Medicine and Morality

Crises in the History of a Profession

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Introduction

In recent years, critics of biomedicine, including physicians and medical researchers, have become increasingly concerned about the problem of conflict of interest in that field. "Conflict of interest," in this context, has been broadly defined as the damaging impact of economic, political, and personal interests on what should be the "pure" scientific and moral imperative of medicine to be objective and to do no harm. Those with concerns about conflict of interest have focused mostly on interactions between medical practitioners, researchers, and the multimillion-dollar pharmaceutical industry. The impact of Big Pharma on medical knowledge and practices has been well documented, including the influence of "detailing" by drug sales-representatives on the prescribing practices of clinicians, the potential bias-inducing impact of privatization and drug industry funding on biomedical research, and the close relationship between the industry and medical schools.[1]

The role of drug industry forces in medicine is an important issue with wide-reaching social, political, and ethical implications for public health, patient care, and scientific knowledge. However, current discussions about medical conflict of interest offer only a limited view of the types of such conflicts that exist, and have existed, in medicine, how they arise, and how medical professionals conceptualize and respond to them in the pursuit of health and the protection of patients from

harm. Current discussions treat conflict of interest as a contemporary phenomenon, coinciding with the emergence of the Big Pharma in the mid-twentieth century, rather than placing it in a historical context. While serious, drug industry influence accounts for only a fraction of the types of conflict of interest that doctors and the medical profession have faced, and continue to face. In the late nineteenth and early twentieth centuries, doctors lobbied various levels of government for laws that would grant the medical profession autonomy and self-regulating powers, as a way to eradicate other health practitioners who threatened the medical profession's dominance in the medical market. In mid-twentieth century, when the Saskatchewan government led by Thomas C. ("Tommy") Douglas moved to institute a publicly funded health insurance plan, the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan vehemently opposed the proposal, organizing a doctors' strike in 1962 that drew considerable public criticism, including in the national press. In these moments, the professional interests of medicine stood at odds with those of the state, other professional groups, and even the public.

Medical professionals are expected to act in the interests of patients and the health of the public – that is, of someone other than themselves. If doctors are involved in research as clinician-researchers, they are expected to act in the interest of scientific progress, the pursuit of knowledge, and the common good – that is, for something beyond their own personal interests. At the same time that they are held to these moral and scientific standards, doctors are rewarded individually and collectively for acting in the interests of others. They often have high incomes, have respectable careers as professionals, and are recognized by the state, the media, and the legal system as experts whose statements about health and illness have tremendous value and credibility. In medicine, there is a tension between the necessary evils of depending on the market economy and state politics for sources of monies and legislative support, and medicine's genuine investment in the pursuit of moral integrity, scientific innovation, objectivity, and neutrality. In other words, for doctors, being medical professionals is a moral paradox.

In this book, I move beyond current considerations around conflict of interest to consider more broadly the ways in which moral and scientific

norms in medicine have emerged and evolved over time. Standards with regard to what is moral and what is scientific are not fixed or abstract; rather, they are historically constituted in relation to social, political, economic, and cultural forces. In the following chapters, I focus on historical moments when patients, journalists, and politicians, all of whom are invested in how medicine is done, questioned doctors' moral and scientific authority. In these moments of moral crisis, the medical profession responded by re-evaluating, rearticulating, and even reshaping what it meant for doctors to act with moral and scientific integrity, doing so in ways that legitimated particular practices with respect to their relationship to the public, the media, and politics, with wide-reaching implications. As I will show, medical professionals have pursued moral and scientific integrity in direct relation to, rather than in spite of, conflict of interest. As they have butted up against other stakeholders in health and medicine, they have shaped what ought and ought not to be done in the name of patient care, public health, and scientific objectivity.

Science, Morality, and Medicine

Medicine straddles multiple domains: it is a science that produces knowledge about the human body; it is an art that bridges the biological and social dimensions of life; it is a moral enterprise that deals in the intimacies of life and death. The medical doctor sits at the intersection of these concerns, grappling with the daily pursuit of benevolence, non-maleficence, scientific objectivity, accountability, respectability, and all the other ideals of the medical professional. Medicine and its practitioners are popular subjects in various disciplines, including history, sociology, anthropology, cultural studies, and the social study of science. Some writers take medicine's own claims to be scientific and morally upright at face value as unquestionable justification for the authority and credibility of the profession. Others are skeptical of the medical profession's moral and scientific claims, treating these claims as the tools of persuasion through which the profession exerts its political power and social dominance. Still others take a more discursive approach, examining practices and language through which medicine articulates and shapes its ideas of "science" and "morality" and, by extension, examining

what it means to enact scientificness and moral integrity in the clinical, scientific, and political pursuits of medicine.

Noble Origins and the Myth of Progress

Ideas related to "science" and "morality" figure centrally in the history of the medical profession, particularly in the profession's own narrative about its origins. The earliest texts about doctors in Canada were written by doctors themselves.[2] These physician-historians portrayed the medical profession as a noble group of "medical men," as they called themselves, deserving the authority to oversee all matters surrounding health and disease. These historical texts often served political purposes for the emerging profession, as doctors struggled to gain professional legitimacy, both in the eyes of governments and among the physicians whom it claimed to represent.

One of the first publications about the medical profession in Canada is William Canniff's *The Medical Profession in Upper Canada, 1783–1850,* published in 1894. The text is decidedly conservative and pro-British, emphasizing the legislative triumphs by British physicians and surgeons to raise the status of their profession over and above that of their competitors, such as homeopaths and other "quacks." During a time when French-British tensions in Canada were high, a primarily British-centric historical account would have served as a way for English-speaking medical men to establish a sense of their common history.[3] H.E. MacDermot's *History of the Canadian Medical Association, 1867–1921,* which was first published in 1935 by the Canadian Medical Association, echoes Canniff's narrative structure. He documents the trials facing medical men during the late nineteenth century as they nobly struggled against what he describes as rampant quackery and ignorance among the masses. In Canniff's and MacDermot's accounts, medical men are already united as a profession with a common set of goals and ideals, including the dominance of Anglo medical doctors and of the British system of professionalization. Both authors claim that scientific innovation and progress in medicine led to the (rightful) dominance and credibility of medical men over other practitioners. Their explicitly self-aggrandizing tone points to a sense of urgency among medical men to legitimize their professional status and respectability.

Their line of argument appears in later historical texts as well.[4] Often, these texts subscribe to the progress myth that better science led to better medicine. These authors claim that the social and political constraints faced by the medical profession in the nineteenth century were resolved by the miracle of scientific innovation and progress in the twentieth century. For example, Colin D. Howell writes that doctors in the nineteenth century could not agree on what counted as legitimate medical knowledge, nor were they substantially different from untrained practitioners in their therapeutic approaches and rates of clinical success. However, he concludes that doctors rose to their eventual expert status by accepting "popular notions of the value of science and responsible social management,"[5] as though "the value of science" and "responsible social management" were concepts that already existed during this time and that doctors simply needed to accept.

Critical writings and historical analyses of medicine by non-physicians from the 1980s onwards provide a more nuanced way of understanding the relationship between morality, science, and medical knowledge and practices. Academic historians in Canada began to problematize the assumption in earlier literature that medical men had always been united as a homogeneous group, pointing to the scientific, political, and social conflicts that shaped medical practice, in particular the medical profession's struggles to claim moral and scientific superiority over other healing professions.[6]

S.E.D. Shortt argues in a 1983 essay that the trend in the historiography of medicine to unproblematically link "the professionalization of medicine in a causal fashion to a growth in scientific knowledge requires substantial modification."[7] He then describes the ways in which science as a form of "polite knowledge" was a tool used by Victorian middle-class physicians in the Americas to forge a group identity, one that was distinct from upper-class medical men.[8] In doing so, Shortt situates scientific discourse, class struggles, morality, and legitimacy in the same relational space. In a similar vein, Paul Underhill's analysis of the medical reform movement in Britain demonstrates that the social and political conflicts among British medical men overlapped with disputes about the very nature of medicine as a body of knowledge and practice.[9] In her book *History of Medicine: A Scandalously Short Introduction,* Jaclyn

Duffin also situates the creation of the medical profession in Canada in the context of the social and political roles of physicians in the construction of knowledge about the human body and about disease.[10] Standards of scientificness and the pursuit of moral integrity in medicine are not separate from doctors' socio-political struggles. Medicine's discourses, practices, and actions around "morality" and "science" are part and parcel of professional medicine's pursuit of legitimacy and authority.

Medical Dominance and Medicine as Culture

Ideas about medicine's authority and power form a central concern in a large body of sociological literature. Rooted in structuralist approaches and political economy traditions, these analyses focus on the concept of "medical dominance," or the medical profession's power "over the content of their own work (characterised as autonomy) and its power over the work of other health care occupations (authority) as institutionalised experts in all matters relating to health in the wider society (sovereignty)."[11] These texts trace the emergence of medical dominance to the early days of the profession in the nineteenth century, during which medical doctors battled other healing practitioners – and won. The lines of inquiry tend to revolve around whether or not the medical profession has or had dominance and the degree to which this dominance may have been eroded in the health care workplace, in policy making and legislation, and in relation to other health professions and patients.[12]

In the structural analyses of doctors as a profession, ethics/morality and science are either moot points or vehicles for the profession's more pressing concerns in establishing and maintaining structural power. In this literature, science is taken up primarily in the form of "medicalization," or the adoption of formerly non-medical issues into the realm of medical knowledge and expertise, a process that serves to reinforce the authority and dominance of professional medicine.[13] The pursuit of dominance is so central to this body of work that Ronald Hamowy goes as far as to state that "it is foolish to suppose that their occupation exalts them above using the means at their disposal to act in their own private interests," a view he diametrically contrasts with the medical profession's own assertion that "its dedication is the public's interest" and "that [doctors] have never sought legislation or acted for selfish ends."[14]

Another type of sociological literature, which emerges from symbolic traditions, treats the profession as a type of culture and examines science and morality in relation to cultural norms and identity formation in medicine. Drawing on anthropological approaches and often presented through ethnographic studies, these works emphasize the ways in which doctors at various stages in their careers – including as medical students[15] and junior doctors[16] – and in various working contexts – such as emergency wards[17] – conduct themselves in relation to expectations from patients, other doctors, and managers. These works emphasize behaviours of and perceptions held by doctors and medical students in relation to the situations and conflicts in which they find themselves[18] in the context of a hierarchized professional culture.[19] Some of these works take up Pierre Bourdieu's concept of "habitus" in order to describe a "medical habitus," which is cast primarily as doctors' identity[20] and embodied clinical practices,[21] and is seen as being shaped via encounters with professional and health care institutions. In these works, the structures of professional culture, among which are scientific practices and moral standards, largely shape the professional identities and embodied practices of doctors.

David Armstrong takes a symbolic approach in his analyses of moral and ethical issues in medicine. In one essay, he finds that doctors observe professional etiquette as a communicative strategy that helps them mediate conflicting opinions around prescribing treatments without compromising clinical autonomy, which he defines as the ability of a doctor to make clinical decisions free from intervention by others, including other doctors.[22] Armstrong has also analyzed the significance of early medical professional codes of ethics (from the nineteenth century onward) in terms of the socio-political concerns of the profession during various time periods.[23] For instance, he finds that nineteenth-century codes demonstrate a metaphoric parallel with the public health approaches at the time, which were concerned with monitoring the boundaries of the body – the public body, the individual body, and the professional body – to guard them from contaminants, including diseases and unfit doctors.

Armstrong's work shows how professional medicine's socio-political interest in authority and legitimacy – ensuring that doctors are seen as experts on all matters of health and illness – and individual physicians'

struggle to practise medicine as they see fit interact with and manifest themselves in everyday practice, such as in clinical decision-making and codes of ethics. The ways in which doctors perceive themselves as autonomous experts and hold themselves to specific ethical norms are part of the daily culture of medicine, which in turn is inseparable from the profession's socio-political struggles. Medicine's moral and scientific claims are not only political strategies to gain authority and power but are also practices that shape the culture of medicine as lived by doctors, particularly when they relate to one another, their patients, and others who have a stake in how care and medicine is done.

Medicine as a Discursive Space

Language and representation are key features of any culture, including the culture of medicine. The ways in which the field of medicine as a whole articulates what it knows, how it knows what it knows, what it does, and why it does what it does offer a window into its understandings of the norms of science and morality in medicine. The study of medical discourse is largely considered to begin with the work of Michel Foucault, particularly his *Madness and Civilization* and *The Birth of the Clinic*,[24] both of which moved away from established narratives of scientific progress, discoveries, and innovations as well as investigation of origins and causes of medical theories and practices. Foucault emphasized patterns of discursive formation, such as the development of new objects and lexicons related to medical knowledge, to institutional networks, and to new ways of seeing and organizing what is knowable. His concept of the "medical gaze" was an alternative to medicalization[25] as a way to understand the power of physicians, which he saw as the capacity and the authority to draw on the entire discourse and institution of medicine when using their gaze and touch in clinical practice.

Foucault's work has inspired a vast range of writing that examines the discursive impact of medical techniques and knowledge, such as diagnostic strategies, clinical categories,[26] and visualizations of the body.[27] The interdisciplinary area of social studies of science and medicine combines influences from the sociology of knowledge, cultural studies, and the history of science and medicine to engage with scientific knowledge and practices as part of the social, cultural, and political lives of scientists

and health professionals. By treating medicine as a discursive space that is susceptible to broader socio-political forces and systems of oppression, scholars have framed medicine as a political space in which the human body is imagined and worked on in order to produce docile bodies,[28] new regulatory regimes,[29] and new ways for medicine to know what it knows.[30] Feminist and critical race scholars emphasize that biomedical knowledge and practices continue to produce particularly gendered and racialized bodies and subjectivities, often in concert with other discourses such as those related to law, citizenship, sexuality, colonization, and religion.[31]

The works that draw on Foucault's approach have highlighted the ways in which medical thinking is heterogeneous and often inconsistent across time and disciplinary boundaries, thereby debunking assumptions about the immutability of scientific facts and truths.[32] Drawing on Foucault's work, science historians Lorraine Daston and Peter Galison argue that, historically in Western science, the standards of what constitutes an objective manner by which a scientist may observe and represent a phenomenon to other scientists were entwined with ideas around moral integrity and self-cultivation of the scientist – specifically, in scientists' ability to control the subjectivity of their gaze and follow the established procedures of observation at the time.[33] Scientific ways of seeing have thus always been inseparable from moral ways of being scientific.

In medicine, the interrelationship between science and morality is evident in the ways in which doctors present themselves to one another and to their patients. Lianne McTavish examines medical treatises written by male midwives in nineteenth-century France. These men deployed visual and textual practices of self-representation that helped them gain credibility during a time when women dominated midwifery. McTavish argues that male midwives often represented themselves as gender hybrids in order to downplay the sexual danger of their presence in the birthing chamber. At the same time, they highlighted their gendered privilege as men, who were considered to be more theoretically competent than women.[34] Working on a similar historical period, Robert Nye finds that scientists and medical men of Victorian England and modern Europe adopted the old duelling codes

of aristocratic men as a socially appropriate way to resolve conflict between one another over scientific views.[35] He draws on the works of science historians Steven Shapin[36] and Mario Biagioli[37] on early modern scientists, for whom personal honour was closely associated with scientific credibility. McTavish and Nye demonstrate that doctors used moralized strategies around gender and class in order to gain credibility, and that these practices were also related to scientific standards and norms of the time.

The discursive relationship between morality and scientificness plays out in the clinic and medical research as well. Kathryn Montgomery[38] combines literary analysis of doctors in fictional narratives with ethnographic observations of medical students in order to examine the ways in which doctors come to think the way they do, particularly as they navigate the uncertainties and messiness of medical practice. She argues that clinical judgment is often based on non-scientific knowledge and practices[39] and asserts that the moral and the clinical are intertwined in the context of medical practice. By insisting that medicine is foremost a science, physicians can block empathetic relations with their patients, thereby de-emphasizing the moral basis for the therapeutic practice of medicine. The tension between the moral and the clinical is one of the foci of Lisa Keränen's *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research*.[40] She explores a recent scandal in Canadian breast cancer research, where a prominent scientist in the field was found to have falsified data for decades. In her analysis of the ways in which the scientist was characterized, Keränen identifies tensions in the figure of the researcher-physician, who must be both a beneficent healer and a career-minded scientist. She links this tension to different norms of what a proper and moral physician-scientist must be.

Doctors negotiate moral and scientific standards through the ways in which they engage with others in the profession as well as those outside of it, particularly patients and the public, on whose behalf doctors are supposed to act. A close examination of the discursive practices through which they present themselves as moral and scientific subjects yields insight into what exactly is meant by "moral" and "scientific" and which practices and ideas are permissible within medicine in the name of these ideals – and which are not.

Understanding Scientific and Moral Norms in Context

French anthropologist Pierre Bourdieu argues that in most social spaces, such as the economic market, schools, politics, and the media, people compete with one another in the interest of themselves, their family networks, and other social groups to which they belong. However, in certain pockets of society, people display interests that go beyond the self, such as in the religious callings of priests, aesthetic visions of artists, and objective commitments of scientists. Altruism, selflessness, and the desire to pursue something – art, knowledge, and so on – for its own sake are some of the qualities that we as a culture associate with people from these social worlds. Bourdieu calls these social spaces "anti-economic universes"[41] because the logic by which they operate is opposite that of a conventional economy, with the latter characterized by competition, self-advancement, and barter/exchange of goods and services. He argues further that artists, priests, and scientists are personally rewarded for acting in the interest of something or someone other than themselves, an outcome that contradicts the selfless premise of their actions. For instance, scientists compete with one another for research funding, recognition, publication, and rewards, although they do so in the name of progress, the common good, and the pursuit of knowledge for the sake of knowledge. Scientists act in the interest of something other than themselves, but to do so they engage in self-interested acts: they act with what Bourdieu calls "invested disinterestedness." He does not dismiss invested disinterestedness as a lie or a delusion that masks supposedly truer and more selfish intentions, nor does he naively take disinterested claims at face value. Instead, he describes such disinterestedness as a genuine motivation, at the same time that it is socially strategic.

Similarly, we can see doctors' claims to be disinterested as a genuine belief that what they do is on behalf of someone, and in the interest of something, beyond themselves. At the same time, we can see these claims as socially, politically, and culturally strategic in maintaining doctors' authority and legitimacy as experts on matters of health and illness. The moral and scientific standards in medicine are determined by a system of rewards that cannot be explained solely by an economic model based on a self-interested and calculating subject, or by an ahistorical and apolitical view of morality in terms of altruism and pure selflessness. Indeed, for

doctors and scientists alike, self-interested and disinterested actions – or economic and anti-economic practices – are not easily distinguishable. Without money for health care through private and/or public insurance systems, medical care is not possible in current health care models. Without money for research, whether it is privately sourced through industry or publicly acquired through government grants, life-saving medications and technologies would be severely limited. Recognition from other scientists and clinicians determines the value of scientific work, and the intellectual work of science relies on centuries of generating, testing, and refuting theories by generations of scientists, a process that engenders, and also benefits from, competition. As much as doctors and scientists may claim that their work is for the common good, they also struggle with hospital and university administrations and the state to ensure that they are paid satisfactorily for their services. According to Bourdieu, anti-economic universes implicitly, and necessarily, rely on economic forces. Moreover, this contradiction is held together by a genuine collective denial of this paradox.

Rather than focus on whether or not doctors' claims to be disinterested are valid, which is a valuable line of inquiry that I leave to other scholars and analysts, I examine in this book how the delicate contradiction between self-interestedness and disinterestedness is held together in medicine, particularly in moments where the contradiction becomes so obvious that the collective denial risks falling apart. These are crisis moments when the medical profession's claims to scientific and moral legitimacy have been put into question by doctors themselves, the public, the media, and politicians, to the point where the profession was compelled to re-examine its priorities, strategize about ways to regain credibility, and redefine what it meant to be a good doctor.

Science and morality are cultural concepts that shift across time and are defined through social, cultural, and political struggles. Thus, what are considered to be matters of science, morality, and ethics today may not have been thought of as such in other moments in history. Conversely, what were considered to be matters of scientific and moral importance in other historical moments may not be recognized as such today. Keeping this historical specificity in mind, throughout this book I avoid judging doctors' actions as moral or scientific according to current

standards. Instead, I pay attention to the specific scientific and moral priorities for doctors during each crisis moment, the kinds of conflicting interests they faced in relation to these priorities, and how they struggled to restore their scientific and moral legitimacy, in the process generating new possibilities of what it meant to do medicine and to be a medical professional. To do so, I examine how doctors expressed their scientific and moral concerns in editorial content in medical journals. Written by (physician) editors of journals published for their colleagues, these editorials are non-scientific texts that contain thoughts and arguments about social, political, cultural, and professional issues that doctors face. The medical journals also publish letters by (physician) readers responding to editorial content. Together these sources serve as a window into how doctors at various times in history highlighted, discussed, and debated matters of scientific and moral importance.

In Chapter 1, I outline in greater detail the concept of medical disinterestedness, which is a map that will guide the reader through the remainder of the book. Drawing on Bourdieu's concept of invested disinterestedness, I develop an analytical framework that takes scientific and moral standards seriously as part of doctors' endeavours to strive for integrity in medicine, and that also accounts for the kinds of social, cultural, and political struggles that doctors faced in the pursuit of authority, expertise, and legitimacy. For Bourdieu, invested disinterestedness is a particular kind of moral disposition and moral order, which emerged in the nineteenth century in concurrence with the rise of the bourgeoisie and the dramatic reorganization of economic, political, and cultural capitals in Europe. By tracing the details of this concept across his works, I posit that medical disinterestedness helps us understand how doctors in Canada, as particular socio-political agents, have developed their scientific and moral ethos and modified it over time, in direct relation to the kinds of conflicts and struggles they faced.

Subsequent chapters examine three crisis moments in the history of the Canadian medical profession, during which doctors' claim to scientific and moral integrity were questioned by the public, the media, and the state. Chapter 2 takes place in the nineteenth century and examines the emergence of medical disinterestedness during a time when doctors in Canada struggled to come together as a cohesive group of professionals

recognized by the public and the state as legitimate experts. Doctors at this time were entrepreneurs, competing with one another and with other non-medical practitioners, such as homeopaths, yet offering very few remedies to their patients that differentiated them from the "quacks," as doctors called these alternative practitioners. The ideal of a scientifically and morally upright doctor, who was a member of a respectable profession, was shaped in the image of the British gentleman, as a direct result of the ethnic, gender, and class conflicts among doctors in this period. At the same time that doctors came together under the banner of the (British) gentleman, they moved away from portraying themselves as self-serving businessmen, frustrated by competition and a lack of regulation by the state, to instead present themselves as moral and scientific agents who practised their craft for the well-being of their patients and the good of the public.

Despite doctors' claim to act in the interest of their patients and the public, they still expected to be paid for their services. The thorny issue of payment for disinterested acts became the heart of a major controversy in the history of Canadian medicine in 1962, which is the setting for Chapter 3. On 1 July of that year, the medical profession in Saskatchewan, with the support of the national medical association, staged a day-long strike in protest against a provincial government proposal to establish a tax-funded, state-administered health insurance system – what is now the cornerstone of the current Canadian health care system. Saskatchewan doctors were intensely criticized in the national media for acting selfishly to protect their lucrative incomes instead of responding to the financial needs of patients – the first time that the Canadian medical profession encountered such profound public distrust with respect to its integrity. As the Canadian medical profession struggled to mend its relationship with the public, doctors began to discuss the idea that they needed to conduct better public relations and media relations, practices they had previously associated with corporate advertising and war propaganda. Doctors came to argue that a close medicine-media relationship was a way for them to be more socially responsible, and thus for the medical profession to better fulfill its moral duties toward the public.

In Chapter 4, I examine how the close medicine-media relationship lay the ground for another controversy involving Canadian doctors,

one in which the interests of journalism and the media conflicted with the scientific interests of medicine. In 2006, the senior editors of the *Canadian Medical Association Journal* (*CMAJ*) were fired by the journal owners, spurring an international outcry that editorial freedom had been violated. However, the significance of the event went beyond editorial freedom, with profound implications for medical publishing. The antagonistic relationship between the editors and the owners of the *CMAJ* was based on conflicting interests between the two parties about what the journal should contain. The editors wanted to engage in journalistic reporting as well as scientific publishing, thereby fulfilling medicine's social responsibility to engage in social and political issues. The owners wanted to avoid such engagement and argued that the journal should uphold "pure" science instead. In this discursive battle over what was moral, what was scientific, and which of the two was a higher priority for medical publishing, the economic forces of the media industry – that is, how to finance a publication – constantly loomed large as a factor that could jeopardize both concerns.

This book is not a history of the medical profession in Canada, nor is it a history of how medicine in Canada became more scientific and morally reliable as a profession. Rather, it is about claims. Specifically, it is about claims to moral integrity and credibility made by a particular group of people – medical doctors – during times when this credibility was brought into question. Notions of "science" and "morality" in medicine are constantly being rewritten and reimagined with every conflict and question, large and small, about the legitimacy and accountability of doctors. I invite the reader to go beyond the contemporary emphasis on the presence or absence of industry ties among doctors as the primary site of conflicts in medicine. Instead, I urge the reader to examine more broadly problems of ethics, social responsibility, professionalism, integrity, and objectivity that emerge when the interests of doctors conflict with those of the public, the media, politicians, and state bureaucrats, and with those of other doctors.

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