One Hundred Twenty Years of Canadian Academic Medicine: How Michael Porter Became the New Abraham Flexner

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Institute of Health Policy Management and Evaluation
University of Toronto

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Doctor of Philosophy
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**Abstract**

One hundred and twenty years after the Flexner report purged for-profit practices from academic medicine in North America, a new era of commercialization, or an era of “de-Flexnerization”, is under way. High cost structures in academic medical centres and limits on funding support seem to have triggered academic medical institutions to engage in a variety of for-profit revenue-generative practices, many targeting the global community. This new commercialization seems in tension with Abraham Flexner’s findings that an over dependence on for-profit practices is linked with poor health care outcomes and poorly trained physicians.

Using the Toronto academic health science centre as a case study, this dissertation employs Foucauldian theories of discourse and space to make
visible the shifts in the economic and management logics of the leadership of a Canadian academic health science centre over 120 years that have made this new commerciality possible. A new management framework for Canadian academic medicine is identified, “The Discourses of Management”. Specific attention is given to Canadian academic medicine’s journey from the “local” to the “global”. More specifically, this thesis documents a change in the global space from being a space of reputational formation to being a space of wealth creation, or more accurately, a rhetorical space of wealth creation. That is to say, this thesis argues that the global space instead of functioning as an actual space of material resource accumulation is in actuality functioning as an imaginary space where wealth may be created but in actuality is not.

The emergence of health care as a policy field, health care as a sector of the economy, and academic health science centres as a new overarching institution are documented in a 120-year history. Evidence is presented that the academic health science centres may be emerging in Toronto as a more tangible overarching governing body for the Toronto’s academic hospitals and its faculty of medicine.
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Articulation B2: State Responsibility and Wealth Creation

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Articulation C2: Professionalization and Wealth Creation

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Selling Milk for Profit

Cost Recovery and Noblesse Oblige or Profit?

The Space(s) of Academic Medicine

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Where Was Academic Medicine from 1900 to 1940?

What Was Being Produced in the Spaces of Academic Medicine from 1900 to 1940?

1940 to 1990

Financial Concerns of the Faculty, the University, and the State

A New Era in Accounting Emerges

Looking at this 50-year period, a clear pattern emerges. Finances, in the broadest sense, became vastly more important in hospital discussions. The ability to navigate financial logic became a requirement for participation in board discussions. Money clearly had become something that mattered in academic medicine, where before it had been essentially invisible.

An Era of Changing Funding Patterns

The Four Discourses of Academic Medicine: 1940 to 1990

Table 7.2: Discursive Articulations and Their Effects, from 1940 to 1990

Discourse A: Academic Medicine is a Social Obligation

Articulation A1: Social Obligation + Wealth Creation

Articulation A2: Social Obligation + State Responsibility

Discourse B: Academic Medicine is a State Responsibility

Articulation B1: State Responsibility and Professionalization

Articulation B2: State Responsibility and Wealth Creation

Discourse C: Academic Medicine is a Professionalization Project

Articulation C1: Professionalization and State Responsibility

Articulation C2: Professionalization and Wealth Creation

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This last point is at the core of the discursive shift. Simply put, Canada and Canadians should benefit financially from any and all discoveries that emerge from the funding of public services and academic medicine. Knowledge and innovation have value, a value that should accrue to Canadians directly.  

**Articulation B6: State Responsibility + Wealth Creation**  

**Academic Medicine is a Professionalization Project**  

**Articulation C1: Professionalization + Wealth Creation**  

**Articulation C2: Professionalization + Wealth Creation**  

**Academic Medicine is an Engine of Wealth Creation**  

**Articulation D1: Wealth Creation + State Responsibility**  

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The Space(s) of Academic Medicine  

**What is Academic Medicine?**  

**Where Is Academic Medicine?**  

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Lexicon of Terms

Academic Capitalism:

A concept that refers to the effects on researchers, research centres, and research careers as a result of academics adopting a business ideology.\(^1\)\(^-\)\(^3\)

Academic Health Science Centre:

A partnership of university and academic teaching hospitals in which institutions share joint responsibility for the education of health professionals.\(^4\)

Academic Medicine:

A domain or practice area concerned with the pursuit of research, education and scholarship as it relates to medicine.\(^5\)\(^-\)\(^7\)

For this research, academic medicine will be understood to include universities, academic teaching hospitals, and other related organizations involved in providing, or governing, medical education.

Discourse:

An abstract construction that is a collection of signs, symbols, and “truths” that empower, or make possible, the thinking of certain ideas, the creation of specific institutions, and the decision to take certain actions.\(^8\)\(^-\)\(^12\)

Discourses can be dominant or marginalized. Multiple discourses can be present and active at the same time, evolve over time, and be replaced by new discourses.\(^8\)\(^-\)\(^12\)

Flexner Report:

A report written by Abraham Flexner, funded by the Carnegie Foundation and published in 1910 that explored medical education in the US and Canada.\(^6\) It is considered a canonical text that established the scientific method as part of medicine and medical education, closed poorly performing schools, and purged for-profit funding models from medical education due to its association with lower-quality educational practices.

It is also associated with the corporatization of academic medicine, establishing the dominance of large prominent schools at the expense of
smaller schools and the closing of schools focusing on social justice, female physicians, and black physicians.\textsuperscript{13-15}

Globalization:

A concept, process, or force associated with the flow of ideas, services, and products across international boundaries and spaces.\textsuperscript{16-19}

Governmentality:

A form of power and a concept that explores the rationales of governing and the ideas, the individuals, and the institutions that they empower based upon the concept of self-governance. Foucault describes it as processes, institutions, calculations, and tactics that allow the deployment of a very specific type of power that has “population” as its target, political economy as its major form of knowledge, and apparatus of security as its essential technical instrument.\textsuperscript{20,21}

Institution:

A concept or trait, a historical rationality, a policy, an instrument of the State—things that are created by a power/knowledge rationality.\textsuperscript{22-24}

Mentalité:

A French word suggesting a collection of idea, beliefs, and psychologies that underpin behaviors of a group in society. In English, the equivalent term is mentality, meaning an attitude of an individual or a group. I used the French word throughout this document to better capture the concept of plurality of ideas.

New Managerialism:

An area of study that explores the uptake of business managerial practices in public institutions.\textsuperscript{25-27}

Political Economy:

An area of study that that explores the effects of the intersection of law, politics, trade, customs and government.\textsuperscript{28}
Any collection of levels of government in Canada, municipal, provincial, federal, in isolation or in aggregate.\textsuperscript{20}

Foucault commented on the idea of the State, saying “maybe the State is only a composite reality and mythicized abstraction whose importance is less than we think.”\textsuperscript{20}

In this document, the term “State” will be used to denote this Foucauldian concept where appropriate and “state” used to denote non-Foucauldian usage.
Citations Lexicon


# Time Line: One Hundred Twenty Years of Canadian Academic Medicine in Toronto

<table>
<thead>
<tr>
<th>Date</th>
<th>Event/Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1854</td>
<td>The University of Toronto’s Faculty of Medicine is closed.¹</td>
</tr>
<tr>
<td>1867</td>
<td>Toronto General Hospital closes due to lack of funds²</td>
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<tr>
<td>1874</td>
<td>Provincial <em>Charity Act</em></td>
</tr>
<tr>
<td>1875</td>
<td>The Hospital for Sick Children opens⁴</td>
</tr>
<tr>
<td>1887</td>
<td>University of Toronto Faculty of Medicine opens¹</td>
</tr>
<tr>
<td>1903</td>
<td>Trinity Medical College merged with Faculty of Medicine at the University of Toronto¹</td>
</tr>
<tr>
<td>1904</td>
<td>Flavelle Commission of Ontario⁵</td>
</tr>
<tr>
<td>1905</td>
<td><em>University Act</em>¹</td>
</tr>
<tr>
<td>1908</td>
<td>Earliest example of use of term “academic medicine”⁶</td>
</tr>
<tr>
<td>1908</td>
<td>SickKids begins sales of pasteurized milk⁷</td>
</tr>
<tr>
<td>1910</td>
<td>Flexner Report published by Carnegie Foundation⁸</td>
</tr>
<tr>
<td>1910</td>
<td>University of Toronto Faculty of Medicine pivots from British model for medical education focused on teaching to American model focused on research⁹</td>
</tr>
<tr>
<td>1911</td>
<td><em>Toronto General Hospital Act</em>¹³</td>
</tr>
<tr>
<td>1912</td>
<td>American Hospital Management Association (AHA) became voice of American and Canadian hospitals²</td>
</tr>
<tr>
<td>1914</td>
<td>The Medical Research Fund established¹</td>
</tr>
<tr>
<td>1917</td>
<td><em>Income War Tax Act</em>¹²</td>
</tr>
<tr>
<td>1917</td>
<td><em>War Charities Act</em>¹³</td>
</tr>
<tr>
<td>1918</td>
<td>World War I ends.¹⁴</td>
</tr>
<tr>
<td>1919</td>
<td>Lady Eaton Chair in Department of Medicine, Faculty of Medicine, University of Toronto created with $500,000 endowment¹⁵-¹⁶</td>
</tr>
<tr>
<td>1920</td>
<td>$1,000,000 donation from the Rockefeller Foundation to the Faculty of Medicine, University of Toronto.⁹,¹⁵,¹⁷</td>
</tr>
<tr>
<td>1921</td>
<td>Insulin discovered at Toronto General Hospital (Connaught Labs)⁹</td>
</tr>
<tr>
<td>1923</td>
<td>Banting and Best Chair of Medical Research established at University of Toronto¹⁸</td>
</tr>
<tr>
<td>1923</td>
<td>Rockefeller Foundation makes donation to support creation of School of Hygiene, University of Toronto ($400,000 for building, $250,000 endowment)¹⁹-²⁰</td>
</tr>
<tr>
<td>1929</td>
<td>Great Depression</td>
</tr>
<tr>
<td>1930</td>
<td>SickKids creates Pablum, a food supplement for babies, and Paediatric Research Foundation to manage its monetization⁴,²¹</td>
</tr>
<tr>
<td>1930</td>
<td>Taxes and death duties begin to rise in Canada²,²²</td>
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<tr>
<td>Year</td>
<td>Event</td>
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<tr>
<td>1930</td>
<td>Ontario Government creates Ministry of Health to recognize the importance of health as policy focus and to create closer oversight of hospitals.</td>
</tr>
<tr>
<td>1930</td>
<td>Private pavilion (Bell Wing) opened in Toronto General Hospital in April</td>
</tr>
<tr>
<td>1937</td>
<td><em>Public Hospitals Act</em></td>
</tr>
<tr>
<td>1941</td>
<td><em>Dominion Succession Duty Act</em></td>
</tr>
<tr>
<td>1941</td>
<td>Ontario Blue Cross for Hospital Care launched</td>
</tr>
<tr>
<td>1947</td>
<td>Department of Health Administration launched within School of Hygiene, University of Toronto</td>
</tr>
<tr>
<td>1948</td>
<td><em>Income Tax Act</em> passed. Makes income tax permanent</td>
</tr>
<tr>
<td>1954</td>
<td>SickKids Research Institute opened</td>
</tr>
<tr>
<td>1957</td>
<td><em>Hospital Insurance and Diagnostic Act</em></td>
</tr>
<tr>
<td>1958</td>
<td>“The Role of Decent Work in the Health Sector”</td>
</tr>
<tr>
<td>1959</td>
<td>Charitable foundations under surveillance</td>
</tr>
<tr>
<td>1961</td>
<td><em>Hospital Insurance and Diagnostic Act</em> adopted by all provinces</td>
</tr>
<tr>
<td>1966</td>
<td><em>Medical Care Act</em></td>
</tr>
<tr>
<td>1966</td>
<td>Ontario Hospital Association launches Ontario Medical Services Insurance Plan (OMSIP) funded by Ontario Government</td>
</tr>
<tr>
<td>1968</td>
<td>Proposals on the Organization of the University Hospital System</td>
</tr>
<tr>
<td>1972</td>
<td>Report of the Community Health Centre Project to the Conference of Ministers</td>
</tr>
<tr>
<td>1972</td>
<td>University of Toronto sells Connaught Labs</td>
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<tr>
<td>1972</td>
<td>Oil shocks plunge North American economy into recession</td>
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<tr>
<td>1972</td>
<td>Ontario Medical Services Insurance Plan (OMSIP) renamed Ontario Health Insurance Plan (OHIP)</td>
</tr>
<tr>
<td>1972</td>
<td>SickKids Foundation created</td>
</tr>
<tr>
<td>1972</td>
<td>Division of Community Health established in the Faculty of Medicine</td>
</tr>
<tr>
<td>1973</td>
<td>Toronto General Hospital Foundation established</td>
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<tr>
<td>1979</td>
<td>The Herbie Fund established at the Hospital for Sick Children</td>
</tr>
<tr>
<td>1981</td>
<td>SickKids creates HSC Applied Research Corporation</td>
</tr>
<tr>
<td>1982</td>
<td>Dean of Medicine, University of Toronto correspondence with King Faisal University, Saudi Arabia</td>
</tr>
<tr>
<td>1982</td>
<td>Dean Lowy of Faculty of Medicine, University of Toronto letter to President of Ontario International Corporation</td>
</tr>
<tr>
<td>1982</td>
<td>Dean Lowy writes to Dean of Pharmacy, University of Toronto</td>
</tr>
<tr>
<td>1982</td>
<td>SickKids approaches Idea Corporation, crown corporation of the Ontario government for funding of for profit ventures</td>
</tr>
<tr>
<td>1983</td>
<td>Hospital Purchasing Incorporated created</td>
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<tr>
<td>1984</td>
<td>C Suite titles adopted in Hospital for Sick Children</td>
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<tr>
<td>1984</td>
<td>Hospital for Sick Children explores setting up a foundation in the United States</td>
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<tr>
<td>Year</td>
<td>Event</td>
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<td>------</td>
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<tr>
<td>1984</td>
<td>Canada Health Care Act&lt;sup&gt;46&lt;/sup&gt;</td>
</tr>
<tr>
<td>1986</td>
<td>Toronto General Hospital and Toronto Western Hospital merge&lt;sup&gt;2,48&lt;/sup&gt;</td>
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<tr>
<td>1986</td>
<td>Ministry of Health orders audit of SickKids’s spending&lt;sup&gt;49&lt;/sup&gt;</td>
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<tr>
<td>1986</td>
<td>TGH Foundation merged with Toronto Western Hospital Foundation&lt;sup&gt;50&lt;/sup&gt;</td>
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<tr>
<td>1986</td>
<td>McDonald’s proposal to run a food restaurant in SickKids presented to its Board of Trustees&lt;sup&gt;51&lt;/sup&gt;</td>
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<tr>
<td>1986</td>
<td>Doctors’ strike&lt;sup&gt;52&lt;/sup&gt;</td>
</tr>
<tr>
<td>1987</td>
<td>SickKids Hospital embarks on era of cost controls&lt;sup&gt;53&lt;/sup&gt;</td>
</tr>
<tr>
<td>1988</td>
<td>CanMEDs competency framework released&lt;sup&gt;54-55&lt;/sup&gt;</td>
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<tr>
<td>1988</td>
<td>University of Toronto’s Faculties of Medicine and Business partner to launch a collaborative program&lt;sup&gt;56&lt;/sup&gt;</td>
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<tr>
<td>1988</td>
<td>SickKids’s board focuses discussions on funding mechanisms for health sector start-up companies (Cyberfluor and RDC)&lt;sup&gt;57&lt;/sup&gt;</td>
</tr>
<tr>
<td>1989</td>
<td>The Journal of Medical Education changes its name to Academic Medicine&lt;sup&gt;58&lt;/sup&gt;</td>
</tr>
<tr>
<td>1990s</td>
<td>“Branding” marks introduction of marketing to academic medicine&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>1991</td>
<td>Creation of Toronto Academic Health Science Council (TAHSC)&lt;sup&gt;60&lt;/sup&gt;</td>
</tr>
<tr>
<td>1992</td>
<td>SickKids board member questions monetization, asking “Does all this mean—there be more emphasis on budgets than on patient care what is best for patient will be dictated by cost?”&lt;sup&gt;61&lt;/sup&gt;</td>
</tr>
<tr>
<td>1992</td>
<td>Barer-Stoddart Report&lt;sup&gt;62-66&lt;/sup&gt;</td>
</tr>
<tr>
<td>1992</td>
<td>Faculty of Medicine mass firing of 89 support staff.&lt;sup&gt;67-69&lt;/sup&gt;</td>
</tr>
<tr>
<td>1993</td>
<td>Holding companies used in United States to manage/oversee multiple hospitals.&lt;sup&gt;2,70&lt;/sup&gt;</td>
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<tr>
<td>1993</td>
<td>“Toronto hospitals to woo patients from the United States”—headline indicating public consciousness of inbound medical tourism&lt;sup&gt;71&lt;/sup&gt;</td>
</tr>
<tr>
<td>1993</td>
<td>“Exporting health care: but who pays?”—headline indicating public concern with commodification of medical care&lt;sup&gt;72&lt;/sup&gt;</td>
</tr>
<tr>
<td>1993</td>
<td>Health Industries Advisory Committee (HIAC) established to encourage health sector development&lt;sup&gt;73&lt;/sup&gt;</td>
</tr>
<tr>
<td>1993</td>
<td>Ontario Enterprise Council established&lt;sup&gt;74&lt;/sup&gt;</td>
</tr>
<tr>
<td>1994</td>
<td>InterHealth Canada Ltd. incorporated&lt;sup&gt;75-78&lt;/sup&gt;</td>
</tr>
<tr>
<td>1994</td>
<td>“Healthy and Wealthy: A Growth Prescription for Ontario’s Health Industries”—policy paper suggesting sales to international clients&lt;sup&gt;77&lt;/sup&gt;</td>
</tr>
<tr>
<td>1994</td>
<td>Health Industries Sector Council created in Ontario (replaced by Health Industries Development Council in 1995)&lt;sup&gt;77&lt;/sup&gt;</td>
</tr>
<tr>
<td>1994</td>
<td>Canadian Medical Discoveries Fund created&lt;sup&gt;77&lt;/sup&gt;</td>
</tr>
<tr>
<td>1994</td>
<td>Ontario government approves $6.6 million in funding for health sector</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>1995</td>
<td>Health Industries Development Council&lt;sup&gt;73&lt;/sup&gt;</td>
</tr>
<tr>
<td>1997</td>
<td>“Commercial Activity” first appears on SickKids’ financial statements&lt;sup&gt;79&lt;/sup&gt;</td>
</tr>
<tr>
<td>1997</td>
<td>Department of Public Health Sciences created in University of Toronto&lt;sup&gt;19&lt;/sup&gt;</td>
</tr>
<tr>
<td>1998</td>
<td>Department of Public Health Sciences integrates Centre for Health Promotion&lt;sup&gt;19&lt;/sup&gt;</td>
</tr>
<tr>
<td>1998</td>
<td>UHN Office of Commercialization created&lt;sup&gt;80&lt;/sup&gt;</td>
</tr>
<tr>
<td>1999</td>
<td>University Health Network created&lt;sup&gt;2&lt;/sup&gt;, &lt;sup&gt;48&lt;/sup&gt;</td>
</tr>
<tr>
<td>2001</td>
<td>Toronto General Hospital’s Bell Wing demolished&lt;sup&gt;81&lt;/sup&gt;</td>
</tr>
<tr>
<td>2002</td>
<td>Salary disclosure insert first appears in SickKids’ financial statements&lt;sup&gt;82&lt;/sup&gt;</td>
</tr>
<tr>
<td>2002</td>
<td>The Kirby Report: “The Health of Canadians—The Federal Role”—argues that money for health care must be raised by federal government&lt;sup&gt;83&lt;/sup&gt;</td>
</tr>
<tr>
<td>2003</td>
<td>UHN completes land sale to MaRS</td>
</tr>
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<td>2004</td>
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Chapter 1: The Commercialization of Canadian Academic Medicine

Factories for the Making of Ignorant Doctors: Carnegie Foundation’s Startling Report that Incompetent Doctors are Manufactured by Wholesale in this Country

New York Times 1910

A so-called “de-Flexnerization” process is underway in which low quality professional schools might be proliferating once again on the centennial of the Flexner Report.

J. Frenk, Lancet 2010

Introduction

In 1910, the Carnegie Foundation released the Flexner Report, a far-reaching analysis of medical education in the United States and Canada. This canonical report established a framework for academic medicine that stands to this day. Structurally, it argued for a model of academic medicine consisting of medical schools situated in universities linked with affiliated academic hospitals as teaching sites. At the level of operations, it embedded the scientific method in the medical curriculum, triggered the closing of underperforming medical schools, and purged for-profit funding practices from academic medicine, raising the standard of academic medicine across North America as a result. One hundred years later, a far-reaching report on medical education in The Lancet, a
prominent academic health policy journal, argued that a “de-Flexnerisation” of academic medicine seemed to be under way around the world. Revenue generation practices were observed to be on the rise\textsuperscript{2,9-12} and for-profit medical schools were becoming common.\textsuperscript{2,13}

In Toronto, a key centre of academic medicine in Canada, academic medical institutions have been engaging in commercial practices for some time.\textsuperscript{9,14,15} Many Toronto academic hospitals have established for-profit consulting services aimed at foreign hospitals and governments\textsuperscript{14-24} and for-profit medical services in Canada for international patients.\textsuperscript{23,25,26} The University of Toronto’s Faculty of Medicine has been marketing postgraduate medical education training\textsuperscript{20,27-31} and a wide variety of educational offerings to global learners and institutions since the 1990s.\textsuperscript{32-36} Money is an explicit rationale in all of these examples; profit (or a surplus) a simple and desired outcome.

**The Problem**

The rationales for this new commerciality have included fiscal limitations of funding bodies, rising operational costs within academic medicine, and a need for business efficiency in public institutions.\textsuperscript{37-42} These rationales notwithstanding, this new commerciality in Canadian academic medicine seems a somewhat perplexing development when one considers the not-for-profit and public-payment ethos long embedded in Canadian health care funding\textsuperscript{43,44} and the
finding of Abraham Flexner that an overreliance on for-profit practices was clearly linked with poor medical educational outcomes and poorly trained physicians.\textsuperscript{3,7} Since the era of Flexner, various scholars have explored the effects of rising commerciality in society. Slaughter and Leslie have investigated its effect in academia and how it has changed the types of research conducted, the physical nature of academic spaces, the power relations within universities, and the relationship between universities and private industry.\textsuperscript{45-47} Scholars such as Deem and Kirkpatrick have examined the effect of the adoption of business practices—a new managerialism, in, and on, public service—finding it to have produced a new concept of public service, one more focused on value and efficiency than on the creation of a civil society.\textsuperscript{48-51} Ichilov, Crouch, and others have explored this new commerciality and its relationship to the concept of citizenship finding that this new focus on commerciality in society seemingly diminishes the concept of citizenship and undermines democracies.\textsuperscript{52-54}

This new global commerciality in Canadian academic medicine is the entry point for my research. My research question was simple: \textit{“How did this new global commerciality become possible in Canadian academic medicine?”} To the extent that academic medicine represents a key policy domain and a very large expense in Canada and in other international jurisdictions, it seems important to understand how this new focus on commerciality has transformed and is, or might be, transforming, academic medicine.
This document provides my findings from an analysis of 120 years of history in the form of economic thought in three Toronto-based academic medical institutions.

This dissertation is structured as follows:

• Chapter 1 provides an introduction to the research and describes the research problem.
• Chapter 2 provides an overview of the literature that informed this research project.
• Chapter 3 describes the Foucauldian theoretical concepts of discourse and space that were used to focus my research gaze.
• Chapter 4 describes the methodology used in the course of the research: the delimitation of the project scope and scale, the creation of the archive of data analyzed, the composition of the archive, the interview categories, scripts and practices, the ethics approval, and the methods of data analysis and coding.
• Chapters 5-8 describe the findings of my research. Chapter 5 describes the discursive formation of Canadian academic medicine and its origins. Chapters 6-8 analyze uses this discursive formation to analyze the transformation of Canadian academic medicine in three eras, 1900 to 1940, 1940 to 1990, and 1990 to 2016 to show what the
various discourses of Canadian academic medicine produced and made possible. Over these three eras, Canadian academic medicine’s journey from local to global is tracked, as is the emergence of Canadian academic medicine’s global commerciality.

- Chapter 9 provides a summary of the full thesis and its findings, and lays out potential future research that flows from this work.

I hope that these findings will be of use to those charged with funding, governing, leading, and managing the institutions of Canadian academic medicine.
Citations Chapter 1


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Chapter 2: Literature

Introduction

This chapter provides an overview of the academic literature that informed this research project. More specifically, it describes the results of my preliminary scans of the academic literature and several core bodies of academic literature that informed my thinking on this project.

Literature Scans

In an editorial in 2010 for a special edition addressing the history of academic medicine, the editor observed that the history of medicine was well documented but this history of academic medicine seemed somewhat underchronicled.¹ My scans of the academic literature did not contradict this comment. More specifically, they revealed that there is limited academic writing about academic medicine in general or about its commercialization or globalization. This lack of writing about academic medicine was however offset by writings about academia, academic hospitals and the commercialization of these constituent institutions of academic medicine. Arguably my work would be a contribution to these existing
bodies of work and a substantial contribution to the writings about academic medicine, a needed academic domain.

**Histories of Medicine**

One body of literature that I delved into quite extensively was the history of medicine. My approach to this literature was twofold. First, I read the histories of the Toronto General Hospital,\(^2\) the Hospital for Sick Children,\(^3\) the Faculty of Medicine at the University of Toronto,\(^4\) and the University of Toronto.\(^5\) These histories were of great interest because they represented data and historical accounts of these institutions that had the sanction of the respective institutions. They were written by historians who were given broad access and broad support by the academic institutions. While I would not say that these histories were biased, they were clearly written to tell a triumphal version of the institutions’ histories, one that marked their accomplishments and their struggles and situated them as important societal institutions. Second, I read more critical and theoretical histories of the creation of health care systems.\(^6\)\(^-\)\(^8\) In the aggregate, these histories provided a detailed overview of notable dates, events, practices, beliefs and eras. What they did not provide was a detailed or focused analysis of the economics of these institutions and domains, leaving me the decided impression that finance and economics were at best a narrative backstory of lesser importance. Within the institutional histories, there was a common financial arc broken into three eras, one defined by charitable giving and instrumental
benefactors, one defined by the creation of a publicly funded health care system, and one in which commercial endeavours were more explicitly discussed.

David Wright’s history of the Hospital of Sick Children follows this arc quite closely. It begins by telling an origin story of the hospital, presenting it as a charitable institution that emerged from the beneficent thoughts of two affluent Christian women. Over the course of the book, discussions about finances appear in a variety of forms. Philanthropy appears in the form of references to influential benefactors of the hospital (such as John Ross Robertson). Commercialization appears in the form of a history of the discovery and monetization of research (specifically Pablum). Ethical challenges associated with commercial interactions are presented as an unintended consequence of industry funding of research (as in the story of Nancy Oliveri and Apotex). Global commercial engagement is presented in the form of an uncritical profile of the creation of SickKids International, a globally oriented consulting service that was one of the entry points for my research. Throughout this history, the hospital is presented as an independent self-governing institution in a valuable partnership with its academic partner, the University of Toronto.

J. T. Connor’s profile of the Toronto General Hospital provides a similar narrative arc. It begins with an origin story of the hospital as a financially precariously fragile institution funded erratically by various levels of government and a
collection of donors. Throughout this history, Connor connects the finances of the hospital with various statutes such as the *Provincial Charity Act of 1874* (an act that provided incentives for charitable giving), the *Toronto General Hospital Act of 1927* (an act that provided clarity on a variety of hospital regulations and the hospital’s governance relationship with the University of Toronto) and the *Public Hospitals Act of 1931* (an act that transformed hospitals from charities to corporations to create a more stable funding platform). Connor also connects the hospital’s financial decisions and its management logics with the American Hospital Management Association, while observing that Canadian hospitals seem to have been spared, but not avoided, the excesses of American corporate management. He closes with a description of the hospital’s corporatization; its adoption of a holding company structure, and its history of corporate mergers with other Toronto hospitals. As in Wright’s history of the Hospital for Sick Children, the partnership with the university is referenced but it is not presented as a prominent part of the hospital’s identity or its institutional or governance structure.

Ed Shorter’s *Partnership for Excellence: Medicine at the University of Toronto and Academic Hospitals* and Martin L. Friedland’s *The University of Toronto: A History* also follow the same narrative arc, albeit one that starts with the university portrayed as financially solid and unconcerned about its finances. In the history of the university, the Faculty of Medicine is not presented as a major player; it is simply one of many. Comments are made that suggest the university
leadership was not completely happy with the strategic approach of the Faculty of Medicine and that its concentration on individual patients and its lack of attention to population health. Shorter’s history spends considerable time exploring the structural aspects of the Faculty of Medicine. He sees it as a stand alone faculty, composed of various departments, and linked to the affiliated academic hospitals, in essence “two institutions, the Faculty of Medicine and the teaching hospitals of the University of Toronto… two institutions as “inseparable and intertwined.” He also sees the Faculty as one part of a larger institution, an academic health science centre’, functioning at various times to attempt to rein in the more “parochial” instincts of the academic hospitals. He frames the creation of the academic health science centre as both a creation of the university and the hospitals intended to increase their ability to resist funding pressures applied by the government of Ontario on them and as an act of resistance of the university as a way to offset the influence accumulated by the hospitals under the hospital mergers of the late 1980s.

For all the focus on space, power, and history in these two books, a discussion of money or funding is for the most part absent. Friedland devotes just one of forty-two chapters to finances and in that chapter frames finances simply as funding from the State, the decline of which triggers consequences such as decreased investment, lack of hiring, and manpower unrest within the academic ranks.

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1 A partnership of a university and academic teaching hospitals in which the institutions share joint responsibility for the education of health professionals. The idea of academic health science centres emerged in Toronto in 1968 with the issuance of the report the Proposal on the organization of the University Hospital System.
Shorter’s history of the Faculty of Medicine is similarly, if not more, silent on finances. It makes the occasional reference to philanthropic support, but for the most part these references are made in passing. Interestingly, his discussion of the researchers Banting and Best and their discovery of insulin is almost completely silent on its financial role in the university, commenting only that insulin was commercialized and that its profit margin was ten cents per thousand units without contextualizing this cash stream in any way to the economics of the day or the institutional finances themselves.4

These various histories were highly informative for my work. The first category of histories provided considerable detail and broad historical arcs. It was also very helpful in that it made apparent how little consideration was given to finances as an influence in the histories of these institutions. At best finances were seen through one or two lenses—tax based funding and philanthropy—with all other financial activities being invisible.

The second type of history I read adopted a more critical approach and focused on the creation of health care systems in Canada and in the US. Four key examples of this type of history were Paul Starr’s Pulitzer Prize–winning book, The Social Transformation of American Medicine, David Light’s Ironies of Success: A New History of the American Health Care System,6 E. Richard Brown’s Rockefeller Medicine Men: Medicine and Capitalism in America,12 and David Naylor’s Canadian Health Care and the State.8 Unlike the Canadian
institutional histories described above, these histories explore the creation of health care systems and their relationship with the State and medical profession. All four books provide an interesting perspective on the power relations inherent in the creation of a health care system in relation to the medical profession and the State. Starr’s work provides a narrative arc that builds to the creation of corporate medicine in the United States and its effect on physicians’ power, arguing that the economic structure of American medicine is based on professional fees, unlike Canadian medicine, which is based on State funding. 

Light’s history of the American health care system adopts a Marxist interpretation, arguing that the American medical profession is in crisis and is undergoing, or has undergone, a transformation from helping those less fortunate to focusing on accumulating power and resources in society. Light goes on to argue that the American health care system is in reality a medical-industrial complex linking corporations, universities, and the State, with its ultimate objective corporate sales and corporate profits. Unlike the other three authors, Light argues that there are three different funding systems for health care: corporate providers, the organized medical profession and its billings, and government or other large payer. He sees these three types of funding mechanism associated with three different financial ethos: maximization of profit, provision of the best clinical care for individual patients, and the creation of a healthy workforce, respectively. Naylor’s book on the Canadian health care system is differently constructed in that it is a collection of essays each providing
a slightly different perspective and historical context.\textsuperscript{8} Many of the essays situate the medical profession or the health care system in service to the State.\textsuperscript{8} Other essays situate the medical system in a class structure, in a for-profit ward context and in a State funding context.\textsuperscript{8} E. Richard Brown provides a somewhat different take, specifically a Marxist analysis of the Rockefellers’ philanthropic support for the creation of the North American medical education system. In his alternative historical interpretation of Flexner’s work Brown argues that instead of being antagonistic to for-profit medical education, Flexner was actually arguing for a strengthening of professionalism to transform the medical profession into a tool of a capitalistic society.\textsuperscript{12} For Brown, this meant that the medical profession and the institutions of medical education are granted power and resources by their obeisance to the most affluent in society.\textsuperscript{12}

Each of these histories provides an illuminating, if partial, picture of the development of academic medicine. More importantly for my work, they make several things quite clear. First, that there are (at least) two understandings of the relationship between a health care system and a medical education system: that they are separate but connected and that they are two subsidiary parts of a larger integrated system. Second, in these histories there is limited consideration given to the influence (s) of finance (s) and financial thought on the development of academic medicine. In fact, in all of the above examples, there seems to be a somewhat naive understanding,\textsuperscript{2} inasmuch as each of these histories for the

\textsuperscript{2} I use the term “naive” to suggest that each of the authors sees only one type of funding, not to suggest that any one of these funding mechanisms is actually easy to understand.
most part simply focus on a single form of financing, either State, professional fees, or philanthropy. None of these histories consider the collective effect of all of the various forms of funding, whether they might interact or the fourth type of funding I have identified, commercial practices.

**Commercialization of Universities and Hospitals**

While the historians whose work I have described above have not explicitly focused on the commercialization of their respective institutions or domains, there are several of bodies of academic literature that do explicitly explore the concept of commercialization in universities, hospitals, and society as a whole.

**The Commercial University**

The first body of literature of note explores the effects and utility of commercialization in universities. While there a variety of names are ascribed to this phenomenon, the most common is “academic capitalism”. Effects that have been documented include a shift in the type of research that is prioritized from theoretical to applied, a rise in the stature and power of academics who are more successful in establishing ties with the business community, a space allocation for offices and labs based on the commercial applications of an academic’s work, and a pronounced decrease in collegiality in academia.
Slaughter and Leslie, two prominent scholars exploring this phenomenon, linked academic capitalism with the rise of the neoliberal State, the multinational organization, and the multilateral agreement.\textsuperscript{19} They found that these changes resulted in the creation of new controls over the flow of knowledge between the academic, professional, and business communities, changing the boundaries between these domains.\textsuperscript{19} They also found that new “interstitial” organizations were created to bridge universities and industry, such as technology licensing, technology transfer, and economic development offices.\textsuperscript{19} Most interestingly they found that these phenomena were associated with a change in how knowledge was understood from a public good freely available to all to a private good to be owned, sold, and traded.\textsuperscript{19} As a result of this commercialization of the university, knowledge was transformed into a tradable and monetizable commodity and the university became an agent of a commercial society. Davies and Quirke found that academic capitalism was linked with an increased stratification in society\textsuperscript{21} and a growing distrust of publicly funded education.\textsuperscript{22} Friedland and others found that academic capitalism was driven by the transformation in the understanding of education in policy circles from a driver of social mobility to a driver of national economic growth.\textsuperscript{17,18,23-25}

The Commercial Hospital

The work on commercialization in health care or in hospitals is not as advanced as that in education.\textsuperscript{26} Early studies in this area tended to focus on simply
documenting the various forms of commercial transactions that occurred in health care. Classic health policy researchers have focused on defining the boundaries of different funding models, such as for-profit funding, not-for-profit funding, private and public models. In this work, scholars have documented the characteristics of different funding systems. For example, they have shown that nonprofit systems offer a substantially lower-cost model for universal coverage, stronger health outcomes, high user satisfaction, and lower administration obligations than for-profit or commercial models. They have also shown that for-profit funding systems seem to be associated with a diminishment of labour agreements, evasions of costs controls, lower quality, and a loss of difficult-to-measure intangibles. More recently, health policy scholars have begun to explore commerciality in hospitals in the form of “entrepreneurialism” and focused on the effects associated with the development of a new type of institution, an “entrepreneurial hospital.” These scholars have found numerous effects in hospitals associated with the adoption of a business ideology. One study found that an entrepreneurial hospital was understood to be more separate and distinct from a university as it pursued its own research. A second study found that entrepreneurial hospitals were believed to be drivers of biomedical innovation, but also potentially undermined historic bonds of social solidarity. A third study found that evidence that a new focus on acquiring venture capital funds in an entrepreneurial hospital might undermine or be in tension with health policy goals. Interestingly, these findings were broadly in
line with the work of Nobel Prize–winning economist Oliver Hart who found that
government contracting of institutional services to for-profit private owners was
associated with a pursuit of cost savings at the expense of investment and
quality.33-36

The Managerial Institution
There is a third body of literature that addresses the commercialization of public
institutions but sees commercialization as a change in management practices
rather than as a focus on profit.37-42 Scholars who approach commercialization in
this way typically call the phenomenon “new managerialism” or
“neomanagerialism.”37-42 This approach explores the shift in public service
institutions away from a welfare state mentality, that is to say a provision of
services to the less fortunate, toward a commercial efficiency-minded focus that
targets the populace as its market.42 Some of these scholars link new managerial
practices with academic capitalism, seeing them as similar and related
phenomena.37,41 Other scholars have explored the effects of new managerialism
on the professions39 and on the operations and ethos of public
institutions.38,39,41,43 All of these studies have found that new managerialism is
associated with an increased focus on audit, efficiency, metrics, and an
emergence of corporate ideas such as return on investment, cost value,
evaluation, and increasing reporting obligations in the various institutions.37-42

Commerciality in Society and Citizenship
Looking outside the boundaries of writings on health care and medical education, I found another interesting body of literature that explored the relationship between increased commerciality in society, citizenship, and democracy.\textsuperscript{44-47} One scholar, Orit Ichilov, found that an increased focus on commerciality in society diminished the concept of citizenship and the institutions of democratic society, making it more challenging for public institutions to pursue their mandates.\textsuperscript{44} John Clark found that a commercial society re-conceptualized citizens as consumers and in doing so decreased consumer choice, increased stratification in society, and privileged managing the relationship between demand and resources for social care over provision of social care.\textsuperscript{45} Crouch and Prabhakar presented contrasting arguments about the effects of commercialization, one arguing that it diminished choice in society the value of citizenship and the other arguing that commercialization had the potential to enhance some types of choice actually bettering society.\textsuperscript{46,47}

\textbf{The Global Institution}

Paralleling my reading on commercialization of universities and hospitals, I also read quite broadly to gain an understanding of scholarly thinking about globalization. The writings in this area explore globalization as a phenomenon,\textsuperscript{48-56} giving extensive discussion to what globalization is,\textsuperscript{52,57-59} what it is not,\textsuperscript{52,53} and how to study it.\textsuperscript{51,52,54,55} Within the medical education there is a small but growing group of critical scholars exploring the effects of globalization on educational practices, institutions and educators.\textsuperscript{55,56,59} Within health care, there
are two groups of scholars. The first group, a small group of scholars approaches globalization with a critical studies lens studying its effects on health care professionals and at the systemic level conceptualizing it as global health projects. \textsuperscript{60,61} The second group, a significantly large group, studies globalization as “global health” focusing on issues at the disease and project operational level.\textsuperscript{62-69} Within the broader domain of education, there is a third group of scholars exploring the effects of globalization on a global state by studying the emergence of a global “knowledge economy.”\textsuperscript{70-75} Much of this work focuses on the effects of globalization as commercialization on universities and how it transforms their structures.\textsuperscript{70-75} Mohrman and coauthors are a good example of this type of work in that they explore the impact of the idea of a global economy at an institutional level, finding that it had produced a stratification among universities and a new Emerging Global Model for universities.\textsuperscript{73-75} The few universities that they identified in this class shared many, if not all, of eight characteristics: 1) an academic mission that transcended boundaries set by nation-states; 2) a greater focus on research and a tendency for scientific methods to be adopted by other disciplines outside the sciences; 3) new roles for faculty that tended to be cross-disciplinary and international; 4) higher cost structures and diversified funding bases that included for-profit spin-offs, for-profit businesses, and technological innovation; 5) new relationships with governments and corporations focused on economic development and social good; 6) worldwide recruitment of academic staff; 7) greater internal complexity in the
institutions; and 8) engagement with international nongovernmental and multi-
governmental organizations to support research, faculty mobility, and
international stature.\textsuperscript{73-75}

\textbf{Conclusion}

These bodies of literature were all very influential on my thinking. They informed
how I defined the research problem for this project, how I structured the research
question, and how I delimited the study and how I determined my object of study.
As commerciality did not seem to be simply limited to hospitals or universities but
to be in both, it seemed problematic to consider this phenomenon solely as a
practice of either a hospital or a university. Instead, as there seemed to be an
explicit link between academic hospitals and universities dating back to Flexner
and permeating all of the literature I read, it seemed more complete to study
“academic medicine”, an overarching idea which encompassed both institutions
and allowed for consideration of the role of other funding and regulatory bodies
and other related organizations.

This logic was supported by my review of the academic literature in that I
identified several clear gaps in it. The first gap in the literature was that
“academic medicine” was seemingly overly looked as an object or domain of
study. To date, scholars seem to have focused on academic medicine’s
constituent institutions, the academic hospital and the university, and been silent
on their collective whole. The second gap was that there was an absence of scholarly work looking at how global commerciality was manifesting in, or affecting, “academic medicine”, its constituent institutions, academic hospitals and universities and the power relations in, and between them. Finally, there was an academic silence on the influence of economic thought on the development of the structure, and practices, of academic medicine.

This research project is an effort to address these gaps.
Citations Chapter 2

4. Shorter E. 2013. Partnership for excellence medicine at the University of Toronto and academic hospitals. Toronto, ON: University of Toronto Press.


Chapter 3: Theory

Introduction

This chapter describes the theoretical concepts used to inform the design and analysis of this research project. It lays out the rationale for the choice of this theoretical approach. It explores the factors influencing that rationale. It describes my own way of understanding of the world (my ontological position)—a key factor in that choice. And finally, it describes some of the limitations associated with this theoretical approach.

Choosing a Theory

Choosing a theory for a research project is in many ways a complex process. It must align with the research question, one’s own ontology, and with the characteristics of the phenomenon under exploration. For me, the process to identify a theory involved a multipronged approach: reading a wide range of theorists, assessing the alignment between the various theorists and my own ontological position and, in doing so, becoming aware of how my reading of the various theorists had acted upon me to transform my ability to see the world and institutions as constructed.
In navigating this process, I read the work of a wide variety of theorists. I read theorists in health policy\textsuperscript{1-7} and education policy\textsuperscript{8-10} I read theorists who studied variations on how to analyze theory\textsuperscript{11} I read social theorists such as Dorothy E. Smith\textsuperscript{12-14} Gilles Deleuze\textsuperscript{15,16} Felix Guattari\textsuperscript{15,16} Pierre Bourdieu\textsuperscript{17-19} and Michel Foucault\textsuperscript{20-26} I read feminist theory\textsuperscript{12,13,27} postcolonial theory\textsuperscript{28-30} discourse theory\textsuperscript{31-38} historical theory\textsuperscript{2,39-41} ethical theory\textsuperscript{42} and Marxist theory\textsuperscript{27,43-45} I read a wide range of financial theories such as academic capitalism\textsuperscript{44,46-48} financialization\textsuperscript{44} globalization\textsuperscript{9,49-54} political economy\textsuperscript{54-57} and business strategy/national wealth creation\textsuperscript{58,59} In reading these various theorists, it became evident that I gravitated to theories that might be described as more systemic or macro and as more constructivist.

To understand how I assessed how the theories aligned with my own ontological position, it seems necessary to provide a bit of background about myself, to comment on my own positionality and to describe three experiences I had that strongly informed my choice of theory. First, who am I? I came to my doctoral studies after quite a long career in private industry working as an advisor to a high-net-worth family. In this role, I managed a portfolio of investments, did venture capital investing, tax and estate planning, and represented the family on a variety of corporate boards. Concurrent with this role, I was engaged in federal politics peripherally to my work. My educational background was an
undergraduate degree in life sciences and a Master in Business Administration (MBA). This background might be aggregated to describe my subject position prior to embarking upon my doctoral studies as capitalistic, scientific, political, positivist, and atheoretical. In a nutshell, my background was not one that suggested a choice of postmodern theorists and/or doctoral studies.

My decision to embark on doctoral work arose some years after I launched a consulting business targeting medical education organizations wrestling with commercialization issues and business practices as a way to supplement their governmental funding. In this work, I helped clients develop business plans, address strategic issues, identify potential markets for their educational offerings; on occasion, I actively engaged with the operationalization of those plans. In the course of this work I began to realize that my business background and education was in some way insufficient to the task of helping my client’s thinking on commercialization. In addition to their challenges to thinking commercially, the projects they often proposed to commercialize were, to my observation, either limited in financial potential or automatically targeted at a Middle Eastern market. I began to develop a sense that there were factors present that were inhibiting their development of commercial beyond a simple lack of skills or commercial competence. My decision to embark on doctoral studies was in part informed by my inability to decode or understand these patterns.
Some years after I had embarked on my doctoral studies and had begun to formulate my approach to exploring the global commerciality of Canadian academic medicine, I arranged a meeting with an individual working in a Toronto-based hospital as a global consultant. My goal for the meeting was to gain an overview of the contracts and the financial data in them that might be available for my project. Coming from business, my first research instinct was to “follow the money”: to see how the contracts were structured, how the funds were flowing, and how the funds were generated.

In hindsight, I was quite naïve going into that meeting. I assumed that since I was meeting with someone working in a publicly funded hospital, there would be a certain amount of transparency with respect to the contracts, their operations, and their financial structures. I was wrong. My attempts to obtain information about the contracts or about how to obtain information about them were strongly rebuffed. Not one to give up quickly, after leaving the office I attempted various other avenues of access to obtain contractual details. I was again frustrated, for I was only able to find the barest minimum of information about the contracts. It became clear that I was unlikely to obtain a significant amount of financial, contractual, or legal data. This was an intriguing finding.

By this point in my studies, as discussed above, I had read quite a few of the theorists listed above but was still somewhat agnostic about whose work most aligned with my project and my ontological positioning. Despite my experience
meeting with the hospital consultant, I had not completely abandoned the idea of drawing on business theories for this project. Thus, I decided to attend a conference organized by the Rotman Faculty of Management that explored the business of health care. At this conference, one session had a profound impact upon me and upon my choice of theorist. Actually, it might be more accurate to say that in one session, it became clear to me that my extensive readings of theory had changed me. The session where this moment happened had two prominent speakers—the dean of the University of Toronto business school, Professor Roger Martin, and a well-known Harvard scholar I had studied, Professor Michael Porter—speaking about the Canadian and American health care systems and how they both needed a more businesslike approach to their management. For someone educated in a business school, their comments were insightful and logical. For me, having read Foucault quite extensively, something clicked in my head and something shifted—I began to see and hear discourses. Where before I would have simply accepted the speakers’ analyses as truths they were disclosing in this moment, I began to see the way they organized their thoughts, the rules that underpinned their thinking and the boundaries of the logic created by their business education. While it may be an exaggeration to say that I had a theoretical epiphany, that was the moment when it became impossible not to see that an education, in this case a business education, while highly valuable and analytical, established limits on what people could think and what solutions they could suggest.
I would also identify this as the moment when I began to see discourse (s), collections of related ideas that made possible what people could say, do and be. As a result of this epiphany, for lack of a better word, my theoretical choices narrowed considerably. Business theories were out, since I could only see them as trapped in one discourse. Health policy theories, education policy theories, and political economy theories all went the same way, since they all seemed to be trapped within their own discourses and discursive boundaries. As a result, it became clear that I needed a theoretical approach that would situate me, and my research gaze, outside the boundaries of traditional policy analysis and its inherent logics. Amongst the theories I had read, critical discourse analysis provided this intellectual positioning. As Michel Foucault had demonstrated the effectiveness of critical discourse analysis in a variety of projects in health care, I decided to base my research on his work.

**Who is Michel Foucault and What Did He Do?**

*Michel Foucault, The Foucault Reader 1983*

In many ways, this quote from Michel Foucault captures the strengths and the grounds for critique of his theories. More specifically his theories focus the research gaze on power, knowledge, and truth and in doing so, they can reveal power relationships and unintended consequences. His theories do not render judgment as to whether something is good or bad. For many critical scholars and
many normative ethicists, this is uncomfortable. Chomsky, captured the thinking of many commenting on Foucault and his work, described him as very nice as a person while describing his research as dissociated from classical moral constructions and thus problematic.60

These observations hopefully provide some sense of the reactions that Michel Foucault, the French academic, the philosopher, the historian, and the postmodern social theorist,61 evoked in other academics. As an academic Michel Foucault was fascinated by the intersection of power, knowledge, and truth.22,24 Foucault himself suggested that rather than studying power per se he created alternative histories that explained the “different modes by which . . . humans are made into certain kinds of subjects.”61,62 In creating these alternative histories, Foucault saw institutions as created by power relations in society, and maintained that it is within those institutions that power relations were given anchor.61,62 This was a very different understanding of power and institutions than that held by policy scholars6,7,63-66 one that shifted the researcher’s gaze towards the ideological or conceptual and away from the tangible or institutional. For Foucault, this meant that he studied imprisonment rather than prisons or madness rather than mental hospitals.61,62

In studying concepts such as imprisonment or madness, Foucault explored how the understanding of these concepts changed over time and how, in those
changed understandings, new institutions were created or empowered. For example, Foucault identified three different understandings, or in Foucauldian terms, three different discourses of madness: madness as criminality, madness as spiritual possession and madness as mental illness. Under these three different discourses, three different institutions were empowered to address madness in society: prisons were built under the discourse of madness as criminality, churches and priests were empowered when madness was understood as spiritual possession, and mental hospitals and psychiatrists emerged when madness came to be understood as mental illness. Under each of these three discourses of madness different roles were created, resources flowed to the institution empowered by them, and the identity of those who were “mad” was constructed to align with the discourse.

While Foucault’s work has not been broadly applied in the field of health policy research, it is not unknown. It has however been used quite broadly in medical education to study a variety of concepts such as professionalism, competence, examinations, the “new” in medicine, and patient safety. In my work, this means that I am studying financial thought with commercial thinking as a starting point (in academic medical institutions) and that my findings will be the discourses and the governing truths that have made Canadian academic medicine’s global commercial engagement possible.
Discourses and Discursive Formations

To understand Michel Foucault’s work it is necessary to understand his concept of discourses, or discursive formations.\textsuperscript{22,61,67,71,72} Discourses are groups of truth statements that make possible what can be thought, said, and done in society.\textsuperscript{22,67,71} Discourses empower the creation of specific institutions, subject positions, and roles in society.\textsuperscript{67,71,72} They determine who can speak with authority on a phenomenon and who has legitimacy.\textsuperscript{67,71,72} Within the discourse of madness, for example, psychiatrists are imbued with authority to speak on madness, on its place in society and how it should be addressed. According to Foucault, discourses produce these effects as a result of how they are constructed in speech and text and how they function at the level of governance of thought, delimiting the intellectual boundaries within which agency can function in a specific period of historical thinking.\textsuperscript{22,67,71,72}

Discourses, Foucault suggests, are identifiable based upon a systemic analysis of text intended to identify the rules that make possible certain statements while precluding others. While a Foucauldian analysis focuses on text, it does not focus on the rules of grammar or of logic; rather, it seeks to identify the implicit rules present in specific historic periods and how they demarcate what can be thought, said, and done in those eras.\textsuperscript{22,61,67,71,72} In other words, a Foucauldian analysis looks for the effects discourses or discursive formations have in society.\textsuperscript{61} It seeks to identify what institutions have been created and what individuals or
subject positions have been imbued with the authority to speak on an issue.\textsuperscript{61} It looks for the boundaries that delimit what people can think.\textsuperscript{22,61,67,71,72} Inasmuch as discourses are not fixed, can be transformed, can change over time, and can emerge under new regimes of thought, a Foucauldian analysis looks for shifts in the social face of an era, to identify when one dominant discourse gives way to another.\textsuperscript{22,61,67,71,72} Finally, as multiple discourses can be present at the same time, interrelating and jointly governing how a discursive object is understood and framed, a Foucauldian analysis also looks for how discourses interact to jointly create new possibilities.\textsuperscript{22,61,67,71,72}

In my study, this translates into an analysis attending to the flows of power and knowledge over the last century in Canadian academic medicine to identify how this global commerciality became possible. Or more specifically, it attends to the discourses associated with the economic practices of Canadian academic medicine and how they have interacted over 120 years to shift the dominant scientific focus of the era of Abraham Flexner to allow the global commercial focus of recent years.

\textbf{Serial History, Nonlinear History, and Discontinuities}

Foucauldian work is highly systematic and historical at its core.\textsuperscript{61} By reviewing vast archives of text to understand how simple concepts such as madness,\textsuperscript{67} sexuality,\textsuperscript{73} criminality,\textsuperscript{72} and the clinic\textsuperscript{71} evolved and were understood over time, Foucault was able to empirically challenge accepted historical truths about them.
One frequently cited example of this work that upends traditional thinking about a concept and an era is Foucault's history of sexuality, in which he showed that the Victorian era, rather than being highly sexually repressed, was in actuality one of the more sexually obsessed eras of history; detailed discussions of sexual proclivities permeated British society, newspapers, and court documents, making sexuality ever present.  

As this example illustrates, how Foucault saw and used history differed quite radically from more traditional or classical historians. Traditional historians, according to Foucault, worked with history as a linear and continuous process, as something within which they have to make apparent the causalities and the relationships between events. Foucault instead saw history as composed of many serial histories, connected but not linear; histories that overlapped, that did not create one linear trajectory with an inherent rationality. History was a multilayered composite of many series of histories broken into what he termed *epistemes*, periods of time in which a certain discourse held dominance with no causal progression from one *episteme* to the next. Instead, Foucault saw *epistemes* as separated by discontinuities, by historical periods or singularities when a dominant discourse was replaced by another, for reasons that are unclear. As a result, his research focused on tracking shifts in dominant discourses and societal truths, in what truths were said, to identify discontinuities between *epistemes* but not to explain why said shifts occurred.
Power and Governmentality

While Foucault's early work is often characterized by his focus on discourses and their effects, his later work dealt more with the relationship between power, knowledge and truth. Under this new focus, discourses became just one of several factors to consider in a Foucauldian analysis. For Foucault, if a discourse was an organized rules-based collection of ideas that made possible certain statements, beliefs, and institutions, it was also the channel through which power flowed. Foucault's concept of power flowing was radically different from that of more traditional policy scholars who conceptualized power as being something held by the State and used on a populace. Foucault’s theorization of power broadened the idea of governing, constituting individuals, families, and institutions as complicit in the act of governance rather than as disempowered subjects acted upon by government. It also broadened the data sources one can look to for evidence of productive uses of power, expanding the focus of the inquiry away from a centre (in this case the government) to include institutions at the periphery (in this case hospitals, universities etc.).

Foucault identified several different forms of power governing behavior, disciplinary power, biopower and governmentality. Governmentality, the form of power I am examining in my research, has three main dimensions. First, it encompasses the institutions, practices, analyses, and ideas that have the population as their target, using political economy as the major form of
knowledge and security apparatuses as the primary regulatory mechanism.\textsuperscript{26,75,76} Using this concept of power, the State is understood to be a product of governmentality rather than the origin of it per se.\textsuperscript{26,61,75} Second, governmentality is understood to be a “tendency or a line force” towards a preeminence of neoliberal government.\textsuperscript{26,61,75} Third, governmentality is understood to have emerged over several centuries, starting in the 16th century as thinking about governance looked beyond the church and God as the origin of power.\textsuperscript{26,61,75}

Foucault saw governmentality as a privileging of a certain kind of power. For him, the emergence of governmentality marked a transformation, away from a society governed by a dominant form of power grounded in the concepts of the Christian pastorate to one grounded in the concepts of liberalism, market preeminence, and personal self-regulation.\textsuperscript{61,75} The effect of this form of power is to discipline or mold individuals through technologies of control and coercion into the kinds of individuals that are desired by a market-oriented society and to make them complicit in this transformation.\textsuperscript{61} These technologies of control permeate society as ongoing or constant states of crisis management, requiring economic intervention rather than the historic forms of intervention (primarily police management of security issues).\textsuperscript{61} Naomi Klein uses this concept effectively in her book \textit{The Shock Doctrine}, arguing that human hardships such as famines and market crashes are being used regularly by governments and corporations as rationales to effect capitalistic changes in society.\textsuperscript{78} Under this view of power
and of the world, government’s role is to intervene to act on society in support of
the market’s regulation of it.\textsuperscript{26,61,75} That is to say, governmentality is not divorced
from a liberal economy; rather it is intimately bound to it and actively involved in
the enforcement of its existence.\textsuperscript{61} As a result, governmentality should be seen
as a \textit{style} of governing rather than as a collection of State institutions.\textsuperscript{26,61,75}

The theoretical flexibility that comes with seeing governmentality as a style of
governing is central to its the appeal for this research project. As such, it allows
and even facilitates an exploration of academic medicine’s engagement in the
global space in the pursuit of revenue at the intersection of regulation, policy,
culture, identity, and ideology. As I mentioned above, it allows the researcher to
see and to make clear that discourses are being used within domains such as
health policy, business, and education. It also means that these same discourses
are also potentially acting upon a researcher constraining their gaze and analysis
as they function as truths, something against which to guard. In this case, using
this concept of governmentality made it possible for me to look beyond the micro
level—that of practice—to the macro level—the level of governance and
management—and to consider how space itself might be affecting a
phenomenon, in this case commercialization.

\textbf{Institutions and the State}

In reading Foucault, it becomes clear that he uses certain ideas and terms quite
differently from other theoretical models. Two terms that I deploy regularly in this
research project fall into this category: “institution” and the “state.” For Foucault, and for me, there is a certain flexibility in the use of the term “institution” that is absent from that of more traditional policy scholars. For Foucault the term “institution” can mean a variety of things ranging from a concept or trait, a historical rationality, an episteme—things that are created by a power/knowledge rationality. In his own work, Foucault uses the term “institution” in a variety of ways: as a part of compound concepts such as “political institution” or “medical institution,” or as suggesting a tool of a government such as an institution of the State or the sovereign. A close reading of his work reveals that his actual range of usage of the term is quite varied and suggestive of a certain casual deployment; a deployment that has been argued to be more philosophical than technical, a point of entry for the concepts he explores in his work.

The term “State” is equally confusing for those not familiar with Foucault’s work or to those acculturated to how the term is used in political science or political economy. For Foucault, and for this work, the concept of the State is decentered—it is not the object of study nor is it the centre of power relations. Rather, power has priority over the State and in actuality creates the various forms of the State present in an era. Thus, it would be accurate to say that the term “State” is a “codification of power relations which permit it to function.” As a result, the term “State” can mean a wide range of things such as revolution, politics, and war. In this work, this means that the term “State” can refer to any collection of levels of government in Canada and that it treats any
constitutional distinctions and separations of power between levels of
government as irrelevant. This is not necessarily an easily accepted idea to those
working or educated within a political science or political economy framework. To
make this idea easier to remember in the reading of this thesis, I have capitalized
the term “State” throughout to capture this different, more Foucauldian usage.

**Spatiality, Utopias, Heterotopias, and Patterns of Organizing**

Space was not and is not a typical object of analysis or inquiry associated with
Foucault’s work. It is, however, more present and a more important theoretical
consideration in his work than is typically thought, and one of special interest to
my work. Foucault himself acknowledged in an interview with the editors of the
journal *Herodote* in 1976 that the concept of space, including location, physical
space, conceptual spaces, and the concept of spatiality, had greatly influenced
his thinking, at least implicitly. On reflection he observed that in fact spatiality
had implicitly provided him with a way to understand “the relationships that are
possible between power and knowledge” because there is a strong effect
derived from the region or domain, typically a national space, in which power and
knowledge is being considered. He went on to say that “anyone envisaging
the analysis of discourses solely in terms of temporal continuity would inevitably
be led to approach and analyze it like the internal transformation of an individual
consciousness.” Accepting this idea, in a Foucauldian analysis space, or the
geography of a phenomenon, acts as “the support, the condition of possibility for
the passage between a series of factors.” Geography, or spatiality, this
becomes a highly important axis on which to analyze power and knowledge and the formation of discourses.\textsuperscript{80}

“Space” for Foucault is a construction, a product of history, and something that affects transitions in thinking, thereby influencing how ideas are organized in the present.\textsuperscript{61} In a lecture to architects in 1967, Foucault expanded upon this thinking on space observing that space was perhaps the emergent issue of the present for him, whereas history was the obsession of the past—of the 1900s specifically.\textsuperscript{21} He observed that “it is necessary to notice that space which today appears to form the horizon of our concerns, our theory, our systems, is not an innovation: space itself has a history in Western experience and it is not possible to disregard the fatal intersection of time with space.”\textsuperscript{21} He saw innumerable types of spaces: the sacred, the profane, protected and open, urban and rural, and so on, all of them influential on, and of concern to, society.\textsuperscript{21}

For Foucault, space could be categorized as either a “utopia” or a “heterotopia.”\textsuperscript{21,61,81} Utopias are imaginary spaces; they are not real, but are related or analogous to real spaces.\textsuperscript{21,61,81} They can be imaginary, conceptual places, such as a true democracy, or “placeless places” such as an image in a mirror.\textsuperscript{21} Heterotopias, on the other hand, are real spaces constituted by society; they are the “counter-sites” to utopias, they are “effectively enacted utopias.”\textsuperscript{21,61,81} Heterotopias can take many forms; they are spaces constituted by
Foucault defined two categories of heterotopias: crisis heterotopias and heterotopias of deviation. Crisis heterotopias he associated with more primitive societies. They could be sacred or forbidden places: sites that require rites of passage to gain access, sites that are reserved for individuals who are in some form of crisis in relation to their society. A crisis could be a stage of life such as adolescence, with the associated place being a boarding school or military service. A crisis could also be a pregnancy or a recent marriage, with the associated places being a maternity ward and a honeymoon respectively. Sites of deviation he saw as more modern constructions; spaces replacing sites of crisis. Rest homes, hospitals (specifically psychiatric hospitals), prisons, retirement homes, cemeteries, and the like are all examples Foucault used to illustrate sites of deviation.

Heterotopias, for Foucault, are places driven by knowledge and by understanding; spaces in which economic and legal battles can be fought, where there is an accumulation of ideas over time. They are spaces that can have societal functions that evolve, and remain the same, over time. The cemetery is an example that illustrates how this paradox can be understood. Cemeteries have been and remain to this day repositories for societies’ dead; but how they are seen, how they function in society, and where they tend to be situated have evolved. Historically they have tended to be seen as sacred spaces, sites of gathering, situated centrally in cities near churches. More recently they have
evolved to be seen more as aesthetic sites or as sites of disease, and as a result they have become more pastoral, more architectural, and are often removed from populated areas. In my work, hospitals and universities seem to be heterotopias, places whose function has evolved from one focused on social service to one that now includes business practices.

Heterotopias are also capable of juxtaposing several spaces that can be – or are – incompatible in a single real space. Foucault used the theatre as an example of this concept, a square space composed of a stage or a screen; a space of three dimensions and two dimensions, of real life watching projected or presented life. I might give the example of an academic health science centre: a shared space, a separated space; an academic partnership, a hospital, a university; a space of health, for the generation of new knowledge and the reproduction of disciplines (academic), and a space to make money and sell products (business).

Heterotopias are also linked to eras, to specific moments in time. Foucault termed the time period of existence for a heterotopia a “heterochomie”; there can be multiplicities of time associated with a heterotopia. Again, he used a cemetery to illustrate this point; cemeteries become spaces for people at the moment of death, but they also occupy a certain “quasi eternity” in which bodies return to the earth. He also played with this concept, suggesting that
heterotopias can be transitory spaces such as fairgrounds—places that are constructed and emerge for society for short, delimited periods of time.\textsuperscript{21}

Issues of access characterize heterotopias. They are isolated from society yet accessible; they have systems that govern access, separating them from public places.\textsuperscript{21} Entry can be compulsory or imposed (e.g., to a prison), or via a rite such as purification (e.g., to gain access to a religious order), or admission (e.g., to gain access to a hospital or university).\textsuperscript{21} Permission may be required (as on a military base), purification may be an obligation (a hammam), or the impetus may simply be cleanliness (a spa).\textsuperscript{21}

Finally, Foucault assigned different kinds of power to different kinds of space. For example, he suggested that territories, such as nation-states, are a juridico-politico space controlled by one kind of power whereas a field, such as health care, is an economic-juridical space controlled by a different kind of power.\textsuperscript{61,80} Foucault also considered political power, as he saw a shift in the 18th century such that space became more politicized (or possibly that politics became more spatialized).\textsuperscript{61,83} This is an important point for any focus on governmentality, because Foucault saw this form of power as emerging through a shift from the historic concept of territory as a focus of government to a new era in which population is the focus of government.\textsuperscript{61}
This theorizing of space and the associated concepts described here seem to be concepts underused by scholars working with Foucault today. I would suggest that my use of these concepts clearly demonstrates the utility of these concepts and how using them can add richness and new insights to a Foucauldian analysis. Without preempting my findings unduly, I would observe that here that my use of Foucault’s concepts of space produced a significantly more complex and interesting finding than I would have had had I simply used his concepts of discourse and temporality.

Two Conceptual Approaches to Inquiry: Archeology and Genealogy

I used two methods of inquiry in my research. The first, called an archeology (of knowledge), is a powerful tool that is considered primarily descriptive, one that can make apparent the discursive structures present and acting upon, or making possible, a phenomenon. The second, called a genealogy, builds upon an archeology of knowledge but is more focused on the politics and the effects of power that are made possible by the various discursive structures present.

Traditionally a Foucauldian archeology is a first methodical step in an analysis intended to identify the discourses present. Its focus is structural and its goal is description. In doing an archeology, one reads a large volume of texts associated with a discursive formation during a defined period of time, in order to identify the types of claims that are consistently made about a topic. Through this coding the researcher is able to identify the truth claims that can be
made about a particular topic and the rules about who can make them. Foucault would refer to “discursive objects” rather than topics, to capture the central idea that the objects themselves are constructed by the words we use to describe them (e.g., madness).\textsuperscript{61,67} Aiding one’s efforts to identify discursive formations and their underlying rules of logic is the concept of \textit{episteme}, mentioned earlier.\textsuperscript{22,61} A core theoretical concept underpinning this type of historical analysis is the assumption of the “priority of language over subjective experience.”\textsuperscript{22,61} In a critical discourse analysis understanding the rules of how we talk about a phenomenon and what those rules accomplish is more important than understanding the details of an experience of a phenomenon.

Foucault described the role of an archaeology as making visible “subjugated knowledges”, knowledges that had been delegitimized or disqualified.\textsuperscript{80} More specifically, he described an archaeology as a methodology that made visible the local discursivities, dominant and subjugated.\textsuperscript{83} Foucault also saw archaeologies as a methodology that could make visible the relationship between discourses and non-discursive formations such as “institutions, political events and economic practices.”\textsuperscript{22,61}

\footnote{The description of the relationship between archeology and genealogy is somewhat conflicted. In \textit{Power/knowledge} an archeology is described as a methodology that informs the development of a genealogy. In the \textit{Cambridge Foucault Lexicon}, a highly useful resource for Foucauldian scholars, archeology is described as an earlier Foucauldian methodology, replaced by genealogy.}
If an archeology is descriptive in its utility, a genealogy makes power relations visible: specifically who is subjugated, who is marginalized in a given context, what is produced, and how various discourses interact. As in conducting an archeology, in doing a genealogy of a phenomenon a researcher reads large quantities of text; but in addition to identifying the rules underlying the discursive formations, the researcher looks for the use of power, how it is exercised, who or what exerts it on others, and what it creates. This work provides a deep understanding of how a phenomenon is constructed at a certain point in time; the result is information about how power relations can be disrupted or interrupted and about how to make those who are oppressing the marginalized aware of the effects of their actions. This opens up the possibility of identifying policy interventions that make practices better, mitigate side effects, and improve the impact of a phenomenon.

**Synthesizing the Foucauldian Concepts in My Work**

As I have argued in this chapter, the goal of a Foucauldian analysis is to make clear the power/knowledge/truth relationship: how dominant discourses emerge, how their dominance is linked to *epistemes*, and how these discourses become uncontested truths that delimit what one can think, do, and say during a particular era. I will focus on how one form of power, governmentality, the distributed form of power intrinsic to a neoliberal society, has made possible, or produced, Canadian academic medicine’s commercial engagement, an arguably
unexpected practice given its history, in a global space, a space outside of the national boundaries of Canada.

This analysis is a genealogy by definition, an exercise to make explicit and describe the various discourses and make their effects in society in terms of roles and institutions apparent. This genealogy’s aim is to reveal the rationales of thought governing the management and funding of academic medicine by looking at them on two distinct axes of exploration, time and space. It will explore how management of ideas have changed over more than a hundred years in and between a variety of spaces such as hospitals, a faculty of medicine, their academic health science centre, their local space, and the global space they have entered.

At its most basic, this analysis will illuminate the various discourses at play at the management level, along with their interplay, their interactions, and their effects, intended or otherwise. Analyzing this interplay over time and in terms of where it is happening will also show whether and how the identity of academic medicine and its constituent institutions has changed from the era of Flexner to today—an era in which Canadian academic medicine’s leaders are expected to function as business people in addition to their core identity as health care professionals.

**Ethical Issues Associated with Foucauldian Work**
There are several ethical issues to consider when using this theoretical approach. For example, Foucault’s work—and as a result this work—can be seen to have a strongly ethical dimension due to its centering on the conceptual and societal constraints on individuals, the effects of power/knowledge. It explores and critiques the disciplines, the practices that establish constraints on individuals’ ability to transform themselves. It problematizes the effects of forces intended to streamline or normalize individuals into certain types deemed useful or productive in society. In this case, the use of Foucault’s theories raises questions about whether and how health care workers, doctors, nurses, and health technicians are being transformed into monetized objects, for sale in a global space, and how they are being disciplined into facilitating that transformation. This work questions the effects of education and educational institutions, academic hospitals and faculties of health sciences. It challenges their identity as simply capacity builders in health care and health professions education. In doing so, it reveals that these institutions are being transformed, and transforming themselves, into neoliberal organizations; into technologies of colonization and diplomacy, into self-funding entities less reliant on the State, arguably moving an obligation of taxation and funding away from the Canadian state and onto foreign partners.

That a change in the spatiality (local to global) of the activities of Canadian academic medical institutions is making possible new practices and new roles is
inherently an ethical shift. Why new practices can be adopted in our global space that we can’t adopt at home is a real question. The effect of this and its visibility or lack thereof to health professionals challenges questions of agency that do not seem to be asked by mainstream researchers. That there is an ethical shift here due to the new roles, identities and responsibilities triggered by this change in spatiality is not in questions. My work will highlight potential consequences or unintended consequences, what it will not do is comment, in a normative way, if those consequences are good or bad. I will simply observe as to what might be “dangerous”.

In addition, Foucauldian work has triggered ethical questions due to its somewhat mysterious nature and method of inquiry.\textsuperscript{85,86} Kvale suggested that since this work focuses on systems of thought and the effects of discourse but interview subjects often assume that the goals of an interviewer are to uncover material concerns and document experiences, a gap between the focus of research and the potential understanding of that focus can emerge.\textsuperscript{85,86} Hammersley argued that this was a significant ethical issue, intrinsically part of any Foucauldian work, that undermined an interview subject’s ability to give informed consent.\textsuperscript{85} This critique is built on the idea that an interview subject will be unable to understand the focus and intent of a critical discourse analysis.

**Limitations of a Foucauldian Analysis**
While Foucault’s concepts of discourse, governmentality, and heterotopia are powerful research tools, they are not without limitations. Their ability to concentrate the gaze on historical shifts and on the present, to make rationales of thought apparent and their interrelations present is the source of their power. This information can reveal the relationships between power and knowledge and provide powerful opportunities to those who want to develop strategies to challenge or interrupt a practice. However, they are not forward-looking tools. They inform about history and the present but provide little information on the future.

A greater limitation or critique of Foucauldian work that is often offered is that Foucault’s work is simply a fiction, not truth. Foucault himself agreed with this critique, commenting “I am well aware that I have never written anything but fictions. I do not mean to say, however, that truth is therefore absent. It seems to me that the possibility exists for fiction to function in truth. One ‘fictions’ history on the basis of a political reality that makes it true, one ‘fictions’ a politics not yet in existence on the basis of a historical truth.” Others have critiqued Foucault’s work for being simply well-written histories that do not offer anything positive, that they do not acknowledge universal concepts of morality, that his archeology of knowledge methods are inherently negative, that his work lacks rigour, and that his work is inherently franco-centric and thus problematic to apply in locations outside of France. However, as I discussed in the previous
chapter, Foucault’s theories and concepts are quite captivating and for me, they removed a filter I had upon my gaze, in the process making visible boundaries on how ideas, or discourses, governed what people could say, do and be.
Citations Chapter 3

contribution to the HIRE-IEHPs initiative. Toronto, ON: Health Force Integration.


43. Bain B, Magnusson J-L. Feminist Materialities and Knowledge Economies. presented at: 2010 Society for Socialist Studies, Montreal, Canada


Chapter 4: Methods

Introduction

This chapter describes the methodological approach used to pursue this research. More specifically, it describes the creation of my archive, the interview methods, and the analysis of archival data. Since Foucault never provided a how-to manual for accomplishing these tasks based on his theoretical concepts, the idea of developing a methodological approach for a Foucauldian research project as an independent researcher can be somewhat daunting. That sentiment notwithstanding, the basic steps to a Foucauldian analysis are quite straightforward.

1. Compile an archive of texts to be analyzed;
2. Analyze that archive to identify truth statements;
3. Analyze the relationships between truth statements to identify the discourses governing them and the relationships of power and knowledge at play.

Compiling the Archive
To compile an archive, it is necessary to choose what types of texts will be included. As I was pursuing a historical avenue of inquiry to explain a current practice, I needed to include texts from a variety of time periods. To obtain historical textual data, I decided to include archival texts in the form of minutes, reports, websites, brochures, statutes, etc. To obtain current textual data, I decided to conduct interviews and make site visits to generate field notes.

**Creating a Diverse Archive**

One important characteristic of a Foucauldian archive is diversity of documents. While there are no specific parameters or metrics to define diversity for a Foucauldian analysis, it is generally agreed that it is advisable to include a wide range of texts, inasmuch as evidence of discourses can be found everywhere. More importantly, incorporating a more varied range of documents into an archive is important so that there is a wider exposure to all of the discourses that might be governing a phenomenon. Furthermore, including a wider range of texts in an archive is helpful because it makes it considerably easier to identify the rules that establish the discursive boundaries. So while it is important to pursue diversity in texts, I would also note that a Foucauldian archive is not intended to be all-inclusive. One simply has to obtain a broad exposure to a wide variety of sources to evidence the diverse ways of thinking about a phenomenon.

**Delimiting the Archive by Time Frame**
While diversity in texts included in an archive is important, it is also important to delimit the size of an archive. There are various methods to do this, one of which is to define the time frame within which texts will selected. Choosing a longer time frame can create an archive that is more unwieldy and more challenging to analyze. Conversely, using a longer time frame can make it easier to identify the discontinuities between dominant discourses.

For this research project, I chose a time frame for my archive of 1900 to 2016. The year 1900 was chosen as the early temporal boundary to capture the ethos when Abraham Flexner, a highly influential figure in medical education, published his canonical 1910 report, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching*¹ (the Flexner Report), which is understood to have established the foundational tenets of academic medicine for North America.²⁻⁷ The year 2016 was chosen as it was when I began to collect data

**Delimiting by Geography**

Defining the geographic boundaries within which to collect texts is a second way to delimit the size and contents of an archive. For this project, I defined the geographic boundaries within which to collect texts to be Toronto sites of academic medicine. These boundaries, while important, were not absolute. While a large portion of my documents came from Toronto academic medical institutions, I also included documents from provincial national institutions that
had governance of an aspect of their operations. This meant that my archival
texts were primarily sourced from three academic medical institutions—two
tertiary care academic hospitals, University Health Network (UHN) and the
Hospital for Sick Children (SickKids), and the Faculty of Medicine in the
University of Toronto—but also included other Toronto and Ontario-based
institutions, such as other hospitals, a regulatory college, an accreditation body,
the Ontario Ministry of Health and Long Term Care, and a corporation
established by the Ontario government to monetize Ontario intellectual property
outside of Canada that participate (d) in the co-constitution of Canadian
academic medicine either locally or abroad, by setting standards, developing
concepts, participating in an academic mission or by establishing new funding
mechanisms for it.

Delimiting by Content

Identifying the texts by content is also a common way that Foucauldian scholars
delimit the size of an archive. For this project, I selected documents or excerpts
of documents with a financial focus and reference to a spatial matter or idea. In
the case of the three primary institutions targeted, identifying a type of document
that would have content meeting these criteria within the time frame of 1900 to
today was challenging. In terms of the two hospitals, the only document records
that met these criteria were board minutes that I then supplemented with
subcommittee reports (medical advisory, research committee, finance committee,
human resource committee), and strategic plans, marketing plans, press
clippings, financial statements, consultant reports and board correspondence. I also selected excerpts from these documents to include in my archive such as president’s or CEO reports, since they often addressed high-level strategic issues, finance matters, and geographic expansion.

In terms of the Faculty of Medicine, the dean’s report to the president’s council of the university was identified as being broadly equivalent to corporate board minutes after consultation with University of Toronto archivists. Two dean’s reports were selected from each decade for inclusion in my archive. In addition to the dean’s reports, documents addressing operational issues, international engagement, relation with the Faculty’s academic hospitals, strategic planning, international medical inbound postgraduate training, press concerns, and business plans were included.

Using these geographic and content criteria, the extensive corpus of texts available in the archives was reduced to a sizable yet manageable amount. Several confounding issues in the composition of the archive should be noted. First, hospitals have merged over the last hundred years, such that Toronto General Hospital has joined with several hospitals and an educational college and undergone a name change and rebranding to the University Health Network. In selecting documents for inclusion in my archive, I decided that this change in name and brand was not problematic, inasmuch as the governance of the
merged institution remained with the original institution and a continuity of documents could be found within the archive.

Second, a formal access to information request was filed to gain access to board minutes for SickKids for the period 1999–2011, because that time frame covered minutes that had not yet been sent to archives but predated regulations that required board minutes to be accessible and posted online.

**InterHealth Canada Inc.**

I also included a variety of texts related to a company called Interhealth Canada Inc. (InterHealth). This company was created by the Ontario government in the 1990s as a vehicle to monetize the expertise of Ontario health professionals in international markets. I believe that this company is the first and possibly only company ever created by a government in Canada to do this. To obtain data on InterHealth, I was obliged to file an access to information request with the Archives of the Government of Ontario (the Archive).

**Business of Health Care Conference, Miami, 2016**

Finally, over the course of my doctoral studies I attended a conference in Miami in March 2016 that explored the globalization of the health sector. I included documents obtained at this conference—website text, materials from conference presenters, material from conference sponsors, and my own field notes—to provide a sample of the discourses active in the United States to contrast with what was available in Canada.
The Archival Dataset

The inclusion of data from all of these sources created a considerable dataset.

The details of these documents can be found in Table 4.1.

Table 4.1: Written Texts

<table>
<thead>
<tr>
<th>Source</th>
<th>Time Frame</th>
<th>Data Source</th>
<th>Type of Documents</th>
<th>Approximate Number of Texts reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto General Hospital/University Health Network</td>
<td>1900 to 2016</td>
<td>Archival, online, and internal request for access to materials held in board office</td>
<td>Board minutes, medical advisory committee minutes, finance committee reports, human resource committee reports, research committee reports, consultant reports, business plans, strategic plans, board correspondence, marketing materials, financial analysis, financial statements, executive chart of reorganization</td>
<td>&gt;100 years</td>
</tr>
<tr>
<td>The Hospital for Sick Children</td>
<td>1900 to 2016</td>
<td>Archival, online access, Access to Information request to hospital for 12 years of board minutes</td>
<td>Board minutes, medical advisory committee minutes, finance committee reports, human resource committee reports, research committee reports, consultant reports, business plans, strategic plans, board correspondence, press clippings, foundation reports, financial statements</td>
<td>&gt;100 years</td>
</tr>
<tr>
<td>Source</td>
<td>Period</td>
<td>Access/Content</td>
<td>Duration</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>University of Toronto, Faculty of Medicine</td>
<td>1900 to 2016</td>
<td>Archival, online archival, and historical accounts</td>
<td>&gt;100 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dean's reports, dean's correspondence, consultant reports, university newspapers, faculty of medicine reports, executive chart of reorganization, business plans, memorandum of understanding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>InterHealth Canada</td>
<td>1992 to 1996</td>
<td>Archive of Ontario (Access to Information Request), online sources</td>
<td>625 pages</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minutes, reports, correspondence, press releases, and marketing materials from the Ministries of Health, Trade, and Industry, governmental white papers, board meeting minutes, announcements, promotional material, corporate resolutions, shareholder details, and shareholder correspondence for InterHealth Canada</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Government of Ontario</td>
<td>1900 to 2016</td>
<td>Online access</td>
<td>400 pages</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(purposive sampling)</td>
<td>Bills, policy papers, reports, literature search of grey sources</td>
<td>(estimate)</td>
<td></td>
</tr>
<tr>
<td>US conference</td>
<td>March 2016</td>
<td>Documents obtained at conference and notes made</td>
<td>250 pages</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Marketing materials, website, site visit summary notes</td>
<td>(estimate)</td>
<td></td>
</tr>
<tr>
<td>Interviews</td>
<td></td>
<td>Taped interviews</td>
<td>26 interviews</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transcription of interviews</td>
<td>&gt; 1,500 pages</td>
<td></td>
</tr>
<tr>
<td>Site Visits</td>
<td></td>
<td>Personal ethnographic notes</td>
<td>4 pages</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notes made on site visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Interviews and Focus Groups**

My archive also included transcripts of 26 interviews. Interview subjects were purposively selected because of their institutional location and their current or historical engagement in, or knowledge of, commercial activities in, or related to, Toronto academic medicine. Please see Appendix 3 for a detailed breakdown of
the interviewees. Please note that certain individuals have been recognized in several categories.

All interviews were conducted in English. Twenty-three interviews were taped, and transcribed by a transcription company approved for academic work. Two interviews were not taped, because they were conducted in a public space at the request of the participants who preferred a less formal interaction. Notes were made after these two interviews. A third interview was not taped because the participant was not comfortable with the interview being recorded. However, extensive notes were taken during this interview over a two-hour lunch in a restaurant. The interviews and semi-structured interviews were conducted based on predetermined scripts. The scripts were used to guide the conversational flow but not limit it. Please see Appendix 1 for examples of the various scripts used. One participant in the interviews was not a native English speaker; however, that individual’s language skills were deemed sufficiently high that neither translation services nor special procedures were required for effective communication.

**Risk for Interviewees**

Interview participants were invited to participate by letter detailing the study, the risks to them, and emphasizing that they could withdraw from the study at any time up to the end of the interview. Please see examples of the invitation letters in Appendix 2.
This research project was initiated with awareness that participating in it could be troubling for interview subjects to speak candidly as large amounts of money were involved in the commercial engagements and as a result the topic might be considered politically sensitive. I was also very cognizant that the world of Canadian academic medicine is quite small and that the world of globally engaged Toronto-based academic medicine is that much smaller. These two factors made methods to anonymize data both important and challenging. They also made it possible that an informed and knowledgeable individual might be able to pierce my efforts to anonymize the data.

**Site Visits**

I visited the offices of three institutions where individuals interviewed for this study were working. Field notes were made shortly after each visit in a quiet, unobserved spot. Field notes were made to capture impressions, observations, and assessments of the role of the spatial layout.

**Coding and Data Analysis**

Coding and analyzing this large volume of data required a multistep process. First, to provide some structure to the data, the archival data was organized into decades from 1900 through 2016. Within each decade, the textual information was read several times and broadly coded for rationales and practices about money, concepts of spatiality (where the respondents worked, the spaces present in management’s thinking) to identify ideas and truth statements present.
That is to say, I looked for examples of thinking about funding, revenue generation strategies, asset management philosophies, ideas on or about business practices, methods of reporting, evaluation, and financial surveillance, and the like. I also looked for evidence of where institutions were active, for shifts in what activities took place in the various spaces, and for the types of spaces present in the thinking of management (e.g., geographic spaces such as local/global and institutional/domain spaces such as hospital/health care or university/academic). Summary notes were made by institution and by decade to further reduce the volume of data, to inform the development of a multilayered time line and to map the epistemes and heterochomies present. In these summary notes, I attempted to map out when and where different ideas and practices occurred, along with the power relations that guided decisions. In this first round of coding, I made no attempt to impose any consistency of terms, so ideas could emerge inductively. Pattern recognition was iterative and developed over the analysis of the decades.

More specifically, in this first stage of analysis I looked for evidence of any changes in the various institutions’ practices of and thinking about financial management. To do this, I looked for statements about financial practices, about the rationales for types of funding choices, for interconnections between institutions, and for the spaces present in management’s thinking. I also looked at the texts for rationales to justify business practices and the creation of new
subsidiaries, organizations, or corporations created for financial reasons. Finally, I looked for issues and challenges identified by management dealing with finances, with realizing their institutional mission, and with where they were actively involved.

I used the summary notes written from this analysis to develop a time line of significant events, which I have presented at the beginning of this document. Concurrent with developing these temporal representations of changes in financial thinking, I developed a temporal representation of the spatial thinking present decade by decade to provide another perspective to explore the power/knowledge/truth relationship. These various coding methods were used to identify the discourses present, the spaces dominating management thinking in various eras, the *epistemes* of the various discourses, the heterochomies for the various spaces I identified, and the flows of power. Please see Table 4.2 below for detail on the codes used.

**Table 4.2: Coding Guide for Archive**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Rationales</td>
<td>What types of funding methods are being used? Who are the funders? Who do institutions look to for funding? What are the financial concerns? What is the size, shape and location of financial statements? What type of financial accounting is used? What are the foci of strategic plans and reports? What is the role of a funding mechanism? What is the goal of the commercial practices? What changes have taken place in the financial statements over time? What are the guiding ideas, practices, and philosophies of management?</td>
</tr>
<tr>
<td>Space</td>
<td>Where are organizations engaged (locally, provincially, nationally, globally)? What organizations/types of institutions are where? When? What rationales are evidenced for being global? Are there different rationales for global engagement in different institutions? What spaces are present in management's thinking and in what era (real and conceptual)?</td>
</tr>
<tr>
<td>Time</td>
<td>What shifts in thinking occur over time? When? What roles are created when? When does support for revenue generation/commercial practices/going global emerge? When does institutional structure change? When do rationales change? How does timing differ between hospital and university regarding management thinking, practices, and concerns?</td>
</tr>
<tr>
<td>Key ideas</td>
<td>What recurring words appear? With respect to finances/funding? With respect to space? Do they change over time? Do they vary from institution to institution? What rationales are used to justify engagement globally/outside national boundaries? Who is for/against global engagement? When does revenue generation emerge? What types of commercial practices are present and when? What changes in organization charts occur and when? What new roles are created?</td>
</tr>
<tr>
<td>Rationales</td>
<td>What are the rationales for and against revenue generation? What are the strategic objectives of the institution? Does revenue generation-going global appear? When does it appear? What is the institutional identity presented to press, to patients, to board members, to foundations? What if any external pressures or internal pressures are driving commercial practices, going global, financial ideas? How do rationales for organizational mission evolve over time? How similar/distinct are different institutional missions?</td>
</tr>
<tr>
<td>Institutional Shifts</td>
<td>What initiatives, subsidiaries, internal departments, projects are created and when? What are the details of contracts, memorandums of understanding, and reports related to commercial or financial practices? When and how do managerial practices change? How do financial pressures change over time? What are the strategic goals of the institutions and how do they change? What are the roles of institutions and how do they change over time?</td>
</tr>
</tbody>
</table>

This stage of the analysis and its coding was done to make evident the shifts in thinking, truth statements, management rationales, and understanding of institutional missions, and to identify the spaces present in management thinking.
I was also very interested to explore whether revenue generation practices existed in Canadian academic medicine following the Flexner Report and if so whether they were renamed, buried, transformed into new versions, or simply forgotten. Given that the standard narrative in Canadian academic medicine is that it is and has been a not-for-profit institution not engaged in revenue generation, I was most interested in assessing that narrative’s historical veracity. I wanted to assess whether this global practice of revenue generation was a reemergence or simply a change in spatiality. Answering this question seemed key to understanding the truth/power/knowledge flows at play.

As part of my coding methods, I drew upon Steiner Kvale’s work as a way to condense the meaning of texts. I read texts for convergent and divergent management rationales, noting all patterns or conflicting ideas that emerged. I summarized the changing rationales and perceptions of value on global engagement. This summarization took several forms: I noted statements and simple words in the margins of documents, I made note of ideas, dates, concepts in a Microsoft Excel spreadsheet broken down by decade and by institution. I also wrote detailed summaries of the transcripts, organizing them by four broad coding categories: “ideas present,” “management rationales,” “space,” and “truth statements.” These summaries were then combined into one large document summarizing the 120 years of archival documents from UHN, SickKids, and the Faculty of Medicine, and nine smaller documents summarizing the interviews by
institution. These summary documents were then compared to the time line built in stage 1 to make visible ideas, shifts, discontinuities, and patterns across and between institutions, and to look for any branches in ideas, patterns, and practices. This last comparison was done so that a more nuanced understanding of the interactions, moderations, and modifications, if any, between discourses about the management of academic medicine, revenue generation, and the global space could be identified.

A final stage consisted of multiple readings of the summary texts and the time lines to identify the power flows in and between institutions and the writing of this document, a final analytical process in and of itself.
Citations Chapter 4


Chapter 5: The Discursive Formation of Academic Medicine

Introduction

This chapter presents the results of my critical discourse analysis of the data, the “discourses of management” of Canadian academic medicine. It describes the characteristics of each discourse, their mentalités, their boundaries and their historical origins. This chapter and its findings also establish the framework for the next three chapters that follow, chapters focused on three eras of Canadian academic medicine, 1900 to 1940, 1940 to 1990, and 1990 to 2016. Chapters 6, 7 and 8 track the discourses of management of Canadian academic medicine through 120 years of history showing their effects, more importantly, how their interactions or their “inter-articulations” made possible, Canadian academic medicine’s global commercial engagement.

Analyzing the Data

To answer the research question “How did this new global commerciality become possible in Canadian academic medicine?” I considered the question to be composed of three concepts. The first concept was economic: “What are the
economic logics of academic medicine?” The second was spatial: “What are the spaces of academic medicine and what are they producing?” The third concept was more basic but core to my research: “What is academic medicine?” These ideas guided my research.

To answer the third question, a key issue for my research project, I looked to definitions and to the U.S., to the home of Abraham Flexner. The American Association of American Medical Colleges (AAMC) defines it thus:

Academic Medicine includes medical schools and teaching hospitals, but it includes many other types of organizations as well; and the number and variety of organizational forms is expanding rapidly. Planning in Academic Medicine may also occur in an academic medical center, within a consortium of teaching hospitals, within an HMO or IPA, within a faculty practice plan, within a university-affiliated research institute, etc.1

I also looked to how the term academic medicine was being used more colloquially. In that more casual usage, I found individuals the term “academic medicine” to refer to their own institutions, and to the collective partnership of medical schools and teaching hospitals. For my work, I used a concept more similar to the AAMC’s, which includes organizations and institutions such as regulatory and accreditation bodies, because I would argue they participate—along with medical schools and teaching hospitals—in the co-creation of the practices, norms, and identities of a country’s academic medicine.
As my exploration progressed, I began to think more deeply how Canadian academic medicine was constructed and to consider the influence of time and space on its identity, its norms, and its practices. In doing so, I began to think that academic medicine might be both a real and an imaginary space. For example, unlike a hospital or a faculty of medicine, two institutions you can visit and find on a map, academic medicine is not a material place or space. You cannot touch it; you cannot give an address for “academic medicine.” And yet, despite this seeming immateriality, it is also apparent that academic medicine does exist. It is a focus of discussion, of policy, and of funding. It is a partnership between institutions. It has an existence that dates back decades. It has an impact on educational practices, on health care, on the norms and identity of its professionals, on the fiscal health of its jurisdiction, and on the health of populations.

These characteristics of immateriality and material effects are classic features of a discursive object. As a discursive object academic medicine exists; this seems quite clear. It also seems quite clear that academic medicine has not always existed. I make this somewhat radical statement knowing that Abraham Flexner did not use the term “academic medicine” in his foundational report on medical education in North America. This is meaningful as it signifies the emergence of ‘academic medicine” as a discursive object is likely to have happened sometime
after 1900 in North America. It is also challenging as it raises the question, how does one study a discursive object that is material, emergent and imaginary?

The solution I arrived at was to look at academic medicine indirectly to get a sense of it. Instead of attempting to focus my research gaze on it directly, I instead focused my gaze on its economic practices and ideas as a way to identify its discourses. This meant that my research question—“How did this new global commerciality become possible in Canadian academic medicine?”—was transformed from simply a research question into an entry point for my research. My research then became an attempt to understand a history of Canadian academic medicine, using its truths, its economic practices, and its space(s) as both an entry point and a focusing tool.

**This Chapter and the Next Three: A Roadmap**

For reasons of narrative clarity, I have chosen to divide my description of the governing logics and the history of Canadian academic medicine into four chapters. I would note that these four chapters should be read together and not in isolation, as in aggregate they provide a more complete understanding of how Canadian academic medicine has changed over 120 years, and thus how it has become possible for it to engage commercially in the global space—something it would not have imagined doing in the early 20th century.
This chapter will present the discourses and the discursive framework of academic medicine, its the ideological underpinnings. The three subsequent chapters, chapters 6, 7 and 8, will track the findings of this chapter, the discourses of Canadian academic medicine, from 1900 to modern day years and present tangible examples of what they, and their interactions, or their “articulations”, have produced to provide a portrait of Canadian academic medicine in three eras: 1900 to 1940, 1940 to 1990, and 1990 to the present day.

The task of writing a 120-year history of Canadian academic medicine that is clear, that tells a story, that shows the change but also the messiness of life and a discursive analysis, is complex and challenging. I am hopeful that my choice of this narrative structure will make it easier on the reader to understand the shifts and changes that have taken place and understand, by the end of this document, the conditions that have made Canadian academic medicine’s global engagement in the pursuit of new revenues possible.

At the risk of preempting the findings discussed in the next three chapters, I will suggest that these three eras are dominated by three separate economic mentalités in tension with a fourth. The first era is dominated by a mentalité of philanthropic charity. The second era is dominated by mentalité of public funding and investment. The third era is influenced, if not dominated by a rise in the

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4 The French term for mentality is used throughout this document to capture a plurality it ideas constituting it. For more details please see Glossary.
mentalité of corporatization and commercialization. Throughout these eras, a mentalité of professionalization was constantly present and interacting with the other three mentalités.

**Am I Really Looking at “Canadian” Academic Medicine?**

I would like to comment briefly on my use of the term “Canadian” to describe academic medicine when I am drawing upon sites that are predominantly Toronto based. Under traditional case study protocols, it seems clear that I should simply be using the term “Toronto” to delimit my findings, to describe my work as “Toronto academic medicine.” Discursive work, however, is not so clear-cut as to be limited by specific or arbitrary geographic boundaries. As my work also focuses on spatiality and the movement of ideas through time and space, the naming protocols, usage of terms, and other research paradigm concepts of “precision” or “accuracy” are challenged and difficult to apply. Inasmuch as my three institutions—University Health Network, the Hospital for Sick Children and the University of Toronto—are active in a variety of ways across Canada, and have extended their operational focus from very localized in the early 1900s to much more national by the late 1990s (approximately), I am comfortable and find it defensible to refer to my findings as “Canadian” rather than “Torontonian.” Theoretically, this is also a reasonable choice, since Foucault conceptualized the flow and influence of discourses at a societal level. That said, I am also comfortable stating that these findings are not complete and that there will be
variation in how these discourses are constructed and manifest from site to site across Canada, that other discourses might appear in other sites, and that the relationship between the discourses may also vary from site to site and from era to era. Thus, I would ask that you read the term “Canadian” with an open mind accepting that it might be accurate and that it might be inaccurate. I might also ask that you consider that it might not be one or the other and that it might also be both.

**Foucault’s Idea of “Statements”**

Before launching into a description of the discourses of academic medicine, I wanted to address one small point I did not highlight in my methods chapter: Foucault’s concept of “statements”\(^2\) as a unit of analysis of discourses.

In general parlance, a “statement” is a simple concept, a declarative enunciation, possibly verbal, possibly written. It is governed by grammatical rules, by context and by intent. Making a statement is generally a conscious act, an act of an individual agent. Foucault was unsatisfied with this somewhat limited description or definition and argued that statements were made regularly without awareness of them. In addition, he did not see statements as tied to text or to rules laid down by rhetoricians or grammatical scholars. Rather, he saw statements as having different boundaries and features, as being interspersed with other ideas, as evidence of organizing or underlying truths.\(^2\) For Foucault, statements could come in in many forms. He said that “signs, figures, marks, or traces – whatever
their organization or probability may be – is enough to constitute a statement.\textsuperscript{2}

For Foucault, this way of theorizing statements opened up the identification of implications associated with their deployment considerably. It separated statements from the constraints of written or spoken text and allowed them to be found in a wide variety of forms, including tables, charts, and images. For me, this meant that financial reports, the organization of documents, and the visual rhetoric of reports were all statements and that they provided information beyond their intended or explicit use. These less explicit features of statements provided evidence of the emergence of specific discourses, the changing relationships between discourses, discontinuities among discourses, the rise and fall of discourses, and the importance of the funding mechanisms of Canadian academic medicine in the various eras.

Practically, this means that in addition to using textual quotes to illustrate or explain aspects of the mentalités of the discourses of academic medicine, I also use visual examples, financial examples, and changes in narrative structure in documents over time as examples of statements.

\textbf{The Discourses of Management}

I identified four discourses that constitute “the discourses of management” governing Canadian academic medicine:
1. Academic medicine is a Social Obligation (of the wealthy).

2. Academic medicine is a State Responsibility.

3. Academic medicine is a Professionalization project.

4. Academic medicine is an engine of Wealth Creation.

I also identified how these discourses are manifesting within Canadian academic medicine and how they have changed over time. That is to say, I have mapped their unique mentalités, their histories, the discursive practices they have made possible, their surfaces of emergence, their characteristics, and their impacts.

I would suggest that these four discourses draw upon economic ideas and practices dating back centuries and as a result are not new per se. In fact, I would argue that these discourses long predate the creation of academic medicine and that my work simply names them and explores their effects in the creation of Canadian academic medicine, their contours, and their changes in a particular era, namely 1900 to 2016. Finally, I would suggest that this work, while economic in nature, is complementary to the traditional work of economic scholars such as Adam Smith\(^3\), Karl Marx,\(^3\) and Milton Friedman,\(^3\) although it may be somewhat unsettling to readers more familiar with their more classical economic thinking because it focuses on the ideological level.

**Academic Medicine Is a Social Obligation**
This first discourse—Academic medicine is a social obligation—would be best defined by the discursive statement “Academic medicine is a responsibility of the wealthy”. This discourse has deep roots in western society. The idea that those with wealth and power in society have a responsibility to others dates back centuries and has manifested in a variety of forms. Various scholars and authors have linked concepts of power and privilege with concepts of responsibility and Christian charity.⁴⁻⁹ Montesquieu’s The Spirit of Laws (1748)⁵ captured these concepts eloquently, linking them to two forms of government (democratic and monarchical) and their respective foundational concepts (community before self and honour as a rationale for privilege, respectively).⁵ In French culture, these concepts have manifested as the concept of noblesse oblige.¹⁰ In English culture, they have manifested as the concept of chivalry.⁴ A later version of these concepts manifested in British society as a societal contract between the affluent and the poor.¹¹,¹² In this societal contract, the middle class and landed gentry were responsible for the funding and the governance of health care institutions for the poor, to the lower class, to their workers, to unwed mothers, and to “indigents.”¹¹,¹² In all of these examples, those with power, with resources, obtained increased social status as a result of honouring this compact, of providing for those less fortunate.¹¹,¹²

These concepts and their influence can also be traced through time and space from the US Constitution to the philosophy of the Canadian “Red Tories.” Andrew
Carnegie, the philanthropist behind the Flexner report, espoused this philosophy in 1889 in published essays on wealth\textsuperscript{7,13} in which he argued that it was a responsibility of the affluent to use their wealth to improve society and suggested that it was immoral for them not to do so.\textsuperscript{7,13} Carnegie lived this philosophical position in that in the last eighteen years of his life he gave away an estimated $350 million, or 90\% of his fortune, and in doing so influenced generations of philanthropists to invest in society.\textsuperscript{14-17} Recently these same ideas have been given new life by philanthropists such as Warren Buffett and Bill Gates who have pledged to donate the bulk of their fortunes in their lifetime.\textsuperscript{18}

This suggestion that the rich have an obligation to give back to society can have positive and negative effects. Economically, philanthropy or philanthropic giving can provide significant support for an institution, a domain, or an idea. As a practice, it can focus on the long term and on projects that public funding institutions might find too politically risky to support. At the social level, however, philanthropy can have potentially negative effects; it can create a power dynamic whereby an institution seeking philanthropic support may have to create rationales to persuade a wealthy individual to donate. These rationales can give philanthropists potentially significant influence over capital expansion and research directions that is at odds with the needs of the institution or the social good.
The role of philanthropy in Canadian academic medicine is well known and long standing.\textsuperscript{14,17,19,20} In 1874, Ontario created the Provincial Charity Act\textsuperscript{21} to enhance philanthropic support of its public institutions. In doing so, the government of Ontario recognized philanthropy as an important funding stream for public institutions, created financial incentives to increase philanthropic giving, and established a requirement for transparency with regard to the use of philanthropic funds.\textsuperscript{12,22,21} Most importantly, this act classified public institutions into three categories—hospitals, refuges for the destitute, and homes for dependent children and single mothers—categories that determined their funding levels.\textsuperscript{12,22}

At the ideological level, this act had several effects. First, it institutionally sanctioned the idea that those who were affluent should support institutions for the less fortunate. Second, it created a domain where women could wield power as fundraisers and connections to money thus having long-term societal effects. This was not a policy objective of the act, merely an unintended consequence; the act provided roles for educated and affluent women in a domain that was male dominated.\textsuperscript{12} Third, it enhanced a linkage between religious organizations, health care institutions and welfare systems, because charitable giving was much espoused by religious organizations in this era.\textsuperscript{11,23} Fourth, it supported a class-based public health care system in which the poor, the indigent, the worker, and the
moral questionable were treated in large public wards while the rich were treated in their homes and in private clinics.\textsuperscript{12,21,23,24}

This discourse has had both positive and negative effects. It has resulted in the creation and funding of institutions and academic medical research that continues to this day with unquestionably positive impacts. It has also resulted in the enhancement of academic medicine as an arena of class-based power and a space in which the upwardly mobile can ascend the social ladder.\textsuperscript{11,23}

**Social Obligation: Discursive Formation**

One can describe this discourse in Foucauldian terms as follows. The surface of emergence\textsuperscript{2} of this discourse, its ideological origin per se, is the upper classes and the religious orders. Accordingly, this discourse has had and has created numerous loci of power ranging from fund-raising committees to advancement offices to religious organizations and charity balls. It has produced numerous objects such as hospitals, research funds, named wings in hospitals and new faculties in the university. It has created roles, or subject positions,\textsuperscript{2} such as socialite leaders who support the institution, board positions for the affluent who donate, and professionals in academic medicine dedicated to advancement. Mentalités\textsuperscript{2} associated with this discourse that serve to map its boundaries include religiosity, noblesse oblige, chivalry, charity, governance by birthright,
social class, morality, management of lower classes, and the production of a social good. Table 5.1 below illustrates the discursive formation of this discourse.

**Table 5.1: Discourse: Academic Medicine is a Social Obligation**

<table>
<thead>
<tr>
<th>Discourse: Academic Medicine Is a Social Obligation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discursive Statement</td>
</tr>
<tr>
<td>Quote</td>
</tr>
<tr>
<td>Economic Practice</td>
</tr>
<tr>
<td>Subject positions Created by Discourse</td>
</tr>
<tr>
<td>Objects Created</td>
</tr>
<tr>
<td>Surface of Emergence</td>
</tr>
<tr>
<td>Institutional Loci of Power</td>
</tr>
<tr>
<td>Mentalités Establishing Boundaries of Discourse</td>
</tr>
<tr>
<td>Instantiating Texts</td>
</tr>
<tr>
<td>Modern Text</td>
</tr>
</tbody>
</table>

Please see Table 5.5 at end of this chapter for the full discursive formation of Canadian academic medicine.

**Academic Medicine Is a State Responsibility**

This second discourse of Canadian academic medicine—Academic medicine is a State Responsibility—is best described by the discursive statement “Academic medicine is a social good and a responsibility of government”. This discourse’s roots can be traced back to the 18th-century Enlightenment and beyond. In the canonical text, The Social Contract,²⁶ published in 1762, Jean-Jacques
Rousseau introduced the concept of the social contract to reference political power that was provided to a government by a sovereign, or free, population in exchange for “legitimate governance and a recognition of service to the population."26

In Canada, the concept of the social contract has been much explored in the context of health care.27-32 Arguably this concept underpins a Canadian belief that health care is a right, not a privilege, along with the five basic tenets of Canadian health care and the Canada Health Act—public funding, comprehensiveness, universality, portability, and accessibility.33 More basically, it underpins the ideas that Canadians have a right of access to high-quality health care wherever they are in Canada and that access should be funded by the state.

The economics underpinning this discourse require certain beliefs. The population must believe that a role of government is to establish and maintain an appropriate tax structure such that it can fund services that are the responsibility of the state, in this case academic medicine. This discourse, popularized as a truth, makes it possible for governments to create revenues from taxes on the services, production, and consumption within their territories, from tariffs on items entering or passing through their territories and from the profits of trade.7 It also allows for academic medicine to be seen as a core State responsibility.
In Canada, this discourse has resulted in a century of funding by government for academic medicine. In the early 1900s, municipalities and the provincial government were the primary source of funding for hospitals. As the century progressed, the funding of health care became primarily provincial, supported by transfers from the federal government.\textsuperscript{34} Faculties of health sciences have been funded provincially with funds flowing via hospitals to faculties of medicine in academic centres.\textsuperscript{35} Costs to fund academic medicine have increased immensely over the last hundred years, challenging governments’ financial resources.\textsuperscript{35} This rise in the funding requirements of academic medicine can be tied to increased costs of health care, salary costs, an increasing focus on drugs as a treatment modality, rising education costs, and—more interestingly—a focus on research, a very costly endeavor.\textsuperscript{36-41}

**State Responsibility: Discursive Formation**

This discourse is based upon the economic practice of tax-base funding. The surface of emergence\textsuperscript{2} of this discourse would be the domain of public health, arising from a desire to manage, and provide care to, a broad segment of the population. It has produced numerous loci of power such as the Ministry of Health, centres of excellence, hospitals, and faculties of health sciences in universities. It has created roles, or subject positions,\textsuperscript{2} such as ministers of health and education, executive directors in hospitals, chiefs of staff, bureaucrats, masters in public administration, and policy analysts. It has created objects such as hospitals, welfare systems, ministries of health, health secretariats, transfer
funds, Social Obligation mandates, the Public Hospitals Act of 1931, and innumerable discourses of health care such as patient safety, physician accountability, and the current discourse of inter-professionalism. The mentalités associated with this discourse include betterment of society, production of a social good, universities serving State needs, hospitals providing health care, government funding, universality, health care as a right, health care as a key determinant of society, and responsibility to the public. Table 5.2 below illustrates the discursive formation of this discourse.

Table 5.2: Discourse: Academic Medicine Is a State Responsibility

<table>
<thead>
<tr>
<th>Discursive statement</th>
<th>Academic medicine is a social good and a responsibility of government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quote</td>
<td>“…plan for building a sustainable public health care system in Ontario is based on helping people stay healthy, delivering good care when people need it, and protecting the health system for future generations.”</td>
</tr>
<tr>
<td>Economic Practice</td>
<td>Tax-Base Funding</td>
</tr>
<tr>
<td>Subject Positions Created by Discourse</td>
<td>Ministers, Bureaucrats, Executive Directors, Masters in Public Administration, Policy Analysts</td>
</tr>
<tr>
<td>Objects Created</td>
<td>Hospitals, Welfare Systems, Ministry of Health, Transfer Funds, Health Policy, Social Obligation Mandates, Public Hospital Act 1931</td>
</tr>
<tr>
<td>Surface of Emergence</td>
<td>Public Health</td>
</tr>
<tr>
<td>Institutional Loci of Power</td>
<td>Ministry of Health, Hospitals, Universities</td>
</tr>
<tr>
<td>Mentalités Establishing Boundaries of Discourse</td>
<td>Betterment of Society, University Service to State, Hospitals as Providers of Health Care, Government Oversight, Government Funding, Public Private Partnerships, Social Obligation, Public Accountability, Fiscal Oversight, Delegated Responsibility</td>
</tr>
<tr>
<td>Instantiating Text</td>
<td>The Social Contract™</td>
</tr>
<tr>
<td>Modern Text</td>
<td>Reform™</td>
</tr>
</tbody>
</table>

Please see Table 5.5 at the end of this chapter for the full discursive formation of Canadian academic medicine.

**Academic Medicine Is a Professionalization Project**

The discourse Academic medicine is a Professionalization Project would be best defined by the discursive statement “Academic medicine is a scientific discipline.”
The origins of this discourse can be traced to the movement of the guilds into the university to increase their power and to address criticisms of their financial monopolies. Discussions about the guilds and their academic place go back to such Victorian texts as Hastings Rashdall’s *The Universities in the Middle Ages*. More recently, scholars such as Eliot Friedson have explored the creation of the professions out of the guild framework in a variety of academic works, tying the creation of the professions to ideas of resource protection.

Flexner’s *Medical Education in the United States and Canada* is most commonly seen as the report that situated medical education in universities. Flexner argued that medicine and medical education had three waves: one of apprenticeship, one of didactic education, and one of scientific learning; he further argued that in an era of scientific learning, medical schools should be situated in sites of academic learning. Evidence-based medicine, a key dimension of academic medicine for the last century, arose from Flexner’s work—as did an economic model for academic medicine built upon ongoing investment in and support of research as a societal obligation. While Flexner’s work did not directly influence the faculty of medicine’s movement into the University of Toronto—inasmuch as the faculty had joined the university some years earlier—his report did reinforce and legitimize its being located there. Flexner’s work also served to maintain and to enhance the faculty’s developing
reputation as an academic centre medicine and as a site of highly professional instructors.⁴⁷

The economics of this linkage has varied considerably over time. It has been fee based in the form of tuition, research funding, or medical fees in a variety of combinations. It has changed in magnitude as a function of need and societal events. There has been an emergence and a subsequent disappearance of fees for medical services over the last hundred years. However, throughout these shifts, through the emergence of different fee types, transfer payments, and the emergence of commercial practices in Canadian academic medicine, there has been constancy in terminology regarding its cash flows. That is to say, irrespective of any accounting categorization applied to describe its cash flows—government funds, transfer payments, tuition, sales, commercial revenue, etc.—those inhabiting this discourse only seem comfortable with the term “funding.”⁴⁸ This suggests to me that irrespective of the practices that generate any cash flows for Canadian academic medicine, those governed by this discourse ultimately see themselves as a beneficiary of the state, not as a business.

**Professionalization: Discursive Formation**

The surface of emergence² of this discourse is the (medical) guilds. The discourse has produced a wide range of loci of power ranging from universities, faculties of medicine, regulatory colleges, to accreditation bodies. It has created objects such as academic health science centres, research centres, research
foundations, institutes, conferences, evidence-based research, merged medical schools, and very complex funding models that link hospitals and faculties of medicine by the chequebook.\textsuperscript{35,49,50} It has created a diverse cross section of roles, or subject positions,\textsuperscript{2} such as professor, dean, research chair, clinician-educator, PhD researcher, vice dean and governance council member. The mentalités\textsuperscript{2} that map the boundaries of this discourse include medical education as academic, power (scientific and secular), research as legitimizing, hospitals as research centres, the university as legitimizing body, collaboration, funding not revenue, Social Obligation, scholarship, and professional dues supporting academic activities. Table 5.3 below illustrates the discursive formation of this discourse.

\begin{table}[h]
\centering
\begin{tabular}{|l|p{0.8\textwidth}|}
\hline
\textbf{Discourse: Academic Medicine Is a Professionalization Project} & \\
\hline
\textbf{Discursive statement} & Academic medicine is a scientific discipline \\
\hline
\textbf{Quote} & “World-class talent, interdisciplinary excellence, and collaboration with peers and partners have helped the University of Toronto Faculty of Medicine continually solve the world’s most pressing medical challenges."\textsuperscript{51} \\
\hline
\textbf{Economic Practice} & Fee Based \\
\hline
\textbf{Subject Positions Created by Discourse} & PhD Researchers, Clinician-Researchers, Deans, Research Chairs, Postgraduates \\
\hline
\textbf{Objects Created} & Faculties of Medicine, Academic Health Science Centres, Conferences, Evidence-Based Medicine, Research Foundations \\
\hline
\textbf{Surface of Emergence} & Medical Guilds \\
\hline
\textbf{Institutional Loci of Power} & Faculties of Health Sciences in Universities, Research Foundations \\
\hline
\textbf{Mentalités Establishing Boundaries of Discourse} & Academia, Power, Scientific Secular Institutions, University as a Site of Influence, Research as Legitimation, Evidence-Based Medicine, Rejection of Profit Motive, Global Knowledge, Collaboration, Partnership, Rejection of Funding Terminology in Favour of Revenue Model, Social Obligation, Globalization of Ideas, Knowledge Sharing, Authorship, Fee-Supported Academic Activities \\
\hline
\textbf{Instantiating Text} & Medical Education in the United States and Canada\textsuperscript{57} \\
\hline
\textbf{Modern Text} & The Social Transformation of American Medicine\textsuperscript{52} \\
\hline
\end{tabular}
\caption{Discourse: Academic Medicine Is a Professionalization Project}
\end{table}
Please see Table 5.5 at end of this chapter for the full discursive formation of Canadian academic medicine.

**Academic Medicine Is an Engine of Wealth Creation**

The fourth discourse is Academic medicine is an engine of Wealth Creation. It would be best defined by the discursive statement “Academic medicine, its experts, and its expertise should be monetized.” This discourse also has its origins in the 1800s in the Enlightenment, more specifically in Adam Smith’s *The Wealth of Nations* (1776). It is characterized by a focus on the productivity of population and a free market as the engine of national wealth creation. Under this discourse national wealth creation is constructed as societal advancement. Regulation of activities and business practices is the responsibility of the periphery, of organizations, of institutions, and of the individual. Foucault theorized this as a State as product of a neoliberal governmentality. Under this discourse individuals, such as health professionals or educators, are transformed into monetizable objects and into individuals responsible for national wealth creation. In policy studies, an aspect of this discourse, the adoption of business logics and practices, was identified as neomanagerialism and argued to produce a focus on efficiency, surveillance, and audit.

Despite a current narrative that business practices have emerged recently in academic medicine my findings suggest that they have been present in a variety
of forms since at least Flexner’s era. My findings also suggest that business practice were not eradicated by Flexner’s work; rather, they have simply changed in their form and focus and manifested in different ways over the last hundred years. Most recently, this discourse produced a new level of commerciality in Canadian academic medicine in that it became possible to sell access to health care, to sell patient health products, to charge more for superior rooms in hospitals, to monetize the findings of research, to transform tuition for postgraduate students into a fee and to do all of this in the global space.

Wealth Creation: Discursive Formation

The surface of emergence\(^2\) of this discourse in Canadian academic medicine is Public Health and industry. It has produced loci of power ranging from health care businesses to for-profit postgraduate education offices to offshore manufacturing sites to public-private partnerships to private for-profit wards in hospitals. It has created subject positions such as CEO, executive officers as a replacement for executive directors, Masters of Business Administration in health care, and managers, accountants, sales people, and consultants in academic medical institutions. The mentalités associated with this discourse include sales, wealth creation, monetization, services, concierge service, efficiency, business logics, consulting in health care, mergers, investments, corporatization and the idea that academic medicine can be a driver of national wealth. Table 5.4 below illustrates the discursive formation of this discourse.
Table 5.4: Discourse: Academic Medicine Is an Engine of Wealth Creation

<table>
<thead>
<tr>
<th>Discourse: Academic Medicine Is an Engine of Wealth Creation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discursive statement</td>
</tr>
<tr>
<td>Quote</td>
</tr>
<tr>
<td>“Does all this mean that there will be more emphasis on budgets than on patient care, that what is best for patients will be dictated by cost?”64</td>
</tr>
<tr>
<td>Subject Positions Created by Discourse</td>
</tr>
<tr>
<td>Objects Created</td>
</tr>
<tr>
<td>Surface of Emergence</td>
</tr>
<tr>
<td>Institutional Loci of Power</td>
</tr>
<tr>
<td>Mentalités Establishing Boundaries of Discourse</td>
</tr>
<tr>
<td>Instantiating Text</td>
</tr>
<tr>
<td>Modern Text</td>
</tr>
</tbody>
</table>

Please see Table 5.5 at the end of this chapter for the full discursive formation of Canadian academic medicine.

The Discursive Formations of Canadian Academic Medicine

Each of these four discourses that govern Canadian academic medicine has been present from the era of Abraham Flexner to today. Separately, each discourse has distinct effects, making possible distinct roles and practices associated with their specific economies. The differences between these discourses are set forth in Table 5.5 below.

Table 5.5: Discursive Formations of Academic Medicine

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Academic Medicine Is a Social Obligation</th>
<th>Academic Medicine Is a State Responsibility</th>
<th>Academic Medicine Is a Professionalization Project</th>
<th>Academic Medicine Is an Engine of Wealth Creation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discursive statement</td>
<td>Academic medicine is an obligation of the wealthy</td>
<td>Academic medicine is a social good and a responsibility of</td>
<td>Academic medicine is a scientific discipline</td>
<td>Academic medicine, its experts, and its expertise</td>
</tr>
<tr>
<td>Subject positions created by discourse</td>
<td>Economic Practice</td>
<td>Philanthropy</td>
<td>Tax-Base Funding</td>
<td>Fee Based</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------</td>
<td>--------------</td>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>• Wealthy on Governance Boards</td>
<td>• Ministers</td>
<td>• PhD Researchers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Female Leadership Positions</td>
<td>• Bureaucrats</td>
<td>• Clinician-Researchers</td>
<td></td>
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<tr>
<td>• Donors</td>
<td>• Executive Directors</td>
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<tr>
<td>• Advancement Professionals</td>
<td>• Masters in Public Administration</td>
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<td></td>
<td>• Policy Analysts</td>
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<td></td>
<td>• Public Health Act 1931</td>
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<td></td>
<td>• Hospitals</td>
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<td>• Welfare Systems</td>
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<td>• Ministry of Health</td>
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<td>• Transfer Funds</td>
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<td>• Health Policy</td>
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<td></td>
<td>• Social Obligation Mandates</td>
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<td></td>
<td>• Public Hospital Act 1931</td>
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<tr>
<td>• Charity Committees</td>
<td>• Faculties of Medicine</td>
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<tr>
<td>• Charity Balls</td>
<td>• Academic Health Science Centres</td>
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<tr>
<td>• Fund-Raising Appeals</td>
<td>• Conferences</td>
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<tr>
<td>• Religious Mandates in Hospitals</td>
<td>• Evidence-Based Medicine</td>
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<td>• Research Foundations</td>
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<td>• Consultancy Businesses</td>
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<td>• Offshore Manufacturing Sites</td>
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<td>• Chief Innovation Officers</td>
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<td>• Luxury Wards</td>
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<tr>
<td>• Upper Classes and Religious Orders</td>
<td>• Public Health and Industry</td>
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<td></td>
<td>• (Medical) Guilds</td>
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<tr>
<td>• Fund-Raising Committees</td>
<td>• Consultancy Businesses</td>
<td></td>
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<tr>
<td>• Provincial Charity Act 1874</td>
<td>• Offshore Manufacturing Sites</td>
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<tr>
<td>• Advancement Offices</td>
<td>• Private-Public Partnerships</td>
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<tr>
<td>• Foundations</td>
<td>• Chief Innovation Officers</td>
<td></td>
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<tr>
<td></td>
<td>• Luxury Wards</td>
<td></td>
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</tbody>
</table>

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As I have shown, these discourses existed prior to the work of Abraham Flexner and the creation of academic medicine. Thus identifying the presence of these discourses in Canadian academic medicine, the economics associated with them, and the mentalités that constitute them was only the first step in my research. The second and arguably more interesting part of my research for most
readers will be found in the next three chapters, where I track the discourse effects, interaction, and collective effect over 120 years to show how the global engagement of Canadian academic medicine became possible. In these next three chapters, I will show how these discourses and their interactions, or in Foucauldian terms their “articulations,” produced material effects in the form of new roles, new institutions, and new practices that made possible Canadian academic medicine’s global commercial engagement.

**Spatiality**

The discourses and the discursive structure I have described above provide quite a detailed picture of Canadian academic medicine. That said, the portrait painted by that analysis is not a complete picture. To obtain a more complete picture, it is important to consider the spaces of Canadian academic medicine and their effects. Adding this second level of theorizing and analysis to the critical discourse analysis of the spatiality is not typically done, despite the fact that it provides a more nuanced, detailed, and complex portrait. It also provides a portrait that might be described as “messier” because it is of course even more complex.

I use the term “messier” for two reasons. First, as I have argued, a Foucauldian critical discourse analysis typically paints a very complex portrait of a phenomenon because it tends to reveal multiple ideas all present, all in tension, and all having effects at the same time. As the resultant portrait already tends to
be quite complex, adding further complexity is, for many, not something that is either desired or useful. Second, Foucault’s work on space and its relation to discourse, while powerful, is undeveloped and somewhat ill defined. It is also not commonly used, and therefore there are neither guides nor models to draw upon to inform an integration of a Foucauldian spatial analysis with a more traditional Foucauldian discursive analysis.

That said, as my research question is inherently spatial, ignoring space as a theoretical concept seemed simply wrong. Second, by theorizing the space(s) of Canadian academic medicine I will accomplish two things. First, I will add significantly more depth to my answer to the research question “How did it become possible for Canadian academic medicine to become commercially engaged in the global space?” Second, I will be able to provide a new perspective on how the Foucauldian triumvirate of power, knowledge, and ethics is manifesting within Canadian academic medicine and between its constituent institutions. To achieve these two goals, I will discuss Foucault’s concepts of space, utopia, heterotopia, and patterns of organization present in each era to add colour and nuance to the understanding of Canadian academic medicine’s four discourses and their effects.

I will make one final comment on this chapter and the next three. As I noted at the beginning, this chapter presents one key finding from my research, the
discourses and the discursive formation of Canadian academic medicine. What it
does not provide are the granular details, the examples, the data that brings the
discourse to life and makes them much more tangible for the reader. That is the
task of the next three chapters.
Citations Chapter 5


35. Brimacombe GG. 2010. Three Missions, One Future—: Optimizing the Performance of Canada's Academic Health Sciences Centres: Ottawa, ON: Association of Canadian Academic Healthcare Organizations.;
Chapter 6: 1900 to 1940

Introduction

This chapter will present a history of Canadian academic medicine in the era 1900 to 1940 based upon my analysis of its discursive formation, which I identified in chapter 5. In presenting this history I will illustrate what the various discourses and their articulations made possible, and in doing so present a version of Canadian academic medicine unique to this period of history. For most readers, the version of Canadian academic medicine presented in this chapter will be quite different from one with which they are familiar, that of the late 20th and early 21st century.

Writing a History of Academic Medicine

There are many histories written about health care. They tend to focus on physicians, on scientists, on triumphs over disease, and on the creation of health care institutions. There are surprisingly few histories written about the institution that underpins health care, namely academic medicine. This history addresses that gap, tracking Canadian academic medicine over 120 years, from its beginnings in the work of Abraham Flexner to its commercial engagement in the
global space. Unlike the traditional histories described above, histories that are focused on illnesses and medical heroes, this history focuses on the economic logics and spaces created by Canadian academic medicine. To make this story of Canadian academic medicine easier to understand, I have written it in three chapters, covering 1900 to 1940, 1940 to 1990, and 1990 till now, or more descriptively three eras. These three eras might be described as an era of philanthropic giving and financial precariousness, an era of government largesse and research investment, and an era of commercialization and financial uncertainty.

Each chapter follows a similar narrative arc. Each starts with a description of key events and financial characteristics of the era. Following this is a description of the four discourses—Social Obligation, State Responsibility, Professionalization, and Wealth Creation—highlighting what they produce and the spaces they occupy in this era. In writing these chapters, both as stand-alone chapters and as one whole history, it is my hope that Canadian academic medicine’s transformation from a locally focused service to a globally engaged and commercial enterprise will be more easily understood.

Several caveats should be mentioned regarding narrative choices I made in writing these chapters. First, since I wanted this history to be accessible, I chose a linear narrative, typical of most historical writing. My apologies to Foucauldian
purists who feel strongly that choice of narrative arc should be governed solely by theory and thus that this history would be better written in a more artistic manner to capture Foucault’s concept of serial history. Second, in presenting this history of Canadian academic medicine, I highlight many but not all of the key events of the last 120 years. Finally, in each era I describe one or two events or objects produced that seem especially iconic and indicative of a shift in the discourse, and the beginning of a new episteme. It is my hope that providing these in-depth descriptions of key events will make this history more tangible to the reader, making clearer the effects of the articulation of the four discourses of Canadian academic medicine over time.

With that said, I begin with my analysis of the first forty years of history of Canadian academic medicine.

1900 to 1940

The years from 1900 to 1940 were a formative, if financially precarious, time for Canadian academic medicine. Government funding was limited and somewhat ad hoc, distributed between provincial and municipal sources. Tuition and other service fees were limited in their growth potential. Commercial revenues were nominal. Philanthropic revenues were helpful but seemingly insufficient to bridge the growing gap between revenues and expenses, a gap that was increasing in size due to inflationary pressures — a product of world events such as World War I.
This era followed several decades of tumultuous operations. The Toronto General Hospital had just reopened after closing in 1867 due to lack of funds.\textsuperscript{1} The University of Toronto’s Faculty of Medicine was still in its early years, having only just opened in 1887.\textsuperscript{2} A merger with Trinity Medical College in 1903 had begun an era of expansion in the medical school. Philosophically, medical education was still quite young in North America in this era and its leaders looked to Europe for more sophisticated models of education.\textsuperscript{3-5} North American educational leaders were shifting the foundation of their institutions from the British model of academic medicine, focused on teaching, to the American model, focused on research.\textsuperscript{6} They were also rejecting a for-profit model for medical schools, accepting Flexner’s findings, discussed earlier, that commercialism in medical education was linked with poor educational outcomes.\textsuperscript{7-11}

Table 6.1 below documents examples of the financial challenges and the ongoing losses in this era, drawn from the archives of Toronto’s Hospital for Sick Children. Several observations need to be made about these statements. First, expenses climbed faster than revenues during this era, a pattern that was to continue indefinitely. Second, while the bulk of the funding was from government, management was clearly making an effort to close the gap between revenues and expenses by launching innovative new funding platforms. Third, despite these funding innovations, the losses continued even as expense growth
outpaced revenue growth. Fourth, governmental funding was from multiple sources, and the Ontario government was not the largest contributor, a surprising fact given its constitutional responsibility and current funding practices. Finally, these same patterns were not unique to the Hospital for Sick Children. The Toronto General Hospital also ran operating loses throughout this era despite also launching various new initiatives in an effort to bridge the funding gap.

Table 6.1: Financial Statements for the Toronto Hospital for Sick Children for Years Ending September 1922, 1926, and 1938

<table>
<thead>
<tr>
<th>Financial Detail</th>
<th>For Year Ending September 30, 1922 12</th>
<th>For Year Ending September 30, 1926 13</th>
<th>For Year Ending September 30, 1938 14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Operating Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Patients</td>
<td></td>
<td></td>
<td>84,887.15</td>
</tr>
<tr>
<td>Private Patients</td>
<td></td>
<td></td>
<td>28,885.67</td>
</tr>
<tr>
<td>Ontario Government</td>
<td>37,760.30</td>
<td>45,484.06</td>
<td>85,794.14</td>
</tr>
<tr>
<td>City of Toronto</td>
<td>91,282.40</td>
<td>87,292.08</td>
<td>135,331.11</td>
</tr>
<tr>
<td>Municipalities</td>
<td>20,585.19</td>
<td>19,628.68</td>
<td>58,149.02</td>
</tr>
<tr>
<td>Operating Room and</td>
<td>10,950.76</td>
<td>10,373.71</td>
<td>1,298.99</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>209,835.69</td>
<td>223,308.99</td>
<td>394,345.98</td>
</tr>
<tr>
<td></td>
<td>Operating Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>(38,468.61)</td>
<td>(29,689.38)</td>
<td>(61,025.79)</td>
</tr>
<tr>
<td>Domestic Departments</td>
<td>(100,004.45)</td>
<td>(112,391.09)</td>
<td>(190,241.71)</td>
</tr>
<tr>
<td>Professional Care of</td>
<td>(94,623.49)</td>
<td>(81,062.23)</td>
<td>(172,182.71)</td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General House and</td>
<td>(65,352.76)</td>
<td>(65,912.85)</td>
<td>(64,184.69)</td>
</tr>
<tr>
<td>Property Expenses</td>
<td>(15,448)</td>
<td>(35,947.49)</td>
<td>(56,269.47)</td>
</tr>
<tr>
<td>Outpatients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating</td>
<td>(318,897.31)</td>
<td>(325,003.04)</td>
<td>(543,904.37)</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results from Operations</td>
<td>(104,061.62)</td>
<td>(101,694.05)</td>
<td>(149,558.39)</td>
</tr>
<tr>
<td>Subscriptions and</td>
<td>56,856.92</td>
<td>58,904.85</td>
<td>64,757.89</td>
</tr>
<tr>
<td>Donations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income (Interest) from (on) Investments</td>
<td>3,715.84</td>
<td>29,774.27</td>
<td>64,510.60</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Total</td>
<td>60,572.76</td>
<td>88,679.12</td>
<td>129,268.49</td>
</tr>
<tr>
<td>Non-operating expenses</td>
<td>(4,022.20)</td>
<td>(133.47)</td>
<td>(4,660.47)</td>
</tr>
<tr>
<td>Total</td>
<td>56,550.56</td>
<td>88,545.65</td>
<td>124,608.02</td>
</tr>
<tr>
<td>Net Gain (Loss)</td>
<td>(47,511.06)</td>
<td>(13,148.40)</td>
<td>(24,980.91)</td>
</tr>
</tbody>
</table>

Surprisingly, despite the financial challenges that marked this era, finances were not the focus of board discussions or annual reports. Financial reporting was nominal at best (typically consisting of half-page reports in 50-page documents), and appeared deep in documents towards the end. The first two-thirds of documents and meetings were instead focused on patients and on the accomplishments of the institution’s health professionals, academics and students. Today, meetings and annual reports have a very different construction. Numbers lead and are manifest in documents as pages of financials, descriptions of performance, and extensive graphs and charts. If employees of the organization are profiled, they are as likely to be the executives as they are the health care professionals. This is a profound change and a strong statement about how issues of importance to health care institutions have changed. Where annual reports highlighted the human face of the organization in the early 20th century, in the 21st century they have been re-conceptualized primarily as financial reports. The statement is quite clear; a focus on finances and on the use of public funds has replaced a focus on the scientific and human dimensions of academic medicine. Over the course of a hundred years, this has been a
drastic shift. Exploring this shift and the economic ideology underpinning it is the focus of my research.

**Academic Medicine: The Emergence**

Today “academic medicine” is a well-understood term. It describes a domain of health care and education practice, research, institutions, and conferences. It is commonly accepted that academic medicine is a scientific domain, that it is evidence-based and situated in faculties of medicine and academic/teaching hospitals. “Academic medicine” is used regularly in common parlance requiring no explanation to those in health care or academia. In the early 1900s, this was not the case. Academic medicine was just emerging as a domain; it was a concept in formation. Most medical schools were not yet situated in universities, and Abraham Flexner’s call for medical education to be built upon a practice of research was only starting to be heard. As I mentioned earlier, Flexner did not use the term “academic medicine” in his canonical report that established the framework of medical education and academic medicine for the next century.\(^7,9,10,15\)

Because of this, I began to research the emergence of the term “academic medicine.” Using PubMed and a simple search string, I found the first usage of the term in the academic press in a 1953 publication titled “Academic Medicine and the Art of Healing.”\(^16\) Using Google, I was able to push that date back to 1908, finding the term “academic medicine” in a speech
published in the *California Journal of Medicine*. In that address, the president of the Medical Society of California stated:

I shall ask the indulgence of the Society on this occasion for departing from the usual custom pertaining to the Presidential Address, and shall present briefly a subject which, though of vital importance, in these days, when the activities of the profession are divided between Academic Medicine and Commercialism, has been relegated to comparative obscurity. The general practitioner, equally appalled by the intricacies of the former, as he is disgusted by the blatant methods of the later, has suffered himself to lose sight of the rich heritage which it is his privilege to enjoy as a member of the profession based on the highest altruistic ideals, and has to a large extent overlooked in his duties to his community in matters pertaining to Public Health, which he has sworn to safeguard.  

Finding the term in seemingly everyday parlance removed my theoretical concerns regarding academic medicine’s existence as a discursive object in the early 1900s. Finding the term used to denote an activity of the medical profession in tension with the activities of commercialism lent credibility to my exploration of the discursive structure of Canadian academic medicine and its adoption of business practices in the global space.

**The Four Discourses of Academic Medicine: 1900 to 1940**

To understand the discursive structure of Canadian academic medicine in this era is somewhat challenging. First, it is necessary to understand the effects of each discourse and the roles and objects they make possible. Second, it is necessary to understand the effects of the articulation of these
discourses. Finally, it is necessary to understand that it is this articulation of the discourses that transformed Canadian academic medicine from a local publicly funded service to a globally engaged commercial endeavor.

To guide the reader through this era, I have prepared Table 6.2 below as a synopsis of the key articulations, a synopsis I then explain in more detail in the sections to come.

Table 6.2: Discursive Articulations and Their Effects, 1900 to 1940

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Major Issues</th>
<th>Articulation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Research Emerges as Core Focus of Academic Medicine</td>
<td>A2: Social Obligation + Professionalization</td>
<td>Support for Research from Donors Emerges</td>
</tr>
<tr>
<td></td>
<td>Hospitals Target Wealthy as Way to Increase Revenues</td>
<td>A3: Social Obligation + Wealth Creation</td>
<td>Launch of For-Profit Private Pavilions in Hospitals</td>
</tr>
<tr>
<td></td>
<td>Focus on Research Radically Transformed Cost Structure of Academic Medicine, Triggered Need for Increased Revenues</td>
<td>B2: State Responsibility + Wealth Creation</td>
<td>Public Hospitals Act and Beginnings of Increased Managerialism in Hospitals</td>
</tr>
<tr>
<td>C: Professionalization</td>
<td>Increased Dependency on State Funds Increased Faculty of Medicine’s Sensitivity to State Needs</td>
<td>C1: Professionalization + State Responsibility</td>
<td>Curriculum Changes Made to Meet State Agenda</td>
</tr>
<tr>
<td></td>
<td>Pablum Discovered</td>
<td>C2: Professionalization + Wealth Creation</td>
<td>Monetization of Research Creates Cash Stream</td>
</tr>
<tr>
<td>D: Wealth Creation</td>
<td>Institutions Launch New For Profit Endeavours</td>
<td>D1: Wealth Creation + Social Obligation or State Responsibility</td>
<td>Selling Milk for Profit, Fees for Radiology, Private Rooms</td>
</tr>
</tbody>
</table>
Discourse A: Academic Medicine Is a Social Obligation

The discourse of Social Obligation has a long history in Ontario and in Canada. Its economic practice, philanthropic giving, was recognized as an important funding mechanism for public institutions in Ontario policy as early as 1874. The *Provincial Charity Act* passed by the Ontario government in that year\(^\text{18}\) was an effort to increase the charitable funding of public institutions by creating tax incentives to donate and to increase transparency in charities’ use of donated funds.\(^\text{18}\) Embedded in this bill was a belief that funding of public institutions should be shared on an equitable basis between the state, private individuals, and corporations. The preamble of the bill states this explicitly:

> WHEREAS it is desirable and expedient that all appropriations from the public funds in aid of charitable institutions should be made upon some properly arranged and equitable system and that municipal and other corporations well as private individuals should be stimulated and encouraged to give a liberal support to such institutions.\(^\text{18}\)

This bill, the *Provincial Charity Act*, was passed in an era of low taxation prior to the creation of income tax and an estate tax in Canada. The economic logic of this era might be summarized as follows:

1. The state’s presence in the finances of the nation should be limited.
2. Multiple sources of funding should support public institutions.
3. The affluent share responsibility for the funding of public enterprises.
4. The affluent have a responsibility to give back to society.

5. The affluent will support public initiatives directly in an era of low taxation.

The discourse of Social Obligation was highly productive in this era. The domain of academic medicine benefited from the effects of this discourse in multiple ways. The Hospital for Sick Children is one clear example. The 1887 annual report states: “More than fourteen years ago, two Christian women, belonging to Toronto, became deeply impressed with the great necessity which existed, for the establishment of a Hospital for Sick Children. In visiting the poor and sick, they found many little ones languishing and dying for want of pure air, good nursing, and proper nourishment. After many months of waiting on God in prayer, at length, led as they believed by the holy Spirit, they resolved to publish in the newspapers a plain statement of the needs of these sick children and await results.”

However, this quote lays out more than a history of the Hospital for Sick Children’s founding; it also lays out the prevailing mentalité of this time with respect to hospitals, society, and class issues quite clearly. First, Christianity, wealth, charity, and responsibility were linked in the mind of the author, as were poverty, poor choices, and illness. Health care for the poor is presented as a benevolent responsibility of the wealthy and hospitals are thus created as spaces of the poor, not the rich. Finally, not necessarily apparent but nonetheless
evidenced here, philanthropy was a path to leadership and social stature for females in this era, a path that was much easier to walk if they were associated with a religious organization.21

**Articulation A1: Social Obligation, Professionalization and State Responsibility**

The discourse of Social Obligation was productive in this era, but as the 20th century developed its role in academic medicine changed. World War I, World War II, and the Great Depression all increased the funding pressures on academic medicine and governments, driving costs sky-high. In World War I alone the price of coal, an important heating product for hospitals, doubled from $3.65 per ton to $7.50 per ton.22 Drug prices ranged upwards from doubling to more than 1,000% in some cases.22 World War II and the Great Depression only increased these financial pressures on academic medicine and vastly increased the cost of social services for governments, an impact that changed the State logics of the time. As these input costs were rising dramatically, the influence of Flexner and the discourse of Professionalization were transforming the cost structure of academic medicine by embedding research as a key practice of academic medicine.

The ability of academic medicine to address these cost increases was limited in this era. Tuition increases were limited.22 Service fee increases in hospitals were also limited by provincial legislation.22 Hospital endowment funds and annual
private subscription drives were unable to bridge the rising gap between revenues and expenses.\textsuperscript{22}

Federal and provincial governments had more room to maneuver to address increases in expenses. New tax initiatives such as the temporary \textit{Income War Tax Act}\textsuperscript{23} of 1917, the \textit{War Charities Act of 1917},\textsuperscript{24} the \textit{Dominion Succession Duty Act} of 1941 (establishing estate taxes),\textsuperscript{25,26} and the permanent \textit{Income Tax Act} in 1948\textsuperscript{25,27} were passed as a result. With the passing of these government bills, Canada began to undergo a notable shift in its governing logic. Where before Canada had been a country in which the government was lightly involved in the economy, in this era it shifted to one in which the government believed it had a more involved role to play, as a taxing body and as a funder of key public initiatives.

Pursuant to these new taxation measures and the change in State logic, responsibility for funding academic medicine also largely shifted to the state. As the discourses of State Responsibility and Professionalization were on the rise, the discourse of Social Obligation diminished in influence. In 1919, the Chairman of TGH, Sir Joseph Flavelle, observed that philanthropic giving to the hospital was falling—a consequence, he thought, of the affluent adjusting to the new taxes on their income.\textsuperscript{28} By 1934 this decline in philanthropic revenue was a concern for the superintendent of Toronto General Hospital, Chester Decker.\textsuperscript{1,29}
In this era, as philanthropic revenues fell, the institutions of Canadian academic medicine began to engage increasingly in commercial activities as a way to replace the lost philanthropic revenue. This rising commerciality and how it made Canadian academic medicine’s global commercial engagement possible will be explored in this and subsequent chapters.

**Articulation A2: Social Obligation and Professionalization**

The rise of the discourse of Professionalization was associated with an era of increasing optimism in society and a belief that the future would be found in scientific improvements. This belief drove investment in academic medicine to discover new drugs, new practices, and new treatment protocols. The articulation of these ideas and the discourse of Professionalism on the discourse of Social Obligation created a new type of donation. Where before the affluent had made donations to support institutional operations and to care for the less fortunate, they began to make sizable donations to support research in academic medicine.

In this vein, in 1919, Lady Eaton committed to a donation of $500,000 to fund the first research chair in the Department of Medicine in the University of Toronto.\(^{30}\) The Rockefeller Foundation followed soon after, with donations of $1,000,000 (1920),\(^{31}\) of $50,000 per year over 5 years (1922)\(^{32}\) and of $500,000 (1924)\(^{33}\) to support research in the Faculty of Medicine in the University of Toronto.\(^{31}\) These donations did not solve the growing challenge of adequately funding research in academic medicine, but they did contribute to the transformation of Canadian
academic medicine into a research domain with a new cost structure that neither philanthropists nor the Ontario government alone had the resources to fund.

Articulation A3: Social Obligation, Wealth Creation, and Professionalization: Leadership and Gender

In this era, admission to medical schools, the power centre of health care, was unavailable to women for the most part. The discourse of Social Obligation had created a pathway to leadership and influence for women as fund-raisers in academic medicine. The discourses of Professionalization and Wealth Creation disrupted this power structure, however. Together they brought a doctrine of scientific secularism to academic medicine, a mentalité directly in tension with the mentalités of Christianity and Christian charity that were part of the formerly dominant discourse of Social Obligation. The rising influence of these mentalités brought more power to the medical guilds and to business leaders in governance roles (on boards) in academic medicine. As a result, male leadership structures were further enhanced at the expense of female leadership.

Articulation A4: Social Obligation and Wealth Creation

The articulation of the discourse of Wealth Creation with the discourse of Social Obligation in this era produced a unique innovation: private, for-profit pavilions in hospitals. Both the Hospital for Sick Children and Toronto General Hospital participated in this trend, launching their own versions of for-profit pavilions in the early 1900s to great fanfare. The explicit motivation for launching these for-profit
wards was to generate cash flow to fund other operations.$^{35}$ The actual impact of this innovation was somewhat more complicated.

Financially, the impact of these wards was not what was expected. In business, timing is everything. The launch of these for-profit wards took place in the shadow of the Great Depression, when fortunes were being lost or diminishing and many previously affluent families were struggling. As a result, the market for for-profit wards was not what was projected. While the wards were an effort to build upon revenue from the private patients who had been treated in hospitals and had been a source of positive cash flow in the past, the results of the private patient pavilions never reached expectations. The creation of hotel-like environments and service levels brought patients and increased cash flows to the hospital. They also brought ongoing losses as expenses grew faster than revenues.

The launch of these for-profit wards had three unexpected outcomes. First, the creation of private pavilions changed the perception of the space of the hospitals. In his article reviewing the history of Ontario hospitals from 1900 to 1953, James Wishart makes a strong argument that these wards transformed hospitals from spaces for the poor into spaces for all.$^{35}$ This transformation was a pivotal moment that laid the groundwork for the emergence of the concept of universalism in Canadian health care. A second impact was the transformation in levels of care available in the hospitals. Architectural consultant B. Evan Parry describes this shift in 1932, stating that “the new standard for hospital
management was to be ‘efficiency for the poor, and service for the wealthy.’\textsuperscript{35,36} I would rephrase this statement as follows. A new standard of care was brought to hospitals to attract the wealthy, transforming hospitals from a place where people went to die or to be housed to places where they went to obtain lifesaving health care and to then reemerge to continue life.\textsuperscript{35} The third and final impact, I would argue, was the transformation of the wealthy from being simply benevolent patrons into “grateful patients”. This last transformation brought new life to the discourse of Social Obligation and the practice of fundraising. It produced the foundation for the development of a much more formalized philanthropy that would lead ultimately to the creation of corporate hospital foundations and paid roles in fundraising. These for-profit wards and the discourse of Wealth Creation introduced the mentalité of gratitude to the discourse of Social Obligation, expanding reasons for giving to academic medicine beyond the historic mentalité of benevolence and caring for the poor.

\textbf{Discourse B: Academic Medicine is a State Responsibility}

Prior to 1900, government funding of academic medicine had been limited and shared between various levels of government. This produced somewhat ad hoc and unpredictable funding streams that resulted in funding instability and institutional failures such as that of Toronto General Hospital itself in the late 1800s. In the early 1900s, this State logic for funding academic medicine was changing. The discourse of State Responsibility was rising in influence as
governments realized the relationship between investing in academic medicine and a healthy population. This shift had several notable effects. In 1904, the Flavelle Commission\textsuperscript{37} recommended that the Ontario government create annual predictable government funding for the university, a recommendation that was acted upon in 1905 with the *University Act*.\textsuperscript{2,37} In 1930, this shift also produced the Ministry of Health as an oversight body for hospitals and the new role of minister of health.\textsuperscript{1} In 1935, this discourse produced the Ontario Medical Welfare Plan, a new funding mechanism overseen by the medical profession.\textsuperscript{38} This development began the regularization of the funding of health care in Ontario. It also established a precedent for oversight of health care spending by medical professionals.\textsuperscript{38} This development established a relationship between funding and oversight by the medical profession that was to reverberate for years.

**Articulation B1: State Responsibility and Professionalization**

The articulation of the discourse of State Responsibility and the discourse of Professionalization produced several other effects in this era. At an ideological level, it produced a new, widely held belief in society that science and health care underpinned the development of a modern and productive society. Government investment in research in healthcare was the result. The Medical Research Fund was created in 1919,\textsuperscript{39} followed by the Banting and Best Chair of Medical Research in 1923.\textsuperscript{40} These funds represented the emergence of a new government logic that suggested that government should make significant investments in scientific research. In decades to come, this logic would produce
numerous more formalized structures for research funding, the Canadian Institute for Health Research\(^1\) being a compelling example.

The most far-reaching impact of these discursive shifts was the creation of an entirely new cost structure for academic medicine driven by a research focus. To this day, the belief that research in health care is about progress through science is unshakable. Though I will not dispute this truth here, I will suggest that its emergence created a cost structure that societies are wrestling with around the world. It was this truth, this rising imperative/belief in research that drove the funding requirements of academic medicine to such stratospheric heights that it was forced to look for new sources of revenue to support itself.

**Articulation B2: State Responsibility and Wealth Creation**

The articulation of the discourse of State Responsibility on the discourse of Wealth Creation created conditions that produced the *Public Hospitals Act* in 1920.\(^2\) This act had several effects. First, it transformed hospitals from charitable organizations into corporate enterprises.\(^1,2\) Second, it made possible the creation of the for-profit wards within the hospitals. It also made possible the corporatization of hospitals and the adoption of business management logics in the hospitals, a phenomenon that was happening across North America.\(^3\) This last change made academic medicine’s commercial engagement in the global space technically and operationally possible, since it brought a focus on profit
and the technical business skills necessary for health care to engage contractually with international partners.

**Discourse C: Academic Medicine Is a Professionalization Project**

This discourse was central to the development of academic medicine as a legitimate domain and a research enterprise. In early 1900s, it changed the power dynamics of health care, diminishing support for holistic medicine while enhancing support for what later became known as evidence-based medicine. In Toronto this shift was well underway, inasmuch as medical education had already moved into the university in the late 1800s. This discourse also brought to medical education a mentalité of *anti-commercialism*, a mentalité that remains broadly held in medical education across North America to this day.

Structurally, this discourse had numerous effects. It established academic medicine as a key domain in society for the subsequent century. It transformed physicians from tradespeople into leaders in society. It transformed medicine from a trade dependent upon a guild structure to a profession based in a university, regulated by its own colleges. In Canada, the articulation of this discourse on the discourse of State Responsibility transformed the payment structure for medicine from a patient-doctor to a state-doctor model. In fact, no other profession has benefited from the influence of this discourse to nearly the same degree as academic medicine.
It is in this very success, however, that the seeds of academic medicine’s future financial problems were sown. As I have argued, it was the rise of this discourse of Professionalization that produced the cost structure for academic medicine based upon research that continues to challenge hospitals, governments, and faculties of medicine. Reconciling this success with the financial challenges that would come with it continues to drive Canadian academic medicine to innovate and look for new funding sources. As I will describe in later chapters, it also led to the need to imagine new utopian spaces where financial solutions could be found.

**Articulation C1: Professionalization and State Responsibility**

Concurrent with the creation of a new cost structure for academic medicine was a closer alignment between its activities and Ontario government motivations. Initially this was a simple relationship. At the most basic level, academic medicine was charged with the mandate to produce doctors to service the needs of the population. In this era this mandate increased as Canada was sending a vast number of its young males to Europe to serve in the war.\(^{46,47}\) As a result, not only did academic medicine need to produce medical school graduates for the home market but it also needed to supply medical graduates for the war effort.\(^{46,47}\) To achieve this, the medical curriculum in the University of Toronto was modified so its graduates could be made available sooner for the war effort.\(^{46,47}\) This pattern of academic medicine adjusting its practices and its curriculum to meet Ontario government demands was to continue for the next century.
Articulation C2: Professionalization and Wealth Creation

The articulation of the discourse of Wealth Creation on the discourse of Professionalization was quite productive in this era. This articulation produced a belief that research could be monetized and that the resultant cash stream could help fund academic medicine. This manifested in numerous ways. In the university, it first appeared as the monetization of the newly discovered insulin and the creation of Connaught Labs, a new type of organization that bridged academia and industry. In the Hospital for Sick Children it manifested as the monetization of Pablum, a new, highly nutritious form of baby food, and McCormick’s Sun Wheat biscuit, two discoveries made in the hospital’s research laboratories. As in the university, this new practice also produced a new corporate structure, the Paediatric Research Foundation (the PRF)—an organization mandated to develop new products for commercialization for the benefit of the Hospital For Sick Children.

Financially this discourse was extremely productive for academic medicine. The example of the Hospital for Sick Children is the easiest to quantify. In 1932, the monetization of Pablum created a cash stream for the Hospital for Sick Children of $72,000. This cash stream continued to grow, reaching $500,000 in 1935; it eventually created a pool of capital of $7 million in 1978. The press described Pablum as “the mush that had made the Hospital For Sick Children rich.” This success and that of Connaught Labs firmly established
research as a legitimate domain upon which academic medicine could build commercial strength to somewhat offset the financial burden associated with the new cost structure that came from this focus on research.

**Discourse D: Academic Medicine is an Engine of Wealth Creation**

The discourse of Wealth Creation was rising in influence in the era from 1900 to 1940. It is important to understand that the mentalités establishing the boundaries of this discourse were not the same as those that construct it today. Simply put, the business logic that was produced by the discourse of Wealth Creation from 1900 to 1940 was different from the logic produced by that same discourse today.

Foucault explored the thinking of economic and the mentalités underlying in *The Order of Things*. In that work, Foucault tracked how the understanding of economics had changed over time: from being something God-given and the right of royalty, to being a product of mercantilism, to being understood as production and labour. In doing so he argued that economics, like other discourses, changes as the truths of an era change. Simply put, the idea of what economics is, and what business is, changes over time; they are not static constructions. Instead they are products of the truths of their era.
The findings from my research mirror those of Foucault’s on economics in that I found that the business models of the early 1900s had very different logics than those of the modern day. Where today business might be described as a calculation of risk versus reward, in the early 1900s business is better described as a calculation of reward versus responsibility to those less fortunate. Profit in the early 1900s was not of paramount concern. Instead, in the early 1900s a mentalité of noblesse oblige was present within the logics of business. The mentalité of noblesse oblige, typically found within the discourses of Social Obligation and State Responsibility, had permeated the discourse of Wealth Creation in this era. This can be seen in numerous examples.

**D1: Wealth Creation + Social Obligation? Or + State Responsibility?**

**Selling Milk for Profit**

In a commercial milk clinic launched by the Hospital For Sick Children in the early 1900s one can see the presence of two business logics; the belief that the working class needed a product (milk and nutritional supplements) and the belief that they would be willing to pay for it. Looking more closely at the financials of the milk clinic reveals a somewhat less obvious business focus. Profit is not a clear driver of this clinic. Instead, the clinic seems to be structured to be a support for the less fortunate, a way for the wealthy to help the poor.
It is unclear if the milk was actually sold at a profit as only half the transaction was documented.\textsuperscript{56,57} A review of the financial statements does not show whether or not the milk clinic was profitable, break-even, or loss making.\textsuperscript{56,57} Looking to the board minutes to better understand the logics of this transaction suggests that the clinic was most likely aiming to be cost neutral, that is to be covering the bulk of its costs. It was not a true commercial endeavour, in that it was more focused on providing a public health benefit.\textsuperscript{56,57} The logic of profit maximization, of commercial focus, was for the most part absent.\textsuperscript{56-58}

While it is difficult to say with absolute certainty that profit was not a driver in this era, it can be said that documenting commercial success within the institutions of Canadian academic medicine was not important in this era, whereas it was important to document the social good that was being provided to the poor. It can also be said that it was not important to provide detailed financials to the institution’s stakeholders, a distinctly different mentalité from that of today. Today, it is expected that financial reporting be detailed and transparent so that financial stewardship can be assessed.

**Cost Recovery and Noblesse Oblige or Profit?**

In 1909, a description of a business relationship with a physician in Toronto General Hospital clearly used a logic of cost recovery rather than a logic of profit maximization: “Dr. Sodd may collect his fees from private, semi-private
and semi-public patients and shall pay to the hospital half of the amount collected to cover the cost of material and apparatus used.\textsuperscript{59} Pricing logic was also based upon concepts of fairness and standardization rather than demand and profit maximization.\textsuperscript{60}

The mentalité of noblesse oblige can also be seen in the business logics of the day. In 1919, in a discussion of rental rates on properties held by the hospital derived from estate bequests, the chairman of the property committee of Toronto General Hospital stated:

There is great scarcity of homes in this city and that consequently rentals are quite high and that the landlord is reaping abnormal rewards. This scarcity was quite evident to anyone interested some two years ago and I then reviewed our entire house rental position and slightly increased our charges, but I was most careful that the increase should bear strict relation, first, to added taxes and second, to added cost for upkeep. In 1918 I again, with the same care for the underlying principle, raised most of the rents, being sure that in no case did the increase of income exceed the increase of forced outgo.\textsuperscript{61}

The chairman further stated: “I have felt that our relation with the citizens was one approaching partnership, and that therefore we would in every respect carry out our Trustee position by acting as I have outlined. We may, and indeed will, miss some present revenue that might be extracted from tenants but it is my view that our standing with the community will be sustained on a better footing over a course of years.”\textsuperscript{61}
This is not a statement one would hear today from a manager focused on shareholder value, on profit maximization. It is a statement made by a person clearly balancing Social Obligation, State responsibility, and stakeholder interest against wealth creation and profit maximization. There is a consideration of social good embedded in this logic.

The form of the financial reports was also a clear statement about the importance of business in this era. Financial statements for academic medicine institutions were either absent (university) or half-page documents situated more than half way through a report (hospitals). Today, financial reports in academic medicine are multiple pages of numbers, charts, and diagrams. Reports are multifaceted, including balance sheets, income statements, cash flow statements, debt instrument details, and numerous appendices and notes to financials. These various financial reports lead off annual returns and strategic reports, with textual details of activities following.

For a Foucauldian this is a clear statement. Academic medicine was not focused on economics in this era. Economics was clearly crucial to operations, but it was also clearly less important than the human dimensions of academic medicine.
The Space(s) of Academic Medicine

Gaining understanding about the ideological construction of Canadian academic medicine’s economic thinking is an important step in understanding how it became possible for it to become commercially engaged in the global space. It is equally important to understand its understanding of space in this era. My exploration of Canadian academic medicine’s ideological construction of space was guided by three basic questions.

1. What is/was academic medicine?
2. Where is/was academic medicine?
3. What is/was being produced in the spaces of academic medicine?

I would note that there are many levels at which to consider the space(s) of academic medicine. I focus on the macro level, not the level of practice. I am not looking at or theorizing about space as classroom or as examination room. Instead, I am thinking about space at a systems level: the spaces that shape academic medicine’s strategic directions, the spaces within which academic medicine is being deployed to help the state, the spaces it creates or maintains as a technology in society.

What Was Academic Medicine from 1900 to 1940?
The first question, “What was academic medicine in this era?” was somewhat harderto answer than might be expected. Several bills that were foundational to the construction of Canadian academic medicine and its institutional relationships were passed between 1900 and 1940. The first bill to consider was enacted as the *University Act* 1905.\textsuperscript{62} This statute established the Toronto General Hospital as a provincial hospital under the joint oversight of the Lieutenant-Governor-in-Council on behalf of the province of Ontario and the University of Toronto via contract. In the eyes of the university this act constructed it as the senior governing body of academic medicine and as having governance oversight of the hospital. It also guaranteed the university that “clinical facilities were to be provided in, and by, The Toronto General Hospital for the Faculty of and the students in medicine of the university”.\textsuperscript{62} The *University Act* created a blended idea of space and an understanding that TGH is an educational vehicle of, to be used as needed, by the University of Toronto.

A second statute, the *Toronto General Hospital Act* of 1927,\textsuperscript{63} somewhat complicated this interpretation. It transformed the Toronto General Hospital from a charity to a corporation, establishing a new tripartite governance structure made up of the University of Toronto, the Lieutenant-Governor-in-Council on behalf of the province of Ontario and the municipality of Toronto.\textsuperscript{63} To the university this was a small change with little impact on its oversight and ownership of the Toronto General Hospital in the space of Canadian academic
medicine. To the hospital, however, the impact of this act was more profound in that it transformed the hospital into an independent corporation, much more in charge of its own management. For the hospital, this created a understanding of its being in its own distinct space with control over itself.

The potential for different interpretations of these bills even to this day provides interesting spatial and management effects. At the most basic level, these statutes created a legal relationship between the university and the hospital. That is, by government enactment, Canadian academic medicine was made more real and located in space. The acts also created a complex governance structure for the hospital that was ripe for misinterpretation. For example for the university, they validated the idea that together the hospital and the university were a co-constituted academic space, with the university in charge. For Toronto General Hospital however, they were evidence of a progression in thinking that transformed the hospital into an institution in charge of its own destiny. Given that these were two different interpretations of the effects of the statutes, it seems inevitable that misunderstandings would arise.

Looking at this construction through a Foucauldian lens, these two acts constructed Canadian academic medicine as both a utopia and a heterotopia. For the university, they created an ideal expansion of its space. It obtained clinical spaces for teaching its students and its authority was documented in statute. As
this interpretation was not necessarily congruent with the hospital's view, Canadian academic medicine can be conceptualized as a utopia, an imaginary space of potential. It was a space in which the university management could dream and imagine a new idea of academic medicine. For the hospital, these bills established a contractual linkage, an obligation to provide physical space and role in the production and education of physicians and other health professionals, a heterotopia per se, a space of operations and somewhat bumpy relations.

This theorizing of the space of academic medicine is borne out when one analyzes the minutes of the two institutions from this era. Simply put, depending on which institution’s minutes one is reviewing, a very different image of Canadian academic medicine is presented. If one is reviewing the university decanal minutes, there is clear evidence that the hospital’s spaces are present and part of the university’s governing strategy. If one were only reviewing Toronto General Hospital’s minutes, or the Hospital for Sick Children’s minutes for that matter, one would have no way to know that either hospital was part of a larger educational structure and in partnership with the faculty of medicine.

Restating these findings in more prosaic terms is helpful. The two hospitals and the faculty of medicine existed in this era as three separate physical institutions located in the downtown core of a major urban centre. They operated as
independent entities linked by statute and an academic medical mandate; however there were varying perceptions of that linkage and that shared mandate. This variance in perceptions of space and governance created a foundation for a somewhat problematic relationship. Yet, it conferred a level of influence and a sense of ownership upon the university.

Where Was Academic Medicine from 1900 to 1940?

In the early 1900s, the institutions of Canadian academic medicine were very locally focused. For all three institutions, the local was a space of work, of service, and of funding. Patients and students came from the local space for the most part. Together the hospitals and the university worked in partnership to support health human resource needs of the province of Ontario. In many ways the term “local space” was, and still is, synonymous with the service or catchment area of the organizations and the space that they were being funded to serve.

Both the hospitals and the university had some engagement outside of their local space—in the global space—in this era. For the hospitals, global engagement appeared in their minutes in the 1920s as a northward flow of ideas from the United States to Canada. This manifested in a variety of ways. Various associations such as the American Hospital Association and various accreditation bodies engaged with Toronto General Hospital and the Hospital for Sick Children to evaluate or comment on their operations. Flexner’s work on
medical education is another obvious example of this northward flow of ideas.\textsuperscript{31,44,65}

This flow of ideas and funds effected a change in the focus and management ethos of Canadian academic medicine. At the operational level, as noted in earlier sections A2, B1, and C2, it transformed Canadian academic medicine into a research-oriented domain. At an ideological level, this northward flow of ideas transformed Canadian academic medicine from a traditional academic institution into what might be described as an academic factory that needed to find new ways of generating funds to survive and grow.\textsuperscript{44}

Engagement in the global space manifested in the decanal minutes of the university a decade earlier than in the hospitals. It also appeared with a different spatiality. In the university, the global meant a European space rather than an American or North American space. The global was also a space for idea or knowledge sharing where legitimacy and reputation were formed. Scholars came from and went to the global space. The global was a space of conferences. For Canada in this era, the global was also the space of the British Empire, especially the British Isles. It was a space that defined a certain kind of legitimacy, one grounded in Western ideas and values.
What Was Being Produced in the Spaces of Academic Medicine from 1900 to 1940?

In my analysis, I coded “global” to refer to two distinctly different ideological spaces with different products. For the academic hospitals, “global” meant the space of North America in this era. For them, it functioned as a space that produced new management ideas and improved operational efficiencies. For the university, “global” meant the British Empire in this era. For the university, the global functioned as a space of knowledge sharing and reputational creation, a space that legitimized the institution and its scholars. Global engagement was a requirement for it to be perceived to be serious academic centre. The global was a space of potential, of identity construction, and a source of “academic capital.” The university entered and colonized the global space long before the hospitals demonstrated any awareness of it and what their role in it would be. The global, both a real space where people could go, was also an imaginary space, an ideological space, which conferred authority upon the university and increased its stature.

For both the hospitals and the university, the local and global spaces functioned discursively in similar ways. The local space was one constructed upon service, duty to the state, capacity building, operations, and human resources supply. It was a heterotopia, an imperfect space of operations, compromise, and funding. The global space was constructed based the promise of answers to perceived
issues or problems. It was an imaginary space of reputational formation. For the university, in this era it looked to the global for influence, for institutional reputation formation and for validation. For the hospitals, the global provided more sophisticated management solutions to help them realize their increasing importance in society. For both institutions, the global space was a utopia of ideas and of stature. For academic medicine, the global enhanced the leadership role of the university in its partnership with the hospital through augmenting its academic capital, a strategic advantage it would use regularly over the next hundred years.

Conclusion

This era—from 1900 to 1940—was one of optimism for the world when science, medicine, and academia were becoming seen as foundational to societal development. Academic medicine was being constructed as a key part of that development. At the same time, construction of research as key to Canadian academic medicine and to societal development was creating a new, exponentially higher cost structure, an unintended and not fully understood impact of this pivot to being research-based institutions. As part of this movement, the Ontario government was recognizing its increasing role in the funding of Canadian academic medicine and beginning a long period of increasing investment in research.
Concurrent with this increasing governmental support of academic medicine, Canada was transforming into a higher-taxation country. World events were also driving up the demands for government resources. Two world wars and the Great Depression transformed the financial demands on governments, requiring further taxation measures. Increasing tax rates in Canada had a direct impact on philanthropic giving, complicating the finances of hospitals and faculties of medicine.

The institutions of academic medicine also became more participatory in their own financing in this era. They launched various new initiatives such as the monetization of services and research, creating significant new cash streams in the process. A transformation of the hospitals from charities to corporations made possible the launch of further innovations, such as for-profit private wards targeting the affluent of society. These for-profit wards greatly increased the cash flow of the various institutions but did not generate the hoped-for profits.

Despite all these changes, the launch of these new funding initiatives, and the adoption of new revenue generation practices, the institutions of academic medicine ended this era as financially precarious as they began it. Losses were substantial, finances were tight, and the future was looking uncertain without new funding or revenue streams emerging.
Spatially the institutions of Canadian academic medicine were engaged both locally and globally. The local was a space of operation, of partnership, of obligation to the province and its residents. The local was a real space, a space of practice, a heterotopia, and an imperfect space of operations. The global was a space of ideas, of influence, of self-creation, a space that suggested the potential of great things to come for both the hospital and the university. For the Canadian academic medicine context of this era it was a space that drove change. In the case of the hospitals it brought innovations in management and leadership. In the case of the university, the global drove reputational formation and academic legitimacy. The global in this era was a space of imagination, a utopia, a space in which power and stature were obtained and in which future versions of the respective institutions were forged.
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Chapter 7: 1940 to 1990

An era of State largesse, State panic and emergent revenue generation

Introduction

The era from 1940 to 1990 is without a doubt a period of historic importance to Canada inasmuch as one of the most Canadian of creations, Medicare, was born. This idea is, for many, the narrative of this period. Others writing a Canadian narrative of this era might instead focus on Tommy Douglas, Pierre Trudeau, Lester B. Pearson, peacekeeping, or Expo 1967 as the defining person, concept, or moment. All of these other narrative arcs have one thing in common; they would all be stories made possible by the discourse of State Responsibility.

The narrative from this era I am telling is one less known; the story of Canadian academic medicine’s formation. It is, however, as Canadian a story as any of the above narratives. It is a narrative that in many ways has to be understood in terms of three threads; one focused on Canadian academic medicine as a single institution, and two subordinate threads focused on its constituent institutions, the academic hospital and the Faculty of Medicine. It is in looking simultaneously at
all three of these narrative threads that two things become visible: the power dimensions of Canadian academic medicine and its transformation into an institution engaged in global revenue generation.

Deploying this “tri-ocular” gaze on Canadian academic medicine brings a history into a somewhat blurry focus. A first observation is that Canadian academic medicine grew enormously from 1940 to 1990 as a result of the massive increases in funding made possible by the discourse of State Responsibility. However, focusing on the institutions of Canadian academic medicine reveals that the largesse of State\(^5\) funding was not shared equally among the academic hospitals and the Faculty of Medicine; the academic hospitals benefited significantly more than the Faculty of Medicine leaving the Faculty feeling relatively poorer and somewhat overlooked. It is in this funding gap that the seeds of global revenue generation were sown and new ideas, new objects, and new practices were produced.

More specifically, as the influence of the discourse of State Responsibility was being felt throughout Canadian academic medicine in this era, the influence of the discourse of Wealth Creation was also rising. It is this rise in influence that produced Canadian academic medicine’s journey to global revenue generation. It was also thanks to the rise of this second discourse that a shift in the power

\(^5\) I would remind the reader that I am using the term “State” to represent the Foucauldian idea of a collective concept of governmental organizations and not the political economy concept of a national level of government.
structure of Canadian academic medicine occurred, in which academic hospitals somewhat usurped the Faculty of Medicine’s position of authority in academic medicine. It was in the negotiation over power and resources in this era that a shift occurred in the understanding of the global space. More specifically, the global space was transformed from one of simply reputational formation and legitimization to one of financial succor and financialization. This chapter describes that story, the story of the discontinuities that made Canadian academic medicine’s new practice of business engagement in the global space possible.

To tell this story, I will follow a similar narrative arc to the one I used in the previous chapter. First, I will provide a brief historical overview of the period, in which I will discuss the evolving social conditions of the era and their effects on Canadian academic medicine and its constituent institutions. Following this, I will explore what the four discourses of Canadian academic medicine—Social Obligation, State Responsibility, Professionalization, and Wealth Creation—produced in this era, in isolation and then in articulation with each other. Finally, I will explore Canadian academic medicine’s spatiality in this era and how its interaction in and understanding of the global space changed in this 50-year period.
This narrative arc provides a solid framework to bring to life and understand this transformation through time. I would caution, however, that the use of Foucault’s theories does not provide a completely neat, completely consistent account. Ideas are in tension, eras of practice overlap. As with life, the picture painted using Foucault is very rich, but it is messy. Making sense of these findings requires some cognitive flexibility and an acceptance that the transformation of a socially constructed phenomenon or object is a syncretic process, one made up of many logically inconsistent ideas and forces, all happening at the same time.

1940 to 1990

The period from 1940 to 1990 was one of scientific discovery. In many ways it is hard to appreciate how many discoveries were made, let alone the breadth of products, scientific innovations, and new thinking that have their origins in this era. To name but a few: the computer (1940s), the microwave oven and the laser (1960s), the laser disc (1970s), and Pac-Man (1980s). Doctor Benjamin Spock started providing guidance to parents on childcare (1940s), surgeons started doing organ transplants (1950s), and researchers discovered the polio vaccine and DNA (1950s), the birth control pill (1960s), and the human immunodeficiency virus (1980s) over this 50-year period.

The period from 1940 to 1990 was also an era of changing economics in Canada, an era of State expansion and the development of the liberal welfare state. Roughly speaking, 1940–1960 was a period of increasing tax rates,
welfare costs, and increasing payments for health care and research.\textsuperscript{8} The 1950s brought a baby boom and a period of prosperity and economic growth to Canada that continued for two decades.\textsuperscript{8} The oil embargo of 1973 imposed by the Organization of Petroleum Exporting Countries (OPEC) and the subsequent oil shock brought an end to this era of robust economic growth.\textsuperscript{8-10} Two decades of inflation, exuberant real estate prices, substantial increases in the consumer price index, and a decade of anti-inflationary policies by central banks followed.\textsuperscript{8,11} In many ways this era ended as it began, in financial uncertainty with a State wrestling with its role in society and the challenge of funding health care and medical education—or more specifically, academic medicine.

\textbf{Financial Concerns of the Faculty, the University, and the State}

As the State wrestled with its finances in this era, the institutions of Canadian academic medicine—the academic hospitals, the Faculty of Medicine, and the university—began to develop their own financial concerns. Initially flush with the new funding from the State, the academic hospitals enjoyed decades of upward financial momentum. This trend was to change when the rising costs of health care brought financial issues, eventual cutbacks, and serious concerns regarding the State’s ability to continue funding health care. By the 1980s, the hospitals were receiving a clear message from the State that fiscal restraint was required and that external cost controls would be imposed upon them.
As the Canadian state focused on funding health care in this era, medical education went somewhat wanting financially. This funding dynamic changed the relationship between the academic hospitals and the Faculty of Medicine; the Faculty began to feel like the poor relation of the academic hospitals.\textsuperscript{32} This was an unexpected shift in the power relations between the two institutions that had material effects. One of those effects was that discussions regarding finances became increasingly present in the minutes and communiqués of the institutions. Finances began to be discussed regularly in the context of operational impact and human resource issues, in board minutes, in decanal minutes and in correspondence.\textsuperscript{12} In the Faculty of Medicine, financing challenges were blamed for increases in teaching loads, staff turnover, and recruitment issues.\textsuperscript{12} In this era, financial health became a constant topic in the institutions of academic medicine, whereas in the early part of the century finances had rarely been discussed.

Financial issues first started manifesting early in this era, in the Faculty of Medicine. In 1942, the Faculty began expressing concern regarding potential resistance by research funding bodies to supporting ongoing maintenance issues and overhead costs within the university.\textsuperscript{12} By the early 1950s the Faculty was concerned that the public and the stewards of public funds seemed to lack an understanding of the cost and complexity of delivering modern medical education and health care.\textsuperscript{12} By the 1980s, the Faculty of Medicine was concerned that the
broader university was abusing its good citizenship and financial strength, effectively disadvantaging it relative to the other faculties of the university. In a letter to the vice provost, health sciences dated February 2, 1982, the dean of medicine laid out his concerns in great detail, stating:

Your memorandum of December 9, with its advice about the proposed reduction in the Medical School’s base budget by $431,000, was received with dismay. We were further disturbed on learning that the preliminary reduction assigned to Medicine is greater in both absolute and relative terms than the Budget Guidelines for 1982-83, there are seemingly only two explanations. Either the administration fails to share what we believe is a national and even international perception as to the quality, distinction and vitality of this Medical School and question its centrality to the purpose of the University; or, the administration, opportunistically, is exploiting the foundation of good will, cooperation, and initiative upon which this vitality is so fundamentally dependent. I would like to think that our performance is acceptable and, if this is true, the latter explanation must be accurate.

. . . In addition, failure in the past to provide even token acknowledgement of many clinical teachers’ voluntary contributions; the curbing of initiative and a seeming reluctance to understand the complexity of our hospital clinical obligations in the pursuit of formulistic complement planning and consolidation. . . have all contributed to deliberate and overt efforts to curb expenditures, to generate new resources, and to maximize fiscal flexibility with a multi-year framework . . . it behooves the University to reassess just what lessons it wants its various divisions to learn.

To the extent that the Faculty of Medicine has displayed evidence of fiscal flexibility over the past decade, it has been able to do so primarily because of the indulgence of its staff and of its own initiatives . . . their preparedness to forego collective security for the sake of academic association—all these have given rise to the comparative fiscal flexibility we have enjoyed and for which now we must now, seemingly, be penalized.
The letter concluded: “I do hope that this submission will receive the very careful and deliberation [sic] consideration of our colleagues. It aims at being as frank and complete as possible given the limitations of having to describe in specific terms the magnitude and complexity of this large Faculty. Your patience both in awaiting its arrival and now in dealing with it is much appreciated.”\(^{13}\)

Unfortunately, financial concerns were not unique to the Faculty of Medicine. At the central university level, they were also pressing. The 1983 “Preliminary draft (Not for Circulation) Report of the Presidential Advisory Committee on Institutional Strategy” detailed the breadth of these concerns:

> For the foreseeable future the financial welfare of the University will inevitably be determined by the size of the income stream that is under the control of government, namely formula grants and student fees. All other sources of income together, irrespective of how energetically developed, will not be able to save the University from descent into mediocrity if government underfunding continues. For this reason, any institutional strategy for the next few years must give first priority to an initiative aimed at improving government support of the university system in Ontario as a whole, and at establishing within the system the particular place and responsibilities of the University of Toronto...\(^{14}\)

While the government was still clearly seen as the primary source of university funds at the time of writing this report, a shift in institutional logic was happening that made the consideration of alternative funding methods possible, including partnering with industry and labour to influence the Canadian State’s funding decisions, as the report continued stating:
Governments are greatly influenced in their actions by currents of thought within both the business and labour communities. It is therefore reasonable for the University to work directly with both these communities also in its efforts to influence government funding.

Industry is giving a higher priority to research that will help rebuild or establish its technological base. Universities see such partnerships as one way to deal with an intensifying financial squeeze that results in outdated and poorly-maintained equipment, inadequate research facilities and diminished opportunities for research by faculty and graduate students.14

The letter also proposed pursuing greater engagement with philanthropists:

“Special efforts should be made to foster close relations with major donors, such as those on the President’s Committee, and to identify those individuals whose success and achievement in our community might allow them to make special gifts to the University.”14

The report also discussed various financial mechanisms whereby the university could engage with industry, as well as the risks associated with each type of engagement:

[There are] three different ways of handling University-Business ventures: research ancillaries. These are not-for-profit, self-sustaining research entities with the university. Their primary purpose is to fund research. b) Profit-oriented corporations responsible for the commercialization of University research. This may involve licensing to transfer the technology; obtaining contract funds to support further development, or participating in the formation of new company ventures. . . . c) Research relationships. These are partnerships between individual faculty
members or University departments and one or more companies or industry associates.¹⁴

Participation in partnerships with business exposes the University to academic and financial risk . . .

The commercialization of new technologies is inherently risky. We do not believe that the University has the policies, or experience to independently manage new commercial ventures or the financial resources to absorb the financial risks . . .

Each of the various potential approaches to University-business relationships poses a different expectation for revenue generation."¹⁴

These comments were made at a time of challenging finances in Ontario. Economically Ontario was not doing well in the 1970s and 1980s.¹⁵ Manufacturing was struggling, inflation was rampant, tax revenues were down, and there was a broadly held perception that Ontario was not competitive in the world.¹⁵ In this context, the government of Ontario’s ability to fund the rising costs of academic medicine was being called into question. The “Report of the Community Health Centre Project to the Conference of Ministers”¹⁶ (called the “Hastings Report”), was released in 1972, evidencing a desire on the part of the government of Ontario to shift the cost curve in health care.¹⁶ Embedded in this report was a philosophical question—“What actually is high-quality health care?”—that was quite antagonistic to the foundational ideas of academic medicine. In this report, research-led health care based in academic medical centres was called into question as something too expensive and ultimately unsustainable by the State. The report proposed a new policy direction, a less research-oriented focus in
health care and the creation of a new type of health care institution: community health centres.\textsuperscript{16} This report, a follow-up and a reaction to the 1969 Task Force on the Cost of Health Services,\textsuperscript{6,17} was ultimately ignored but it sowed the seeds of new thinking with respect to the funding of academic medicine in Canada.

By the late 1970s, the financial concerns expressed in the 1960s were having tangible effects. The structure and the historical relationship underpinning Canadian academic medicine were under siege. Assumptions and beliefs were being called into question. The discourse of State Responsibility’s boundaries were being challenged as concepts having their origin in the discourse of Wealth Creation such as “economic and effective use of resources”, began to appear in governmental and institutional discussions.\textsuperscript{16} Government also began to reach out to the medical profession, intending to engage it in the design of a new model of care that was more managerial in nature,\textsuperscript{16} more Fordian,\textsuperscript{18,19} more focused on efficiency.\textsuperscript{20,21}

In the Faculty of Medicine and in the university, these forces were having effects. The financial viability of the Faculty of Medicine was being called into question. The value of the Faculty of Medicine being situated in the university was being challenged. Most simply, the basic tenets of the Faculty’s arc of professionalization were being called into question. The discourse of State

\textsuperscript{6} This report projected funding increases for health care in Ontario of 10% per annum.
Responsibility’s over focus on health care destabilized the discourse of Professionalization and created a vacuum into which the discourse of Wealth Creation could rise. This shift in the construction of the discursive formation of Canadian academic medicine made new thinking possible and changed its institutional character at a foundational level. That is to say, commercial and financial thoughts began to circulate broadly and explicitly throughout the Faculty of Medicine and the greater university.

A New Era in Accounting Emerges

This rise in the acceptance of commercial thinking in Canadian academic medicine can be seen at a granular level in the changes in financial accounting practiced by its institutions over the fifty-year period from 1940 to 1990. These new ways of reporting are Statements in the Foucauldian sense in and of themselves. At the most basic level the clear Statement is that commercial thinking was becoming increasingly dominant in the administration and strategic planning of Canadian academic medicine in this era. Canadian academic medicine began to transform into something more corporate and more commercially minded.

One other Statement that can be seen is the change in the construction of decanal reports and strategic plans that happened during this era. As described in the last chapter, financial results in the early part of this century were placed deep into these reports, appearing as unimportant discussion points, almost as
afterthoughts. In the early part of the 1900s, the Statement made was that finances were not a topic of discussion with respect to hospitals. Instead, the Statement was that the accomplishments of the institution and its health professionals were what needed to be discussed. Diagrams and pictures in the reports were of buildings and people, of health professionals and patients. Over the period from 1940 to 1990, the placement of financial statements and the amount of detail in these reports changed dramatically. Financial statements moved forward to become lead-in discussion points. Simple half-page summations of financial revenues and expenses became multiple pages of charts, statements, and images. Ideas, terms, and concepts from business began to permeate throughout the text of the reports. Terms and concepts such as “cost centre,” “depreciation,” and “financial model” began to appear. Photos and biographies of the executives managing the institutions replaced profiles of health professionals and patients. As Foucauldian Statements go, this one is quite clear: financial thinking and financial managers had risen in importance in Canadian academic medicine relative to medical thinking, health professionals, and patients.

A variety of other Statements can be seen in the granular changes in accounting practices over this era. Table 7.1 details the accounting logic, the changes in it, and the growth in the finances of the Toronto General Hospital over fifteen years using 1952, 1959, and 1967 as examples. To guide the reader through these
changes in accounting categories and accounting logic, I will focus attention on three categories and the implications of their changes from 1952 to 1959 and to 1967.

Table 7.1: Financial Statements (Income) for Toronto General Hospital

<table>
<thead>
<tr>
<th>Financial Detail</th>
<th>Summary of Operating Results for year ended December 31, 1952 (including Wellesley Division)</th>
<th>Summary of Operating Results for year ended December 31, 1959 (Including Wellesley Division)</th>
<th>Operating Results for the year ended December 31, 1967</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue from hospital services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received from patients (including insurance plan payments on behalf of patients)</td>
<td>$4,739,812.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from in-patient services (Note 2)</td>
<td></td>
<td>$11,174,187.98</td>
<td></td>
</tr>
<tr>
<td>Ontario Hospital Services Commission</td>
<td></td>
<td></td>
<td>$18,917,069.00</td>
</tr>
<tr>
<td>Received from province of Ontario for public ward beds, indigent patients, and clinics</td>
<td>957,541.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from outpatient services (including outpatient clinics and emergency departments)</td>
<td></td>
<td>602,130.25</td>
<td></td>
</tr>
<tr>
<td>Workmen's Compensation Board</td>
<td></td>
<td>1,348,790.00</td>
<td></td>
</tr>
<tr>
<td>Received from municipalities for indigent patients</td>
<td></td>
<td>418,357.75</td>
<td></td>
</tr>
<tr>
<td>Revenue from other services (including cafeterias, student fees, and extra services to patients)</td>
<td></td>
<td>423,170.80</td>
<td></td>
</tr>
<tr>
<td>Payments from patients, insurers, cafeteria and other sales, and investment income</td>
<td></td>
<td></td>
<td>3,624,468.00</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>$6,115,712.01</td>
<td>$12,199,489.03</td>
<td></td>
</tr>
<tr>
<td>Received from Endowment fund investments, sundry revenue and donations (excluding donations made in trust or for specific purposes)</td>
<td>120,132.70</td>
<td>177,668.67</td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$6,235,844.71</td>
<td>$12,377,157.70</td>
<td>$23,890,327.00</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>(4,232,634.45)</td>
<td>(8,275,374.04)</td>
<td>(17,368,228.00)</td>
</tr>
<tr>
<td>Provisions and kitchen supplies</td>
<td>(649,773.73)</td>
<td>(637,247.77)</td>
<td></td>
</tr>
<tr>
<td>Drugs and medicines</td>
<td>(298,665.15)</td>
<td>(581,289.40)</td>
<td>(2,911,968.00)</td>
</tr>
<tr>
<td>Surgical instruments and supplies</td>
<td>(457,395.91)</td>
<td>(919,953.07)</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>1952</td>
<td>1959</td>
<td>1967</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Linen, laundry, and housekeeping supplies</td>
<td>(187,558.01)</td>
<td>(312,506.75)</td>
<td>(2,547,751.00)</td>
</tr>
<tr>
<td>Dietary, Laundry, Linen, Housekeeping, Operating and Maintenance Supplies, and administrative expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heat, light, power, and maintenance (including cost of operating steam plant less revenue from steam plant)</td>
<td>(445,881.31)</td>
<td>(635,892.06)</td>
<td></td>
</tr>
<tr>
<td>Printing and stationery, telephone, insurance, and postage</td>
<td>(115,293.96)</td>
<td>(302,045.46)</td>
<td></td>
</tr>
<tr>
<td>General administration, including legal, audit, collection, and financial expenses</td>
<td></td>
<td>(194,155.70)</td>
<td></td>
</tr>
<tr>
<td>All other expenses</td>
<td>(93,539.67)</td>
<td>(33,744.65)</td>
<td></td>
</tr>
<tr>
<td>Provision for depreciation of the hospital building and equipment</td>
<td>(220,932.28)</td>
<td>(745,290.12)</td>
<td>(1,009,698.00)</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>(6,701,612.47)</td>
<td>(12,637499)</td>
<td>(23,827,644.00)</td>
</tr>
<tr>
<td>Amount by which the operating expenses exceed the revenue for 1952 (see note 1)</td>
<td>(465,767.76)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount by which the operating expenses exceed the revenue for 1959 (Note 2)</td>
<td></td>
<td>(260,341.32)</td>
<td></td>
</tr>
<tr>
<td>Net income (Note 4)</td>
<td></td>
<td></td>
<td>$62,683.00</td>
</tr>
</tbody>
</table>

Note 1: The above figures do not include a supplemental grant of $144,281.07 received from the city of Toronto in 1952 in respect of 1951 city indigent patients. The grant in respect of 1952 indigent patients has not yet been determined.

Note 2: In 1959 the Ontario Hospital Services Commission commenced to reimburse the hospital for the principal costs of services to insured inpatients. The 1959 costs so recovered or recoverable have been included in revenue from hospital services above.

Note 3: The above figures do not include a supplemental grant of $180,374.90 received from Metropolitan Toronto in 1959 in respect of 1958 indigent patients.

Note 4: The financial statements for 1967 did not provide a final Net Income category. I have inserted one to provide a comparable net income to the other examples.

The first financial category I would draw attention to in the above table is the primary income category of the hospital. In 1952, this category was called “Received from Patients (including insurance plan payments on behalf of patients)”, a name that captured the financial transition from direct payment to the hospital by patients to public payment for health care. In 1952, this primary
income category showed $4,739,812.39 in income. By 1959, this category had been renamed “Revenue from inpatient services” and had more than doubled to $11,174,187.98. This new primary income category captured a new era of more pure public payment supplemented by a third-party payer on behalf of patients and the significant expansion of health care services that resulted. Fueling this change was the influence of the discourse of State Responsibility, which produced Canada’s Hospital Insurance and Diagnostic Act, an act that established national public payment of hospital health care costs. By 1967, the terminology for this category had again changed to become “Ontario Hospital Services Commission,” a new name that formally marked health care as a provincial jurisdiction and indicated a permanent era of national health care funding. With this new name came a new stability in health care funding and a further increase in revenue to the Toronto General Hospital, totaling $18,917,069.00. Looking at these changes in terminology as Foucauldian Statements, two things are apparent. First, health care had transitioned from something of a private good, available to those with resources or great need, into a social good broadly available to all. Second, it had transitioned from being the responsibility of individuals to being the obligation of the Canadian state.

The next accounting category I would draw attention to is the second revenue category on each of the three statements. This category changed in concept and focus in each of the three years profiled. These changes present a clear
Statement of evolution, of change, in the Canadian State’s understanding of its health care obligation. In 1952, this category was named “Received from province of Ontario for public ward beds, indigent patients, and clinics.” With this name, the State’s responsibility for health care was framed in terms of a characteristic of the patient, social class. This term harks back to Canadian hospitals’ legacy identity; that of institutions more involved with the social regulation of society than with the provision of health care services. By 1959, the second category had become “Revenue from outpatient services (including outpatient clinics and emergency departments)”. With this new name, the State’s responsibility for health care was now framed in terms of a patient’s medical status and how they were being treated. Financial status was no longer important in the determination of whether or not the State would fund a patient’s care. This new accounting name also captured a shift in health policy’s importance to the State, from lesser to major. By 1967, this second category had again changed and become “Workmen’s Compensation Board.” With this new name, the State’s expansion of its health policy file could again be seen. Costs for health care were being shared by a variety of governmental ministries and industry. Each of these terms, while economic in nature, can be read as a rhetorical representation of the Canadian State’s policy intent with respect to health care. Looking at the changing terminology as a Statement, the rising economic importance of health care to the State is evident, as are its efforts to rationalize health care’s rising costs.
The final issue to which I would draw attention is the changing institutional relationship with alternative income streams. In 1952, reading the financial statements, there is no evidence that alternative revenue streams exist for the hospital. There is no unique category listed that documents the hospital’s “other” income from cafeteria sales, student fees, or other businesses in the hospital. In the naming of types of income in 1952, it would appear that all income is derived from patient care. As this was not the case, the conclusion is that either it was not important to document these types of income or that it was important that they remain undocumented and hidden for an external audience. Internally these various alternative income streams were tracked, so clearly they were important at some level. By 1959, these revenues began to appear on the public financial statements as “Revenue from other services (including cafeterias, student fees, and extra services to patients).” Clearly something shifted between 1952 and 1959 such that it became important to document these revenues, as distinct from patient care, for a public audience. It might be possible to track the origin of this new logic to a new directive in the accounting profession, or possibly to a new business focus by the board of directors. I have not undertaken the research necessary to determine the answer to this question. Irrespective of that logic’s source, however, it is apparent that the influence of the discourse of Wealth Creation was being felt by the management of the hospital and that a more commercial mentality was emerging. By 1967, a further shift happened and the
revenue category became “Payments from patients, insurers, cafeteria and other sales, and investment income”. “Investment Income” has been added to this revenue category, blending two types of distinct non-health care income streams. I would make two observations about this shift. First, in the previous two years, 1952 and 1959, any investment income or endowment income was located below the operating income total. (It appears in Table 7.1 under the heading “Received from Endowment fund investments, sundry revenue and donations (excluding donations made in trust or for specific purposes.”) That is to say, investment income was separate from the operations of the hospital and not part of strategic management planning. It was recognized for accounting purposes as a supplemental, noncore income stream that functioned simply to offset any loss from operations. In 1967, the accounting term captured a shift in how investment income was understood. Investment income and its generation had become a core part of the Hospital’s operational focus. This is a material change and speaks of a shift in logic—either a growing financial concern or a growing importance of documenting a higher operating income irrespective of how it was generated. Again, I am not sure why this was done but my instinctive interpretation of this is that it was important for the hospital to present itself as participating in its own funding and as not fully dependent upon the State. The second observation I would make is that investment income was blended in the financial statements in 1967 with income from active commercial enterprises such as cafeteria income. Based upon modern accounting theory, this is an odd
choice because passive investment income is characteristically distinct from active business income (i.e., income from businesses you manage). Today, these two types of income would be accounted for in separate lines to recognize their distinctly different characteristics. In doing so, accountants make it possible for a reader of the financial statements to evaluate the changes year over year in the active business income and in the investment income. That the accountants blended these income streams means something at a business level and at a policy level. These choices were made to send a particular message to the readers of these statements and as result a Statement is being made. Again, my interpretation is that this message was directed at those negotiating the hospital’s annual budget and its funding request; however, saying that with any certainty is beyond the scope of this analysis. For now, I would limit my interpretation of this Statement to say simply: This was an era in which business logic was on the rise and the discourse of Wealth Creation was gaining power.

The rise in business logic and the use of accounting as a strategic tool can also be seen in other accounting changes. A good example of this is the emergence of the concept of depreciation\textsuperscript{26} as a cash management tool in the hospital’s financial statements. Depreciation is an accounting concept that is used to capture the decrease in value of a purchased piece of equipment in every year of that equipment’s life.\textsuperscript{26} It was developed as a concept when business was moving away from cash-based accounting and taxes were increasing, so that it
began to be important to spread the cost of acquiring equipment over the life of the equipment. The emergence of this term marked an increasing complexification in financial thinking that developing to deal with an increasing complexification in corporate taxation. Using the concept of depreciation, companies could improve their after-tax financial results (i.e., minimize the taxes they had to pay), and thus bolster their cash reserves. For the hospitals, this term functioned as a cash management and funding negotiation tool. It documented capital expenses in each year, a useful disclosure in funding negotiations that had a material effect on the cash position of the hospital. The effects of the adoption of this business concept can be seen in the changes in the financial results between 1952 and 1967. In 1952, when the accounting entry for depreciation was quite small ($220,932.28), only one half of the operating loss was offset; the Toronto General Hospital was in the unenviable position of having to report a loss. By 1968, the accounting entry for depreciation had grown substantially ($1,009,698.00) and capital costs had become part of the budget negotiations. Funding of the hospital had gone up to fund the depreciation expense, the past loss had been transformed into a positive result from operations, and most importantly, $1 million was gained in free cash flow.

This permeation of business logic throughout the hospital can also be seen in the minutes of board meetings in this era. By the 1970s, the usage of business concepts such as zero-based budgeting, cost accounting, appropriate allocation,
and audit were becoming commonplace in board discussions. New financial reports were coming into common usage. For example, the cash flow report, a business accounting report that details cash sources and cash expenditures, was first used in 1976 by the Hospital for Sick Children. By 1978/1979, financial discussions were the lead item in board reports. In a report from 1979, six out of the seventeen paragraphs in annual report of the executive director of the Hospital for Sick Children were devoted to money and hospital finances, a significant shift from just a decade earlier. In that same year, the minutes of the directors’ meeting of the Hospital for Sick Children showed a similar pattern of hospital finances as a strategic lead topic in meetings. The scope of financial discussions in board minutes also expanded significantly in this era. Not only did financial reporting mean discussing the costs and incomes of the organization, it also began to mean reporting on negotiations over finances with the Ministry of Health. For example, in 1979, the executive director commented in the annual report that

“the financial deficit has caused considerable discussion within the hospital and has been the subject of meetings with Ministry officials and has ended with the problem of separation of costs between the budgeted deficit, which may or may not include the programs which the hospital has been funding over the years, and the 1 and ½ million over and above that which was budgeted.

We should attempt to identify the global costing of the new programs which had been implemented on our own to help in ascertaining exactly the amount of the deficit which has resulted from inflationary causes and the outside salary settlements to strengthen our claim for that portion.”
Looking at this 50-year period, a clear pattern emerges. Finances, in the broadest sense, became vastly more important in hospital discussions. The ability to navigate financial logic became a requirement for participation in board discussions. Money clearly had become something that mattered in academic medicine, where before it had been essentially invisible.

**An Era of Changing Funding Patterns**

Beyond bringing a focus on finances to Canadian academic medicine, the era from 1940 to 1990 also brought massive financial disruption. As mentioned above, it brought an aggregate exponential increase in State funding to Canadian academic medicine. However, Canadian academic medicine’s constituent institutions did not benefit from this State largesse to the same degree. Hospitals received massive increases as their responsibilities for the delivery of care increased, but the Faculty of Medicine was somewhat overlooked in terms of relative funding increases. This funding divergence had notable effects. Academic hospitals grew enormously and it became normal for them to make further requests for funds as new diseases were identified and new treatments emerged. Because the Faculty of Medicine’s funding did not increase to the same degree, its leadership began to become concerned that its budget would be insufficient for it to meet the Faculty’s future needs as an educational institution and as servant to Canadian society.
At the level of the State, the impact of these financial changes was experienced somewhat differently, as a massive increase in expenditures that had to be financed from a population that was becoming increasingly resistant to new taxation. As a result, a potential financing gap began to become visible and the Ministry of Health became more and more concerned that health care and health care costs might expand beyond its ability to fund. To address this concern, the government of Ontario established a commission to explore what alternatives to the academic medical model of health care in which it had invested might be possible, inasmuch as that model was looking unacceptably expensive. The “Report of the Community Health Centre Project to the Conference of Ministers”\(^\text{16}\) was the result. This report laid out the Ministry of Health’s concerns in bleak terms, stating:

\[
\text{[There is] a growing concern of both federal and provincial governments about the accelerating rate of spending in health services. During the 1955-68 period the average rate of annual increase in the cost of providing all health services in Canada was approximately 10.7 percent. In 1968, government sources accounted for 69 percent of combined operating and capital spending in health services in Canada. Spending from all sources in the same year represented some 6.6 percent of the gross national product. In the last three years, the rate of increase was running well above the 10 percent average and for 1971 the indicated rate of increase in spending is about 12.5 per cent.}^{16}
\]

This report’s recommendations were not acted upon; however the logic embedded in it triggered other new thinking. More active surveillance of hospital spending and management practices was one outcome. A second
impact of this logic was an emergence of a new focus on alternative funding sources in Canadian academic medicine.

The impact of this new logic can be first seen in the Faculty of Medicine in the 1950s, years before this report was released. Long before the Ministry became concerned with the potential cost of funding health care, its policy choice to fund health care was having effects in the medical school. As the health insurance funding for health care began to increase in the 1950s, discussions expressing financial concern began to appear with increasing regularity in the Faculty of Medicine. In 1959, the dean of medicine discussed this topic extensively commenting:

The advent of hospital insurance in Ontario has been viewed with interest and some concern by those responsible for the maintenance of undergraduate teaching and resident training programs for young specialists. The Hospital Insurance Commission has two further meetings during the year with representatives of the medical schools and teaching hospitals. The Commission is disposed to leave any difficulties in maintaining teaching units of adequate size to the schools and hospitals concerned, rather than to legislate or make regulations concerning such matters.\(^{32}\)

He went on to express his concerns regarding the impact of the hospital insurance funds on the medical school–university relationship, and—though not explicitly on the power relationship between them observing…
In our own faculty there is a local committee under the able chairmanship of Dr. Botterell which reviews from time to time the whole question of medical school-hospital arrangements and the impact of health insurance on such relationships. Failing any regulation from the government which will safeguard the “teaching-unit” there will probably be need for a careful review of existing by-laws and agreements between the University and the various hospitals. Many of these agreements were made several years ago and need revision and strengthening in the light of new developments.32

He also addressed the impact of funding shifts on research, Human Resources, and the other sources of funds stating...

While grants in aid of research come to us from many sources, we must have a reasonable nucleus of investigation-minded teachers and laboratories in which they can work before we can attract the necessary added finances to aid their efforts. We are grateful again that many granting bodies which have assisted us, particularly the Departments of National Health and Welfare and National Defense, and the National Research Council which has been able to substantially increase the amount of money available for medical research in Canada in the present fiscal year.33

By the 1970s, the level of concern regarding finances had gotten much higher. In 1972, the dean of medicine commented:

Another major report sponsored by the government, on postsecondary education, suggests major sweeping changes in the operation and financing of universities, including the professional faculties. Yet another government agency, the Ontario Hospitals Services Commission, which has been responsible for major financial support of clinical teaching services, now questions the appropriateness of its involvement in financing medical education.

In light of these multiple studies and reports, or rather in the absence of illumination as to the ultimate intentions of the
government, planning even for the immediate requirements, to say nothing of the distant needs, appears to have little solid base upon which to build. . . . it is to be hoped that some firm government commitments will soon make it possible to develop a coherent plan of action with some sense of stability for a reasonable period of time.\textsuperscript{34}

By the time this report was issued, it was apparent to the Faculty of Medicine that funding from the Ontario government was becoming insufficient to meet its needs. The government was, and would remain, the Faculty of Medicine’s primary funder, but it was becoming clear that the Faculty’s existence as a publicly funded institution was coming to an end and a new era as a publicly assisted institution was coming. This dawning awareness triggered a new acceptance of commercial thinking in the Faculty. The influence of the discourse of Wealth Creation on the Faculty began to increase and the use of business logic within it began to be normalized.

**The Four Discourses of Academic Medicine: 1940 to 1990**

The gradual rise in influence of the discourse of Wealth Creation can be seen quite clearly in the new objects created in this era. While it was not a dominant discourse, the effects of its articulation on the other discourses can be charted. Business logic began to permeate the other discourses, resulting in increasing corporatization in the management of philanthropy,
the university, and the government. Table 7.2 below documents some prominent examples produced by these articulations.

**Table 7.2: Discursive Articulations and Their Effects, from 1940 to 1990**

<table>
<thead>
<tr>
<th>Discourse</th>
<th>Major Issues</th>
<th>Articulation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Social Obligation</td>
<td>Increasing corporatization of fund-raising</td>
<td>A1: Social Obligation + Wealth</td>
<td>The Hospital for Sick Children's Foundation (1972) and the Toronto General Hospital's Foundation (1973) set up as stand-alone corporations distinct from their respective hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The Herbie Fund (local fund established to pay for care for foreign children to come to Canada to obtain care they could not obtain in their home country) (1979)</td>
</tr>
<tr>
<td>B: State Responsibility</td>
<td>Monetization of research findings</td>
<td>B1: State Responsibility + Professionalization + Wealth Creation</td>
<td>SickKids Research Institute (1954); Research</td>
</tr>
<tr>
<td></td>
<td>Increasing managerialism in hospitals: pursuit of efficiencies and cost savings</td>
<td>B3: State Responsibility + Wealth Creation</td>
<td>Toronto General and Toronto Western merge—beginning of era of hospital mergers (1986)</td>
</tr>
<tr>
<td>C: Professionalization</td>
<td>University looking for new funding sources</td>
<td>C1: Professionalization + Wealth Creation</td>
<td>Postgraduate medical students become monetized objects and begin to generate an important revenue stream for the Faculty of Medicine. The global space becomes a potential source of the Faculty’s financial woes. Tuition for postgraduate students becomes disconnected with educational practice, a commercial fee (1982)</td>
</tr>
<tr>
<td></td>
<td>Identification of Middle East as potential customer for Canadian Academic Medicine</td>
<td>C2: Professionalization + Wealth Creation + State Responsibility</td>
<td>Dean of Medicine identifies Middle East as ripe to purchase Canadian expertise. Adopts role of business broker with respect to consulting contracts regarding hospital construction. (1982)</td>
</tr>
</tbody>
</table>
Faculty of Medicine partners with Faculty of Business

C3: Professionalization + Wealth Creation

Institute of Health Management proposed. Mandate to bring business skills (a profit focus) to hospital management (1988)

D

Wealth Creation

Hospital considers new revenue options to address funding crunch

D1: Wealth Creation + State Responsibility

The Hospital for Sick Children receives, and rejects, proposal for a McDonalds to be located in hospital—marks beginning of era of the transformation of hospital space into a commercial shopping zone (1986)

Medical profession and government come into conflict over money

D2: Wealth Creation + Professionalization

Doctors strike for extra billing rights; public animosity develops toward the profession; the Educating Future Physicians project (EFPO) and the CanMEDS competency framework are launched to address reputational hit profession took in strike

Discourse A: Academic Medicine is a Social Obligation

The discourse of Social Obligation was quite active in this era, producing a regular, if not massive, income stream to Canadian academic medicine. Looking at the financials for Toronto General Hospital documented in Table 7.1 above, philanthropy (endowment funds) generated approximately 2% and 1.5% of total income in 1952 and 1959, a relatively small portion of the hospital's income. The financial statements for 1967 are less helpful in quantifying the philanthropic contributions as any funds received from donors or endowment funds were merged with other revenue streams. Given the magnitude of these funds, it is not surprising that discussions about philanthropy in the minutes were nominal at best; philanthropy was not a strategically important activity for the hospital for the first several decades of this era. Instead, it was simply a practice that had to be acknowledged, appreciated, and documented.
This passive relationship with philanthropy and donors during the 1950s and 1960s is somewhat surprising given the significant role that philanthropy had played in the transformation of Canadian and North American medicine into an academically legitimate area. American donors’ support for various academic medical initiatives in Toronto over the decade was well known and acknowledged.\textsuperscript{35-37} The Toronto-based Lady Eaton’s funding of the first research chair in the Faculty of Medicine was also recognized as pivotal in the transformation of Toronto’s medical education into a globally known academic endeavour.\textsuperscript{38-40} Philanthropy was clearly understood to have fueled the growth of Canadian academic medicine and to have been instrumental in the creation of new departments within the Faculty of Medicine and various global engagements.\textsuperscript{35-37}

Despite this well-known history of philanthropic productivity, it is not so surprising that philanthropy was less important to hospital finance in the 1950s and 1960s, because the concept of philanthropy was undergoing significant changes. Whereas in the early part of the 1900s philanthropy had been practiced as a direct relationship between a donor and a recipient institution, in the period from 1940 to 1960 philanthropy began to transform into something more formal and more distant from the recipients of its largesse. Donors began to set up

\textsuperscript{9} Foundations for the Rockefeller, Carnegie, and Kellogg families had made numerous material contributions in Toronto directed at transforming Toronto’s medical community into an academic community.
foundations to hold and to manage their philanthropic funds. The government of Canada, however, saw this move to foundations as having two roles: foundations were useful for the practice of philanthropy, but also useful for the practice of tax avoidance. This second possibility triggered a period of heightened government surveillance of foundations and lower philanthropic giving until 1959, when the Canadian government passed new regulations that required foundations to issue receipts for all charitable giving and to pay out 90 percent of their annual incomes.\textsuperscript{41,42} After this, levels of philanthropic giving began to rise again.

**Articulation A1: Social Obligation + Wealth Creation**

In this era, the articulation of the discourse of Social Obligation on the discourse of Wealth Creation brought concepts such as efficiency, good management, and maximization of resources from the world of business to the world of philanthropy. A new object, the stand-alone corporate foundation, was the result. These new companies had separate management and governance from their hospitals. Their mandate was to manage their hospital’s fundraising activities and its endowment funds.

This corporatization of fundraising appears to have begun in Toronto in or around 1972, when the Hospital for Sick Children created its fundraising corporation, the Sick Kids Foundation.\textsuperscript{43} In 1973, the Toronto General Hospital followed suit, creating its own corporate fundraising entity.\textsuperscript{44} In 1984, this concept was taken
further by the creation of US-based fundraising corporations that enabled Canadian hospitals to accept donations from US citizens.\textsuperscript{45} In 1989 the articulation of the two discourses brought the business practice of corporate mergers to the management of corporate foundations. The merger of the Toronto General Foundation with the Toronto Western Foundation in the pursuit of greater scale and cost savings was the result.\textsuperscript{38} With the creation of these corporate foundations came the creation of new subject positions such as chief executive officer and vice president of fund-raising. New reporting practices also followed: audits became a normal practice, detailed financial statements appeared, and the management of donor relationships was professionalized. The articulation of these two discourses transformed fund-raising from an informal practice, run by external disempowered organizations such as a Women’s Auxiliary, into one more managerial in nature, run by professionals steeped in business logic. With this transformation, executives managing hospitals’ endowments also became powerful members of their hospital’s corporate executive suite and the influence of the discourse of Social Obligation increased.

**Articulation A2: Social Obligation + State Responsibility**

A second articulation was that of the discourses of State Responsibility and Social Obligation. Its product was an innovation—the local fund-raising drive to pay for the care of inbound international patients. The best-known example of this is The Herbie Fund,\textsuperscript{46} a fund created by the Hospital for Sick Children in 1979 to bring a child named “Herbie” to Toronto for life-saving medical care he
could not obtain in his home country, the United States. This innovation had successes on several fronts. It created a new link between the hospital and the broader public. It also linked the ideas of global engagement, nationality, cultural confidence, compassion and benevolence to create a new financial model of philanthropic funding for the hospital. Finally, though it was not apparent at the time, it also triggered the creation of a new business model for the hospital, based on the concept of medical tourism.

I have categorized the creation of the Herbie Fund as an articulation of the discourses of Social Obligation and State Responsibility based upon my analysis of the textual data. However, an analysis of the financial model renders a slightly different conclusion as it constructs The Herbie Fund as a new payment stream for hospital services. Under this analysis, the discourse of Wealth Creation is part of this articulation and producing much needed revenues for the hospital to offset rising costs of operation and at the same time creating a new health care funding triumvirate consisting of unrelated payers, a patient, and a hospital and a financial linkage between the local space and the global space.

For some, this second analysis of the Herbie Fund may be an overly aggressive interpretation of the data, but in its defense I would observe that just over one decade later, in 1982, the Hospital for Sick Children charged 282 international patients for medical services in Toronto and medical tourism had become a
strategic business focus of the Hospital for Sick Children—a development I will describe in the next chapter.

**Discourse B: Academic Medicine is a State Responsibility**

The decades from 1940 to 1990 were, as I have observed, for the most part dominated by the discourse of State Responsibility. In many ways, this period defined and still defines Canadian health care, because Canadian Medicare was born in this era. However, Medicare was not the first object produced by the discourse of State Responsibility in this era. I would argue that that honour goes to the Ontario Blue Cross for the Hospital Care Plan created in 1941. This fund was created by the Ontario Hospital Association and funded by the Ontario government as a vehicle to pay for health care costs in hospitals in Ontario. This fund brought the financial stability that had been heretofore missing to Ontario hospitals and marked the beginning of the transformation of health care into a core Canadian policy domain.

This transformation of health care can be situated in a broader policy phenomenon, the creation of the welfare state in Canada. A succession of new tax bills that greatly expanded tax revenues in Canada funded this transformation. Nineteen forty-eight brought the Income Tax Act, created to replace the Income War Tax Act of 1907 and to transform the income
tax from a temporary measure into a permanent part of Canadian” lives. In
1957, the transformation of health care into a central policy field in Canada
continued with the passing of the Hospital Insurance and Diagnostic Act,\textsuperscript{25} a
bill that brought public payment of hospital and diagnostic costs to Canada.\textsuperscript{1}
This bill was adopted by all provinces in 1961, and public payment for
health care spread across Canada.\textsuperscript{1} Nineteen sixty-six brought the Federal
Medical Care Act,\textsuperscript{57} the Ontario Medical Services Insurance Plan (OMSIP),\textsuperscript{h}
and payment of health care costs was expanded to include costs incurred
by patients outside of the hospital environment.\textsuperscript{1} In 1984, to complete this
policy journey, the Federal government of Canada passed the Canada
Health Act,\textsuperscript{51} thereby amalgamating the Medical Care Act of 1966 and the
Hospital Insurance and Diagnostic Act of 1957.\textsuperscript{50,51,58,59}

The Canada Health Act (CHA), in many ways, gives substance to or
textually instantiates decades of productivity of the discourse of State
Responsibility. This is especially visible in the act’s preamble, which states:
“It is hereby declared that the primary objective of Canadian health care
policy is to protect, promote and restore the physical and mental well-being
of residents of Canada and to facilitate reasonable access to health
services without financial or other barriers.”\textsuperscript{60}

\textsuperscript{h} In 1972, this plan would be renamed the Ontario Health Insurance Plan or OHIP.
The ideas embedded in this quote were the culmination of decades of cumulative work, thought, and philosophical development and for many, define the philosophy underpinning Canadian health care and Canadian academic medicine—that health care and academic medicine are social goods.

Articulation B1: State Responsibility and Professionalization

While this era was primarily defined by the rise of state-funded medical care, a new discursive object also emerged, a product of the articulation of the discourse of State Responsibility and Professionalization: the (hospital based) research institute. This new object brought the idea of funded academic research into the hospital. In 1954, the product of this articulation was given form as the SickKids Research Institute. The creation of research institutes in hospitals had several effects. First, it continued the transformation of hospitals from low-status spaces for the poor to high-status spaces for learning and research. Second, it began a shift in the power relationship between the Faculty of Medicine and the hospitals as it transformed the hospitals adding academic and research spaces to what had been primarily clinical and teaching spaces. Third, it substantially increased the financial resources of academic hospitals, a shift that changed the power structure of Canadian academic medicine arguably in favour of the academic hospitals.
Articulation B2: State Responsibility + Wealth Creation

Ten years after the creation of the research institute, the articulation of the discourse of State Responsibility and Wealth Creation made possible the creation of another new object, the research corporation. This new object, while quite similar to the research institute, differed in that it was created to conduct research to monetize its discoveries for the benefit of an institution. Research institutes were expected to function as classic academic spaces and apply for grants, while research companies were expected to function as businesses and transform research findings into profits.

In 1982, leading the charge, the Hospital for Sick Children set up the HSC Applied Research Corporation with C$250,000 in seed capital. These funds were earmarked for the purchase of equipment and to cover initial operations. While this company demonstrated initial success obtaining some licensing deals, it also ran into problems because it was set up as a not-for-profit corporation like its parent company, the Hospital for Sick Children. This choice of structure was found to be discordant with its mandated goal. To better accommodate this company’s business focus, its corporate articles were amended and it was re-launched as a more classical limited liability corporation. These tensions were laid out clearly in the hospitals’ minutes: “Initially a non-taxable corporation without share capital was formed to meet the legislated requirements of HSC. Subsequent identification of problems with granting agencies strongly indicate the
need for a more conventional, private sector approach, and the process of re-
organization is underway.\textsuperscript{62}

This change, driven by the discourse of Wealth Creation, made possible an
“applied” research mentality and a commercialization mentality in the same
organization. The creation of the research company embedded an explicit
business mentality into the research paradigm and thereby transformed research
from simply a determinant of academic legitimacy and academic capital to a
determinant of financial strength. This was a significant shift.

\textbf{Articulation B3: State Responsibility + Wealth Creation}

The influence of the discourse of Wealth Creation in this era produced significant
changes in the logic governing state-funded institutions—specifically from
“administration” to “management.” With that shift, the concept of citizen gave way
to the concept of customer.\textsuperscript{63} Stewardship of resources gave way to efficient use
of resources, and to concepts of return on investment (ROI) and client service.\textsuperscript{63} Scholars have called this new logic that permeated public service and the
academy "neomanagerialism."\textsuperscript{63-66} The uptake and effects of its adoption have
been explored in public service,\textsuperscript{63,66} hospitals,\textsuperscript{67} and academia.\textsuperscript{68} Studies show
that the it transformed the focus of public service leaders from service to society
to the value of offerings to society: a subtle but significant shift.\textsuperscript{63,69,70} In
educational circles, this same shift has been described as “Academic
Capitalism.”\textsuperscript{71-73} While the details of these two theoretical concepts vary
somewhat, they share a common core concept: the domains of public service and the academy, respectively, adopting the logic and practices of commerce.

Abraham Flexner was an early critic of this phenomenon. In his book Universities: American, English, German, Flexner strongly critiqued commercial logic as nonacademic in character and antagonistic to academic achievement. He singled out the newly formed Harvard Business School as an especially bad example of commercial logic in a supposedly academic environment: “There are in the Harvard Business School men of scientific turn of mind—students of economic history, of the phenomenon of economics, transportation and banking, for example. While then the scholars on the staff of the Harvard Business School are really and critically interested in phenomena, the main emphasis of the School from the standpoint of its administration is concentrated on “getting on”—the canker of American life. A pamphlet of 145 pages describes the school; from beginning to end and there is not a sentence or a word indicative of professional or scientific conception.”

He went on to explore this idea in the context of academic medical schools: “What university school of medicine would dare to define its ideals and results in such terms? Contrast these wretched ad hoc appeals with the incisive utterances of an Oxford professor who is at once, a scholar and a man of affairs.”
For Flexner, the commercial logic espoused and performed by the Harvard Business School was simply incompatible with the creation of an legitimate academic institution. His ideas on this topic seem to be logical extensions of his findings in his 1910 report on medical education, which found for-profit practices to be incompatible with the delivery of high-quality medical education.

While the concept of neomanagerialism does not include the concepts of commercialism that Flexner decried in his work, I would also argue that discursively they are linked. An adoption of neomanagerialism by an academic medical organization is a first discursive step towards the financialization of health care and academic work.

Other examples of the impact of the articulation of the discourses of State Responsibility and Wealth Creation and neomanagerialism are not hard to find in this era. One is the Canadian academic hospitals’ adoption of mergers and acquisitions as a way to consolidate markets and to achieve operational scale. In Toronto, this trend began in 1986 with the merger of the Toronto General Hospital with the Toronto Western Hospital. Toronto General’s focus on mergers continued over the next several years, culminating in the creation of the University Health Network, a conglomerate of four hospitals and one educational institution. The focus on mergers as a tool to address health care issues continues to this day in the recent mergers of Sunnybrook Hospital with St. Joe’s
Rehabilitation Hospital in 2012, Mount Sinai Hospital with Bridgepoint Hospital in 2015,76 and the coming merger of St. Michael’s Hospital with St. Joseph’s Hospital and Providence Health Care77,78.

Another product of this articulation is the adoption by the hospitals of a corporate executive structure and corporate suite titles such as president, chief executive officer, chief financial officer, chief operational officer and eventually chief marketing officer and chief strategy officer. Up to this change, the titles used in hospitals had been similar to those used in not-for-profit organizations, such as executive director and director.45 A third example of the impact of this articulation was the increase in surveillance and the use of audits by the Ministry of Health in Ontario in its oversight of the institutions of Canadian academic medicine. In 1986 this practice was used against the Hospital for Sick Children when the Ministry hired an outside consultant to analyze the management practices of the hospital. This is an especially interesting example because the consultant’s positive findings on the management practices of the hospital were rejected by the ministry because they were in tension with its beliefs about the hospital’s fiscal propriety.79,80 The influence of this logic then extended to a challenge to the separation of the hospital and the hospital’s foundation.79,80 The ministry called the foundation’s stand-alone charitable status into question and referred to its funds as “public funds.”80 The message was clear: find sources of income other

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1 I would note that the name of this ministry has changed over time. It is currently called the Ministry of Health and Long Term Care. That said, for the purposes of this document I am retaining the name Ministry of Health for simplicity’s sake.
than the government to support your obligations to the public, as we are in extreme fiscal difficulty.

This articulation also had a tangible impact on the Faculty of Medicine, producing a message of financial restraint in the 1950s to the effect that the public and public servants were questioning the value they were getting from their funding of academic medicine. Commenting on this in 1952, the dean of the Faculty of Medicine stated:

The cost of medical education and research has of course increased tremendously in the past quarter of a century. Fortunately support for many research projects can be sought from sources outside the University. But such funds, providing as they do annual grants for workers, do not take into account the added cost of overhead, maintenance of buildings, increased supplies, and increased space. The budget of our school, although it has increased steadily since the war, does not reflect sufficiently in that increase either the normal increase in the cost of living, cost of maintenance, cost of supplies, or, what is important, the steadily increasing responsibility of the school in the training of doctors in modern methods, the training of specialists, and the provision of leadership in medicine in a modern community, which the public quite rightly expects. One wonders whether there is sufficient awareness on the part of Canadian citizens, particularly those who administer public funds, of the cost of providing personnel who will give them the standards of health and medical care to which they are so well aware they are entitled in this enlightened age of science.81

In this quote the dean’s concern regarding the future and the Faculty’s funding support is clearly evident. The dean’s formulation of the Faculty’s work as an obligation to society is also clearly evident. The combination of these two ideas,
can have only resulted in one thing—the dawning awareness that the Faculty would need to more actively engage in securing its own financial future.

In the 1960s, the dean’s concerns proved prescient as a Royal Commission on Health Services was created. In 1962, reporting to the president of the university on the commission’s findings, the dean stated: “In his last report, Dr. MacFarlane remarked upon the close scrutiny to which medicine and the medical profession were being subjected. During the past year the creation of the Royal Commission on Health Services has forced not only the practicing profession but also the schools of medicine to formulate their objectives and policy for the future.”

Pressure was building on the Faculty to find new, more efficient ways to conduct its operations. This pressure had an impact upon the mentalities and boundaries of the various discourses. New ideas and new thinking became possible. Concepts such as monetization and self-funding became ideas that could be given voice in the Faculty of Medicine. The discourse of Wealth Creation’s influence was on the rise.

**Discourse C: Academic Medicine Is a Professionalization Project**

From 1940 to 1990, academic medicine continued to develop as a domain and as a legitimate area of academic study. In this development, its visibility in the
academic press rose. On March 15, 1953, the academic journal Hippokrates published the article “Academic Medicine and the Art of Healing,” the first example of the term “academic medicine” being used in academic publishing. Prior to this the term had existed and been used in less formal venues and talks, but it had never appeared in a scholarly article. To the extent that the naming of an idea or an object makes something real, I would argue that the naming of “academic medicine” in a peer-reviewed journal marked its transformation into a legitimate scholarly area and the realization of Abraham Flexner’s vision from 1910. In 1989, academic medicine took its next step on this journey when it became a brand and the Journal of Medical Education changed its name to Academic Medicine.

As the domain of academic medicine was undergoing this process of becoming, at a more granular, curricular level, the University of Toronto’s Faculty of Medicine was wrestling with what topics it should be teaching and what areas of knowledge would be appropriately housed within its curriculum. It was an era of intellectual boundary work as well, inasmuch as the Faculty was creating new internal departments to make it possible for new questions to be asked in medical education. For example, in its creation of the Department of Health Administration it became possible to ask new questions about health administration and health policy. In creating this new department, the Faculty was also doing two strategic things. First, it was creating a legitimizing body for
its voice so that it could speak with authority and be heard in policy circles. Second, it was using the power of academia to give that voice more weight. With this action, the Faculty was attempting to replicate its past success in legitimizing the profession of medicine with the studies of health administration and health policy.\textsuperscript{37}

Not wanting to rely on the creation of a new faculty department for undergraduates focused on policy studies to give it weight in policy circles, the Faculty also created a professional development program for health administrators already working in the field.\textsuperscript{37} This program, targeted at hospital administrators working in “increasingly complex organizations,” explored questions of interest to the Faculty that potentially affected medical practice.\textsuperscript{37} In Faculty meetings, policy questions such as What is health? and Is health an issue of drugs, physicians, or social determinants? also became more common.\textsuperscript{34} In 1988, the educational offering expanded to include concepts from business.\textsuperscript{37} Management theory, finance, and human resource theories came to academic medicine in Toronto via a partnership between the Faculty of Medicine and the Faculty of Business in the form of a management program directed at physicians and a new research program.\textsuperscript{37,85}

The discourse of Professionalization also had effects on the institutional relationships between the Toronto academic hospitals and the university in this era. In addition to producing research as a practice in the academic hospitals,
this discourse produced an awareness that the hospitals’ affiliation with the university was of importance for their reputation. In 1965, the chairman of the board of directors of the Toronto General Hospital commented: “It is also our intention to have our hospital work closely with the Faculty of Medicine, University of Toronto and the other Teaching Hospitals and Institutes towards the common goal of an outstanding Medical Centre that will assure us of continuing leadership in the health field.”

Fifty-five years after Abraham Flexner’s report on medical education espoused the importance of the university to the medical profession, his ideas began to make possible the idea of tighter hospital-university relationships, setting in motion the development of closer ties between the university and academic hospitals and creating a more formalized space for academic medicine: the academic health science centre.

Articulation C1: Professionalization + Wealth Creation

The articulation of the discourse of Wealth Creation on the discourse of Professionalization in this era created new thinking about revenue generation in the Faculty of Medicine and the university in general. More specifically, it became possible to consider new ways to monetize education. The line between tuition and educational charges became blurred. Tuition fees, I would argue are charged by educational institutions to students to cover a portion of the cost of their education. Educational costs are further offset by State funds, so that the cost of
education is shared between the student, their family, and the state. Traditionally, market pressures only partly influence tuition amounts. In private educational institutions, this is not the case. Tuition in private educational institutions might more accurately be described as an educational fee, one that is set to more completely cover the full cost of education and potentially generate a surplus or profit.

In 1981, public education thinking and private education thinking on fees began to merge. In the University of Toronto’s Faculty of Medicine, the costs charged to students applying for postgraduate studies began to shift from something best described as traditional tuition to something more accurately described as an educational fee. In a letter to the vice-provost of health sciences, Dean Lowy (of the Faculty of Medicine) proposed this shift, arguing that postgraduate medical education student fees could be used as a financial tool to address the Faculty’s financial challenges.89 In making this proposal, the Dean began to transform postgraduate students from learners into monetized objects. While this proposal did not quite represent a full return to the for-profit medical education thinking that Abraham Flexner had attempted to purge from the domain at the start of the 20th century, it was nevertheless a regressive move and marked a shift in how educators in Canadian academic medicine conceptualized students.
The influence of this business logic increased in the 1980s. After a trip to Saudi Arabia in the early 1980s, Dean Lowy began a campaign to sell that ‘region’ as a potential market for Canadian academic medicine’s expertise. In doing so, he expanded the role of the dean to include concepts that could be described as business brokering. In this new role, he contacted individuals in the Ontario government and in other faculties at the university about the potential business the Gulf nations. He advocated for the sale of expertise and services of Canadian academic medicine, its hospitals, and its education to that region. In a letter to J. A. Young, the president of the Ontario International Corporation he stated: “As you know, an agreement is now in effect whereby the University of Toronto (and, I believe, the University of Ottawa) will provide post-graduate training for physicians who wish to become specialists. This will likely continue to develop during the next few years, depending upon our experience.” He went on in that same letter to make the explicit comment that “the idea of marketing Ontario Educational expertise deserves support.”

As Dean Lowy was advocating that other organizations engage for profit in the Middle East, internally in the Faculty he continued his transformation of postgraduate tuition into educational fees—this time focusing on foreign-trained medical students from the Gulf. In this shift, he significantly distanced postgraduate fees from anything that resembled tuition, and in doing so transformed the postgraduate medical education program into a core financial
unit for the Faculty.\textsuperscript{89,91} This shift also represented a substantial increase in commercial thinking present within the faculty, albeit one that was couched in classic academic and educational terms.

Finding the data documenting these actions of the dean of medicine was a pivotal moment in my research. When I started to research how it became possible for Canadian academic medicine to be engaged in the Middle East, I did not have any clearly formulated idea of how the practice might have started. That said, since my entry point for this research was UHN’s engagement in Kuwait and the Hospital for Sick Children’s engagement in Qatar, I now realize that I entered into this research presuming that the idea for global commercial engagement had originated in an academic hospital. Finding the first emergence of the idea of engaging in the Gulf States for the purpose of revenue generation in the actions of the dean of medicine in the University of Toronto was completely unexpected.

This finding notwithstanding, in analyzing the data, it is also evident that the discourse of Wealth Creation was having broad effects and that it was rising in dominance. As financial pressures were emerging in the Ontario government, the broader university, the academic hospitals, and the Faculty of Medicine, this discourse’s rising influence was triggering the emergence of commercial thinking everywhere. That this idea took form in such a specifically global way in the
Faculty of Medicine makes sense for two reasons. Its funding growth had substantially underperformed that of its hospital peers, leaving it feeling hard done by. And its history of global engagement for academic legitimacy made the potential of the global space that much more visible to it. In aggregate, these ideas and these forces triggered a discontinuity in the discursive formation of academic medicine in the 1980s. As a result, Canadian academic medicine had become something that could be commercialized.

**Articulation C2: Professionalization + Wealth Creation + State Responsibility**

The acceptance of business practices was not limited to the institutions of Canadian academic medicine. It also was permeating the thinking of its funder, the Ontario government—encouraged by Dean Lowy who, as mentioned above, wrote several letters to the president of the Ontario International Corporation, a governmental corporation. In those letters, he described the Middle East in no uncertain terms as a potential market for Canadian academic medicine’s expertise: “The time is right for vigorous Canadian initiatives to sell hospital expertise to Saudi Arabia on a contract basis. Other countries that have no more to offer than Canada have already taken successful initiatives in this area. Given the high esteem in which Canadian medicine and our hospital system are held it should be possible for us to be competitive in a country that has the need, the determination and the resources to develop better hospital services.”

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The idea of selling the university’s services may have been a step too far for Dean Lowy when this letter was written, but it was not too much of an intellectual stretch for him to argue that his academic hospitals should sell their services in the Middle East by providing consultants and consulting services. The Faculty of Medicine’s long-held sense of ownership of the academic hospitals was arguably reflected in the above quote and commercial logic clearly underpinned it. But fascinatingly, it seems to have been filtered through a lens of thought about medical education that was actually established by Abraham Flexner nearly a century before. As a result of this filtering, the argument for Middle Eastern business engagement was directed outside the Faculty at the supplicants of the Faculty of Medicine: the academic hospitals.

This idea was welcomed by the president of the Ontario International Corporation, who replied in a letter to the Dean stating “It is very gratifying to have the enthusiastic response to our proposal.” And “I have just returned from Kuwait, Qatar and the United Arab Emirates where the groundwork is now laid for Health Care activity from here . . . I totally agree on Saudi Arabia and we will orient ourselves to expand on your activities there as quickly as we can.” And “I am delighted at the role your prestigious institution is prepared to play.”
This letter to the Ontario government was not the only one Dean Lowy wrote advocating for commercial engagement in the Middle East. He also wrote to the dean of the Faculty of Pharmacy, the chair of the department of microbiology and the president of the University of Toronto. In his letter to the president of the University of Toronto, Dean Lowy laid out in no uncertain terms his idea of Middle East engagement and the deployment of his academic hospitals: “the Saudis are actively expanding their hospital system. There seems to be considerable opportunity for marketing Canadian expertise in the hospital (and especially teaching hospital) field.” The dean’s letters, whether or not they were the catalyst for it, did foreshadow other faculties’ similarly becoming commercial consultants in the global space.

As stated above, more seems to be at play in these letters than simply the influence of the discourse of Wealth Creation. For all that the dean was advocating for commercial engagement, he was not arguing that the Faculty should become a business. Instead, he was arguing that the hospitals should become global consultants to generate funds for themselves. Looking at this another way, it could be argued that by advocating for the hospitals to become businesses, he was trying to free up State funding presently directed at the academic hospitals so that it could be redirected to the Faculty of Medicine—in his mind, its rightful claimant. This analysis suggests
interplay among or an articulation of the discourses of State Responsibility, Professionalization and Wealth Creation, not simply Wealth Creation. The intent—political, tactical, or commercial—underpinning this correspondence notwithstanding, these letters marked the beginning of an era of increasing acceptance of commercial activity in Canadian academic medicine and a transformation in how the global space was understood.

**Articulation C3: Professionalization + Wealth Creation**

As Dean Lowy was proposing that the academic hospitals engage in commercial activity in the Middle East, the articulation of the discourses of Professionalization and Wealth Creation was concurrently producing interesting partnerships within the university. In 1988, the University of Toronto’s Faculty of Medicine and the Faculty of Business came together to propose a joint creation, the Institute of Health Management.\(^{85,95,96}\) This proposed institute had quite different characteristics from more traditional faculties or departments in this era. Specifically, its financial model was based on commercial logic and the generation of profit.\(^{85,95,96}\) A second difference was that it was more applied in its focus and that it targeted established managers in the health care system with the goal to “improve the quality of organization and management within the health services system in Ontario,\(^{85}\) and an overall objective “to enhance the cost-effectiveness of the delivery of health care services in Ontario through the provision of executive education to individuals seeking to obtain or currently occupying senior management positions in health care systems.”\(^{85}\)
As this was a partnership with the Faculty of Business, the “business plan” for the institute proposed to use a business faculty innovation, an Executive Masters structure (Health), a high-priced educational offering structured to fit into a working professional’s schedule. This new educational offering was designed…

- To provide practicing health service executives with the critical conceptual base and management skills necessary to the efficient and effective management of the health services field.
- To employ the unique resources of the University of Toronto to extend the scope of health administration education to include executive level and continuing education.
- To serve as a provincial resource for executive education in health administration.
- To promote cooperation and the sharing of skills and knowledge between the private and health services sectors.
- To develop an applied research thrust.

Underlying the creation of this new offering was the belief that there was a need and a demand for a Masters in Business Administration (Health) distinct from the professional Masters in Administration already offered by the Department of Health Administration. Embedded in this belief was the idea that business knowledge and business skills, skills focused on the generation of profit, were needed in the not-for-profit Canadian health care system. That this thinking was possible is further evidence that a discontinuity had happened and that a new era in which commercial logic was foregrounded had begun. Ultimately short-lived, the Institute for Health Management’s lifespan was cut short when its government
funding ran out, and ironically, it was unable to survive based solely on a for-profit model.\textsuperscript{96}

**Discourse D: Academic Medicine is an Engine of Wealth Creation**

In the earlier sections of this chapter, I have given numerous examples of objects produced by the articulation of the discourse of Wealth Creation on the various other discourses. I have attempted in my analysis to categorize objects and ideas based upon a determination of a dominant discourse and a secondary discourse acting upon the object. However, this is not an exact science. It may be that upon reflection, the exact categorization could be called into question.

That caveat expressed, in this section I would argue that the discourse of Wealth Creation also acted as a dominant discourse to produce a variety of new ideas, objects, and practices in this era. Several of these new creations were embedded within curriculum and institutional practices. At the level of curriculum, in 1942 discussion in the medical school focused for the first time on the business of running a medical practice.\textsuperscript{12} The dean of medicine’s report to the president of the university took the unprecedented step of commenting on this new curricular offering, in essence marking the ‘business’ of medicine an item of note.\textsuperscript{12} Given that up to this point the dean’s report had typically commented only on the achievements of individual faculty members, this represented a material change in thinking. It also represented a shift in curriculum bringing skills previously assumed to be acquired in the real world, in practice, into the medical school. In
other words, the discourse of Wealth Creation produced a blurring of the boundaries between what was academic in this era.

At an institutional level, the influence of the discourse of Wealth Creation can be seen in a variety of examples. One that was produced the past era and discussed in the last chapter is the private for-profit wards. This object, created in 1930 to much fanfare, failed in or around the late 1960s. The disappearance of the for-profit wards was likely inevitable in an era transitioning to a universal publicly paid system—a product of the surge in influence of the discourse of State Responsibility. But their failure and closing were done quietly with no press recognition whatsoever.

This silence is significant on several fronts. First, it is an example of the fallibility of the logic of the discourse of Wealth Creation. Foreshadowing financial failures on a greater scale in later years (which we will discuss in the next chapter), this lack of attention to the outcomes of a particular business model illustrates a sort of blindness that will be echoed in future eras. It is fascinating that new ways for Canadian academic medicine to create wealth were being strongly advanced at the same time as a previous for-profit health care model was failing. This suggests that Canadian academic medicine was still being heavily influenced by this discourse of Wealth Creation to find ways to enrich itself, and needed to attach that imperative to a new target.
Though the for-profit wards had opened with much fanfare and a focus on the new resources they would bring, I was surprised to learn that locating actual details on their performance and the date of their closure in the hospital and university archives was very challenging. From a Foucauldian perspective, the absence of any analysis of something that was so strongly advocated suggests purposeful management of discourse. This absence—in the language of Foucault—a “*non-dit*” (something not said)—suggests that the existence and then closing of the for-profit wards was not something to be celebrated or recognized. It suggests that the closing was instead something to be managed, something to be hidden.

It may be that information on the closing does exist but I was simply not able to find it. If it does exist, however, I will note that it did not turn up in a focused effort to pin the date down so that I could include the wards’ closing in my time line. This focused effort was, to be clear, quite extensive. I searched for press reports, for public histories of the wards’ performance. Neither I nor a librarian helping me with the search were able to find anything on this topic in the public records. As these for-profit wards were a creation of an institution for a commercial purpose, I assumed that there would be discussions of them and their performance in the board minutes of the hospitals. Perhaps, I thought, I had overlooked these discussions in my earlier excursions into the archives of the hospitals.
With that in mind, I returned to the archives to review the records of Toronto General Hospital from 1930 to 1967.¹ I had limited success in my quest. The hospital’s financial statements and strategic plans were essentially silent on the performance and fate of the private wards. The minutes of board of directors discussions were silent for the most part as well, an especially odd finding at governance level. I say “odd” because these for-profit wards would have needed management and oversight as well as financial evaluation. There was none documented or more specifically there were none sent to archival storage, an interesting finding.

I did find a few clues about the wards’ performance. For example, I found an audit report on the performance of Toronto General Hospital’s Private Patient’s Pavilion’s performance from 1946. It documented a loss of $19,421, or 8.59%, on revenue of $226,090 in the ward. It also documented considerable concern with respect to the management of the wards, stating that…

> arbitrary allocations are made between the Private Patient’s Pavilion and the remainder of the hospital and also between different departments comprising the Private Pavilion. This arbitrary allocation was necessary as basis information is not available to provide an accurate distribution of these expenses for the period and it is not [a] reflection on the preparation of the statement itself.

> It will not be possible to obtain more accurate results until the methods of originally distributing expenses are changed.³⁷

¹ I chose these dates because 1930 marked the ward’s opening and 1967 marked the closing of the Toronto General Hospital wing where its for-profit ward was housed.
One reason for much of this silence might simply be that there was a gap of almost thirty years from 1927 to 1954 when the Toronto General Hospital did not issue any annual reports at all. The reason for this gap is not known. It might have been a choice of management. The reports might simply not have been sent to archives. Whatever the reason, the absence of annual reports does not explain why the board minutes had no discussions of the ward’s performance.

After 1954’s resumption of annual reports, financial results were aggregated, rendering any details of the Private Pavilion unavailable. Interpreting this accounting choice is challenging, since I have not reviewed the accounting rules of that era. It may be that this method of recording results was the norm in this era. That said, looking at that accounting choice through the lens of today’s standards and today’s rules it does not make sense. The for-profit ward had a unique operational characteristic, and unlike the rest of the hospital, a financial structure focused on the maximization of profit. Again, as it was a business that needed to be managed, data would have been collected. The absence of that data and any discussion of it again suggests either a decision was made to withhold the information or the presence of a Foucauldian *non-dit*, something that could not be discussed. I would argue that this silence evidences a shift in thinking happening in the hospital and in society; that the idea of for-profit health
care for the rich was shifting from a perception of it as socially beneficial to a perception of it as socially unacceptable.

A statement in the 1967 financial statements of the Toronto General Hospital supports this interpretation and provides the only guidance I could find on why the for-profit wards were closed. In those financial statements, the chairman of the board, Thomas J. Bell, stated: “With the introduction of the government-subsidized OMSIP programme, it became evident that the traditional patterns of care, through which this hospital served the Community for well over a century, would have to change with the times. It was agreed that all patients requiring the health services of the Hospital and its Staff should share in the benefits which accrue from an excellent teaching and research program. It was therefore agreed that the former ‘private’ and ‘public’ system which has been the pattern for many years should give way to the modern University Teaching Hospital approach.”

Rhetorically, Mr. Bell linked past ways of delivering health care with tradition and suggested that the time of that tradition had passed. Two concepts are embedded in this statement. It constructs patients in Mr. Bell’s eyes as a homogeneous group undivided by class. And it constructs the health care system as previously operating as a binary of private versus public. This binary could be analyzed in either of two ways: as an incompatible binary based upon class or as an incompatible binary based the distinction between profit making and publicly
funded. Inasmuch as other new for-profit practices and objects were being created in this era, referring to the closing of these wards as a closing of for-profit wards may be a poor description. Their closing may more accurately be described as a closing of a class-based health care system.

A new practice emerged in the hospitals two decades later that evidenced the continuing influence of the discourse of Wealth Creation, bolstering the above analysis. Hospitals began actively investing in health care companies for financial reward. This new practice was distinct from the practices of managing of endowment funds and setting up for-profit companies to monetize research findings. Hospitals became investors in companies in the burgeoning health sector, heavily influenced by business logic, that is to say, profit maximization and risk minimization.

An example that lays bare this business logic can be found in the minutes of a meeting of the board of directors of the Hospital for Sick Children in 1988. In that meeting, the board worked through a variety of pure financial questions to help it decide whether to make an investment. These questions included…

- How much money the company had
- How long the company could survive
- The financing options available for the company
- Liability to the hospital associated with this investment
- The potential of the company needing further capital
- The book value of any investment
• The Hospital for Sick Children’s Foundation ability to invest in parallel with the Hospital (pooling funds 80/20) 

Compare these questions to those posed several decades earlier when the board of directors of the Toronto General Hospital was considering an appropriate rental increase on its property. In those earlier questions, commercial logic was clearly regulated by concepts of Social Obligation to the lower classes. Profit maximization was not dominant in the early 1900s. The questions documented from 1988 have a distinctly different tone than those earlier questions. Here the tone seems to be simply financial; profit maximization, risk management and financial structure are the issues. Concepts of social good are absent. In these discussions, there is no evidence that the other discourses were active to regulate the commercial thinking present in this period.

**Articulation D1: Wealth Creation + State Responsibility**

The articulation of the discourse of Wealth Creation on the discourse of State Responsibility also brought a new level of commercialization to the physical spaces of academic medicine. In the 1980s, this manifested in a transformation of the physical space from being a clinical space into a more blended clinical/commercial space. Franchises began to replace services historically run onsite, and corporate names began to decorate buildings. Hospitals and universities began to transform into spaces that were part health care and part shopping mall/food court. In 1986, the Hospital for Sick Children received its first proposal for this type of transformation, for a McDonald’s franchise to
operate on its premises.\textsuperscript{101} Though ultimately rejected by the board of trustees,\textsuperscript{79} this proposal foreshadowed a new level of acceptance of commercialization in the hospitals and increasingly proactive approach to commercial revenue generation.\textsuperscript{101} Proposals for drug stores, bookstores, and other restaurant franchises were soon to follow and such enterprises subsequently appeared on hospital and Faculty premises.\textsuperscript{38,71,102}

**Articulation D2: Wealth Creation + Professionalization**

The discourse of Wealth Creation’s articulation on the discourse of Professionalization produced several notable changes within the profession of medicine. Ideas of wealth creation, efficiency, audit, value, and billing came in conflict with ideas of professionalism, the practice of medicine, the right to bill, and professional independence. These conflicts led to the Ontario doctors’ strike of 1986.\textsuperscript{103} This month-long strike over Ontario physicians’ right to extra bill above and beyond the fees paid by Canadian Medicare produced several somewhat unexpected outcomes. First, the public did not react well to the medical profession’s aggressive wage action and its focus on its own financial circumstances over patient care.\textsuperscript{103} As a result, the profession’s reputation and image were negatively affected.\textsuperscript{103} Second, to preempt further strike action and to put a conclusive end to the practice of extra billing, the Ontario government passed the Health Care Accessibility Act.\textsuperscript{104,103} Third, in 1987, recognizing the self-harm done by the medical profession, Associated Medical Services\textsuperscript{105} (a physician-run charity set up by the Ontario government in 1937 to cover health
care costs pre-Medicare) launched an initiative to address this reputational damage: Educating Future Physicians of Ontario (EFPO), an exploration of the concept of professionalism at the undergraduate medical level.\textsuperscript{105} A secondary goal of this initiative was to make the profession more responsive to a changing society’s needs.\textsuperscript{105} Its ultimate legacy was CanMEDS, a new national competency framework created by the Royal College of Physicians and Surgeons of Canada.\textsuperscript{106} The CanMEDS competency framework embedded concepts of social responsibility and management alongside concepts of educator and scientist in a new model of competency for physicians.\textsuperscript{106} This framework has now been adopted by 26 other countries around the world and informed the teaching of thousands of post-graduate local and international medical trainees in Canada.\textsuperscript{106,107} The international trainees return to their home countries acculturated to a Canadian medical model, taking Canadian ideas of professionalism that predispose them to further outreach from Canadian academic medical institutions. Many of the countries from which these trainees came, such as Bahrain, Kuwait, Qatar, and Saudi Arabia,\textsuperscript{107} are also those where Canadian academic medicine now habitually goes to pursue commercial opportunities. This is not, of course, a coincidence.
The Space(s) of Academic Medicine

What Was Academic Medicine from 1940 to 1990?

During the years from 1940 to 1990, academic medicine continued the journey it started in the early 1900s to become a legitimate domain of study and practice. As part of that journey, its relationship with its community, between its constituent institutions, and with the world was evolving. While academic medicine as a concept was intangible and the term was unknown as this era commenced, over the space of this fifty-year period it became a well-understood concept. The term “academic medicine” began to appear in academic journals. Those in academic medicine were becoming more and more persuaded that it was also a domain in which to carry out research. Academic hospitals were transforming from clinical-teaching spaces to clinical-teaching-research spaces. As academic medicine’s hospitals were undergoing this transformation, the university was continuing to pursue its linkages with them and in the process facilitating academic medicine’s transformation into a much more integrated, if still somewhat nebulous, space and domain.

By 1957, the annual report of the Toronto General Hospital was presenting this hospital-university relationship and education and teaching as important strategic considerations. In that report, the superintendent, J. E. Sharpe, stated:
This Report will show that in addition to the new building project which is underway, the program of modernization and improvement of facilities within the Hospital has been going on.

With the close of 1957 the plans were completed to take over the accommodation for Undergraduate and Postgraduate teaching in the new building, consisting of an auditorium seating 275, two lecture rooms, each accommodating 75... 108

This was a new way of speaking about the hospital. Its educational responsibilities were visible. The teaching spaces were not a subcontracted or controlled space of the university located in the hospital. The hospital was a participating partner in the education of both undergraduate and postgraduate medical trainees. It was also responsive to the 1960s discourse of modernity, to a societal shift.

The superintendent’s choice to begin his report with this comment was a clear statement that the relationship between the Faculty and society was something he imagined his readers would consider important and want to see embedded in his report and in his thinking. Thus, the discussion of the relationship with the university and the educational nature of the hospital was placed where readers were guaranteed to find it. Prior to this, the more traditional content of the superintendent’s reports had been clinical issues, staffing decisions, space utilization, and volunteer appreciation. These issues came much later in this report, making a statement about their importance as messages relative to that of the Faculty-hospital relationship. The choice of
what to report and where to report it speaks volumes about how academic medicine evolved and what the idea of it was bringing to the hospital. For Toronto General Hospital to be seen as and understood to be an educational space was a dramatically new first impression for that hospital and its superintendent to make.

By the 1960s, the leaders of academic medicine began to send the message that it was part of, and responsive to, a changing society. Messages emerged presenting Canadian academic medicine as having porous boundaries, as being inclusive, as sharing the same ideas as its host community. In 1968, the chairman of the board of trustees of Toronto General Hospital adopted an almost Beat Generation tone and lyricism in his description of the hospital as a medical/educational institution that reflected the living breathing city of Toronto. For him, academic medicine was modern, caring, ever changing:

No longer does a city like Toronto ever sleep—it is vibrant, alive and constantly growing at all hours of the day. A large hospital must resemble the city it serves . . .Its pulse may be the quiet footsteps of a nurse as she keeps a constant check on the patients assigned to her care or the first cry of yet another infant Torontonian responding to the doctor’s hand, or the bright bead of light on an electronic monitor screen, constantly recording the heart beat of a seriously ill patient. . . .

In this age of technological progress to stand still is to fall behind. TGH and its staff have no intention of falling behind and the past year has been one of constant progress . . .
For the first time, the private patient and teaching aspects of our hospital have been integrated for better instruction of doctors-in-training, and the betterment of patient care to a standard university-hospital level. However, the greatest change of all has been in the human element which is the real heart of the Hospital.¹¹⁰

The executive director expanded upon the importance of this inter-institutional relationship: “It is becoming increasingly apparent that this Hospital will have a major role to play in the University teaching complex of the future. Our formal relationships with the University will be closer than they have been in the past, and we will have more responsibility in the clinical education and research programmes.”¹¹¹

This sense of importance about the hospital-university relationship was not unique to Toronto General Hospital. In 1969, the dean of medicine also described the Faculty-hospital relationship and the need for closer integration as follows: “The most pressing problem has been the need to determine the amount of space required by the University in the teaching hospitals. Government has required that both the total needs and the individual needs of each hospital be clearly stated and justified before construction proceeds in any one. Because four hospitals, the Toronto General, the Toronto Western, new Mount Sinai and Sunnybrook, are all seeking approval for major expansion the pressure for an answer from the University is great.”¹¹²
He went on to say that “This necessitated a degree of co-operative planning between the University and the hospitals that has never occurred before.”

Academic medicine was finally coming into focus. It was on the verge of becoming an actual place. That idea emerged in the “Proposal on the Organization of the University Hospital System,” a 1968 report that called for a more formalized arrangement between the academic hospitals and the Faculty of Medicine.

As we shall see in the next chapter, in 1991 this report triggered a process to create a formal space for academic medicine, a health sciences council in Toronto—the Toronto Academic Health Science Council (TAHSC). This council would become the current location of academic medicine, an academic health science centre, the Toronto Academic Health Science Network (TAHSN). The creation of this new space was a product of fifty years of articulation of the discourses of Wealth Creation, Professionalization and State Responsibility on each other. This articulation created the modern object we know called academic medicine: a construction, a space, and a legitimate entity. Academic medicine was no longer simply an emergent idea; it was a contractually and materially defined space supported and
regulated by a tight net of agreements between the Faculty of Medicine and its affiliated hospitals.

**Where Was Academic Medicine Active from 1940 to 1990?**

The space of activity of Canadian academic medicine expanded considerably over the period from 1940 to 1990. While academic medicine’s primary operational focus remained locally based, the boundaries of its operations expanded to eventually reach far beyond the borders of Canada. By the 1950s, students were coming to study in Toronto from parts of Canada and the Caribbean that did not have their own local medical schools. By the 1960s, patients began to come to Toronto from across Canada to receive the specialized care they could not obtain in their local hospital. As the decades passed and as transportation improved, hospitals started accepting international patients and receiving dignitaries, just as the university had in the early part of the century. With this expansion of operations, by the 1970s the hospitals began reporting place of origin of patients in their annual reports in three categories; local, national, and international.

By the 1980s Toronto General Hospital was actively considering how it might provide its services to a more geographically dispersed patient base outside Canada. To this end, it began to consider the ideas of telemedicine and taking patients from the United States. This more global focus resulted in
the creation of new roles in the hospitals focused on the global space. By the late 1980s, the Faculty of Medicine was undergoing its own transformation. While it had always been more global than the hospitals, its idea of “global” was expanding. In the 1980s, its engagement outside Canada began to broaden considerably, to be more than simply the British Commonwealth and the United States.

This broader operational spatiality brought with it more a more reflexive engagement. Questions began to be asked as to what global engagement was producing. Directionality became part of the discussion. No longer was global engagement simply about what it could provide; questions began to be asked about what Canadians and Canadian academic medicine were and could be bringing into the global space and what they might be doing to other cultures. As early as 1959, culture, standards, health care and the education of physicians began to become contextual concepts. Assumptions of universality in health care and education became problematic; relativity became the basis of activity.

The Faculty of Medicine’s struggles with these new ideas appeared in the dean of medicine’s annual report in that same year:

Again during the year there have been discussions about methods of teaching and curricular changes. This ferment about how young men and women should be educated is world-wide, and will probably reach a climax in the second International Conference on Medical Education to be held in Chicago in the first week of September. It may be somewhat difficult to bring the meaning of medicine to a common international denominator.
Conditions, environment and ideals still vary from East to West and from North to South, but nevertheless it will be useful to take stock of our own values and to define for ourselves in Canada what we expect from our Doctors in the next quarter century, and what sort of education and training we should provide for those who bear the responsibility for this increasingly complex and varied discipline we call medicine.\textsuperscript{32}

If one had to summarize the changes in the spatiality of Canadian academic medicine in this era, two comments would suffice. First, it began to regularly operate in a truly global space. Second, with this global expansion, it began to think more reflexively about what it was doing, who was being affected, and what it might be transmitting in that global engagement. Or, more simply put, as Canadian academic medicine became more globally engaged it also became more sophisticated. It came to question the effects of its global engagement in terms of the power relationships involved.

**What Was Producing the Spaces of Academic Medicine from 1940 to 1990?**

Analyzing the space of Canadian academic medicine discursively in this era reveals several significant shifts in how the global space was understood. New rationales for going global began to emerge.

In the early part of this century, the global space was a Foucauldian utopia, a space of knowledge. The hospitals obtained new management insights in the global space. Their management practices were benchmarked against American
standards and institutions based outside of Canada performed their accreditations. Hospitals became better, and arguably more managerial, because of this global engagement. At the same time, the university also saw the global space as a utopia, a space of knowledge acquisition and reputational formation. Canadian academic medicine participated in the global space because it imagined itself improving because of that engagement. It saw that space as one in which to increase social, academic, and professional capital.

As this 50-year period progressed, the understanding of what the global space represented began to shift substantially. Three new understandings of it began to emerge. The first shift was a new directionality. Actions and activities in global space began to be connected to the local space. Canadian academic medicine’s assumptions and values were seen to travel with its professionals when they ventured outside of Canada. Global engagement lost its neutrality; the global space became one of potential consequences.

The second new understanding was that the global space was a place of social good, of service. Whereas before Canadians had gone outside of Canada to share knowledge or acquire it, for reputational formation per se, they began to go into the global space to help others. Hospitals had rarely looked to less developed countries to help patients. In this era, they began to consider how they could help foreign patients. At the same time, the university began to set
aside spots in its medical school for students from the Caribbean whose home
countries did not have one. The global space became one of social mandate, of
social good.

The third shift in understanding the global space happened in the late 1980s.
Canadian academic medicine began to think about financial matters in the
context of global engagement. Students from the global space came to Canada
with their governments’ resources supporting them. The Middle East became a
space of seemingly bottomless wealth. The United States became a place of
potential patients. The global space became a space of wealth creation.

Yet despite this new understanding of the global space as one of wealth creation,
this was not an era of a vast surge in global business engagement by either the
university or its hospitals. Few globally focused businesses were actually
established. It was an era in which the idea of business in the global space
emerged. Seeds were sown. Leaders began to think about how the potential
riches clearly available in the global space might be obtained to service Canada’s
needs. Imagination was running wild. The global space became an imaginary
space of financial solutions that would solve the rising financial challenges in
Canada. It became the space in which Canadian academic medicine’s expertise
could be monetized.
In the next chapter, I will explore the results of this new understanding of the global space in detail. More specifically, I will discuss how this new thinking made possible a partnership between the Ontario government, several of Toronto’s academic hospitals, and a cross-section of private industry to form a new object: a health care consulting company called Interhealth Canada. I will chart its creation and its spectacular collapse, exploring how both were made possible by the ferment of discourses and the conceptions of spatiality established between 1940 and 1990. Just as the collapse of the private patient pavilions gave way to efforts to monetize the global space, the collapse of Interhealth and, with it, certain aspirations for wealth generation in the global space gave way to the creation of yet another new object, a new child of academic medicine and government. The next and current era would witness the rise of a new institution to link Canadian academic medicine and industry in the global space: the MaRS Discovery District.

**Conclusion**

The era from 1940 to 1990 was one of State investment in Canadian academic medicine—in which health care benefited to a significantly greater degree than education. This was the era in which a national publicly funded health care system was created. As this investment in health care was happening, educational leaders in the Faculty of Medicine were watching with increasing concern, concern that the increasing flow of funds to health care would reduce
needed investment in education. This concern was to be proven prescient by the 1970s.

As the State made investments in health care, it became aware by the 1970s its ability to fund health care might eventually be exceeded the rising costs of delivering it. As this awareness was emerging, the Ministry of Health of Ontario became more managerial and invested in the oversight of how its funds were being used by the institutions of Canadian academic medicine. It also began to question the management practices of the hospitals more actively. Audits and increasing surveillance of hospitals were the result. As the government became more managerial and concerned with the use of its cash, the institutions of Canadian academic medicine began to adopt a more commercial logic. As this commercial logic gained influence and legitimacy in Canadian academic medicine, an era of corporatization gained steam. Accounting practices in the hospitals and in the Faculty became increasingly sophisticated. Business concepts and terms began to permeate the administration of these institutions. New corporations were created to manage risk, to oversee investments, and to generate new revenue streams to supplement State funding.

By the 1980s, the University of Toronto Faculty of Medicine was quite concerned with its own financial situation. It began to actively consider new ways to generate revenues and to free up State funds for its own use. The dean of the
Faculty of Medicine’s trip to the Middle East in the mid-1980s marked a turning point that set in motion global commercial engagement in the hospitals and in the Faculty that was to expand rapidly in the 1990s. Upon the dean’s return from the Middle East, he was persuaded that its resources and its demand for consulting regarding health care systems could be the answer to the Faculty’s financial problems. Based upon his analysis, he embarked on a letter-writing campaign to stimulate Middle Eastern commercial engagement on the part of the Ontario government, the academic hospitals, and other faculties in the University of Toronto.

As the Dean was prosecuting this campaign to broker Middle East commercial engagement, he was also actively involved in transforming the Faculty’s financial structure. Based upon the same commercial logic, he began to make changes in the Faculty’s fee structure. The educational model for postgraduate medical education began to change into a business model. An initial rise in fees for Canadian students was followed by significant fee increases for international students. In this shift, the Faculty began to charge fees based upon a market concept of supply and demand—an innovation, albeit a somewhat regressive one.

Spatially, Canadian academic medicine changed in two distinct ways in this era. Operationally its reach expanded dramatically to include a truly global space. It
began to engage regularly with countries, students, and patients from outside its normal catchment area, from anywhere outside Canada per se. Shifts in technology made travel to Canada for medical care and medical education more feasible.

More importantly, a new spatial logic emerged. Up until this era, the global space had functioned primarily as a space of knowledge, of reputational formation and academic legitimacy. By the 1990s, the global space began to be seen as a space of riches, of potential financial salvation and commercial engagement for Canadian academic medicine. Whereas before Canadian academic medicine had gone abroad to bolster reputations and gain knowledge, the leadership of Canadian academic medicine began to formulate plans to mine the global spaces for riches—or more precisely, to access the oil wealth of the Middle East to pay for healthcare and education services in Canada. It had become possible for the leadership of Canadian academic medicine to conceptualize the monetization of its expertise to self-fund. While no actual contracts were signed, and cash had yet to begin to flow, this era nevertheless marked a dramatic shift in the logic dominating Canadian academic medicine. As of the late 1980s, the global space had become a potential financial utopia and plans were afoot for global commercial engagement.
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Chapter 8: 1990 to Current Day

Introduction

The era from 1990 to 2016 was a period of financial challenge for the province of Ontario. Without going into excessive detail, suffice it to say that its economic challenges were many. It had multiple deep recessions. It was dealing with the effect of a volatile Canadian dollar and its effects on Ontario’s exports, problems in key industrial sectors, declining tax revenues, rising expenses, a boom-and-bust stock market, and most worrisome, rising debt levels.\textsuperscript{1-4}

The Commission on the Reform of Ontario’s Public Services’ report, “Public Services for Ontarians: A Path to sustainability and Excellence,”\textsuperscript{5} released in 2012 described Ontario’s economic situation as facing more severe economic and fiscal challenges than most Ontarians realized, saying…

We can no longer assume a resumption of Ontario’s traditional strong economic growth and the continued prosperity on which the province has built its public services. Nor can we count on steady, dependable
revenue growth to finance government programs. . . . Many of these benefit programs are not sustainable in their current form. . . . The treatment may be difficult, but it is worth the effort.15

This report was released after years of policy efforts by the Ontario Government to control its expenditures. Those policy efforts included reports and bills directly targeting the costs of medical education (e.g., “Toward Integrated Medical Resource Policies for Canada” [the Barer-Stoddard Report]2,6-11) and health care (Bill 8, “An Act to establish the Ontario Health Quality Council”12 and the Social Contract Act,13 a bill that imposed substantial funding cuts across all of its publicly funded institutions and unpaid leave obligations on their employees.13,14

In this same era, the federal government of Canada was also wrestling with the cost of Canadian health care. In 2002 it released the Kirby Report,15 a somewhat philosophical exploration of health care and the federal government's role in its funding.15 In 2004, two years after the release of the Kirby Report and extensive negotiations with the provinces, the federal government agreed to supplement its annual health care transfers to the provinces with a further $10 billion paid over ten years.16 These funds, while welcome, did not solve the Ontario government’s health care financing issues.5,12 Nor did they solve the funding issues of the Toronto academic hospitals and the university, where they were seen as too little and too late to offset the effects of decades of cost cutting.16-20
These policy initiatives did send a message to the leadership of Canadian academic medicine that changes in management practices were required.\textsuperscript{2,16-21} Discussions of alternative funding, or ancillary revenues, began to appear in the minutes, strategic plans, and financial reports of Canadian academic medicine as early as 1990. Over the next decade, the tone of discussions about ancillary revenues began to change. Where in the early 1990s discussion about ancillary revenues manifested as a seeming afterthought, as the decade progressed they began to be discussed as matters of strategic import to the various institutions.

**Michael Porter and Centres of Excellence**

In the early 1990s Michael Porter, a business scholar at Harvard, was publishing findings on the determinants of national prosperity that challenged scholars and policy researchers. He argued that classical economic ideas about prosperity were simply wrong.\textsuperscript{22-24} That labour, interest rates, natural resources, and currency rates were, if not unimportant to the creation of national wealth, not nearly as influential as a nation’s capacity to innovate.\textsuperscript{22} He also argued that a nation’s capacity to innovate was dependent on strong domestic industries composed of strong competitors, extensive supply chains, and, as he put it, “demanding customers.”\textsuperscript{22} Leaving aside the validity of his arguments, which have been much critiqued, their impact was profound and far-reaching.\textsuperscript{23-26} Simply put, his research triggered a new era of thinking about determinants of national wealth creation, making it possible for health care to be thought of as a sector of the Canadian economy and a potential contributor to national wealth.\textsuperscript{27-}
Porter’s work triggered two decades of policy activity in Ontario focused on the creation of a local health sector. It made a new way of thinking about Canadian academic medicine possible, one that conceptualized it as a domain that could contribute to national wealth creation. It also linked health care, academic medicine, and wealth creation with the global space. In fact, his work had a major effect on thinking globally.

I would not argue that Porter’s work is the reason it became possible for Canadian academic medicine to commercially engage at a global level, or that he invented the idea that health care is a sector of the economy. What I would argue is that his work contributed to a shift in thinking about the role of the State in wealth creation by creating a pathway for a health sector in Ontario that lay in global space.

**The Rise of Commercial Thinking—1990 to 2016**

In the shadow of the policy actions described above and Michael Porter’s work, there has been a significant rise in the level of commercial thinking in Canadian academic medicine. Financial statements, strategic plans, annual reports, and board minutes acquired a more corporate tone and focus in this era. Financial issues became lead topics of discussion in meetings and in documents. New financial terms such as “ancillary revenue,” “alternate revenue generation,” and “non-ministerial revenue” began to appear in board documents in 1991.
Questions such “Who is our customer?” “What needs do we meet?” and “What advantages do we have?” began to be asked in strategic retreats. This was an era in which business logic began to dominate the executive offices of Canadian academic medicine.

The Financialization of Canadian Academic Medicine

I would describe this shift in management thinking as financialization. That is to say, management thinking in Canadian academic medicine moved from being focused on concepts such as patients, health impact, health professional practices, and societal benefit to include such concepts as customers, markets and, most importantly, profitability. Descriptions of clinical issues began to include financial metrics: “Due to limitations from staff shortages in PICU, foreign patients requiring cardiac services were deferred. Media attention and Ministry of Health intervention resulted in a decrease in foreign patient revenues of approximately $1,000,000.”35

Where numbers were not used, financial concepts and business terms such as “maintenance plans” and “downsized” were often used to give weight to observations: “Although the budget is balanced, underfunded inflation and legislated increased costs that were absorbed have created identified risks in the plan. . . . [The plan] is best described as a maintenance plan. The Hospital for Sick Children’s current position as Canada’s leader in paediatric health care will be preserved within a balanced operating budget. In order to accomplish this
objective, the Hospital will operate at full strength in clinical areas, while management and support groups will be downsized.” 35

Strategic plans began to order their strategic objectives somewhat differently, with finances ranking as the primary objective and clinical services ranking last out of five: “1. To create and maintain an operating surplus in order to allow us to achieve our strategies and meet our goals . . . 5. To ensure that a full range of clinical services is maintained to meet the needs of children in Metro Toronto through collaboration with other hospitals.” 36

This represented a decided shift in logic. After this shift, revenue generation was understood to be a responsibility of Canadian academic medicine. Questions about revenue generation shifted from whether Canadian academic medicine should, or should not, engage in commercial activities to how and where Canadian academic medicine could commercialize its activities. While it was not stated explicitly, under this logic obtaining and maintaining financial security seemingly became the institutional objective, and thus clinical services became the mechanism through which to achieve it.

This financialization gained strength as Canadian academic medicine wrestled with rising costs and merely nominal increases in government funding. The financial challenge is illustrated below in Table 8.1, which shows financial statements for the University of Toronto for the fiscal years ending April 30, 2007, 2015 and 2016.
Table 8.1: Financial Statements for the University of Toronto for the Years Ended April 30, 2007, 2015 and 2016 (Millions of Dollars)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Revenue</strong></td>
<td>1,942.0</td>
<td>2,839.4</td>
<td>2,999.0</td>
</tr>
<tr>
<td>Investment Income (Loss)</td>
<td>134.4</td>
<td>191.8</td>
<td>109.1</td>
</tr>
<tr>
<td>Expendable Donations</td>
<td>74.8</td>
<td>85.8</td>
<td>113.6</td>
</tr>
<tr>
<td>Sales, Services, and Sundry Income</td>
<td>212.9</td>
<td>292.0</td>
<td>301.6</td>
</tr>
<tr>
<td>Grants for Restricted Purposes</td>
<td>319.7</td>
<td>397.4</td>
<td>382.9</td>
</tr>
<tr>
<td>Student Fees</td>
<td>538.9</td>
<td>1,158.6</td>
<td>1,291.7</td>
</tr>
<tr>
<td>Grants for Operations</td>
<td>661.3</td>
<td>714.1</td>
<td>710.1</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>1,807.5</td>
<td>2,551.6</td>
<td>2,689.4</td>
</tr>
<tr>
<td>Other</td>
<td>127.3</td>
<td>181.4</td>
<td>216.5</td>
</tr>
<tr>
<td>Utilities</td>
<td>52.5</td>
<td>55.5</td>
<td>61.4</td>
</tr>
<tr>
<td>Inter-institutional Research Contributions</td>
<td>61.2</td>
<td>67.0</td>
<td>68.3</td>
</tr>
<tr>
<td>Cost of Sales and Services</td>
<td>77.7</td>
<td>85.0</td>
<td>88.7</td>
</tr>
<tr>
<td>Repairs and Maintenance</td>
<td>61.4</td>
<td>107.3</td>
<td>124.8</td>
</tr>
<tr>
<td>Amortization of Capital Assets</td>
<td>99.1</td>
<td>152.1</td>
<td>158.6</td>
</tr>
<tr>
<td>Materials and Supplies</td>
<td>150.5</td>
<td>151.8</td>
<td>162.3</td>
</tr>
<tr>
<td>Scholarships, Fellowships, and Bursaries</td>
<td>115.9</td>
<td>206.0</td>
<td>218.5</td>
</tr>
<tr>
<td>Salaries and Benefits</td>
<td>1,061.9</td>
<td>1,545.5</td>
<td>1,599.3</td>
</tr>
</tbody>
</table>

Reviewing these statements, several comments can be made. At the most basic, the University appears to be financially healthy, in that its revenues exceed its expenses in each of the three years. Looking more closely at these statements reveals that an increase of 140 percent in student fees, from $538 million in 2007 to $1.3 billion in 2015, was the primary source of this financial health. The increases in the university’s other revenue streams were significantly less impressive. Investment income was quite variable over this period. It rose by approximately 50 percent from 2007 to 2015 but then fell by approximately 43 percent, or $80 million, from 2015 to 2016. Sales, services, and sundry income increased by approximately 42 percent, from $213 million to $301 million. Philanthropic income ("Expendable Donations") increased by 52 percent from $75
million to $114 million. However, government grants increased by only 12 percent, from $981 million to $1.1 billion over this same period.

These trends were not sustainable, and by 2016 the university found itself in what it would describe as a “structural budget challenge.” Its revenue growth was being outpaced annually by its expense growth. Table 8.2 below, from its 2016 to 2020 budget forecast document, quantifies this annual structural deficit as 1 percent based upon a 0 percent increase in government operation grants, 3 percent increases in domestic tuition, 5.9 percent increases in international tuition, and 2 percent increases in other income.

**Table 8.2: Structural Budget Challenge at the University of Toronto**

<table>
<thead>
<tr>
<th>Revenue Share by Category</th>
<th>Percentage of Revenue</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Grants</td>
<td>28 %</td>
<td>0.0%</td>
</tr>
<tr>
<td>Domestic Tuition</td>
<td>27 %</td>
<td>3.0%</td>
</tr>
<tr>
<td>International Tuition</td>
<td>25 %</td>
<td>5.9%</td>
</tr>
<tr>
<td>Misc. Other Revenue</td>
<td>20 %</td>
<td>2.0%</td>
</tr>
<tr>
<td><strong>Weighted Average Increase</strong></td>
<td></td>
<td><strong>2.7%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expense Share by Category</th>
<th>Percentage</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation</td>
<td>65%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>27%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Student Aid</td>
<td>8%</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Weighted Average Increase</strong></td>
<td></td>
<td><strong>3.7%</strong></td>
</tr>
</tbody>
</table>
While it was not possible to access internal finance statements for the University of Toronto’s Faculty of Medicine, it was clear from the university’s financial statements that the Faculty was in poor financial shape. In those statements, the Faculty was described as being in “financial difficulty” and as having “intractable budget challenges.” It was also described as being the recipient of $1 million in supplemental financial support from the central university to address its financial challenges, specifically to aid its basic science department’s expenses.

In this era, the Ontario government was wrestling with its finances and reducing its support of Canadian academic medicine. The government was also aggressively pursuing legislative actions focused on cost controls that sent very strong messages to academic medicine to focus on its financial structures. That message was received by Canadian academic medicine as an injunction to become more commercial. The leadership of Canadian academic medicine focused on ancillary revenues and a new era of commerciality arrived. In this context, the global space became the new frontier for Canadian academic medicine, a distant and imaginary space where it could pursue commercial activities that it could not within the boundaries of Canada. Expertise in health care, education, and management became something that could be sold. These changes can be seen in the shifts within the discursive formation of Canadian academic medicine, shifts that made possible its global commercial engagement.
The Four Discourses of Academic Medicine: 1990 to 2016

The discursive formation of Canadian academic medicine entered the era from 1990 to 2016 in a state of flux. Simply put, the discourse of Wealth Creation was in ascendancy, transforming many aspects of Canadian academic medicine profoundly. The belief that Canadian academic medicine should be, or could be, funded by the State out of tax revenues was fading. A new belief was emerging, one that imagined funding solutions for Canadian academic medicine could be found in private industry, and more importantly, in its commercial logic. Business logic began to displace, if not replace, public service logic in Canadian academic medicine. The ideas of “patients” and public payment for services were being replaced by ideas of “customers” and fees for service.\textsuperscript{41-43}

As the discursive formation for Canadian academic medicine shifted, it produced a wide variety of new ideas, concepts, objects, and subject roles. Many of these new ideas, objects, and subject roles were part of a shift in Canadian academic medicine to become a fiscally productive domain based upon health care. That is to say, they were part of a shift to realize Michael Porter’s ideas within the domain of academic medicine and to transform it into a contributing part of the Canadian economy. Table 8.3, presenting the discursive articulations of this era, illustrates this shift and the new character of Canadian academic medicine.

Table 8.3: Discursive articulations and their effects, 1990 to 2016
<table>
<thead>
<tr>
<th>Discourse</th>
<th>Major Issue</th>
<th>Articulation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Social Obligation</td>
<td>To enhance funding of medical education research</td>
<td>A1: Social Obligation modified by Wealth Creation</td>
<td>Creation of research chairs in medical education research funded by industry as part of a corporate Social Obligation mandate (BMO Chair, Wilson Centre, University of Toronto)</td>
</tr>
<tr>
<td></td>
<td>To create and fund global health engagement</td>
<td>A2: Social Obligation modified by State Responsibility and Professionalism</td>
<td>Philanthropic donation made to create a school of public health and increase a Social Obligation mandate within the Faculty of Medicine, ($24 Million Paul and Alessandra Dalla Lana School of Public Health)</td>
</tr>
<tr>
<td></td>
<td>To align strategic goals between executive offices and foundations</td>
<td>A3: Social Obligation modified by Wealth Creation</td>
<td>Ties between foundation offices and corporate offices became closer. Strategic planning for corporate offices and foundation offices became jointly coordinated so that resources were used more &quot;efficiently.&quot;</td>
</tr>
<tr>
<td>B: State Responsibility</td>
<td>To transform academic medicine from public service to an industrial domain</td>
<td>B1: State Responsibility modified by Wealth Creation</td>
<td>The idea of a “health sector” emerged in the early 1990s. This new idea transformed academic medicine from being simply supported by the State to being an engine of wealth creation. This idea made possible the ideas of tax incentives and government sponsored investment funds directed at the creation of the health sector. (Canada Medical Discoveries Fund)</td>
</tr>
<tr>
<td></td>
<td>To create an accessible pool of private capital for the medical sector</td>
<td>B2: State Responsibility modified by Wealth Creation</td>
<td>Direct financial investment by the government in the health sector, the intent of the investment being to bridge companies to profitability. ($6.6 billion Ontario Government Fund)</td>
</tr>
<tr>
<td></td>
<td>To encourage the growth of the health sector</td>
<td>B3: State Responsibility modified by Wealth Creation</td>
<td>The creation of government-industry councils with mandates to develop a health sector. Councils were established to bridge academia and the public and private sectors, to provide marketing support for the health sector in the local and global space, and to inform government policies with respect to the development of a health sector. (Ontario Enterprise Council)</td>
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<td>B4: State Responsibility modified by Wealth Creation</td>
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**Academic Medicine is a Social Obligation**

In the era from 1990 to 2016, the discourse of Social Obligation was undergoing a significant change and remerging as a significant economic force in Canadian academic medicine. Along with revenue generation, fund-raising became an increasingly important source of funds for academic medicine. Large fund-raising drives were launched by all of the hospitals and the university. The largest donation in the University Health Network (UHN)’s history, $100 million, was received in 2017 to fund medical research. As fund-raising rose in importance for Canadian academic medicine, the professionalization of fund-raising offices continued to increase. They began to integrate more closely with the leadership of Canadian academic medicine and to align their strategic foci with those of their academic medical institution more closely.

**Articulation A1: Social Obligation and Wealth Creation**

In this era the articulation of the discourse of Wealth Creation on the discourse of Social Obligation produced donations to Canadian academic medicine from a new category of donor—corporations. As a result of the increasing professionalization of the fund-raising offices, a more aggressive push to raise funds brought corporations with a corporate Social Obligation agenda under their...
scrutiny. One product of this articulation was the BMO Chair in Medical Education Research\textsuperscript{49} located in the Wilson Centre, an extra-departmental unit jointly governed by the University of Toronto’s Faculty of Medicine and UHN.

**Articulation A2: Social Obligation, State Responsibility and Professionalism**

The articulation of the discourses of Professionalism and Social Obligation on the discourse of State Responsibility produced a $24 million donation to fund a new academic centre within Canadian academic medicine, the Dalla Lana School of Public Health.\textsuperscript{44,50} The creation of this new school within the Faculty of Medicine in the University of Toronto brought the domain of public health, with its ideas of social accountability and a broader idea of health, back into the University of Toronto’s medical school, ideas that had been de-emphasized in the Faculty approximately eighty years earlier.\textsuperscript{44,50}

To understand the importance of this articulation, it is important to understand the history of public health and its relationship to the Faculty of Medicine in the University of Toronto. At the turn of the 19th century public health was a domain hosted within the Faculty of Medicine. Discussions are recorded in the minutes of Canadian academic medicine about determinants of health and how the Faculty and its hospitals might function at a systemic level to improve societal health. In that era, concepts of health and health care supported a broad tent, one in which interventionist procedural medicine shared space with public health. Over time, as
medicine became more and more focused on science and research, public health became less valued as a domain within the Faculty, until it was finally expelled from the Faculty of Medicine in the 1930s. With that expulsion, the ideas of what defined academically important and legitimate work within the medical school became much more focused on medical research at the individual, micro level. Interestingly, that same era was when academic medicine was also actively exploring revenue generation in the form of the private pavilions for health care.

These transformations in the Faculty provided important evidence for me about the boundaries of the various discourses and how their composition had changed over time. More specifically, I would argue that public health’s expulsion from and subsequent readmission to the medical school are indications of how the Faculty’s conceptualization of mentalities of social good, societal improvement, and societal engagement have been constructed and changed over time. I would also argue that these ideas of social good, of public health, and of a collective are in direct opposition to the ideas of commercialization and financialization, and that the creation of the Dalla Lana School in the Faculty of Medicine was made possible because of resistance to the recent rise in commercial thinking in academic medicine. Finally I would argue that this pattern is evidence of a regulatory relationship present within the discursive formation of Canadian academic medicine that imposes limits on how much any one discourse can manifest at one time. This finding also suggested to me that it was possible that Canadian
academic medicine could only permit so much revenue generation within it before its identity became destabilized.

**Articulation A3: Social Obligation and Wealth Creation**

In this era, the articulation of the discourse of Wealth Creation on the discourse of Social Obligation brought a new integration between fund-raising offices and executive offices in Canadian academic medicine. This integration took the form of much closer strategic planning processes, so that resources and organizational goals became much more coordinated. Communications about strategic objectives from both categories of offices began to show a striking similarity and to reference the other office.\(^{51,52}\) They regularly and explicitly discussed shared objectives such as “to develop a joint operating process in collaboration . . . that will maximize the use of combined Hospital and Foundation resources . . . to meet the Strategic needs of the Hospital, by achieving the goals of the Foundation.”\(^{51}\)

Where before there had been a distinct separation between fundraising offices and the leadership offices of Canadian academic medicine, the distance and the boundaries between these offices began to disappear.

**Academic medicine is a State Responsibility**

The era from 1990 to 2016 was one of financial adjustment for Canadian academic medicine. After fifty years of funding increases, Canadian academic medicine had become an immensely important and enormously expensive
operation. While cognizant of the importance of Canadian academic medicine as a societal service, the State had begun to see its regular requirements of funding increases as simply unsustainable. In this environment, new thinking began to emerge about the financing of Canadian academic medicine. Commercial ideas began to appear in a variety of forms. Canadian academic medicine began to monetize its assets more aggressively. Parking rates began to rise. Hospitals began to rent space to commercial enterprises. Pharmacies were opened in hospitals as way to generate substantial revenues. Bookstores began to appear. At a system level, this shift in logic triggered a long process of transformation in how Canadian academic medicine was understood, managed, and financed. Where before the administrative gaze had been focused on policy goals and health impacts, now it began to focus on ideas of efficiency, of value for money, and of Canadian academic medicine as a monetizable domain.52-56

Articulation B1: State Responsibility + Wealth Creation

This shift in logic, a product of the articulation of the discourse of Wealth Creation on the discourse of State Responsibility, produced a wide variety of new objects, roles, and ideas in Canadian academic medicine. One core idea that was produced under this articulation was that Canadian academic medicine, its research, its practices, and its offerings could be monetized to the benefit of their institutions and the country. In essence, Michael Porter’s ideas began to permeate the domain of health and education in Canada. This was a profound shift for Canada and the domain of academic medicine, one that defined a new
way of thinking about the governance, funding, and management of Canadian academic medicine.

Under this new logic, it became possible to think of Canadian academic medicine as a domain of service to society and as an industrial sector of the economy. Where before Canadian academic medicine had been understood to be a service that the State funded to benefit society, under this logic it became a domain of industry and a new object was produced—a “health care sector”. This new idea blurred the boundaries between the ideas of industry and public service and as a result produced a radically different way of thinking about health care and academic medicine. Under this way of thinking, it became possible to focus on the monetization of research, health care, education, and the services of health care professionals. It also became possible to understand Canadian academic medicine as participatory in its own funding. Terms such as “revenue generation,” “sales,” “marketing,” “business consulting,” “offshore manufacturing,” and “profit” began to circulate within Canadian academic medicine. Strategic plans and board discussions began to focus on how Canadian academic medical institutions might commercialize their offerings and generate revenues.

A reasonable working definition of a health sector that captures much of this idea can be found in Wikipedia: “[the health care sector is] an aggregation and integration of sectors within the economic system that provides goods and
services to treat patients with curative, preventive, rehabilitative, and palliative care. It includes the generation and commercialization of goods and services lending themselves to maintaining and re-establishing health. The modern healthcare industry is divided into many sectors and depends on interdisciplinary teams of trained professionals and paraprofessionals to meet health needs of individuals and populations.\textsuperscript{57}

Under this definition, the health care sector is conceptualized as a domain of private industry, clinical services to patients, and innovation. Trying to understand the spatiality of a health sector in my data was challenging. The term “health care sector” seemed to be used in three ways. It was used to describe a domain that was distinct from academic medicine, that was attached to academic medicine, that was part of academic medicine and held academic medicine within it. In addition to this descriptive use, it was used aspirationally, to indicate a space under formation, an imaginary commercial space undergoing a process of becoming in Canada, a heterotopic space of commercial productivity in the United States.\textsuperscript{2} Finally, the term also had a productive characteristic. While “health care sector” was primarily used to describe something external to Canadian academic medicine, it was also used formatively, to imply that Canadian academic medicine and its constituent institutions were, or should be, part of a health care sector. In essence the term was used in three ways: descriptively, aspirationally, and formatively, all at the same time.
My analysis of who first used the term was interesting. For a Foucauldian, identifying who is authorized to say things, what role they occupy when they say them, and what they represent when they say them provides evidence on what discourses are producing. My review of the academic literature found the first usage of the term “health care sector” in 1967, in the title of an article addressing health policy in the journal *Medical Care.* Over the next several decades the term began to appear more and more frequently, evidencing increasing acceptance, a shift in thinking per se. As of the early 1990s the term began to appear in Ontario Ministry of Health documents and ministerial speeches as an industrial domain described as biotechnology. “In its broadest sense biotechnology is neither an industry nor a sector. It is an enabling technology which has applications in a number of industries or industrial sectors, e.g. agri-biotechnology, biopharmaceuticals, bio-diagnostics, environmental biotechnology.”

“Biotechnology,” while often used to describe a domain external to Canadian academic medicine, one part of private industry, was also used as a term that incorporated Canadian academic medicine’s institutions into its idea: “Ontario has many of the ingredients for a thriving biotechnology industry . . . . Ontario boasts an impressive 18 research-affiliated hospitals, 17 universities, and 18 government research laboratories. Toronto’s teaching hospitals and their
research institutes form the nucleus of one of the largest centres of medical and clinical research in North America.\textsuperscript{66}

Eventually the term biotechnology gave way in ministerial speeches to the more precise term, “health sector”: “Premier Bob Rae and Health Minister Ruth Grier today announced that Ontario Health Industries will invest $28 million in the Ontario health sector—more than matching the government’s $6.6 million in start-up finding. Over the next 10 years, the government’s Sector Partnership Strategy could bring 40,000 new jobs to Ontario. That strategy is designed to encourage growth in Ontario-based industries by working co-operatively with the private sector.”\textsuperscript{67}

The arguments in support of this new idea, the creation of a nascent health sector in Ontario, often relied upon concepts such as provincial leadership and provincial pride. “Ontario has been accused of lacking leadership or a unified approach to dealing with biotechnology. This, coupled with a growing investor and media interest in biotechnology applications, requires the government to re-examine its role with respect to biotechnology—or the biotechnology industries.”\textsuperscript{65} The arguments for the creation of an Ontario health sector were also quite pragmatic in nature, recognizing that a core driver of cost increases in health care in Ontario was trade related, that a majority of the input costs for health care were shipped across the border from the US to Canada.
Also driving the creation of a health sector in Ontario was a belief that it would materially change the economic relationship between Ontario and the United States: 80% of what was consumed as supplies, products, drugs, etcetera, in the Ontario health system, came over the border by truck from the United States. 80%... you could understand advanced medication coming from elsewhere, you know, plastic bedpans, all the kind of, you know beds. So... had started some work... on how do we could get more stuff for the health system manufactured in Ontario instead of coming over the border. So here we are, in those days spending 20 billion now its 50 billion a year, and nobody is really looking at the potential for economic benefits²

This drive to create a health sector in Ontario shifted thinking in Canadian academic medicine dramatically. While it did not radically transform Canadian academic medicine into a purely commercial domain, it did make commercial thinking significantly more legitimate within it. With the legitimization of commercial thinking, the norms of professionalism, scientific research, and public service began to shift and the idea of monetizing their practices and discoveries became more broadly accepted. These changes, and the decades of policy efforts underpinning them, eventually transformed thinking within Canadian academic medicine such that commercial global engagement became an easily accepted idea.

**Articulation B2: State Responsibility + Wealth Creation**

One policy initiative produced by the articulation of the discourses of State Responsibility and Wealth Creation was government support for junior companies in the nascent health sector. These funding initiatives emerged from a new office created by the Ministry of Health, the Health Economic Development
Office, and came in several forms.\textsuperscript{68} One funding initiative produced by this articulation, a $6.6 billion fund, was established to provide direct government investment in junior health sector companies to help bridge them to profitability.\textsuperscript{68}

A second funding initiative produced by this articulation was the creation of tax incentives for companies to create investment funds for the health sector. The Canadian Medical Discoveries Fund was created as a result in 1994.

**B3: State Responsibility + Wealth Creation**

In the same vein, the articulation of the discourses of Wealth Creation and State Responsibility also produced health sector councils. These councils were composed of individuals drawn from the health domain, from private industry, and from government. They were intended to create a forum in which political, academic, clinical, and commercial knowledge could be shared. Examples of this new object include the Ontario Enterprise Council (1993),\textsuperscript{64} the Health Industries Sector Council (1994),\textsuperscript{67} and the Health Industries Development Council (1995).\textsuperscript{67}

While the mandates of these councils varied somewhat, they all were tasked with a common goal: to facilitate the development of a healthcare industry sector in Ontario via the monetization of the intellectual property of the health domain in Ontario government. The terms of reference for the Ontario Enterprise Council typified this mandate in that it was tasked with “initiating and maintaining a
network comprised of interested Ministries to pursue marketing opportunities and partnerships for public sector expertise." Further, it was expected to “evaluate Government of Ontario potential for the marketing of services in domestic and international markets” and to “examine Government of Ontario revenue regulations with a view to recommend ways and means of encouraging entrepreneurial activities on the art of provincial Ministries and agencies for the domestic and international marketing of government expertise and services.” Finally, it was to “promote, broker, supply and provide support to the private sector in partnerships to access markets.”

The creation of an international trade mission to explore “market opportunities” outside Canada flowed from this idea. “Team Ontario” trade missions consisted of health sector companies, health care institutions, and government bureaucrats, and were modeled on the Canadian federal government’s “Team Canada” missions.

**Articulation B4: State Responsibility + Wealth Creation**

In addition to producing new objects and new policies, the articulation of the discourses of Wealth Creation and State Responsibility also produced a shift of behavior in the Ontario government. Where previously the Ontario government had functioned as a governing and funding body for the academic medical domain, under the influence of this articulation it decided to become directly involved in the management of the domain and the monetization of the expertise.
of Canadian academic medicine.\textsuperscript{3,69,70} In 1994 this manifested in the formation of a new object, a private company jointly funded by the Ontario government and private industry, InterHealth Canada (InterHealth).\textsuperscript{2,70-74}

This company and the government policy driving it emerged from two assumptions. The first assumption, described in my last chapter, was that there was a significant demand for Western expertise in the health profession’s education, hospital construction, and health care in the Middle East. The second assumption was that Ontario, and Canada, lacked companies that had sufficient financial capacity and managerial depth in the health sector to compete for business in the Middle East.\textsuperscript{2,72}

The story that got told frequently was that there had been a tender in Asia, maybe Malaysia, maybe the Philippines, and they wanted someone to come in and do 911 in the whole country. Bell was interested in bidding, but they didn’t have the health expertise, and they couldn’t find anyone in the consulting world big enough to step up and be their partner. There were, like, 20 smalls firms, and they tried a consortium. And there ended up being three or four Canadian bids. So, the other countries had clearly figured out, and we had in other aspects like SNC. Well, we had, in those days Lavalin and SNC [large Canadian engineering companies], and they eventually merged. But in engineering we had the capacity to go globally and bid on railway, or on subway system, or that. But in health care we had a fragmented collection. So the recommendation was from the government of the study was that we create, essentially a marketing company. That ended up being called InterHealth Canada.\textsuperscript{2}

The proposal to create InterHealth was presented to the Ontario cabinet in a briefing document on March 30, 1994.\textsuperscript{69} This briefing document observed:
In February 1993, The Minister of Health appointed the Health Service Exports Advisory Committee, chaired by Graham Scott, to develop a strategy to assist Ontario’s health consulting companies secure international contracts on a major scale. The Committee was drawn from a cross-section of consultants, architects, health product firms, health service providers, health associations, the health academic community, labour, and the provincial and federal governments.

The Committee identified significant market opportunities in the international health-consulting sector. For example, the International Financial Institutions [IFIs] have committed approximately $6 billion to health care sector projects around the world over the past two years. The committee also concluded that Ontario’s health consulting firms, product firms, and other organizations are well positioned to benefit from this increasing international allocation of funds for health consulting projects. The excellence of Canada’s health care system has an international reputation and a number of our private sector firms have begun to establish a solid reputation in world markets.

The briefing document concluded with the recommendation that the Ontario government create a private company capitalized with $7 million of public money and $3.5 million from private investors:

The Health Services Export Advisory Committee concluded that Ontario’s real competitive advantage and opportunity lies in the ability of the private and public sectors to come together cooperatively to present competitive packages to the international marketplace. The Committee unanimously recommended that a permanent, identifiable and credible organization was the only way to ensure an ongoing internationally successful track record. It was recommended that a for-profit corporation, InterHealth Canada Limited, would have the greatest chance of success. InterHealth would function as a general contractor combining the expertise of its private and public sector organizations, institutions and associations drawn from across Canada. The Committee estimated that InterHealth would require $7 million over four years in order to become self-financed and profitable by its fifth year. In its final report, Outward Bound, submitted to the Minister of Health in September, 1993, the Committee recommended that the Ontario Government invest up to $3.5 million over four years in InterHealth, to be matched by the sector.
Interestingly, a secondary rationale was also circulating to support the creation of InterHealth. It built upon the analysis of the Barer Stoddard Report\textsuperscript{6-8} that there was an oversupply of health professionals in Ontario who could not find work in the Province: “the economy was in the tank. We had an oversupply of doctors, an oversupply of nurses and an oversupply of consultants, mostly in Ontario. This is a well-educated resource so surely there is something we can do with them. It was a creative idea.”\textsuperscript{3}

This secondary rationale constructed InterHealth as a health human resource solution for this oversupply of health professionals in Ontario, a solution that would offer them an alternative to emigrating to the United States to find work.\textsuperscript{3,75}

Together these two rationales created a political story that presented the Ontario government of the day in a favourable light: “The Minister should be high profile, and should deliver the message that economic development is healthy public policy. The Premier and the Minister of Economic Development and Trade should be included in the announcement launching Interhealth, along with the newly elected Chair of the Board of Directors.”\textsuperscript{69}

InterHealth was framed as progressive public policy that evidenced a forward-thinking government; one that was innovative, business friendly, and financially progressive.

Interhealth Canada will finance its private projects though conventional or venture financing. Retained income generated by these projects will be used initially to support the long–term costs of
bids in the public sector as illustrated below. Ultimately, these will become self-sustaining.

The company will continue to take a conservative financial approach, but expects to be breaking even in three years. By the fifth year, we expect to have shown a record of growth and returns sufficiently attractive to satisfy our shareholder’s return expectation while supporting increased pursuit of IFI business.  

The creation of InterHealth represented a decided shift in public policy. It brought financial concepts and a focus on return on investment to a policy framework that had previously been focused on health impact and scientific discovery. The vision that the Ontario government put forward was quite far reaching. It argued that the government’s funding of InterHealth would demonstrate the government’s willingness to invest in the private sector, establish a model for public–private sector partnerships, create over a thousand high-value jobs over five years and lead to an early success story in the health care sector. Furthermore, it argued that its investment in InterHealth would generate an enthusiastic reaction to its announcement of a health care sector strategy by supporting Ontario’s industrial policies, while cautioning that its creation had the potential to create “the perception that government is being directed to health issues in other jurisdictions over issues at home. Private health care providers may question why the government is reducing the provision of private providers, while funding a private health company to work internationally.”

The creation of InterHealth marks a shift in Canadian academic medicine’s discursive formation. Before this shift, Canadian academic medicine had
engaged in revenue-generative activities but they had been limited in scope and scale and seen as somewhat déclassé. After this discursive shift, it became normalized to think about Canadian academic medicine in terms of its commercial possibilities.

**Articulation B5: State Responsibility + Wealth Creation**

In 2008, the articulation of the discourses of State Responsibility and Wealth Creation produced a new company designed to help Ontario businesses and institutions do business in the local and global space, MaRS Innovation (MaRS).76 MaRS, was set up by the Ontario government to function as an “interstitial” institution between the academy, the public service sector, and private industry to further the development of a health sector in Ontario. Interestingly, the idea for MaRS emerged from many of the same minds that were involved in the creation of InterHealth. “I think it’s interesting that some of the key players in InterHealth went and did . . . . MaRS was their next thing. . . . So, the idea morphed from an export focus to an intellectual, commercializing, intellectual property focus.”2

Discursively MaRS and InterHealth were also born out of the same ideas. They and the various tax and funding policies described above were created to transform Ontario investment in academic medicine and health care into a financial benefit for the province. Details between all of these policy initiatives differed but discursively they all emerged from the same source. My own analysis
of this was supported by an observation from one of my interviewees, who said “So, I think his support of InterHealth, his support of MaRS, they are all connected to the same thing. That Canada developed a lot of stuff and didn’t get the commercial and economic development benefits of it that we tend to give away intellectual property, or sell it for a song.”

This last point is at the core of the discursive shift. Simply put, Canada and Canadians should benefit financially from any and all discoveries that emerge from the funding of public services and academic medicine. Knowledge and innovation have value, a value that should accrue to Canadians directly.

**Articulation B6: State Responsibility + Wealth Creation**

One final example I would give to illustrate the productivity longevity of the articulation of the discourses of State Responsibility and Wealth Creation is the recent creation by the Ontario government of a new assistant deputy minister role in the Ministry of Health, a Chief Health Innovation Strategist. The role was created in 2015 to support the development of a health sector in Ontario. This Chief Health Innovation Strategist was tasked to advance five initiatives:

- Establishing a new $20-million Health Technology Innovation Evaluation Fund to support made-in-Ontario technologies
- Using newly created Innovation Broker positions to connect innovators and researchers with opportunities in the health care system
- Streamlining the adoption of health care innovations across the health system
• Shifting to procurement practices that focus on outcomes, such as fewer hospital readmissions and the long-term value of medical devices

• Investing in the assessment of emerging innovative health technologies to get those products to market faster. 77

This role, created some twenty years after the creation of InterHealth, continues a long period of productivity of the articulation of the discourses of Wealth Creation and State Responsibility. Looking at the number of objects that have been produced, it seems obvious that this is a highly productive articulation. But if one looks more closely, that productivity is called into question as the objects produced are predominantly governmental with very few that have been categorized as commercial. 78 Considering these two findings it is hard not to conclude that there is a very big difference between the idea of a health sector and the actual creation of a health sector.

**Academic Medicine is a Professionalization Project**

While I have argued up to this point that this era was dominated by the discourse of Wealth Creation and a financialization of Canadian academic medicine, this was not the only change that took place. The discourse of Professionalization, arguably acting as a counterweight to the discourse of Wealth Creation, was also highly productive in this period. One of its major impacts was the creation of a new institution to house academic medicine, an academic health science centre. 79,80 Prior to this era, the space of academic medicine had been broadly understood to be the premises of a medical school situated in a university and
the teaching spaces located in that medical school’s affiliated academic hospitals. This idea of academic medicine, while defined by legislation and based upon Abraham Flexner’s work, was somewhat nebulous and understood to apply to institutions in partnership with distinctly separate governance and ownership structures. At best the boundaries of academic medicine were disputed; at worst academic medicine consisted of hospitals and the university, combined but not integrated. With the emergence of the idea of an academic health science centre, a new institution was created that began to transcend the individual identities of academic medicine’s constituent institutions.

In Toronto, the creation of this institution happened in two stages. Stage one of this process began in the early 1990s when the University of Toronto and the Toronto Council of Teaching Hospitals were wrestling with the dual challenges of rising costs and declining funding. Their discussions on how to address these two issues produced the “Proposal for a Joint Initiative to Manage Major Strategic and Planning Issues,” a report that proposed a closer, more formal integration amongst the institutions. While this initial stage focused on creating a forum to explore the potential for “high level” collaboration, it also argued for the creation of a single unified voice among the institutions in negotiations with the Ontario government over funding. The arguments to create a single voice produced the Toronto Academic Health Science Council (TAHSC). TAHSC’s mission was “To identity and resolve issues of strategic and mutual importance
to the University and teaching hospitals, and to agree on and communicate a collective will for the Toronto Academic health sciences complex.”  

It took three years to create TAHSC, but this was only the first step in the creation of a formalized joint governance structure for Toronto academic medicine. The second step in this process came several years later with the creation of the Toronto Academic Health Science Network (TAHSN). This network, while quite similar in many ways to TAHSC, had a more formalized governance structure and a broader mandate that incorporated academic research, health care practice, medical education, and global engagement into its mission statement: “Together, these organizations work collaboratively to advance and sustain a shared academic mission of providing high quality patient care, conducting innovative research, offering world renowned top-quality education programs, and participating in knowledge transfer activities.”

Today TAHSN consists of the University of Toronto’s Faculty of Medicine and thirteen affiliated hospitals. It is the largest academic health science centre in Canada and one of the largest in North America. Operationally, TAHSN functions primarily as a forum for strategic discussions and explorations of common interests. As of yet, it has not transcended the individual institutions that constitute it, but that potential is embedded with the ideas that drove its creation.

**Articulation C1: Professionalization + Wealth Creation**
The creation of TAHSN happened while Canadian academic medical institutions were acquiring a more businesslike management focus, a product of the articulation of the discourses of Wealth Creation and Professionalization. This articulation began a process of transformation of Canadian academic medicine’s management that was somewhat difficult for many involved.

This transformation was especially painful in the University of Toronto’s Faculty of Medicine, where the contrast between business management and academic administration was especially strong. In the early 1990s, the Faculty was wrestling with the cumulative effects of decades of funding cuts. Its financial situation was becoming dire and it was looking for ways it could bring its finances into balance. In this context, the Faculty retained the management consulting company Deloitte and Touche\textsuperscript{82} to conduct a review of its operations.\textsuperscript{83} The six questions that guided this engagement were:

1. Are these services unique to the Faculty of Medicine or can they be provided centrally by the University of Toronto?
2. Can these services be outsourced at a cheaper rate?
3. What is the quality of the service?
4. Who are the predominant customers?
5. Who are the intended customers?
6. What is the level of customer satisfaction?\textsuperscript{83}

Unsurprisingly, the recommendations that resulted from this consultation came straight out of a business textbook. Duplicate services were to be closed.\textsuperscript{84} Services were to be purchased from the central university wherever possible.\textsuperscript{84} And most notably, seventy-nine support staff positions within the Faculty of
Medicine were to be cut.\textsuperscript{84} This last recommendation and how it was implemented shocked the university community. The press release that accompanied the firing stated:

\begin{quote}
The University of Toronto announced today it is eliminating 81 positions in the faculty of medicine [sic], effective immediately.

All positions are in the non-academic support sector of the faculty, and involve the layoff or release of 79 employees.

‘Our first priority is to maintain the integrity of our academic programs. The reductions are the result of a desire to improve overall efficiency within the faculty, along with the need to implement budget cuts over the next several years,’ said Dr. John Dirks, dean of medicine.\textsuperscript{85}
\end{quote}

Letters to employees laying out the terms the lay-off were short and to the point:

\begin{quote}
Further to our meeting of today’s date, I confirm that as a result of the elimination of your position in the Faculty of Medicine, you are indefinitely laid off as of today.

Enclosed please find a cheque in the amount of $229.80, equivalent to two weeks salary in lieu of notice.

Thank you for your contribution to the Faculty of Medicine.\textsuperscript{86}
\end{quote}

Campus-wide reactions to these actions were quite severe. Employees from other faculties immediately expressed their severe dismay and disapproval of this decision, how it was implemented, and its implications for the institution as a whole. An article appeared in a local newspaper that described the action as a “purge.”\textsuperscript{87} The outcry against the Faculty’s action was so severe that the president of the University of Toronto felt it necessary to publish an apology to the university community in the university newspaper.\textsuperscript{88} Within the month, the
employees were reinstated and apologies were issued. By years’ end, Dean Dirks, the dean of medicine, had tendered his resignation and a more nuanced process of consultation had been initiated by the university.

This event took place in the early 1990s, just as the idea of a health sector and an acceptance of business practices were beginning to circulate in Canadian academic medicine. These ideas were somewhat radical at that time and discordant for those working in the academy. At that time, business and business practices were understood to be external to Canadian academic medicine and antagonistic to academic life, an intellectual position espoused some sixty years earlier by Abraham Flexner in his book *Universities: American, German and English.* In the early 1990s, the idea that Canadian academic medicine could be managed like a business with a focus on the bottom line was still nascent and even antithetical to the broad academic community.

By the end of the decade 2000–2010, the attitude towards commercial engagement in Canadian academic medicine and in the broad university community had changed dramatically. Strategic plans and annual reports for Canadian academic medicine had been transformed, such that large sections of them were devoted to metrics, to measurement, to contracts, to numbers, and to audit reports. Business terms such as “measure,” “benchmark,” “manage,” “rankings,” and “commercialization,” drove narrative arcs. An imperative to...
generate revenue has become more broadly accepted and institutions are actively engaged in in a wide range of business endeavours.\textsuperscript{91-95}

**Articulation C2: Professionalization + Wealth Creation**

The effects of the articulation of the discourses of Professionalization and Wealth Creation were not limited to the traditional domain of academic medicine. Their ideas and their logic triggered discussions between the Faculty of Medicine’s Program in Health Administration (now the Institute of Health Care Management and Evaluation) and the University of Toronto’s Faculty of Management.\textsuperscript{101,102} These discussions resulted in a collaboration between the two schools that created a short-lived health care business management program structured to be profitable to both schools.\textsuperscript{101,102} Some years later, this same articulation produced the Centre for Health Sector Strategy located in the University of Toronto’s Rotman business school’s space.\textsuperscript{103} The centre’s academic focus was unique within the university in that it explored the intersection of business and health care. Areas under exploration in the centre included:

- The commercialization of life-sciences products and services
- The role of the private sector in healthcare delivery and technology
- Alliances: public-public, private-private and public-private
- Performance management, governance and control
- Organizational redesign and system integration
- Sustainability of public funding in Canadian healthcare\textsuperscript{103}

The influence of the discourse of Wealth Creation can clearly be seen in the above ideas. The influences of the other three discourses are somewhat harder to identify, suggesting that this centre and the ideas driving it represent a different
discursive formation; arguably, this is possible because it is situated in a somewhat different space from that of the more traditional objects of Canadian academic medicine. Given the limitations of a discursive analysis, it is impossible to say exactly what the creation and existence of this centre suggests is happening, or will happen, to Canadian academic medicine. However, its existence does show that the discursive formation of Canadian academic medicine had shifted so dramatically that it was easily possible for the leadership of Canadian academic medicine to see global commercial engagement as a normal activity of its institutions.

**Academic Medicine is an Engine of Wealth Creation**

To this point in this chapter, I have described the far-reaching influence of the discourse of Wealth Creation on the other three discourses. This discourse was also active in isolation this era, bringing increasing acceptance of business logic, business concepts, and business practices to Canadian academic medicine. This influence can be seen in the increasing usage of terms from the domain of business; finance brought concepts such as “return on investment” (ROI), “institutional mergers,” and “ancillary revenue” to Canadian academic medical reports. It can be seen in the adoption of terms having their origins in marketing, such as “hospiversity,” introduced as hospitals wrestled with developing a commercial branding strategy that incorporated a university identity. It can be seen in the increasing use of business analytics and analysis in this era, as well
as terms such as “customers” and “market share.” Operating plans for the institutions of Canadian academic medicine began to track multiple revenue streams and use new income categories such as “Approved MOH Allocation,” “Patient’s Foreign/Non Res.,” “Preferred Accommodation,” “Outpatients,” “Dietary,” “Pharmacy,” and “Other Revenue.” Foreign patients and research monetization began to be seen as important sources of revenues. The use of “public-private partnerships” (P3s) as funding mechanisms for hospitals brought a greater acceptance of business management strategies to Canadian academic medicine.

Two key premises drove the acceptance of these and other business ideas and concepts. The first was that public funding of Canada academic medicine would remain static or fall and thus be insufficient to meet its institutions’ future needs. The second premise was that ancillary revenue growth would provide for Canadian academic medicine’s survival and growth. In this context, the institutions of Canadian academic medicine became more businesslike. They began to create new roles such as Medical Director, External Affairs, Vice President, Strategy, and Director, International to focus on ancillary revenue generation.

This increasing focus on commercialization in academic medicine did not go unnoticed. A board member for the Hospital for Sick Children commented in 1992...
in a private note: “Does all this mean – there be [sic] more emphasis on budgets than on patient care what [sic] is best for patient will be dictated by cost?”

Clearly the shift in logic to focus on finances rather than patient care troubled or surprised this individual. To me this suggests that this shift was reasonably recent, that the discontinuity in the discursive formation of Canadian academic medicine was either still happening or had just recently happened. Before this discontinuity, it would have been very difficult for the leaders of Canadian academic medicine to consider global commercial engagement as a financial option to support their institutions. After this shift, it would have been very difficult for them not to consider it.

**Articulation D1: Wealth Creation + State Responsibility**

The articulation of the discourses of Wealth Creation and State Responsibility brought the idea of using “holding companies” to hospital management. This idea that a parent company with its own board and management might own subsidiary companies came to hospital management from business, and provided a new way for hospitals to grow that did not require them to merge. Using this idea, hospitals could acquire other hospitals with different clinical foci —something that would have been problematic prior to the arrival of this concept.
In Toronto, for example, the use of the holding company concept made possible the creation of the University Health Network (UHN), one of the largest hospital conglomerates in Canada.\textsuperscript{115} The creation of UHN began in 1999 with the acquisition of the Princess Margaret Cancer Centre by the Toronto Hospital (the new name for the merged entity of Toronto General Hospital and the Toronto Western Hospital) under the joint ownership of a holding company.\textsuperscript{116} Some years later UHN followed up that acquisition by adding the Toronto Rehabilitation Institute to its portfolio of hospitals.\textsuperscript{116}

Prior to the arrival of this business concept to Canadian academic medicine, the merger of all of these disparate hospitals would have been highly problematic if not impossible. Afterward, it became possible for hospitals to grow exponentially, drastically consolidating their power and radically increasing their influence in the health care system and within academic medicine. This has had effects that are still being processed to this day, as the understanding of what an academic health science centre is continues to develop.

Most recently the use of this holding company concept made possible UHN’s acquisition of an educational institution, the Michener Institute.\textsuperscript{116} The effects of this recent addition to the discursive formation and the financial structure of Canadian academic medicine are also as yet unknown. That said, this acquisition is likely to produce far-reaching changes, since it brings three things to an
academic hospital: new academic powers it previously lacked, an ability to grant diplomas, and a potential pathway to become degree granting, that is to say become a university in and of itself. At minimum these three things will vastly increase UHNs’ ability to commercialize their educational offerings to create new revenue streams. More troublingly, UHN has begun to blur the boundaries between an academic hospital and a university in an unprecedented way, opening the door to a potential change in how academic medicine is constructed in Canada.

**Articulation D2: Wealth Creation + State Responsibility**

Ten years after the creation of InterHealth and Canadian academic medicine’s first foray into the global space for commercial reasons, the discourses of Wealth Creation and State Responsibility reproduced the same concept but this time it was situated in the institutions of Canadian academic medicine. This iteration of this articulation was especially productive. In 2004, this articulation began to produce consulting businesses such as UHN Global Ventures, PRISM@UHN, and Mount Sinai International, all targeting the global market. In 2006 it produced SickKids International, in 2010 UHN International, in 2012 Baycrest Global Solutions, and in 2013 Sunnybrook’s version, Sunnybrook International. With the creation of these new consulting business came new roles within the hospitals themselves. For example, the Vice President for International Affairs in the Hospital for Sick Children focused on global revenue generation.
This articulation also produced businesses in hospitals that sold healthcare services based upon a commercial business model, and a commercial focus in the university that monetized various educational offerings. In UHN, this took the form of Altum Health (Altum)\textsuperscript{127} a company set up initially to provide health services to injured parties paid for by third-party insurance companies.\textsuperscript{128,129} Over time, Altum’s business model expanded, at the request of the federal government, to include health services for war-wounded Libyan soldiers.\textsuperscript{128,129} By 2014, UHN was accepting international patients from Kuwait, the Caribbean, and Libya generating $3 million on gross revenues of $9 million per annum and Altum Health was hiring American international medical tourism consultants to provide advice on the US market.\textsuperscript{130} In the University of Toronto this articulation produced global commercial engagement in the university’s various departments, schools, and educational units in a variety of forms.\textsuperscript{91,92,131} It also produced a new role—the Vice Dean, Partnerships—in the Faculty of Medicine in 2016 to bring oversight to all of the Faculty’s global engagements.\textsuperscript{131,132}

Reading this list of new objects and roles, it is evident that this was an era of global business development for Canadian academic medicine. The number of globally focused businesses it generated in this era dwarfs the number created in all other eras combined. This was only possible because of a discursive shift that made revenue generation that much more palatable to the leaders of Canadian
academic medicine. That said, it is important to note that this was simply an increase in commerciality, not a complete transformation into commercial entities. Yes, these various companies, divisions, and departments generated tens of millions of dollars in revenue for their respective institutions on an annual basis, but the revenues generated represented at best 1 percent of the total revenue of each institution. At an ideological level it can be argued that the effect of the discursive shift was more profound in that it triggered a far-reaching transformation in management and accounting practices and accounting throughout Canadian academic medicine. Most notably, it triggered a new acceptance of financialization in Canada, an acceptance that may fuel further changes to come.

The Space(s) of Academic Medicine

What is Academic Medicine?

Analyzing the spaces of Canadian academic medicine in this era is a somewhat confusing exercise. It is difficult to integrate all the different changes taking place. As I have discussed in this chapter, Canadian academic medicine was changing from a financially secure and growing space to a financially precarious space.\textsuperscript{5} It was creating a new overarching institutional space, an academic health science centre, to address this financial precariousness.\textsuperscript{133} Its governance was beginning to transcend individual institutions to be located in this overarching space.\textsuperscript{79-}
The boundaries between individual institutional domains were blurring with the acquisition of an educational institution by a hospital. The creation of a health sector has also blurred the traditional boundaries between academic medicine and industry.

These are not small changes and their individual and collective impacts are as yet unknown. Given that they are still ongoing, answering what Canadian academic medicine is or more accurately what it is becoming is quite challenging at this time. I might simply say that it is a domain in flux, in a process of becoming something new, something that is likely to have a distinctly different composition and character that is impossible to describe at this point in time. This is not however a satisfactory conclusion.

The discursive formation of Canadian academic medicine is also undergoing a significant shift, with the discourse of Wealth Creation rising in influence and having a profound effect. That said, my analysis of the discursive formation of Canadian academic medicine in the local and global spaces suggests that possibly more change is still to come. When I analyze its discursive formation in its global projects there seems to be a great variation in how it is structured. Projects seem to be governed by different discourses, by different dominant logics. They are either revenue generative and governed by the discourse of Wealth Creation or they are funded by charity or grants and governed by a
combination of the discourses of Social Obligation and Professionalization. Simply put, the discursive formation of Canadian academic medicine seems to be constructed differently when its institutions operate outside of the boundaries of Canada, with individual discourses rising in influence.

Expanding upon these two types of engagement, I would argue that projects dominated by the discourse of Wealth Creation and located outside of Canada are focused on providing resources to Ontario. They are less concerned with concepts of social good, academic merit, or the enhancement of the medical profession. Concepts of service and capacity building are present but they function as subsidiary activities that drive the billing receipts of the projects. The three other discourses—Social Obligation, State Responsibility, and Professionalization—were present in projects of this type but they were less influential than they are in Canadian academic medicine’s activities that benefit from public funding and that are located in Canada proper.

The second type of engagement driven by the discourses of Social Obligation and Professionalization is focused on bringing resources and intellectual capital from Ontario/Canada to the world. Such engagements focus on concepts of capacity building, knowledge sharing, and social good, and are governed by a “not-for-loss” mentality. These projects are distinctly different from the commercial projects, inasmuch as they represent costs to the respective
institutions and to the health care professionals working on them. This second type of project might be characterized by classical academic knowledge sharing or by projects like the Toronto Addis Ababa Academic Collaboration (TAAAC), an educational partnership between the University of Toronto and the University of Addis Ababa designed to create educational capacity in Ethiopia.136 As with the first type of project, the two other discourses, the discourses of State Responsibility and Wealth Creation are present and active in these projects, but are limited in their influence.

The finding that Canadian academic medicine activities are governed by different ideological constructions outside of the boundaries of Canada is interesting for me, but what it means is not entirely clear. I see several possible interpretations. One is that the regulatory influence present in Canada is absent in the global space, providing a free range of expression for its institutions and its professionals. More specifically, more purely commercial projects are possible in the global space than in the local domestic space.2,95,121,122,137 It could also mean that in an imaginary space, a utopic space, Canadian academic medicine is constructed simply by local context—by the motto “When in Rome . . .” and by local needs. It may also mean that Canadian academic medicine’s identity is simply constructed by purely economic forces in the global space, as engagement by Canadian academic medicine with wealthy developing nations can only be rationalized in Canada if it is built upon a financial rationale.
Finally, it may mean that Canadian academic medicine’s activities and identity in the global space foreshadow the construction of a new identity for Canadian academic medicine, one that might eventually manifest in its domestic space, in Canada.

Neither of these two analyses—a critical discourse analysis and a spatial analysis—provides a clear answer as to what Canadian academic medicine is or what it may be becoming. In many ways they at best evidence the messiness of life and of a Foucauldian discursive analysis. As I have argued in my theory chapter (chapter 3), a Foucauldian analysis does not provide a simple or single truth, nor does it prognosticate well. All I can say with any certainty is that Canadian academic medicine seems to be undergoing a transformation: what that transformation will produce is impossible to say.

Where Is Academic Medicine?

Looking at the spaces, or regions, of activity of Canadian academic medicine reveals several geographic patterns. Canadian academic medicine engages in the global space for three reasons. I would categorize the first reason for global engagement as international capacity building, or more broadly as service. This category of engagement takes several forms, ranging from educational to academic to clinical. Geographically, these types of engagements are broadly dispersed around the world, manifesting in North America, South America, Asia, Africa, and Europe. More specifically they tend to be located in
less affluent regions in the world and to be funded by granting agencies, department funds, clinical fees, and philanthropic contributions.\textsuperscript{44,96,134,136,139,140}

I would categorize the second reason for engagement as commercial.\textsuperscript{2,72,93,94,122,138,141-143} These commercial engagements could be further broken down by type of commercial activity and by region. One type of commercial engagement might be described as offshoring manufacturing operations for health care supplies or research services.\textsuperscript{2,72,138,141-143} These projects tend to be located in Asia to access that region’s lower-priced labour markets.\textsuperscript{98} A second type of commercial engagement is the international consulting and management services I have discussed extensively earlier in this chapter.\textsuperscript{2,93,94,122} Such projects tended to be located primarily in the Middle East.\textsuperscript{2,94,122,144} The third type of commercial engagement was the marketing of educational or clinical services to the global community to attract students and patients to come to Canada as customers.\textsuperscript{92,138,145} This type of engagement also tended to be focused on the Middle East, with a specific focus on Saudi Arabia.\textsuperscript{92,146-148}

I would categorize the third and final reason for global engagement as academic.\textsuperscript{96,98,149} Such engagement takes the form of conference attendance, visiting scholars, and teaching, and tends to be primarily located in North America, Europe, and to a lesser extent Asia.\textsuperscript{44,150,151}
These patterns of global engagement of Canadian academic medicine in this era were quite similar to the patterns of earlier eras, with two main differences. First, Canadian academic medicine’s commercial focus on the Middle East was a new, unique characteristic. Second, whereas global engagement had previously seemed discretionary, a supplement to Canadian academic medicine’s regular activities, in this era it seemed to be obligatory, driven by a Canadian financial imperative to find resources to support Canadian activities.

**What Are the Spaces of Academic Medicine Producing?**

My first observation on this question is that the local space continued to produce an institutional stability for Canadian academic medicine, one built upon its operations and the majority of its funding from the State and philanthropists. This space simply produced legitimacy and tangibility for Canadian academic medicine.

The second space I would identify is the product of an analysis of 120 years of history, a utopic imaginary space of revenue generation. Where this space is and what its boundaries are have varied completely from era to era. In the 1930s, this imaginary utopia of revenue generation was located within the institutions of Canadian academic medicine in the private for-profit wards. In the 1960s it was in research labs in the hospitals and university, where it was focusing on the commercialization of research findings. In the 1990s and 2000s, this imaginary space of riches and revenue generation moved to the global space.
This space has been for the most part imaginary, a true utopia, for it has rarely actually provided the riches that Canadian academic medicine was supposedly seeking. Apart from Pablum, commercialization has been of limited success financially. InterHealth closed under difficult financial circumstances, barely returning capital to its investors.\textsuperscript{2,3,70,74} The international consulting businesses have not provided the financial benefit that they were created to do.\textsuperscript{94,122,144,152} The income derived from international postgraduate students, while substantial, seems simply to have shifted the funding calculation for the Faculty of Medicine away from public funds, and to have created debates with the academic hospitals where the students are placed over the ownership of those funds.\textsuperscript{92} The efficacy of MaRS and the creation of a health care sector in Ontario are still uncertain and in process.\textsuperscript{2}

Given this history, the major product of this utopic and imaginary space of revenue generation and financial salvation for Canadian academic medicine seems to be simply a useful narrative that it can tell the State in funding negotiations. By being in this space, it can say that it is trying to help the State fund its activity but sadly still requires more financial support for the time being. By being in this utopic space, it can present itself as a financially responsible entity while arguing for greater State funds. This, I would argue, is the primary role of this space. While achieving commercial success in this space would
undoubtedly be helpful financially, it may be more helpful to be financially unsuccessful, because financial failure establishes, and reestablishes, the State as the funder of Canadian academic medicine.

If this analysis proves accurate, I would argue that the era of the global space as the utopic imaginary space of Canadian academic medicine is rapidly coming to an end. A new utopic potential space of revenue generation seems to be emerging—the virtual space, the cloud, the space of technology. I am somewhat skeptical that this new utopia will be any more successful financially than its predecessors. But that said, it seems important that Canadian academic medicine believe in its new utopic space, or at least speak as if it believes it does, as it continues its 120-year funding dance with the Canadian State.

**Conclusion**

The era from 1900 to 2016 has been an era of rising commercial thinking in Canadian academic medicine. This change has been driven by a sense of financial insecurity and declining State funding for its institutions. Over this period, Canadian academic medicine has experienced a shift in its discursive formation as the discourse of Wealth Creation has gained in influence. At the State level, this has meant the creation of innumerable policies and bills aimed at creating a health sector in Ontario; the goal has been to transform Canadian academic medicine or its output, services, and professionals from costs to the State into financially productive assets of the State. These efforts triggered an
increasing acceptance of the financialization of Canadian academic medicine. Business practices and ideas rapidly gained a foothold in Canadian academic medicine, transforming its management into a more commercial and managerial form. With the acceptance of a more commercial focus in Canadian academic medicine, a shift in what could be commercialized or sold took place, such that it became possible (if not normal) for Canadian academic medicine to begin to commercialize its offerings outside the boundaries of Canada in a variety of forms.

This analysis of the changes in the discursive formation of Canadian academic medicine and its resultant transformation into a globally focused commercial entity notwithstanding, my analysis suggests that more may be happening than a transformation of Canadian academic medicine and its institutions into a neoliberal machine. Instead, it may be that Canadian academic medicine is participating in an intricate dance with the Canadian State, in which it must perform the role of revenue generator as it continues its century-long negotiation over funding. Whatever the truth of this observation, it is clear that Canadian academic medicine is undergoing a process of change, the result of which may radically change its form and its institutional composition.
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Introduction

Analyzing 120 years of history of Canadian academic medicine across three institutions—Toronto General Hospital, the Hospital for Sick Children, and the University of Toronto’s Faculty of Medicine—has been a fascinating endeavour. In trying to understand how it became possible for these three institutions to change from being locally focused charities into global commercially engaged institutions, I have gained a deep appreciation of the complexity inherent in concurrently prosecuting a tripartite mandate of teaching, research, and patient care. This is not a simple challenge for their leadership and their management and it requires considerable cognitive flexibility, one that can navigate a complex ideological framework I have named The Discourses of Management of Canadian Academic Medicine.

The Discourses of Management (of Canadian Academic Medicine)

To review briefly, this discursive formation comprises four discourses: Social Obligation, State Responsibility, Professionalization, and Wealth Creation. Each of these discourses is connected with a specific economic practice and logic. The first discourse, the discourse of Social Obligation, is linked with the practice of
philanthropy or fund-raising. Key ideas underpinning it are that the wealthy have a responsibility to society and that their strategic ideas for investment have merit and must be recognized if Canadian academic medicine is to receive their financial support. This discourse produces an obligation for the leadership of Canadian academic medicine to develop strategic directions for their institutions in partnership with affluent donors.

The second discourse, the discourse of State Responsibility, is linked with State funding from taxation. Ideas underpinning it include the betterment of society, academic medicine as a service provided by the State, State governance of academic medicine, public/academic partnerships, health as an attribute of a population, and public accountability. This discourse produces an obligation for the leadership of Canadian academic medicine to think in terms of health systems, populations, and political necessity. The third discourse, the discourse of Professionalization, is linked with university fees, tuition, and professional fees. The ideas underpinning it include academic capital, academic freedom, reliance on funding over revenue, and the globalization of ideas. This discourse obligates the leadership of academic medicine to think in terms of educational imperatives, health human resources, and the role of the professions. The fourth discourse, the discourse of Wealth Creation, is based upon commercial practices. Ideas underpinning it include profit generation, business logics, efficiency, sales, monetization, reliance on revenue over funding, and innovation. This discourse
obligates the leadership of Canadian academic medicine to think in terms of profit and return on investment.

These four discourses represent four distinct ways of thinking that can be difficult to reconcile. Balancing their influence seems key for successful leadership in Canadian academic medicine, inasmuch as an overreliance on any one way of thinking has the potential to destabilize an institution.

**The Eras of Canadian Academic Medicine**

I identified three eras for Canadian academic medicine: 1900 to 1940, 1940 to 1990, and 1990 to 2016. The first era, discussed in detail in chapter 6, was dominated by the discourse of Social Obligation and the practice of fund-raising. The finances of Canadian academic medicine were quite precarious and various revenue-generative activities were tried to supplement a somewhat erratic funding model. These activities had limited success. Canadian academic medicine’s dominant management ethos was responsibility to the less fortunate.

The second era, discussed in chapter 7, was dominated by the discourse of State Responsibility. The Canadian state dramatically increased its funding of academic medicine, primarily focusing on its twin mandates of patient care and scientific advancement. This dual focus proved somewhat more costly than anticipated, triggering underfunding of education, increased surveillance of management’s spending by the government, and a newfound focus on revenue generation and business practices in the management of academic medicine. By
the end of this era, the discourse of Wealth Creation was in ascendancy, management was becoming more corporate, and the institutions of Canadian academic medicine were beginning to look to the global space as a source of new wealth. The third and final era, 1990 to 2016, was dominated by the rise of the discourse of Wealth Creation. Commerciality and business logic permeated leadership discussions in Canadian academic medicine. State funding of Canadian academic medicine was not increasing as in the past era, and the leadership and management of Canadian academic medicine launched a variety of commercial endeavours to bridge the growing funding gap.

**Articulation of the Discourses Drives Change**

The discursive framework and the historical eras of Canadian academic medicine are important but insufficient to explain how new practices become possible in Canadian academic medicine. Rather, it is in the articulations among the various discourses that a deeper understanding is found. In brief, the discourses interact, transforming each other and the tonality of the full discursive formation of Canadian academic medicine.

For the purpose of answering the research question “How did this global commerciality become possible in Canadian academic medicine?” it is necessary to understand that the discourse of Wealth Creation acted upon the other discourses. It transmitted ideas such as corporatization, a focus on profit and efficiency, and monetization to each of the other discourses and changed the
global space into a space of financial potential. The discourse of Wealth Creation's articulation on the discourses of Social Obligation, State Responsibility, and Professionalization transformed their practices to more closely resemble those uniquely produced by the discourse of Wealth Creation, thereby creating more corporate versions of them.

It is also important to understand that as the discourse of Wealth Creation was acting upon the other three discourses, they were also interacting, producing changes in their constituent mentalités. For example, just as the discourse of Wealth Creation brought concepts from the business world to the other three discourses, the discourse of Social Obligation brought ideas of ministering to the less fortunate, and Social Obligation to Canadian academic medicine’s commercial engagements. The discourse of State Responsibility diffused ideas of public good, societal investment, universality, equality, public health, and responsibility to a population. The final discourse, the discourse of Professionalization, made it important that commercial engagements consider ideas such as scientific legitimacy, educational initiatives, bidirectional knowledge sharing, and relationships among the professions. All three of these discourses disseminated the idea that the value or worth of commercial projects should be more than simply financial.
Theoretical Contribution of This Work

There are several theoretical implications of my work that will provide a useful guide or understanding for those in a governance or leadership position in Canadian academic medicine.

The Discourses of Management of Canadian Academic Medicine

The first theoretical implication of my work is that there are four “discourses of management” of Canadian academic medicine. These are the discourses of Social Obligation, State Responsibility, Professionalization, and Wealth Creation that I have discussed in detail throughout this dissertation. However, these discourses represent more than simply a lens through which to understand how history has unfolded and how certain practices became possible. They represent a new, complex way of understanding the management framework of Canadian academic medicine. This is a unique conceptualization of management thinking that suggests that success requires a multiplicity of objectives and a multiplicity of logics, all active and present at the same time. It also suggests that it is necessary for a successful leader to understand that Canadian academic medicine, whether an academic hospital, a faculty of medicine (nursing or other health profession), or other related regulatory body, cannot be managed by overemphasizing any one discourse over the others. A successful leader cannot see the institution through a single-focus lens, as a commercial, scientific,
educational, professional, or health care institution, without the risk of sending a message of discord and creating operational tensions.

**The Expressions of Bad Management (of Canadian Academic Medicine)**

This second theoretical implication of my work suggests that there are dangers for the leadership of Canadian academic medicine in being over reliant on any one discourse of management. I have seen evidence in my analysis of the discourses that an overreliance can have a negative or unintended impact, producing what I would call the “expressions of bad management”—or specifically, the expression of *social entitlement, politicization, professional self-importance* and *profitability*. Table 9.1 below outlines the potential characteristics or outcomes that can result from an overreliance.

**Table 9.1: The Expressions of Bad Management**

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<tr>
<th>Expressions of Bad Management</th>
<th>Unintended Consequences</th>
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<td>Social Entitlement</td>
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<td>• Social judgment of value and merit</td>
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<td>• Entitlement to preferential care/access to education</td>
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<td>Politicization</td>
<td>• Political expediency driving funding decisions</td>
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<td>• Politics over evidence-based decisions</td>
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<td>• Short-term strategies</td>
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<td>• Cost controls</td>
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<td>• Strategy developed by the State</td>
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<tr>
<td>Professional Self</td>
<td>• Resource accumulation for the profession</td>
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</table>
| Importance          | • Distance from practice and practical concerns  
|                     | • Overtreatment  
|                     | • Investment in esoteric concerns  
|                     | • Focus on global space over local space  
|                     | • Research valued over care  
|                     | • Ivory-tower isolation  
| Profitability       | • Underinvestment in quality and care  
|                     | • Cost cutting  
|                     | • Diminishment of concept of citizenship  
|                     | • Expansion of administration and accounting departments  
|                     | • Rise in salaries of executives  
|                     | • MBAs replacing health professionals  
|                     | • Commoditization of care, research, and education  

While further elucidation of this intriguing concept merits more in-depth study, my preliminary assessment suggests that an over-activation of any of the four discourses can be problematic for Canadian academic medicine. These findings may be of especial importance to senior leaders and Boards of academic medical institutions, the individuals tasked with the governance of these complex institutions.

**Academic Medicine Is One Domain**

A third theoretical implication of my findings is that Canadian academic medicine seems to be, or to be becoming, one single domain. Conceptualizing it as a domain of health care and a domain of education, or as a hospital and a university, seems insufficient. It may be that the era of Canadian academic medicine as an imaginary space consisting of two separate and distinct constituent domains—health care and health professions education—is coming, or has come, to its end. This finding is an alternative theorization to that of Frenk.
et al. in the 2012 *Lancet* article that conceptualized academic medicine as two domains, health care and education, linked by the labour market and a population’s needs.\(^2\) Furthermore, I would argue that as ideas, funding, space, and collective missions are shared among the various institutions of Canadian academic medicine, it would seem that the boundaries traditionally described as dividing them are instead constructions of intellectual and policy convenience.

It may be that what I am describing is underway and not fully realized yet. Based upon a legalistic or policy lens, what I am suggesting might be somewhat heretical. Based upon a Foucauldian critical discourse lens, the creation of a more tangible institution of Canadian academic medicine seems to be far along in development. The recent emergence of a new idea, an academic health science centre, is evidence of a transcendence of the individual domain boundaries and a discontinuity and change in *episteme*. I would argue that the legal and policy structures will follow as this new logic of integration coalesces. The creation of an academic health science centre or network seems to be the most recent but not the final step in a potential transformation of Canadian academic medicine into a more integrated formal institution.

**Concluding Thoughts**

As I have been refining my thinking on the history of Canadian academic medicine and its global commercial engagement, I have also been reflecting on the entry point for this research project, the idea there has been a “de-
Flexnerization of Canadian academic medicine. This reflection has led me to ask the question “Can there have been a de-Flexnerization of Canadian academic medicine if there has not been as complete a ‘Flexnerization’ of Canadian academic medicine as is generally understood?” If Canadian academic medicine has actually been engaged in a variety of revenue generation activities for the last 120 years, is its recent commerciality actually a de-Flexnerization or is it simply a new and different form of revenue generation? Is the de-Flexnerization of academic medicine that Frenk describes a phenomenon that is external to Canada?

I do not have a definitive answer. I would observe, though, that at this point in time Canadian academic medicine’s global commercial engagement seems to be in retreat. Contracts are not being renewed. Staff are being recalled and reassigned. I would observe that there is also a new revenue generation space that is emerging, the virtual space of the Internet. Based upon my reading of 120 years of history of Canadian academic medicine, it does not seem a large intellectual stretch to see this shift as simply a pattern being repeated, such that this emergent space of revenue generation is simply the newest manifestation of Canadian academic medicine’s imaginary space of financial riches.

**Future Research**

I see several possible avenues for future research based upon this doctoral work. First, I have created a nontraditional time line and history for Canadian academic
There remain certain pivotal moments on the timeline such as the creation and closure of the private pavilion wards in the hospitals, the history of InterHealth, and the creation of the MaRS Discovery District. These and other moments in my history are stories that need further research.

Second, I have developed a discursive model for Canadian academic medicine, that of the “discourses of management”. My preliminary work developing it, along with other academic work I am engaged with in northern Europe and in the United States, suggests that this discursive formation is not unique to Canada. I am interested in exploring how well this model applies to centres of academic medicine in other jurisdictions and in the development of a more universal management framework for academic medicine.

Third, this discursive formation, this management model for Canadian academic medicine, became visible after extensive analysis focused on Canadian centres. I am fascinated to explore how Canadian academic medicine reads to our international partners. More specifically, I am interested in whether the discourses I have identified manifest to our international partners and whether they play a role in why they choose to engage with us.

Fourth, I am interested in studying what other roles revenue generation might play in the operations of Canadian academic medicine. Revenue generation does
not seem to have functioned as a real financial solution for Canadian academic medicine over 120 years of history. Its financial contribution has been at best marginal. Thus, I am not suggesting undertaking a financial analysis here. Rather, I would like to explore what value revenue generation might have for Canadian academic medicine at a symbolic or political level rather than a financial one. Might it be more accurately seen as a negotiating tool for Canadian academic medicine in discussions with its funders? Is it simply necessary for Canadian academic medicine to be able to say that it is trying to generate funds, that it is attempting to be self-supporting, and not succeeding, so that it can then legitimately ask the State for funding and maintain its identity as a public good?

Canadian academic medicine plays an important role in Canadian society. Studying the history of its leadership’s thinking has been an extremely rewarding experience over the last seven years. The complexity of thought required to manage it is considerable. It is my hope that my research findings will provide insights useful to those tasked with stewarding Canadian academic medicine’s institutions into the future.
Citations Chapter 9


Appendix 1: Interview Scripts

Interview Guides

Not all questions will be asked of all participants.

Interview will be iterative in nature.

Participants: Local Hospital Executives

Introduction to the Interview:

Thank you for agreeing to meet with me. I know your time is very limited. My name is Robert Paul and I am conducting interviews for this research project that is the focus of my PhD dissertation. Thank you for agreeing to participate in the interview today. I am very much looking forward to talking with you.

As you may know from reading the material sent to you before the interview, I am exploring the history of revenue generation in the Toronto academic health science centre, its hospitals, its faculty of medicine, and regulatory oversight of it. I am interested in how revenue generation has evolved over approximately the last hundred years and how it went global in the last ten years. I’d like to ask you about your thoughts on the practices involved, how revenue generation is being managed, and how its management has evolved over time.

We are interviewing people like you who have knowledge or oversight of an aspect of this practice. Our goal is to better understand how the practice is being governed, what roles are being created as a result of the practice, and how its governance is evolving or might evolve.

I’m wondering if you have any questions before we begin and if you had a chance to fully read over the information letter and consent form that were sent to you before today. I do have your consent form, but I want to see if you have any other questions that may not have been answered before.

(Answer any questions).

(If this was not previously discussed when the interviewer answered their questions.) I want to remind you that we will be tape recording the interview. And I want to let you know how we are addressing anonymity and confidentiality. As was explained in the information letter,

We will be using pseudonyms or other approaches to disguise your identity in reports of the research. Therefore, information obtained and
expressed in interviews will be anonymous. We would like to explain how the information you express would be used when reporting the research. Research of this type looks for similarities, differences, and rationales or logics of governance across the interviews. It uses direct quotes from the interviews to support the patterns identified. When we use direct quotes from an interview or examples of governing practices or their evolution over time, we will not identify a participant by name. Similarly, references to key figures in the field made by you or other informants will be anonymized.

If you are uncomfortable with the nature of this research, you are most welcome to withdraw at any time. Data gathered from participants who subsequently withdraw (prior to completion of the data collection phase) will not be included in the study reporting. You will be provided the opportunity to read the transcript of your interview before we use your interview. When you read your transcript, you can withdraw any information that you would like to withdraw.

I also wanted to add that you are free to ask me to stop the tape recorder at any point during the interview and to refuse to answer any question. Do you have any questions before we start?

**Personal Background and Experience of Interviewee**

- Can you tell me a bit about yourself (your personal background) and your involvement in revenue generation contracts here in Canada and abroad?
- (If not answered in the previous question) Can you tell me about the range of projects you have overseen or managed in this area?

**History of the Contracts**

- Can you talk to me about how these contracts came to be?
- Can you describe your institution’s rationales for engaging in commercial global contracts?
- What would you suggest made a successful contract? An unsuccessful contract?

**Governance of Global Revenue Generation**

- Can you tell me about how these contracts are managed?
• How do you keep track of what is happening in them, what might be about
to happen in them, and what you would like to make sure does not
happen?
• Ask to see any examples of types of forms, accounting reports, reporting
documents, memos regarding issues, concerns—if possible

**Governance Relationships Due to Global Engagement**

TAHSN is a partnership of the university and academic hospitals. You are all
connected, while acting independently. This is interesting because relationships
can develop on a global stage that do not happen locally. Also, how one
institution acts globally can have repercussions at home.

• What might help you and your organization manage or oversee these
types of engagement?
• Are there any ways that you think these types of projects might be better
monitored? Managed?
• Is there any organizing group in TAHSN that discusses this practice?
• As you oversee these global projects, do you see any potential need to
partner with the University of Toronto? In the short term? In the long term?
• If conversations were to happen about ways to partner with the university,
what might you look to the university for in the way of support, expertise,
or shared responsibility?
• Do you see any possibility for the contractual engagements globally to
change if a hospital were to partner with the university?
• The university engages globally as well in a variety of ways and seems to
be quite well known internationally – do you see this helping or hindering
your institution’s global engagement?
• Do you give any advice to your staff going oversees managing these
contracts on what to watch out for, how to deal with the unexpected?

**Management of Health Professionals**

• Can you talk to me about the management of the various health
professionals who are engaged in these contracts?
• How do you keep track of what they are doing on the contracts and in
Canada?
• Have you run into any challenges recruiting health professionals to work
on these contracts?
• Have you run into any challenges managing the health professionals as
they engage in this practice?

**Relationship with the Ministry of Health and Long-Term Care**
• How do you report on these projects to the Ministry of Health and Long-Term Care?
• Are there any reports, forms, documents, etc. you provide to the ministry?
• Are any reports submitted to any other governance body?
• Hospital association?
• Other ministry (e.g. Trade, Foreign Affairs)?
• Can you see how any reporting to the ministry might evolve or need to evolve?

Relationships with Foreign Governments, Foreign Institutions

• Do you have any reporting obligations to any foreign partner as you engage in these contracts?
• How do they work?
• What kind of issues are they concerned with?
• What kind of issues do you think they should be concerned with?
• If you were advising a foreign body on how to monitor or evaluate a typical contract, would you have any strong recommendations?

Closing Final Broad Question

That is all very interesting. I am most appreciative of your time and very aware that you have been very generous to discuss this with me in such thoughtful depth. Before I turn off the tape, I might ask you—are there any other thoughts you would like to add about oversight, now or in the future, for these types of engagement that I have not asked about?

Thank you so much!
Participants: Local Government Bureaucrats

Introduction to the Interview:

Thank you for agreeing to meet with me. I know your time is very limited. My name is Robert Paul and I am conducting interviews for this research project that is the focus of my PhD dissertation. Thank you for agreeing to participate in the interview today. I am very much looking forward to talking with you.

As you may know from reading the material sent to you before the interview, I am exploring the history of revenue generation in the Toronto academic health science centre, its hospitals, its faculty of medicine, and regulatory oversight of it. I am interested in how revenue generation has evolved over approximately the last hundred years and how it went global in the last ten years. I’d like to ask you about your thoughts on the practices involved, how revenue generation is being managed, and how its management has evolved over time.

We are interviewing people like you who have knowledge or oversight of an aspect of this practice. Our goal is to better understand how the practice is being governed, what roles are being created as a result of the practice, and how its governance is evolving or might evolve.

I’m wondering if you have any questions before we begin and if you had a chance to fully read over the information letter and consent form that were sent to you before today. I do have your consent form, but I want to see if you have any other questions that may not have been answered before.

(Answer any questions).

(If this was not previously discussed when the interviewer answered their questions.) I want to remind you that we will be tape recording the interview. And I want to let you know how we are addressing anonymity and confidentiality. As was explained in the information letter,

We will be using pseudonyms or other approaches to disguise your identity in reports of the research. Therefore, information obtained and expressed in interviews will be anonymous. We would like to explain how the information you express would be used when reporting the research. Research of this type looks for similarities, differences, and rationales or logics of governance across the interviews. It uses direct quotes from the interviews to support the patterns identified. When we use direct quotes from an interview or examples of governing practices or their evolution over time, we will not identify a participant by name. Similarly, references to key figures in the field made by you or other informants will be anonymized.
If you are uncomfortable with the nature of this research, you are most welcome to withdraw at any time. Data gathered from participants who subsequently withdraw (prior to completion of the data collection phase) will not be included in the study reporting. You will be provided the opportunity to read the transcript of your interview before we use your interview. When you read your transcript, you can withdraw any information that you would like to withdraw.

I also wanted to add that you are free to ask me to stop the tape recorder at any point during the interview and to refuse to answer any question. Do you have any questions before we start?

**Personal Background and Experience of Interviewee**

- Can you tell me a bit about yourself (your personal background) and your involvement in the development of revenue generation contracts here in Canada and abroad?
- (If not answered in the previous question) Can you tell me about the range of projects you have overseen or managed in this area?

**History of the Contracts**

- Can you talk to me about how these contracts came to be?
- Why do you think they happened at that time?
- Why do you think they happen now?
- What were the arguments in favour of the contracts happening? What were the arguments against them?

**Governance of Global Revenue Generation**

- Can you tell me about how these contracts are managed?
- How do you keep track of what is happening in them, what might be about to happen in them, and what you would like to make sure does not happen?
- Ask to see any examples of types of forms, accounting reports, reporting documents, memos regarding issues, concerns—if possible
- Do you see any future changes needed in the oversight of these projects? If so, what do you see as possible?

**Governance Relationships Due to Global Engagement**

TAHSN is a partnership of the university and academic hospitals. The various institutions are all connected, while acting independently. This is interesting
because relationships can develop on a global stage that do not happen locally. Also, how one institution acts globally can have repercussions at home.

- What might help you manage or oversee this collective engagement?
- If an institution was to be created to oversee this practice of TASHN, what might that be?
- Is there any organizing group in TAHSN that discusses this practice?
- As you oversee these global projects, do you see any potential need for organizations to partner with the University of Toronto? In the short term? In the long term?
- If conversations were to happen about ways to partner with the university, what might the university provide in the way of support, expertise, or shared responsibility?
- Do you see any possibility for the contractual engagements globally to change if a hospital were to partner with the university?
- The university engages globally as well in a variety of ways and seems to be quite well known internationally—do you see this helping or hindering a hospital’s global engagement?

Management of Health Professionals

- Can you talk to me about the management of the various health professionals who are engaged in these contracts?
- How do you keep track of what they are doing on the contracts and in Canada?
- Have you run into any challenges managing the health professionals as they engage in this practice?

Closing Final Broad Question

That is all very interesting. I am most appreciative of your time and very aware that you have been very generous to discuss this with me in such thoughtful depth. Before I turn off the tape, I might ask you—are there any other thoughts you would like to add about oversight, now or in the future, for these types of engagement that I have not asked about?

Thank you so much!
Participants: Local University Deans and Senior Administrators

Introduction to the Interview:

Thank you for agreeing to meet with me. I know your time is very limited. My name is Robert Paul and I am conducting interviews for this research project that is the focus of my PhD dissertation. Thank you for agreeing to participate in the interview today. I am very much looking forward to talking with you.

As you may know from reading the material sent to you before the interview, I am exploring the history of revenue generation in the Toronto academic health science centre, its hospitals, its faculty of medicine, and regulatory oversight of it. I am interested in how revenue generation has evolved over approximately the last hundred years and how it went global in the last ten years. I’d like to ask you about your thoughts on the practices involved, how revenue generation is being managed, and how its management has evolved over time.

We are interviewing people like you who have knowledge or oversight of an aspect of this practice. Our goal is to better understand how the practice is being governed, what roles are being created as a result of the practice, and how its governance is evolving or might evolve.

I’m wondering if you have any questions before we begin and if you had a chance to fully read over the information letter and consent form that were sent to you before today. I do have your consent form, but I want to see if you have any other questions that may not have been answered before.

(Answer any questions).

(If this was not previously discussed when the interviewer answered their questions.) I want to remind you that we will be tape recording the interview. And I want to let you know how we are addressing anonymity and confidentiality. As was explained in the information letter,

We will be using pseudonyms or other approaches to disguise your identity in reports of the research. Therefore, information obtained and expressed in interviews will be anonymous. We would like to explain how the information you express will be used when reporting the research. Research of this type looks for similarities, differences, and rationales or logics of governance across the interviews. It uses direct quotes from the interviews to support the patterns identified. When we use direct quotes from an interview or examples of governing practices or their evolution over time, we will not identify a participant by name.
Similarly, references to key figures in the field made by you or other informants will be anonymized.

If you are uncomfortable with the nature of this research, you are most welcome to withdraw at any time. Data gathered from participants who subsequently withdraw (prior to completion of the data collection phase) will not be included in the study reporting. You will be provided the opportunity to read the transcript of your interview before we use your interview. When you read your transcript, you can withdraw any information that you would like to withdraw.

I also wanted to add that you are free to ask me to stop the tape recorder at any point during the interview and to refuse to answer any question. Do you have any questions before we start?

**Personal Background and Experience of Interviewee**

- Can you tell me a bit about yourself (your personal background) and your involvement in or responsibility for revenue generation (e.g., postgraduate trainees) contracts here in Canada and abroad?
- (If not answered in the previous question) Can you tell me about the range of projects you have overseen or managed in this area?

**History of the Contracts**

- Can you talk to me about how these contracts came to be?
- Can you discuss the history of the contracts?
- Why do you think they happened at that time?
- Why do you think they happen now?
- What were the arguments in favour of the contracts happening? What were the arguments against them?
- What makes a successful contract? An unsuccessful contract?
- How would you describe the relationships among the contractual partners? Are the vendor/supplier, partnerships, academics, etc. collegial or adversarial?
- Would you say these relationships have changed over time?

**Governance of Global Revenue Generation**

- Can you tell me about how these contracts are managed?
• How do you keep track of what is happening in them, what might be about to happen in them and what you would like to make sure does not happen?
• Ask to see any examples of types of forms, accounting reports, reporting documents, memos regarding issues, concerns—if possible
• What roles have been created to manage these types of projects?
• Have the reporting structures of your organization changed since it has engaged in these types of projects? Should they?
• What metrics do you focus on when you are monitoring this project?

Governance Relationships Due to Global Engagement

TAHSN is a partnership of the university and academic hospitals. The institutions are all connected, while acting independently. This is interesting because relationships can develop on a global stage that do not happen locally. Also, how one institution acts globally can have repercussions at home.

• What might help you and your organization to manage or oversee these types of engagement?
• Do you have concerns regarding other organizations as they engage globally?
• If so, how do you prepare for any consequences of other organizations’ strategic or operational choice?
• Are there any ways that you think these types of projects might be better monitored? Managed?
• If an institution was to be created to oversee these practices of TASHN, what might that be?
• Is there any organizing group in TAHSN that discusses this practice?
• As you oversee these global projects, or consider others, do you see any potential need to partner with a (several) hospital(s)? In the short term? In the long term?
• If conversations were to happen about ways the university and hospitals might partner, what might each institution have or need in the way of support, expertise, or shared responsibility?
• The university engages globally as well in a variety of ways and seems to be quite well known internationally—do you see this helping or hindering a hospital’s global engagement?

Relationship with the Ministry of Health and Long-Term Care and the Ministry of Education

• Do you report on these projects to the Ministry of Health and Long-Term Care and the Ministry of Education?
• Are there any reports, forms, documents, etc. you provide to the ministry?
• Are any reports submitted to any other governance body?
• Can you see how any reporting to the ministry might evolve or need to evolve?

Relationships with Foreign Governments, Foreign Institutions

• Do you have any reporting obligations to any foreign partner as you engage in these contracts?
• How do they work?
• What kind of issues are they concerned with?
• What kind of issues do you think they should be concerned with?

Closing Final Broad Question

That is all very interesting. I am most appreciative of your time and very aware that you have been very generous to discuss this with me in such thoughtful depth. Before I turn off the tape, I might ask you—are there any other thoughts you would like to add about oversight, now or in the future, for these types of engagement that I have not asked about?

Thank you so much!
Appendix 2—Recruitment Letter

For further information:
Principal Investigator:
Tel: +1
Fax: +1
Email:

DATE, 2015

Title: Canadian Academic Medicine Abroad: The Experience of Exporting Academic Medicine’s Expertise in a Global Marketplace

You are being invited to participate in a research project that aims to understand the rationales for, and the management of, global revenue generation in the Toronto Academic Health Science Network (TAHSN) and with its global partners. This study is being done as part of a PhD dissertation.

Description of the Project and Research:

TAHSN hospitals and faculties of health professions education have engaged in contracts with international partners to deliver services such as consulting for capacity building, medical tourism, manufacturing, and postgraduate education. These types of engagements are a reasonably new phenomenon, the globalization of Canadian health care and the Canadian health profession’s education. This research is exploring how these types of engagements became possible, how they are being managed, and how engagement in the phenomenon might be affecting TAHSN and its institutions. Data will be gathered for this research by a variety of methods, including review of public archival records regarding revenue generation and key informant interviews with approximately 30 individuals in Canada and abroad.

Why Are You Being Asked to Participate in This Research?

You are being asked to participate in this research because you have a role in management or policy oversight of a contract between a Canadian institution and an extraterritorial institution. As a result, you are being approached because you have an understanding of the history of this phenomenon, the current practice associated with it, and/or the governance or management of it. If you agree (or do not agree) to participate, your decision will be kept entirely confidential.

You may also withdraw from the study at any time without any consequences by contacting the principal investigator.
What Will Participants Be Asked to Do?

Participants will be asked to participate in a semistructured interview focused on the history of globalization and revenue generation in TAHSN and their current governance. The interview will take approximately one hour. The interview will be audio recorded and some notes will be made. Participants will be asked to confirm that they agree to participate in the interview and they may decline to answer any questions at any time.

Confidentiality and Anonymity:

This research will use the following safeguards to provide anonymity. Pseudonyms will be instituted to protect your identity. Tape recordings and transcripts of the tape recordings will be stored in a locked filing cabinet in the Wilson Centre in the University of Toronto. Electronic files will be encrypted and stored in a password-protected cloud server.

Please note that research of this type looks for similarities, differences, and themes across the interviews and uses direct quotes from the interviews to support themes with examples. Therefore, when we use direct quotes from your interview or examples to support themes in the research, we will not identify you by name. Similarly, references to key figures in the field made by you or other informants will be anonymized. If you are uncomfortable with this research, you are most welcome to withdraw at any time. Data gathered from participants who subsequently withdraw (prior to completion of the data collection phase) will not be included in the study reporting.

An independent transcription company that has signed a confidentiality agreement may transcribe your interview.

What Are the Risks and Benefits of Participating?

There are no anticipated material risks for participants. Every effort will be made to reproduce quotations and opinions as accurately as possible. Should there be any information that you divulge during the interview that you wish to be excluded from the reporting of this research, this will be duly noted and excluded.

You may also experience a number of possible benefits related to your participation. For example, you may benefit from having a forum to share your experiences and to potentially identify concepts and ideas that may inform policy, leading to better management or oversight of these types of contracts. You may also benefit from learning of potential issues that might arise from these types of contracts to allow you to proactively address them.
There is no specific compensation for participation.

The University of Toronto Research Ethics Board has approved this study. Results of the study will be available via the researchers upon request, once the study report has been completed. If you have any questions regarding your rights as a human subject and as a participant in the study you may contact the Health Sciences Research Ethics Board (416-946-7664).

**How Will the Research Results Be Used?**

The research will be used for the PhD dissertation of Robert Paul. It may be used to inform the content of subsequent presentations, academic articles, and publications.

**What Choice Do I Have?**

As stated above, participation is entirely voluntary. Individuals can refuse to participate, refuse to answer any interview question, and can withdraw from the study at any point in time. A decision whether or not to participate in the research will have no repercussions for you and your decision will be kept confidential.

**What do I Need to Do to Provide Consent to Participate in This Study?**

By signing below you state that you have read the above information and indicate willingness to participate in the above-described study.

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In addition, by signing below you give specific consent for audiotaping of the interview.

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Member of the Research Team Obtaining Consent:

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Should you wish to further discuss the content of this consent form or any other aspect of this research you may contact:

Tel:  
Email:

The University of Toronto Research Ethics Board has approved this project,
### Appendix 3—Demographics of Interviews—Table A3.1: Employment Profile

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