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Section 2: Paper 4

Before the Birth of Bioethics: The Shaping of Physicians' Ethics in Canada, 1940-1970

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Introduction

Students who study bioethics today usually learn very little about the medical ethics of physicians prior to the 1970's. The practices of earlier physicians are often characterized as being paternalistic and lacking in respect for patient autonomy and justice. Yet just as the emergence of bioethics was shaped by social context, so was the medical ethics that preceded it.¹

Before the discipline of bioethics, there was medical ethics. Traditional medical ethics has a long history usually beginning with the Hippocratic Oath (5th century B.C. E.). Earlier understandings of medical morality were associated with customary medical etiquette and decorum rather than our current understanding of medical ethics that focuses on the principles and values governing decisions in medical practice. Medical etiquette consisted of a set of conventional rules regarding the proper conduct of physicians in relationship to their patients and to other doctors. A more recent contributor to this traditional medical ethics is Thomas Percival (1740-1804). Until the middle of the twentieth century, medical ethics was largely an internal conversation among physicians often without a clear distinction between etiquette and ethics. However, advances in science and medicine that took place after the Second World War created

the need for a broader conversation. The 1960s were a time of great social change and major developments in medicine. In this decade, the traditional patterns of life were being altered. Cultural changes were being driven by the prosperity of post-war Canada and the development of a wide range of social programs including universal health insurance and hospital insurance. In addition, there was the emergence of a consumer culture, the availability of effective methods of birth control and the rise of secularization.

It was during this time that medical practitioners, theologians, philosophers, and scientists, came to the realization that the new developments in medicine and its related technologies created new and perplexing ethical dilemmas that could not be adequately addressed by traditional medical ethics. Medical specialization created changes in the physician-patient relationship. A new sensitivity to the rights of suffering and terminally ill people was recognized. As organ transplantation became an effective way of saving lives, a definition of death was needed. And the developments in reproductive technology and genetics generated a new range of ethical questions.

This paper is a work in “descriptive ethics,” which explores the *de facto* morality of physicians roughly between 1940 and 1970. *De facto* morality refers to the profession’s officially endorsed standards as stated in its codes of ethics and related documents, the beliefs held by most physicians about the moral issues in medicine, and the patterns of morally relevant conduct practiced by most physicians. ²

Philosopher Mike Martin holds the view that a person is required to act with integrity in both one’s personal and professional life. In addition to personal morality, professionals have responsibilities to the ethical standards established for that profession. Personal morality prior to

medical education exerts an influence on the physician's ethics. Personal morality is shaped by family, religious beliefs, culture and life experience. Professional morality is influenced by the medical school curricula, physician mentors, codes of ethics from professional associations, hospital directives and codes, the social context in which medicine is practiced and the law.

A number of books have been written by American scholars on the history of medical ethics. Albert Jonsen has written two books, respectively entitled, *A Short History of Medical Ethics* and *The Birth of Bioethics*.³ John Williams has pointed out that developments in bioethics in the United States have exerted important influences on the discipline in Canada.⁴ John Dossetor shares his reflections on the developments in medical ethics in the form of a memoir.⁵ Wendy Mitchinson found that from 1900-1950, Canadian medical schools assigned their students textbooks that were usually of American or British origin.⁶ The perspectives in these texts influenced how the medical students would come to practise medicine. Religious moral directives regarding medical practice were not geographically limited. In 1947, the Nuremberg Code, which set out the principles for ethical research, was adopted slowly by researchers throughout the world. The history of Canadian medical ethics cannot be isolated to events and trends in Canada alone, but has multiple international influences.

The literature on the origins and evolution of the discipline of bioethics identifies the late 1960s and early 1970s as its beginning.⁷ Since that time, bioethics has become a distinct discipline engaging a wide range of clinicians and academics, including philosophers, theologians, other health professionals, legal experts and public policy makers. But what was happening before this time? What were the sources of ethical guidance for physicians? How did physicians deal with their ethical quandaries in the decades before contemporary bioethics?

The Morality of Medical Students

Many features of the morality of young adults entering medical school would have already been shaped by earlier influences in life. Mike Martin notes the importance of personal moral commitments and ideals. They comprise a set of considerations which would make acts moral or immoral for persons in their private life.⁸ Beliefs, values and attitudes would have been shaped by their families, friends and colleagues. Religious tradition, prior education and the historical events and cultural trends of the time would also have exerted a significant impact on the moral vision of the prospective medical student.⁹

Medical Ethics and the Curriculum

Kenneth Ludmerer, an historian, has noted that the goal of medical education over the last hundred years has been to produce physicians who are able to think critically, be scientifically competent and who are sensitive to both the emotional and medical needs of the patient. He states that even though the ideal remains valid, the problem has been putting it into practice.¹⁰ Implicit in this goal for physicians is the acknowledgement of the ethical dimensions of their medical practice.

In 1967, the *Canadian Medical Association Journal* published an article by R. H. Lent and R. Scott which examined medical education since 1950. The authors concluded that the conventional medical curriculum that was in place from 1920-1950 did not meet the educational requirements of current physicians. Specifically, they pointed to the fact that the orientation of

medical educators with regards to the teaching of values to medical students had changed from the previous practice. The authors note that medical schools have tended more to the theoretical research side of medicine rather than the practical side. As a result, medical education moved away from the “art of patient care.” Science and technology created the conditions for the “dehumanization” of the patient. The authors identified a trend that viewed the patient more objectively rather than subjectively. Illness was seen as a separate entity rather than being understood as the overall condition of the patient.¹¹ This scientific approach to the care of the patients was identified as being responsible for the poor quality of communication between the physician and patient. Dr. Jean Saucier, president of the Quebec Division of the CMA in 1950, appears to corroborate Lent and Scott’s conclusions. In his address, Saucier advocates that his fellow physicians see their patients as persons. He extols sympathy as the proper way for a physician to relate to the patient. He points out that

The patient is an individual of whom some-law abiding and God-fearing physicians still think with some kindness. For many, however, the patient is a test-tube, a vague unimportant entity, an instrument for scientific advancement, a source of income, an unexpected heaven-sent product to test the effects of cortisone, an excuse to win applause of the students, a laughing-stock to whom the most impertinent questions are addressed, an unknown person for whom a lobotomy is cheerfully recommended, an illiterate foreigner that one bullies at the out-door clinic, a moron that one ridicules, a nice-looking girl to whom advice is given that often deviates considerably from the accepted code of ethics, an old man who is received with an attitude of pity that is a trifle too loud, etc.¹²

Lent and Scott state that the increase in specialization by physicians was a factor contributing to the depersonalization of the physician-patient relationship. Also, because there was more than one physician who was involved with the care of the patient, no one single physician took responsibility for the well-being of the patient.¹³ These are some of the factors

that led some physicians to lose sight of the patient as a whole person, a foundational assumption in ethics.

The Teaching of Medical Ethics at McGill and the University of Toronto, 1940-1970

A review of the course descriptions at McGill University in Montreal and at the University of Toronto during the period from 1940-1970 shows that the topic of medical ethics was included as part of the curricula for medical students.¹⁴ These lectures were usually offered in the final year of the medical program. At McGill University, medical ethics was included with the teaching of jurisprudence whereas at the University of Toronto, it was included in the course on medical economics.

The academic calendar for McGill University Medical School for 1940 lists a course on “Clinical Therapeutics, Medical Jurisprudence and Toxicology.”¹⁵ The topics include medical ethics, the law, and the obligations of the physician as a citizen. In 1958, a course with the title “Medical Ethics and Jurisprudence” was listed.¹⁶ The topics were covered in twelve lectures given to the class as a whole in the second year. The lectures covered the following topics: the legal status of physicians; obligation of the doctor to the state, professional secrecy-privileged communications, responsibility to the patient-implicit and expressed contracts, physical examinations, surgical operations and consent, and malpractice as well and other issues related to jurisprudence, such as legal procedures addressing coroner’s court, other courts, and being a medical witness. The orientation of this course focused on the legal aspects of medical practice.

During the 1940’s-1970’s, the academic calendars for the medical school at the University of Toronto included a description of the courses, the name of the lecturers, but did not included

course textbooks. The medical economics course was taught in the sixth year of the program by C. S. Young.¹⁷ The course includes the discussion of the following subjects:

... the advantages and disadvantages of various types of practice, the furnishings , equipment and management of an office , book-keeping and the handling of accounts: the relation of the doctor to preventive medicine and to public activities in his own communities.¹⁸

In 1947-1948, the lecturer was V. F. Stock.¹⁹ The course description includes topics that would later become standard in the 1970's such as the nature of the doctor-patient relationship and issues regarding professional colleagues. The objective of the course was

to acquaint the student with the essentials of medical ethics and medical economics. It includes a discussion of the problems of medical practice such as the conduct of the physician in his relationship to the patient, his fellow practitioner and the community; medical economics and socialized medicine, etc.²⁰

At that time, physicians and their professional associations were discussing their role regarding various proposals for insurance and state medicine.

W. G. Cosbie, a Fellow of the Royal College of Surgeons of Canada, as well as the Royal College of Obstetricians and Gynaecologists, was listed as the lecturer in the 1955 calendar.²¹ The course description remained unchanged until 1963.²² R. L. Perkins was the lecturer for the 1965-1966 academic year.²³ These lectures were given with the goal to

relate the history and philosophy of medical ethics to contemporary medical practice. The relationship of the physician to his patients, to other physicians and to society is explored in depth. The practical aspects of medical economics and the problems likely to be encountered in medical practice are both fully discussed.²⁴

This course shifted the focus from economics to medical ethics. By the 1969-1970 academic session, the undergraduate curriculum introduced a new course that integrated values and ethical principles within the whole medical program.²⁵ One stated objective was to “endow the student

with knowledge, skills, values, attitudes and professional and ethical principles basic to the furtherance of any career in medicine” while another objective was to “instil in the student a determination to provide conscientious care with scientific and clinical excellence without losing a sense of compassion and sympathetic understanding.”

The lectures in medical ethics were taught by prominent and well-respected physicians from varied medical backgrounds. But the conversation on medical ethics remained largely within the medical community during these decades.

Professional Codes of Ethics

The code of ethics sets out the moral requirements attached to the profession and is applicable to all members of the profession. Keith Brownell believed that an overview of the Canadian Medical Association’s codes of ethics would facilitate the development of educational materials for medical students. He and Elizabeth Brownell gathered the 18 CMA codes of ethics and examined their content. The 1938 CMA Code of Ethics was different in form and content from earlier versions.²⁶ MacDougall and Langley examined the development of the codes in the changing social and historical context beginning with the first CMA code in 1868.²⁷ They suggested that there were a number of factors that might have lead to the kinds of changes that went into the 1938 version. The CMA sponsored three conferences during the 1920s. Topics ranged from changes in medical education and practice to public relations and the rise in interest in health insurance. The 1930’s was the decade of the Great Depression. Patients who were able to pay for services provided income for the physician and his family while providing charitable work to those who could not pay. In 1934, the CMA Committee on Economics issued a report in favour of government funded health care. In 1929, the Royal College of Physicians and

Surgeons was formed. Its task was to create a standard examination for specialty degrees. In the 1930-1931, the CMA Code of Ethics was adopted.

Some of the changes to the 1938 version of the CMA Code of Ethics include the Hippocratic Oath, sections of the prayer of Maimonides, the Golden Rule, along with selected quotes from Francis Bacon, Ambrose Pare, Thomas Browne and Louis Pasteur were added. New topics were added as well. Brownell and Brownell list these topics as follows:

The need to be up to date in the art and science of medicine, the need for specialists to have adequate general medical knowledge to care for patients, the entitlement of the patients to adequate examination by the physicians, the specification of situations where consultations should be sought, relationships with hospitals and the role of the hospital physicians in teaching and enlarging knowledge, the induction of abortion, communication with the laity and radio broadcasting, discoveries, group practice and ethics, locum tenens and contract practice, and nurses and nursing.”²⁸

These changes reflected changes in medical practice of the day. The Golden Rule, “As ye would that men should do to you, do ye even so to them,” is stated as the guide for personal non-professional morality. The Code recognized personal morality as the foundation for professional morality. It states that “a code cannot change a low-grade man into a high grade-doctor, but it can help a good man to be a better man and a more enlightened doctor.” This connection between personal morality and professional morality was reflected in the requirement by the Royal College of Physicians and Surgeons to have the examiners seek “proof of candidates’ morals and ethics” prior to writing the exam for specialty degrees.²⁹ Physicians are told to give the same quality of service that would be received by the physicians themselves and their families when needed.

There were changes to subsequent versions of the CMA Codes of Ethics. Some were minor changes, others of significance. In 1956, the Declaration of Geneva, which had been

adopted by the World Medical Association was included. This version acknowledged that certain religious traditions did not recognize the threat to the mother's life as a justification for abortion. The 1961 version contained the World Medical Association's Code of Ethics. The most extensive changes to the CMA Code of Ethics during this period appeared in the 1970 version. The language of rights is adopted. The patient has the right to reject recommended medical care. New topics include acknowledging the physician's responsibility for the continuity of care, clinical research, death with dignity, and transplantation.

In the 1970 version, the CMA claimed responsibility for setting the standards for ethical behaviour of Canadian physicians. All physicians, even those who were not engaged in clinical practice, were bound by the Code of Ethics. Also, the CMA assumed responsibility for setting out the standards of ethical behaviour for Canadian physicians.

Discourse on Medical Ethics in Medical Journals

Another source that reveals the ethical views of some physicians were medical journals. The ethical views are those expressed by the authors and cannot be generalized to the whole of the medical profession. The journals' editors deemed the authors' views worthy of publication. Reputable journals, such as *the New England Journal of Medicine* and the *Journal of the American Medical Association*, included articles and commentaries on ethical aspects of practice. A PUBMED search with the term "ethics" in *Canadian Medical Association Journal* for the 1940-1970 produced 378 sources. There was an increase in the number of sources for each decade. In the 1940s, there were 53 sources. During the 1950s, there were 114 sources. Between 1960 and 1970, there were 211 sources.³⁰

Jonsen has found three recurring themes in the literature on medicine and morality over the course of Western medicine.³¹ The first theme is reflected in the writings of the Hippocratic School. In this literature, the qualities of a good physician are described, such as the decorum and deportment that the physician should show toward patients.³² The second theme addresses the duties of the good physician. These duties may arise from oaths, church directives, law or by the profession itself. The enduring duties of the physician required that person to benefit the sick and not to harm them, to maintain confidentiality, not to exploit the patient sexually or monetarily, and to show concern for those in need of medical help. Jonsen notes that these duties were tied to deep moral beliefs rather than the physician's decorum. The Hippocratic Oath was the paradigm statement of these duties.³³ The third theme establishes the social ethics of medicine. In the Middle Ages, the professionalization of medicine began with the teaching of medicine in the universities, the establishment of guilds and colleges and the concern over untrained practitioners. The social ethics of medicine served to regulate professional relationships, establish public trust in the profession and to contribute to the creation of a monopoly for the medical profession.

Jonsen cites the book entitled *Medical Ethics* by Thomas Percival in 1803 as an example of the literature that addressed issues related to physician-surgeon relationships and medical decorum.³⁴ These themes identified by Jonsen are reflected in the *Canadian Medical Association Journal* articles. In 1945, Dr. J. B. McClinton wrote a satirical piece on the CMA Code of Ethics which was published in the form of a little blue book. He begins by saying the “The ants in the pants of society is ethics. It is the most disquieting term.” In a rather mocking tone, he talks about the situations when it is appropriate for the practitioner “to retire” in the presences of another physician, the rules for consultations, fee-splitting , stealing patients, death bed

statements, and abortionists. McClinton's view of the directives in the code are critical, sarcastic, and poetic. It is unclear if McLinton felt bound by the Code in any way. He states that the little blue book is "small enough to lose, flimsy so that it falls apart, and dull enough to be forgotten." Assuming that the author is referring to the Code and not the cover of the brochure, the question could be raised of the editor's intent regarding the publication of this article. It is impossible to know if McClinton's views were his alone or if there was a wider audience which shared similar views.³⁵

In 1941, C. J. Tidmarsh wrote an article on the confidential nature of medical records. He explained that "the medical record of a patient is an integral part of the confidential relationship between patient and physician." He noted that many hospital records were not treated that way. He noted that records were left in the open view of non-professionals.³⁶ Even though the article was published in 1942, the concerns of Tidmarsh remain a topic of ethics today.

An example of ethical discourse on truth-telling in the 1950s is shown in an article entitled "The Care of the Dying" by Frank Hebb.³⁷ He asked whether the patient should be told the truth if there is a definite diagnosis and poor prognosis. He acknowledged that there are "gallantly and remorselessly sincere" doctors who urge truth-telling at all costs. This statement counters some of the paternalism that has been attributed to this period. However, Hebb referred to an article in the *New England Journal of Medicine* by Willard Sperry, a Doctor of Divinity at Harvard University.³⁸ Sperry believed that truth-telling depends on the patient's temperament and mental state at the time.³⁹ Hebb endorsed Sperry's position saying that no single categorical rule can be laid down. Physicians needed to trust their instinctive knowledge of human beings and be guided accordingly.

Hebb then described by what he meant by caring for the dying. He begins with the principle of non-maleficence: the physician must avoid doing harm. Caring and avoiding harm meant not subjecting the patients to treatments that increased discomfort and offered no benefit. Rather, the physician should offer relief of distress including pain, make home visits, avoid whispered conversations with hearing range of the patient, allow visitors, and discuss the need to write a will with the patient.

In 1953, H. E. MacDermott wrote specifically on medical ethics. While he affirmed that most physicians devote themselves to the needs of their patients, he did acknowledge that there are less desirable misfits in the medical profession “who charge all that the traffic will bear.”⁴⁰ With the development of medical insurance and hospital insurance, some physicians had a greater focus on their income rather than on their patients.

The issue of the relationship between specialists and the general practitioners was a recurring theme in this period. Medical information, disseminated via the media of the day, increased the knowledge and expectations of the public in relationship to medical professionals. The relationship of the physician to the state, hospital, physician consultants and specialists, the patients, and the public were all changing. Many of these issues, which had been addressed in the 1938 CMA Code of Ethics, remained troubling for physicians. The 1956 version of the CMA Code included a section on “Fees and Commissions.”

By the 1960s, the *Canadian Medical Association Journal* articles began to address the types of topics commonly addressed in bioethics such as human experimentation, organ transplantation, sterilization and abortion. An editorial comments on the perception that the standards of medical ethics in the Western world are declining. This trend is part of a general fall in ethical and moral standards in society as a whole. Other reasons include the changes in the

way physicians were paid, the focus on medicine as a science and not on the patient as a person, and a lack of ethics in organization medicine.⁴¹

Hospitals and Other Health Care Professions

Mitchinson explains how the expansion of hospitals had an impact on Canadian physicians in the first half of the twentieth century.⁴² Hospitals grew in number, size, technology and specialization. Each hospital developed its own culture.

Even though most medical care was provided by general practitioners, those physicians who were on the staff of teaching hospitals became the medical elite who set the standards. These physicians encountered other professionals who set out the ethical precepts of their respective professions. While the primary responsibility of nurses was obedience to the physician during this period, nurses carried their own personal and professional values into the hospital. In 1950, a nursing textbook listed the essential attributes of the ideal nurse as truthfulness, obedience, punctuality, observation, sobriety, honesty, quietness, devotion, tact, loyalty, sympathy, and humility.⁴³ By 1954, the Canadian Nurse's Association adopted the Code of the International Council of Nurses. The physician-nurse relationship did reflect the social relationship between men and women of the time. However, since the nurse's presence was so large in the day-to-day care of patients and their role was indispensable to the activities of the hospital, it is reasonable to assume that nurses did exert an influence on the hospital's culture and

on the ethical practice. During the 1960s, with the influence of the feminist movement, the subordinate model of the nurse underwent a change and the nursing profession began to claim its own sphere of practice.

The hospital administration was responsible for the culture that took place within the hospital walls and affected the physician's practice. Hospital administrators were guided by their own ethical guidelines.⁴⁴ In Canada, there have been hospitals founded and operated under Jewish, Anglican, Salvation Army and Roman Catholic auspices.

In Catholic hospitals, for example, Andre Cellard and Gerald Pelletier described the code of medical ethics for the hospital as similar to what personal conscience is to an individual. It is assumed that all physicians, surgeons and other hospital staff who work in Catholic institutions were bound to follow the code.⁴⁵ In 1921, Rev. Michael Burke wrote out the medical ethical norms for the hospitals in the Archdiocese of Detroit. These directives, by Burke, were either accepted verbatim or in a modified version by dioceses in both the United States and Canada and were posted on the walls in the hospital's operating rooms.⁴⁶ They consisted of a list of "dos and don'ts" for various procedures. By 1970, the approach was not to impose rules of conduct but to provide ethical guidelines. The preamble stated that "the Guidelines should serve to enlighten [the] judgment of conscience."⁴⁷ The intent of the *Medical-Moral Guide* was not to replace conscience. The primary philosophical assumption was that the basic morals of a Catholic hospital should flow from the "personal morals" of the Catholics working in it rather than being governed by a strict code what was composed of directives and sanctions. However, there were certain practices that were prohibited. If physicians worked within a Catholic hospital, then they were required to abide by the hospital's directives.

Conclusion

The transformation from traditional medical ethics to bioethics was based on many factors. Personal morality, conscience, common sense, the Hippocratic Oath and a variety of sources influenced the individual moral decisions of the physicians during these decades. The specific sources that may have been used to justify a particular decision by an individual physician would have reflected the moral understanding of that physician at that time. There was an awareness by some prominent physicians that advances in medicine could not only help but also dehumanize the patient. During these three decades, some physicians explicitly criticized other physicians for the way that they cared for their patients. The adjustment to the changes in the delivery of health care along with the establishment of the hospital and medical insurance posed their own ethical issues for the physicians to work through, such as fee-splitting.

The Canadian Medical Association regularly revised its Code of Ethics. Even though physicians were aware of the Code, how it factored into actual decision-making is not clear. By 1970, The CMA stated that its role was to define the ethical behaviour of physicians. By this time, both McGill University and the University of Toronto had revised their curricula to include a more integrated teaching of ethics within their wider programmes. Prior to this time, a small number of lectures in medical ethics were given to medical students. During the 1960s, the number of articles on medical ethics increased in the *CMAJ* and the topics were those that were discussed in the early days of bioethics, such as abortion and organ transplantation. Hospitals that had been founded by religious groups and were operating under their auspices created other ethical considerations, such as the religious directives for Catholic hospitals.

The birth of bioethics was preceded in Canada by pervasive changes in medicine and society. The conversation on medical ethics that had primarily taken place among the medical

profession did not have sufficient analytical tools for an ethical understanding and analysis of the issues that were arising in medical practice. Philosophers, theologians, lawyers, sociologists and anthropologists were among those who contributed to a deeper comprehension of the medical and scientific developments taking place and the definitions and concepts necessary for their ethical analysis

Endnotes

¹ Heather MacDougall and G. Ross Langley, “Medical Ethics: Past, Present and Future,” *Primers*, Royal College of Physicians and Surgeons of Canada. http://www.royalcollege.ca/portal/page/portal/rc/resources/bioethics/primers/medical_ethics

The history of medical ethics must be understood in the broader context of the history of medicine and medical education in general, which in turn are enmeshed in the culture of the period. Heather MacDougall and G. Ross Langley have written a comprehensive history of the development and use of oaths and codes of ethics for the Royal College of Physicians and Surgeons from antiquity until 2008.

² See Mike Martin, *Meaningful Work: Rethinking Professional Ethics*, (Oxford University Press, 2000), 6, for this understanding of *de facto* morality and the information in the next paragraph.

³ Albert Jonsen, *A Short History of Bioethics* (New York: Oxford University Press, 2000) and *The Birth of Bioethics* (New York: Oxford University Press, 1998).

⁴ John R. Williams, “The Influence of American Bioethics in Canada” *Journal International de Bioéthique* 4, no. 20 (2009):95-105.

⁵ John B. Dossetor, *Beyond the Hippocratic Oath: A Memoir on the Rise of Modern Medical Ethics* (University of Alberta Press, 2005).

⁶ Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto, University of Toronto Press, 2002), 15.

⁷ Jonsen, *The Birth of Bioethics*, 27. He discusses Warren Reich’s explanation for the “bilocated birth” of the term “bioethics.” In 1970, Van Rensselaer Potter, who was a research oncologist at the University of Wisconsin, used the term in an article entitled “Bioethics: The Science of Survival.” A year later, he wrote a book with the title, *Bioethics: Bridge to the Future* (1971). For others who discussed the beginning of the discipline of bioethics, see Daniel Callahan, “Bioethics as a Discipline” *Hastings Center Studies* 1 (1973), 66-73, and Edmund Pellegrino, “The Origins and Evolution of Bioethics: Some Personal Reflections,” *Kennedy Institute of Ethics*, 9, no.1 (1999), 73-88.

⁸ Martin, *Meaningful Work*, 4

⁹ See, for example, R.D. Gidney and W.P.J. Millar, “Medical Students at the University of Toronto, 1910-40: A Profile,” *Canadian Bulletin of Medical History* 13 (1996), 29-52. This article describes the nature of the student body of the University of Toronto medical school in terms of age, socio-economic background, ethnic and religious affiliation in the early part of the twentieth century until 1940. It can be reasonably assumed that this profile extended to some degree into the 1940’s.

¹⁰ Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (New York, Oxford University Press, 1999), 277-278.

¹¹ R. H. Lent and Rose Scott, “Knowledge, Numbers and Values: Medical Education Since 1950,” *Canadian Medical Association Journal* 97 (1967): 1418. The authors focus on three areas: medical knowledge, numbers of physicians and the values of medical personnel.

¹² Jean Saucer, “On the Patient,” *Canadian Medical Association Journal* 63 (1950), 393.

¹³ Lent and Scott, “Knowledge, Numbers and Values: Medical Education Since 1950,” 1424.

¹⁴ The curricula of other Canadian medical schools during this time were not examined.

¹⁵ Calendar, McGill University, Montreal, 1940-1941.

¹⁶ Calendar, McGill University, Montreal, 1958-1959, 1625.

¹⁷ Young had a distinguished career, serving in executive roles for the Royal College of Physician and Surgeons, the Ontario Medical Association, as a member of the Commission for the Investigation of Cancer Remedies for the Ontario Government, and as a former editor for the *Canadian Journal of Medicine and Surgery*.

¹⁸ Calendar, University of Toronto, Faculty of Medicine, University of Toronto Press, 1939-1940. 86.

¹⁹ V. F. Stock was a doctor and a councillor for the Medical Protective Association from 1948 until 1953. The Medical Protective Association was formed to provide professional liability protection for Canadian physicians in the form of advice and legal assistance. See: Roll of Service. http://www.cmpa-acpm.ca/cmpapd04/docs/about_cmpa/com_history-e.cfm#9.

²⁰ Calendar, University of Toronto, Faculty of Medicine, University of Toronto Press, 1947-1948, 85-86.

²¹ Cosbie , <http://www.ctg.queensu.ca/public/meetings/Spring/cosbie/cosbie.html>

²² Calendar, University of Toronto, Faculty of Medicine, University of Toronto Press, 1955-1956, 85.

²³ At the time, R. Perkins was a member of the College of Family Physicians of Canada, eventually serving as President. He is credited with establishing the Department of Family and

²⁴ Calendar, University of Toronto, Faculty of Medicine, University of Toronto Press, 1965-1966, 53.

²⁵ Calendar, University of Toronto, Faculty of Medicine, University of Toronto Press, 1970, 30-31.

²⁶ A. Keith W. Brownell and Elizabeth Brownell, "The Canadian Medical Association Code of Ethics 1868 to 1996: A Primer for Medical Educators," *Annals, Royal College of Physicians and Surgeons of Canada* 35, no. 4 (2002): 240-243. Brownell and Brownell note that seven of the eighteen codes of ethics have significant differences from their predecessors. They are the 1922, 1938, 1956, 1961, 1970, 1990 and 1996 versions respectively.

²⁷ MacDougall and Langley, "Medical Ethics: Past, Present and Future," Part 2, Medical Professionalization and Ethics Codes, www.royalcollege.ca/resite/bioethics/primers/medical-ethics-past-present-future-e and A. Keith W. Brownell and Elizabeth Brownell, "The Canadian Medical Association Code of Ethics 1868 to 1996: A Primer for Medical Educators," *Annals, Royal College of Physicians and Surgeons of Canada* 35, no. 4 (2002), 240-243.

²⁸ Brownell and Brownell, "The Canadian Medical Association Code of Ethics," 241

²⁹ MacDougall and Langley, "Medical Ethics: Past, Present and Future," Part 2, Medical Professionalization and Ethics Codes."

³⁰ When the search was conducted with the term "morals," 72 sources were found in the *CMAJ*. Many sources contained both terms. There was an increase in the number of sources for each decade. In the 1940s, there were 53 sources. During the 1950s, there were 114 sources. Between 1960 and 1970, there were 211 sources. It is possible that there were articles which addressed aspects of ethical practice in other articles in each decade, even though the terms, "ethics" and "morals" were not specifically used.

³¹ Jonsen, *The Birth of Bioethics*, 6.

³² Jonsen, *The Birth of Bioethics*, 6.

³³ Jonsen, *The Birth of Bioethics*, 6.

³⁴ Jonsen, *The Birth of Bioethics*, 7.

³⁵ James B. McClinton, "The Doctor's Own Ethics," *Canadian Medical Association Journal* 52 (1945), 199-202.

³⁶ C. J. Tidmarsh, "The Confidential Nature of Medical Records" *Canadian Medical Association Journal* 45, no. 3 (1941): 275-277. Tidmarsh then focuses his discussion on how the physician-patient relationship becomes complicated regarding the confidentiality of medical records in industrial medicine. He told of an actual incident when a physician, who worked in industry,

was fired because he refused to divulge the diagnosis of a patient/employee without that person's permission to the president of the company. The physician was told that he was a paid servant and that his loyalty was to the company. When the physician raised the issue of medical ethics, the response was "business efficiency is not interested in medical ethics." The information about the patient/employee belonged to the company because it paid for the information. Tidmarsh noted that the courts had already established that the relationship between the company doctor and the workman was privileged and confidential. However, in spite of the legal protections in place, he was concerned that industrial doctors and company officials needed a greater understanding of the nature of the physician-patient relationship.

³⁷ Frank Hebb, "The Care of the Dying" *Canadian Medical Association Journal* 65 (1951), 261-262.

³⁸ W. L. Sperry, "The Moral Problems in the Practice of Medicine," *New England Journal of Medicine* 239 (1948), 985.

³⁹ Hebb, "The Care of the Dying," 262.

⁴⁰ H. E. MacDermot, "Medical Ethics," *Canadian Medical Association Journal* 68 (1953), 168.

⁴¹ Editorial, "Ethics-Up or Down," *Canadian Medical Association Journal* 82 (1960), 154-155.

⁴² Mitchinson, *Giving Birth in Canada*, 19-46.

⁴³ M. Hainsworth . *Modern Professional Nursing*, Vol. 2, second edition (London Caxton, 1949), 238.

⁴⁴ D. Neuhauser, "Ethics in Hospital and Health Administration" *Health Matrix* 3, no. 2 (1984), 49-53.

⁴⁵ Andre Cellard and Gerald Pelletier, *Faithful to a Mission*, Catholic Health Association of Canada, 1990, 71, http://www.chac.ca/alliance/online/docs/brochure_faithfultoamission_en.pdf In 1942, the Canadian bishops adopted a *Code of Ethical Directives for Catholic Hospitals in Canada*. The new *Code* was clearly more liberal than its predecessors. Its preamble, which laid out some general principles, expressly stated that: "In questions legitimately debatable, the physician remains free to follow the opinions which seem to him more in conformity with sound principles of medicine" (Article 5). The *Code* continued with a series of guidelines for medical and surgical care.

⁴⁶ K. O'Rourke, T. Kopfensteiner and R. Hamel, "A Brief History: A Summary of the Development of the Ethical and Religious Directives for Catholic Health Services," *Health Progress* (November-December 2001), 18-21.

⁴⁷ Cellard and Pelletier, *Faithfull to a Mission*, 155.