to standardize and routinize professional

decisions and actions, leaving little for discretionary judgment – the indeterminacy side of the ratio. In addition, they can be used to assess the decision making of doctors and used for the purposes of management, which has occurred in the United States where they have been used as the basis for utilization reviews of individual doctors by insurance companies and managed care organizations (Armstrong & Armstrong 1998:84; Stoeckle 1988:81). However, there is little evidence as yet that such procedures are widely used in Canada, but they have been used to embarrass doctors into conforming (Rappolt 1997). However, when asked about guidelines, 22 to 26 percent of physicians in one survey expressed concern over the loss of autonomy, the rigidity of guidelines, and decreased satisfaction with medical practice (Hayward et al. 1997). In addition, physicians are suspicious of guidelines that emanate from the government or health insurance plans and are more comfortable with guidelines from professional colleagues or organizations provided that an organization is not perceived as being co-opted by the government (Hayward et al. 1997; Rappolt 1997). The promotion of voluntary clinical guidelines by the Ontario Medical Association in the early 1990s proved unsuccessful because the OMA was perceived to have been co-opted by the government despite the fact that the goal of the OMA was “to improve the quality of medical care and to protect corporate technical autonomy by controlling individual practitioners’ clinical and economic autonomy” (Rappolt 1997:983).

Ostensibly, the defining aspect of nursing – caregiving – is indeterminate; it should grant nursing clinical autonomy. However, the trend toward scientific nursing, as the elite of nursing seek to professionalize, has increased the technical side of nursing work to the detriment of the indeterminate caring side. The drive toward professionalization has focussed on the creation of “a distinct scientific core of nursing knowledge” (Wotherspoon 1994:571), but this lends itself to patient classification systems and the control of nursing practice by management who may or may not be nurses. In addition, management and some nurses consider nursing that involves machines or occurs in a highly technical setting as more skilled than nursing in other settings (Choiniere 1993:76).

Caring is not a controlled act; it does not lend itself to measurement, and it is a complex process that cannot easily be defined (Graham 1983; James 1992). However, unlike medicine, this indeterminate side tends to be downgraded as women’s work that anyone can do, and because it cannot be measured it is ignored or considered an appropriate sphere for a generic worker. Although caring is defined by nurses as the core feature of their work, Choiniere (1993:76), in her study of nursing work, found that nurses considered treatments to be more important than caring duties, and James (1992), in her study of a hospice in the U.K., observed that nurses’ sense of work reflected management analyses of nursing work and that physical labor had primacy over emotional labor. Paradoxically, the technocratic side of nursing faces the twin dangers of being subdivided into discrete tasks

that can be controlled by management, or the management of machines that may be performed by other professionals or non-professionals, and the indeterminate side is downgraded by management and nurses themselves.

B. THE ORGANIZATION OF WORK

The effect of the RHPA on the organization of the work of the physician and the nurse is both direct and indirect. The complaints and discipline procedures are constructed to process complaints about individual practitioners, not about systems problems, so both professions are wary of complaints. The RHPA requires that discipline proceedings be published and that the committees reviewing complaints and discipline have greater public representation, thus lessening the degree of regulation by a professional's peers.¹⁶

As facilities move toward professional managers, the power of physicians is reduced, thus lessening their leverage over the distribution of resources in the hospital. One result may be that they experience an increase in their workload, such as covering a busy emergency with insufficient staff or, in the case of family physicians, fewer resources and more critical cases (Baer 1997; Beardwood et al. 1999). For example, one physician complained to the CPSO that, in one emergency situation, because of resident cutbacks, there was no resident on call and that he had had to return to the hospital (Bell 1998).

Nurses face different problems. Nurses have always been subject to the demands of management, physicians, and their profession, but the distribution of power among these groups has changed. In the past, physicians were dominant in the hospital, and not only were their goals in patient care similar to those of nurses, but at the bedside they were also likely to be influenced by nurses (Jones 1994; Stein 1987). The RHPA has redistributed the balance of power in favor of management by blurring the boundaries of controlled acts and creating opportunities for management to increase the workload of nurses. RNs can initiate their controlled acts, but they can perform other controlled acts that are delegated to them by other health professionals, and they can also perform some of the work of other health professionals. In addition, they can be responsible for supervising the performance of controlled acts by generic workers, which, given the workloads of nurses, may be just token supervision and may result in the inadequate performance of the authorized act (Sky 1995).

The RHPA has, therefore, assisted management in reorganizing nursing work to meet the goals of management rather than the professional goals of nurses.¹⁷ Management is task oriented rather than patient oriented. It assesses the amount of labor time allowed for a task, instead of the individual nurse using her skill and judgment of the time required to meet the needs of individual patients (Brannon 1994; Campbell 1994; Choiniere 1993).

XIII. CONCLUSION

This paper is a case study of the reorganization of power relations among health professions and the Ontario government, and the effects on the professions of nursing and medicine. It is beyond the scope of this paper to examine trends in regulation in other countries or even other provinces in Canada. As health care is ultimately a provincial responsibility, each province has responded in similar ways to the challenges that public health insurance and responsibility for effective health care have posed. This response has been within a context of a reduction in funds from the federal government necessitating restructuring and increased accountability. The paper suggests that cost cutting has implications for professionals in their work, and that changes in the regulation of professions can broaden these implications. Other governments or private organizations may respond in different ways. For example, insurance companies in the United States place restrictions on doctors' decisions, question whether procedures are desirable, and often check doctors' diagnoses and prescriptions (Armstrong & Armstrong 1998:68). But the present circumstances of high-cost health care, combined with pressures to reduce costs, are likely to encourage some measures to reduce the costs of professional work.

In Ontario, the Regulated Health Professions Act heralded a change in the relationship between the state and the health professions. Through the act, the state initiated a major shift in power relations and created more flexible occupations in order to facilitate restructuring. Medicine suffered a decline in dominance with the acknowledgement of the independent status of other health professions. In addition, its influence on policymaking regarding health professions was usurped by the active entry of the state/public into the process through the creation of a new lay committee, the Health Professions Regulatory Advisory Council. The act also limited the clinical autonomy of all health professions to a few controlled acts and thus ended professional health monopolies and loosened the boundaries among health professions.

The above changes have occurred at a time of restructuring of the Ontario health care system, which has included downsizing of resources and staff, the closure of hospitals, reorganization of health care organizations, and the application of managerial tools that have been developed in the private sector. The measurement of work, the limitation of monopolies to controlled acts, and the ability to delegate controlled acts have facilitated management's ability to transfer much of nursing work to unregulated professionals. In addition, if nursing is limited to three controlled acts, and if they can be delegated, it makes it easier for management to discount claims for the recognition of the indeterminate aspects of nursing work. When this occurs within the context of lay-offs resulting from hospital closures and an increase in part-time and casual work, it is difficult for nurses to oppose these trends.

At the same time, medicine is encountering an emphasis by the Ontario government on evaluative medicine and guidelines. In 1991, the Ministry of Health and the Ontario Medical Association established the Joint Management Committee (JMC) for ongoing policy development, and this committee established the Institute for Clinical Evaluative Sciences. While guidelines are voluntary, there is the potential for future requirements for OHIP coverage to be linked to compliance, as some members of the medical profession fear (Rappolt 1997).

Health professions also lost some organizational autonomy. Paradoxically, the formation of colleges to control entry, practice, and discipline created the opportunity for the state to impose conditions on the internal organization of all health professions and to interpose representatives of the public at the heart of the various professions. Thus the ability of the colleges to regulate their members became "a two-edged sword," as their members became subject to some degree of control imposed by forces external to their profession (Abbott & Wallace 1990).

The province has therefore restructured its opposition in the health care sector. No longer is it faced with a dominant medical profession that objects to the restructuring of the health care system. It has constructed multiple health professions with different degrees of power and permeable boundaries, who are to some extent preoccupied with protecting their own turf, meeting the standards of the new act, and coping with an increased public presence in professional regulation.

The concept of "profession" has also been reconstructed. Medicine is still a powerful profession but it no longer possesses the same degree of autonomy. Other health occupations have defined "profession" as the possession of various traits, especially credentials, and an organization to enforce social closure.¹⁸ The state has used this illusion of professionalism to encourage these occupations to claim the designation of "regulated health profession." However, the terms of self-regulation have been changed. Professional status conferred by the province has little relationship to that held by traditional professions in the nineteenth century. These regulated health professions are subject to greater surveillance from the state/public. They do not possess monopolies over areas of care as they have scopes of practice that overlap. Their monopolies are limited to the right to perform controlled acts that can be delegated to other personnel and that have the potential to be designated to other health professionals at some future date. The boundaries among these professions are loosening and their autonomy is being diminished. Moreover, the central tenet of the RHPA is that regulation is to protect the public, so some professional acts should be controlled or limited to certain regulated professionals. Therefore, those professions that do not have any controlled acts face the possibility of deregulation in the future.

Ontario thus changed the distribution of power in the health care system. It limited professional clinical autonomy, which abolished some of the

restraints that managers might encounter in their rationalization of the health care system. This poses a threat to the control of the content of professional work. An emphasis on the indeterminate aspects of professional work focussing on the uniqueness of the patient and the importance of interaction and relationships might prevent this from occurring. Yet, the elites of neither medicine nor nursing show signs of pursuing this route. In the former case, elites emphasize the science of medicine rather than the art. Longley (1996:161) suggests that "evidence-based medicine," EBM, has become "the flavour of the nineties," and, while it has much to recommend it, it does have its disadvantages, such as excluding consideration of the variation in the social context of the individual patient. Nursing elites have emphasized the technical aspects of nursing rather than the caring (Wotherspoon 1994). However, there is some evidence that the rank and file in both cases take a different view. Clinical guidelines have had little effect on physicians' practice patterns (Hayward et al. 1997:1715-23; Rachlis & Kushner 1994:104-5; Rappolt 1997), and nurses complain that they are unable to practice caring (Campbell 1994:605).

This is not to say that there are not positive aspects to the RHPA. The central tenet is to protect the public, and there have been considerable changes in this direction. It has resulted in the creation of colleges and administrative infrastructures, such as complaints committees and discipline committees, for the newly regulated professions. It has also opened up the existing discipline committees of medicine and nursing by making them open to the public and publishing accounts of their proceedings in their colleges' journals. With the introduction of quality assurance committees, there has been a greater attempt to ensure that professional standards are maintained in both the old and the newly regulated professions. In addition, patient relations committees¹⁹ have been created to focus on all forms of abuse: sexual, physical, verbal, and emotional, which were not being treated as seriously as the public felt was warranted.²⁰ However, the assumption underlying the complaints and discipline process is that, through professional regulation, the nature and quality of health care services can be maintained or improved. While this is appropriate for addressing the problem of "bad apples," it is less likely to achieve the goals of quality care when the root of the problem can be located in the health care system unless managerial practices are amenable to professional concerns, and facilities are more willing to address complaints in-house rather than transferring them and the costs to the colleges.

Restructuring also does have its brighter side, although this is difficult to admit in the midst of massive changes to the health care system in Ontario, which some would argue have occurred too quickly and without adequate planning. The emphasis on community care, if an adequate infrastructure is created, has the potential for positive aspects for the clinical autonomy of nurses and doctors, who may be able to provide holistic care away from the constraints of the hospital.²¹ Whether the provincial government is prepared

to invest sufficient funds to develop this area of health care remains to be seen.

Professionalization is a dynamic and complex process, which varies according to the needs of the state and capitalism, potential clients, prevailing ideologies, and relations with other health care occupations that may be regulated by the state. Johnson (1972) argues that professions have different provider-consumer relations in different periods: patronage, collegiate, and third-party mediation. Patronage existed in nineteenth-century Canada, and typically the client defined his needs and the manner in which they would be met. Collegiate control is a relationship in which the producer defines the needs of the client and the ways they should be met. Mediation occurs when a third party defines the needs of the client and the ways they should be met. At present, provider-consumer relations in Ontario have some resemblance to the mediation model, whereby the provincial level of the state defines the needs and the ways they will be met. However, a more complex model needs to be developed – one that takes account of the interrelationships and intrarelations of health professions and their relationships with management, the state, and the public. There is no longer one third party, but rather many parties. In Canada, the decentralized nature of the Canadian state means that both levels of the state define the needs through health care policies; management and bureaucracies define the appropriate provision of care and providers of that care, but within the constraints enforced by the provincial government; and the colleges regulate their profession to meet certain standards of care (but not those occupations to whom work may be delegated but who are not members of a profession). Also in Ontario, the government defines who can provide what care with the assistance of a lay body, HPRAC, and regulates these providers through professional colleges. In addition, the colleges and the government have relationships with other professional organizations that represent their members. Although the consumers of this care are represented by public members on the college committees and by the lay committee at HPRAC, they have little control over the definition of their needs and how they should be met.

The future for health care professionals is uncertain. Health professionals may find that they prefer medical dominance to managerial dominance and to state/public representation in their colleges. The RHPA is concerned with the practice of the individual professional, not the social context of that work. But this has deflected concerns from the workplace, which forms the context for the performance of professional work at a time when this context is less amenable to professional goals. Paradoxically, public protection against professionals has increased at a time when professionals are losing control over their work and patients are receiving more care from unregulated caregivers. As professional boundaries become blurred and the health care system changes, professionals may become more active as advocates for patients and emphasize the altruistic aspects of profession-

alism, especially with the increased emphasis on community care. What is clear is that, following the RHPA, health care professions will never be the same again. More professions are now regulated, but they are different from the traditional professions of the nineteenth century. They are still distinct from other occupations with respect to their traits and their organizations, but they possess only a quasi-monopoly over their area of practice, and their autonomy is limited. They also may be blamed for system problems over which they have little control. In the future, some may question the advantages of becoming a regulated health profession, and ask, like Anne Oakley (1984) with respect to nursing in the United Kingdom, "... what is so wonderful about being a professional anyway?"

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NOTES

1. I have used the term "state/public" because the government appoints the members to the various regulatory committees more for political reasons than their ability to represent patient populations. This does not mean that they do not attempt to represent the public interests, but it does suggest that this is done within a particular political context.
2. The concept of professional project suggests that once a monopoly and status have been attained, a professional group has to continue developing strategies to maintain its position. See Larson (1977), Macdonald (1995), and Witz (1992) for further discussion of this concept.
3. Restructuring has also been called "downsizing" and "reengineering."
4. A user fee is one that physicians, who felt that they did not receive sufficient remuneration for a service, charged on top of that allowed by medical insurance, or a fee that the physician charged for additional services. The federal government calls this extra billing. It is also a nominal fee charged by hospitals for use of their services.
5. In 1996, the federal government introduced the Canada Health and Social Transfer, which amalgamated payments for health, post-secondary education, and social assistance, so that provincial governments can now allocate funds the way they wish.
6. Government professional relations in various provinces are discussed in Boase (1994).
7. Marylou Gignac is the Coordinator, Health Professions, Professional Relations Branch of the Ministry of Health.
8. "Social medicine" refers to efforts to improve public health. In the middle of the nineteenth century, Virchow identified social and economic conditions as the primary causes of an epidemic of typhus fever and advocated improved living conditions for the poor as a preventive technique. However, the germ theory of disease resulted in a focus on the bacterial causes of disease and an emphasis on laboratory medicine (Weiss & Lonnquist 1997).

9. Over seventy-five health occupations sought incorporation under the act, possibly as a step toward public payment, as a method of gaining a monopoly over an area of practice and as a means to obtain the status of recognition as a health professional (Coburn 1993:135).
10. The twenty-one regulated colleges are for audiology and speech-language pathology, chiropody and podiatry, chiropractic, dental hygiene, dental technology, dentistry, denturism, dietetics, massage therapy, medical laboratory technology, medical radiation technology, medicine and osteopathy, midwifery, nursing, occupational therapy, opticianry, optometry, pharmacy, physiotherapy, psychology, and respiratory therapy. As osteopathy has virtually disappeared in Ontario, there are twenty-three health care professions that are regulated.
11. The scope of the practice of nursing is the promotion of health and the assessment of the provision of, care for, and the treatment of health conditions by supportive, preventive, therapeutic, palliative, and rehabilitative means in order to attain or maintain optimal function. The scope of the practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis of, treatment and prevention of any disease, disorder, or disfunction.
12. Their request for a separate college during the Health Professions Legislative Review was rejected in 1987, but they resubmitted it during the hearings of the RHPA. The government referred it to the HPRAC, which recommended that a separate college should not be created, but that the CNO should be restructured to address the tensions and disputes between the two types of nurses (HPRAC 1996a).
13. Medicine expressed concern over the extension of the power of diagnosis to nurse practitioners on the basis of public protection (Dixon 1995).
14. According to the CNO, 51,816 RNs, (63.4 percent of 81,736 total employed, with 111,486 RNs registered), and 15,017 RPNs (58.3 percent of 25,766 total employed, with 35,392 registered) worked in Ontario hospitals in 1996. The CNA notes that a small number of nurses have established their own businesses providing nursing services that are usually paid for by the client (CNA 1998).
15. The Canadian Nurses Association (1997) predicted a future shortage of nurses, but the response of management to this potential crisis is as yet unknown.
16. One can speculate whether these changes may have encouraged changes in practice. Fear of litigation has encouraged doctors to practice defensive medicine in the form of increased laboratory tests, radiography, and other diagnostic services as well as more documentation and increased time with patients to discuss risks and benefits of treatment, despite the fact that Canadian doctors are less likely than doctors in the U.S. to be sued for malpractice (Coyte, Dewees & Trebilcock 1991). Whether the same applies to fear of complaints remains to be investigated. Moreover, nurses in the U.K. have been shown to have changed their practice because of fear of the implications of patient consumerism and accountability, and nurses in Canada have expressed fears about being blamed for mistakes (Annandale 1996; Walters et al. 1995).
17. Control is a complex issue. It does not always equal autonomy. Brannon (1994) argues that with the task unification and a flattened hierarchy of primary nursing, RNs gained control over their work but were more clearly answerable for violations of hospital protocols and procedures. Thus, they became more accountable to management as well as to physicians.
18. Social closure is a term commonly used in the sociology of the professions. It refers to the process by which groups in society gain a monopoly over an area of work and resources, and erect cultural and legal barriers to keep others out. For a full discussion of the concept of social closure, see Macdonald (1995).
19. This is called the client relations committee at the CNO, where it was established in 1992.

20. This requirement arose out of the publicity surrounding a College of Physicians Task Force on sexual misconduct, and an independent study of HPRAC (Coté 1994; Task Force 1991).
21. This may also be positive for patients who may prefer to be treated at home. However, unless adequate support structures are created, this increases the burden on the family, usually the female members (Armstrong & Armstrong 1998).

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