Professionalism and medicine's social contract

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Introduction

For over 2000 years, the values and beliefs of medicine have been embedded and articulated in the word *professionalism*. Scribonius, in Roman times, is believed to have been the first to link the concept of professionalism with the healing arts, defining it as "a commitment to compassion or clemency in the relief of suffering" (Pellegrino & Pellegrino, 1988). He associated this commitment with the traditions and practices inherent in the Hippocratic Oath. Thus medicine was regarded as a profession for centuries before the learned professions of clergy, law and medicine emerged in the Middle Ages in the universities and guilds of England and Europe (Krause, 1996). However, medicine's impact on society was limited due to the scarcity of effective treatments, the small number of physicians available and the inability of the majority of the population to pay for their services. This changed as the Industrial Revolution created wealth, and science made medicine worth purchasing. By the middle of the 19th century, the modern medical profession as we know it emerged throughout the western world. As physicians were now able to influence the course of disease with increasing effectiveness, the profession became more necessary, and social scientists began to examine the place of medicine and other professions in society.

Until the middle of the 20th century, the assumption was that the medical profession was beneficial to society because, in return for its privileged position and the monopoly granted to it, it would assure competent healthcare through self-regulation and a perceived commitment to altruism. While the early social scientists certainly understood the potential conflict between altruism and self-interest, they and the public believed that medicine's commitment to altruism was real, resulting in an extremely high level of trust in physicians and in the concept of the profession. Without question, these

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social scientists were examining both medicine's place in society and its relationship to the society it served. However, this relationship was recorded and described without actually being defined or categorised.

As is widely understood, this changed dramatically in the latter half of the 20th century due to a multiplicity of factors in society, healthcare and the medical profession itself (Krause, 1996; Starr, 1984). The development of the "questioning society" was significant, as all forms of authority, including the professions, came to be viewed with skepticism and diminished trust (Mechanic & Schlesinger, 1996). Healthcare became more complex, expensive and effective and therefore was felt to be necessary for the wellbeing of all citizens. As a result, to diminish individual financial risk, third-party payers—either the state or the corporate sector—became dominant (Light, 2001; Mechanic, 1991). Finally, the medical profession itself changed, becoming more specialised, more prosperous and entrepreneurial, and driven by science and technology. Coincident with these changes, and certainly in part caused by them, the approach of the social scientists altered. While there had been criticism of the professions in the past—witness Shaw's statement that "professions are a conspiracy against the laity" (Shaw, 1911)—the social sciences literature now became highly critical of the concept of the profession and of the performance of medicine. Elliot Freidson (1970a, 1970b) led the way, pointing out that medicine exploited its position in order to dominate both healthcare policy and other healthcare professionals. He also noted that self-regulation was carried out capriciously, with weak standards and discipline. Larsen (1977) and Johnson (1972) proposed that the profession had used its privileged position to further its own interests over those of society. In looking to the future, Haug (1973) believed that medicine would become "deprofessionalized", and McKinley and Arches (1985) correctly predicted that reliance on the market system would force physicians in the United States to become entrepreneurs in a competitive marketplace, a process that he termed "proletarianization". It is interesting to note that the tone of this largely critical literature changed near the end of the 20th century as social scientists observed the results of the emerging dominance of the state or the marketplace on healthcare. Krause (1996) pessimistically lamented the loss of the value system of the professions and doubted that these systems could be maintained. Freidson (1994) actually entitled a book "Professionalism Reborn", and his last works indicated strong support for healthcare organised around the ideal of the profession rather than a bureaucratic or market oriented system. Finally, Sullivan (2005) and Hafferty and Castellani (2010) are strong proponents of the benefits to society of a functioning medical profession. All recognise that the professionalism for which they advocate is not the "nostalgic professionalism" of the past, but one which is adapted to current and future societal needs.

Medicine's place in society has, therefore, been under close scrutiny for more than a century. For much of that time, there appeared to be no attempt to actually categorise the relationship. It was understood that professional status was granted to medicine on the understanding that physicians, individually and collectively, would behave in a certain way and that benefits to society would result. One can speculate that as long as medicine and society were reasonably satisfied with the relationship, there was little pressure to question its fundamental nature or to categorise it precisely. Only when substantial dissatisfaction developed did it appear necessary to define the relationship.

Starr (1982) appears to have been the first to describe the relationship between medicine and society as contractual. In his epic 1982 book, he wrote that the contract between medicine and society was being redrawn in response to dramatic changes in healthcare and that the changes were "subjecting medical care to the discipline of politics or markets or reorganizing its basic institutional structure" (p. 380). Subsequently, many observers, including social scientists, policy analysts, bioethicists and physicians, turned to the historical concept of the "social contract" as being a useful and accurate description of the relationship (Cruess & Cruess, 2008). Indeed, it constitutes an important part of the introduction to the International Charter on Medical Professionalism which has been endorsed by over 140 medical organisations throughout the world (ABIM, 2002).

The idea that the relationship between medicine and society involved reciprocity has been extant in the United Kingdom for some time. In discussing the establishment of the National Health Service, Klein (1983) proposed that a "bargain" had been struck in which the medical profession preserved its autonomy and privileged position in return for supporting the new healthcare system. Following this, others have used the term "implicit bargain", particularly during recent years, as they pointed out that the bargain appeared to have broken down. Ham and Alberti (2002) and others (Edwards, Kornacki, & Silversin, 2002; Rosen & Dewar, 2004) called the relationship an "implicit compact", and the Royal College of Physicians of London (2005) refer to a "moral contract". None of these terms have roots in either philosophy or political science.

The term *social contract* also has been used to outline other relationships in contemporary society in which medicine is involved: between society and its medical schools (Inui, 1992; Schroeder, Zones, & Showstack, 1989); between society and science (Gallopin, Funtowicz, O'Connor, & Ravetz, 2001; Slaughter & Rhoades, 2005); and between society and universities (Kennedy, 1997; Kirp, 2003; Lewis, 2006). In all, society delegates authority and autonomy to those engaged in specialised activities that are believed to be important, along with an expectation that society will benefit.

The changing nature of healthcare, professionalism and the social contract

The social contract which existed until the middle of the 20th century was relatively simple (Krause, 1996; Starr, 1982). Medicine was practised by solo practitioners treating individual patients who were generally responsible for paying for the services received. There were many opportunities to demonstrate altruism because of the large numbers of medically indigent patients who physicians often treated for free. Accountability was to the patient with minimal accountability to wider society. Individual physicians and the medical profession were trusted and had unquestioned authority. Freidson's (1970a, 1970b) observation that the medical profession was "dominant" was accurate, as it was a snapshot of the picture that existed in the 1960s. As medicine became a "mature" and established profession, it became inherently conservative and often defended what it regarded as the substance of its professionalism based on an understanding of the social contract of that era. Hafferty & Castellani (2010) have labelled this "nostalgic professionalism" and pointed out that it is not applicable to the contemporary practice of medicine. They also propose that the basis of the current social contract is being

pushed towards different forms of professionalism, including "lifestyle" and/or "entrepreneurial" professionalism. What is eminently clear is that the social contract of the early 21st century is very different from that of 50 years ago.

The social contract: Its origins and evolution

The early philosophers who developed the concept of the social contract did so in response to the injustices that existed in a time of hereditary monarchs (Bertram, 2004; Crocker, 1968; Gough, 1957; Masters & Masters, 1978). They sought to explain the origins of the state and society and to delineate their relationship. A contemporary definition of the term *social contract* is:

> A basis for legitimating legal and political power in the idea of a contract. Contracts are things that create obligations, hence if we can view society as organized "as if" a contract has been formed between the citizen and the sovereign power, this will ground the nature of the obligations, each to the other. (Blackburn, 1996, p. 335)

While not all philosophers or social scientists endorse the application of the term social contract to the field of healthcare, there is a respected and influential group that do (Bertram, 2004; Daniels, 2008; Rawls, 1999, 2003). Rawls (2003) proposed that the organising principle in society should be justice based on fairness. While he did not classify health as a "social primary good", he did believe it necessary for individuals to be "normal and fully cooperating members of society over a complete life" (p. 174) and that this constituted an entitlement to health services. Daniels (2008) expanded this approach by arguing that healthcare was an essential part of the social contract as it was necessary to ensure equality of opportunity in society.

It is important to emphasise another point. No formal contract, in the legal sense, exists. Rather, as stated by Gough (1957), the rights and duties of the parties to the contract "are reciprocal and the recognition of this reciprocity constitutes a relationship which by analogy can be called a contract" (p. 245). Contemporary interpretation of contract theory leans heavily on the idea of "legitimate expectations" as being fundamental to mutual understanding (Bertram, 2004; Rawls, 2003). Obviously, a failure of one party to meet the legitimate expectations of the other has consequences in the attitudes and, hence, the responses of the other.

In placing healthcare in the context of the social contract, it can be located within what has been labelled a macro contract (Donaldson & Dunfee, 1999), which includes all essential services required by citizens. Another approach suggests that there are a series of "micro" contracts which apply to individual services that must conform to the "moral boundaries" laid down by the macro contract (Donaldson & Dunfee, 1999). Healthcare could be included in the overall relationship as Rawls and others have suggested, or given its importance to the well-being of both individuals and society, it could be governed by its own micro contract. It appears to us that this latter approach better describes the reality of the relationship. It has the further advantage of allowing healthcare issues to be addressed in isolation from other issues in society within the context of the overall macro contract.

Finally, the details of the social contract between medicine and society differ substantially between countries, being influenced by cultural, economic and political factors. While there are many documented commonalities, there are also significant differences in the funding and organisation of healthcare (Anderson, Hussey, Frogner, & Waters, 2005; Ferlie & Shortell, 2001; Schoen et al., 2004), how professionalism is expressed and in the expectations of the general public (Cruess, Cruess, & Steienert, 2010; Hafferty & McKinley, 1993; Hodges et al., 2011; Krause, 1996; Tuohy, 1999; Vogel, 1986). What probably does not differ is the role of the healer, which that has been present as long as mankind has existed and that answers a basic human need in times of illness (Kearney, 2000). Those elements of the social contract that refer to the healer's role will, therefore, be relatively constant across national and cultural boundaries, while those that refer to how the services of the healer are organised, funded and delivered will vary (Cruess & Cruess, 1997).

Medicine's social contract

When one wishes to illuminate the details of the relationship, it is apparent that the contract is a mixture of the written and the unwritten. The written portions are numerous, and many impose legal obligations on the profession and its members. These include licensing laws and documents mandating the organisations responsible for self-regulation, licensing, certifying and accrediting bodies as well as the medical education establishment. Codes of ethics are publicly available documents governing the behaviour of physicians. The laws outlining the nature of the healthcare system in every country are explicit expressions of important parts of the social contract in that country.

The legally binding portions of the contract are obviously important. However, of extreme importance to both patients and physicians are those portions of the social contract which cannot be legislated or imposed. They spring from the inherent moral nature of the medical act (Pellegrino, 1990). Caring, compassion, altruism and commitment are essential parts of the professional identity of every practising physician and also represent fundamental expectations of patients and the public. Expressing them must spring from a sense of who a physician is, rather than just what they do.

A frequent statement in the literature is that "a social contract exists between medicine and society", implying that each side is monolithic. This is not true. We have proposed an outline of the nature of the social contract between medicine and society (Figure 1) (Cruess & Cruess, 2008), one which differs from the only other published outline of which we are aware (Ham & Alberti, 2002). As can be seen, the medical profession consists of individual physicians and the many institutions that represent them, including national and specialty associations and regulatory bodies. Within the circle chosen to represent the medical profession is found a myriad of firmly held opinions, vested interests and political orientations. Individual physicians often disagree with the associations that represent them; generalists and specialists may have different desires, and there are often regional differences of opinion. Nevertheless, in most countries, some form of consensus emerges within the medical profession when it is negotiating the details of its social contract, although this term is almost never invoked to describe the process.

A democratic society is even more complex. It consists of citizens and those who they choose to govern them. When one focuses on healthcare, citizens can be designated as patients or members of the general public. Obviously, members of the general public have a clear and personal interest in the relationship with the medical profession, as virtually every citizen will eventually need the services of the healer. For patients the need is immediate. While there may be tension between patients and patients' groups, and the wider public, their needs and desires are generally not dissimilar as they approach the negotiations.

As healthcare in most countries has come to be regarded as a right, governments have become responsible for ensuring that minimal levels of care are available to its citizens, thus giving them a major and often determining role in setting the terms of the social contract. However, governments are not monolithic, and there are many vested and often conflicting interests within them. Elected politicians are answerable to their constituents; civil servants are responsible for the proper functioning of the system; and managers in the field have their own responsibilities and desires. Government policy results from a dialog among these hierarchically organised parties, with elected politicians being ultimately accountable.

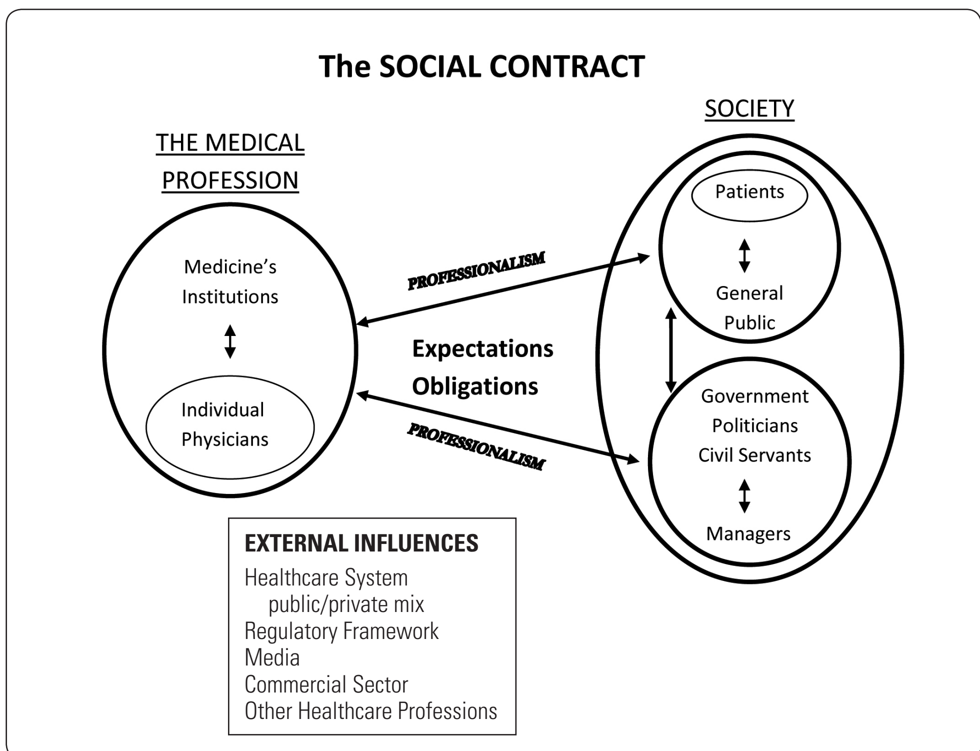

Figure 1. A schematic representation of medicine's social contract with society.

Within the circle representing society, the relationship between patients and the public and government is primarily political, with the public in democratic societies expressing its satisfaction or dissatisfaction with government policy in health through the electoral process. It is thus much more reminiscent of the original meaning of the social contract.

Professionalism has been defined as "a set of values, behaviors, and relationships that underpins the trust that the public has in doctors" (Royal College of Physicians of London, 2005). Trust is absolutely essential if the social contract is to function (Goold, 2002; Sullivan, 1995). Society's expectations of both individual physicians and of the medical profession are based upon both trust and its understanding of these values and behaviours. This underlies the belief that professionalism is the basis of medicine's social contract with society. Society expects physicians to behave professionally in return for their privileged position. If they fail to do so, society will alter the contract.

Mediators of the social contract

While the social contract for medicine involves the profession and society, there are structures and powerful stakeholders external to medicine with legitimate and vested interests in the overall healthcare system that have a profound impact on medicine's social contract (Rosen & Dewar, 2004). The nature and financial structures of the national healthcare system are undoubtedly the most powerful of these. For example, the United States and Canada share a continent and many values, but the presence of a national health plan in Canada and its absence in the United States is a reflection of the different social contracts on each side of the border. In Canada, healthcare is regarded as a right, and responsibility for access and funding is given to government. In the United States, individual responsibility is stressed, and there is resistance to government intervention (Touhy, 1999).

The nature of the regulatory system in force directly impacts the social contract. Medicine exercises authority that is granted to it by society, including the nature of the regulatory framework. This has included self-regulation, which historically has constituted an important part of the contract. Trust in the profession is heavily dependent on how well it exercises its authority in this area. As recent events in the United Kingdom have demonstrated, when society no longer believes that it can trust the medical profession to regulate itself, it may choose to alter the regulatory framework. This has transformed the nature of medicine's professionalism and its social contract in the United Kingdom (Secretary of State for Health, 2007).

The commercial sector, which consists of a wide array of players, including insurance companies and other third-party payers, the pharmaceutical industry, suppliers of products to the healthcare industry and so forth, also impact medicine's social contract.

Other healthcare professions, such as nursing and occupational and physical therapy, that have their own social contracts, have the ability to influence medicine's contract. Most worked diligently to escape medicine's dominance (Starr, 1982), and as pointed

out by Abbot (1988), compete directly with medicine and often with one another for jurisdiction over certain tasks. The outcomes of these disputes frequently impact medicine's social contract.

Finally, the modern media, in its many forms, not only reflects public opinion but also often leads it. Examples of this fact can be found in virtually every country. The attempt of the insurance industry to impose so-called "gag laws" on physicians led to a public outcry expressed largely in the media. It obviously represented a major attempt to alter the social contract, and the public reacted (Patel & Chernow, 2007). The gag laws in the United States were withdrawn.

In summary, the current social contract between medicine and society represents the "bargain" that has been established. It is based in part on historical practices, in part on direct negotiations between medicine and society, and is heavily influenced by the input of the many stakeholders who have legitimate vested interests in how healthcare is organised and delivered. As both healthcare and society are in a period of rapid change, how this contract will change and how it is renegotiated becomes important.

The negotiations leading to expectations and obligations

In *Just Health*, Norman Daniels (2008) discusses the process of "social negotiation" that determines the nature of physician's obligations and powers. He states that negotiation consists of "various forms of interaction between professional organizations and broader political institutions. It may lead to … specific legal arrangements … or there may be broader understandings that emerge from public debate about specific issues" (p. 225). He points out that there is a socially negotiated ideal of "the good physician" and that at any given point in time, physician behaviour is constrained by the nature of this ideal. On joining the profession, an individual must accept this concept and is not free to pick and choose among the obligations that result from it. However, the concept of the good physician is not immutable and is being constantly renegotiated as "conditions inside and outside medicine change" (Daniels, 2008, p. 226). As an example, the paternalistic model of the doctor–patient relationship has gradually altered as the patient's rights movement firmly established the principle of patient autonomy in decision making (Emanuel & Emanuel, 1992; Truog, 2012). The negotiations that led to this change took place in a decentralised fashion over many decades. Other changes occur more precipitously.

The introduction of national health plans in the United Kingdom (Klein, 1983) and in Canada (Marchildon, 2006) changed medicine's social contract the moment that the legislation was enacted. In both instances, prolonged negotiations involving the profession preceded the change. Recently, the perception of both the general public and the government in the United Kingdom that the medical profession had failed to exercise the authority delegated to them to self-regulate caused the government to withdraw some of that authority. The regulatory framework in the United Kingdom is now substantially different, and as a result, the nature of the social contract, and of the substance of medical professionalism, has changed (Secretary of State for Health, 2007).

The transfer of responsibility for certain medical tasks from physicians to other healthcare professionals is another example of a negotiated change in the social contract. In this case, the details of medicine's monopoly over the use of its knowledge base are being altered, sometimes with its agreement and sometimes without (Abbott, 1988; Baerlocher & Detsky, 2009).

Who negotiates the social contract?

As should be clear, there are a host of issues that, together, make up medicine's social contract. The nature and the substance of the healthcare system itself is without doubt the most tangible expression of this social contract, and it imposes the distinctive characteristics that are found in different countries and cultures (Hafferty & McKinley, 1993; Krause; 1996). As the professionalism in any given country is based upon the social contract, it is not surprising that differences are found in the nature of professionalism across national and cultural lines (Cruess et al., 2010; Ho, 2011).

With one prominent country, the United States, serving as an exception, the negotiations that result in the social contract are carried out at national or regional negotiating tables. Society is usually represented by members of the government or an organisation mandated to act on government's behalf, a situation that has been present since most countries in the developed world established national health plans. Medicine is usually represented by a national or regional medical association. For example, in the United Kingdom, the British Medical Association became a legal union whose activities are covered under the labor code (Klein, 1983). The British Medical Association negotiates on behalf of the profession. In Canada, where responsibility for health is a fiercely protected provincial jurisdiction, each province or territory has its own healthcare system that, while adhering to national standards, can accommodate differing regional needs (Marchildon, 2006). The provincial medical associations are either unions or quasi-unions and are mandated to negotiate on behalf of the medical profession. In Europe, medical unions are the norm. While the term social contract is almost never used during the negotiations, fundamental aspects of the social contract are negotiated directly between the medical profession and the government.

The exception to the rule is the United States, which until recently had not introduced a true national health plan. As pointed out by Stevens (2001), in the United States, "there has been no similar concentration of responsibility for universal health insurance at national, state, or local levels and no single government agency responsible for delegating formal power to medical organizations in relation to organized payment and service systems" (p. 327), a situation that still appears to be true.

The expectations of medicine and society, "each to the other"

All contracts impose obligations on the parties to the contract, and social contracts, in spite of their amorphous nature, are no different. The expectations of one party to the contract lead to the obligations of the other party. It, thus, becomes important that all parties to the contract understand the expectations of the other parties. If medicine fails to meet the legitimate expectations of society, society will wish to change the contract.

On the other hand, if what individual physicians and the medical profession regard as their legitimate expectations are not met, they will respond by either attempting to alter the contract or perhaps by changing their own behaviour.

In a previous publication, we proposed an outline of the obligations between physicians and medicine on the one hand and physicians' obligations to patients and the general public on the other; among physicians, medicine and government; and finally among government, patients and the general public (Cruess & Cruess, 2008). This analysis was based on a review of the literature. Patient's expectations of individual physicians and of medicine are well documented. They wish accessible care within the context of a healthcare system that itself is value laden, equitable and adequately funded and staffed. They wish their physician to be competent, caring and compassionate, to listen to them, to be accountable and to demonstrate qualities that lead to trust. They wish to be able to preserve their own dignity and autonomy in decision making. Finally, they wish some input into public policy. Government expectations, while less explicitly documented, are made known. They make assumptions upon which public policy is grounded, and these assumptions serve as the basis of their expectations of medicine (Le Grand, 2003). As long as the privilege of self-regulation is granted to the medical profession, the government wish the profession to assure the competence of its members. They require compliance with laws related to healthcare and also expect that members of the medical profession be trustworthy. They believe that professions should serve as a source of objective advice—even if this advice is often ignored—and they believe that because of the privileged position of the medical profession, it and its members must be devoted to the public good. Finally, they require new levels of accountability (Wynia, Latham, Kao, Berg, & Emanuel, 1999) and wish the profession to practise team healthcare, expectations that have become much more important in recent times.

It is interesting that the expectations of individual physicians and of medicine as a whole are rarely made explicit in a coherent fashion. This is somewhat surprising because it is quite legitimate for physicians to have expectations of patients, of the general public and of governments. However, one can infer these expectations from the negotiating stances of the profession and from surveys of physicians that document levels of satisfaction and dissatisfaction (Cruess & Cruess, 2008). An important expectation of medicine is sufficient autonomy so that physicians can exercise independent judgment in giving advice to patients. Physicians also expect to be trusted, as the role of the healer requires such trust. Because of their expertise, physicians do expect a role in forming public policy in health. There is also considerable evidence that physicians, like patients, wish to have a healthcare system that is value laden, equitable, adequately funded and staffed and with reasonable freedom within the system. Although rarely articulated, physicians clearly wish that the monopoly granted to them through licensure laws be maintained. In many parts of the world, the profession's ability to self-regulate remains a significant expectation. The recent changes in the United Kingdom will certainly alter expectations in that country and in this global world; other countries may well re-examine self-regulation.

Finally, physicians do expect rewards—both financial and nonfinancial. Several surveys indicate that autonomy and respect rather than increased remuneration are important to physicians.

Significance

One might legitimately ask why it is necessary or desirable to invoke the concept of the social contract in describing the relationship between contemporary medicine and society. There is a consensus that events of the past few decades have resulted in a situation where neither medicine nor society is satisfied with the relationship (Dunning, 1999; Sullivan, 2005). Furthermore, there is also agreement that medicine's professionalism is under threat, with the threats coming from two well-documented but separate sources (Freidson, 2001; Krause, 1996; Starr, 1982; Sullivan, 2005). The first series of threats arise from the failure of the medical profession to meet some of the legitimate expectations of both patients and society in areas over which the profession exercises independent authority. Self-regulation and the belief that physicians are not as altruistic as were their forefathers are examples (Freidson, 2001; Jones, 2003). As these issues lie within medicine's control, direct action by the profession is necessary, and indeed, the profession has reacted. Regulatory procedures are becoming more rigorous and transparent. Maintenance of competence, re-licensure and/or revalidation are being considered or implemented throughout the world (Irvine, 2003, 2005). Attempts are being made to inform physicians of their obligations through educational programs whose purpose is the explicit teaching of professionalism (Cohen, 2006; Cruess & Cruess, 2006).

A second series of threats arises from the society that the profession serves and the healthcare systems within which medicine must function. Society and the healthcare system can either support or subvert professional values, and in many instances, the latter appears to be true (Cohen, Cruess, & Davidson, 2007; Lesser et al., 2010). Obviously, medicine has no direct control over society or the healthcare system. An obvious recourse is to negotiate for a healthcare system that actually supports professional values, a direction that can benefit both medicine and society (Cohen et al., 2007; Sullivan, 2005; Wynia, 1997). Framing the discussion in terms of negotiating medicine's social contract has several advantages. In the first place, the very use of the word "contract" implies negotiation. Second, it recognises the principle of reciprocity. The central idea included in the discourse in the social sciences, which indicated that medicine was granted a privileged position on the understanding that it would behave in ways that benefited society, is both legitimised and formalised. In this way, medicine's professional obligations become both logical and understandable. Third, it implies that there will be consequences if the terms of the contract are not met. If medicine fails to meet legitimate societal expectations, society will wish to change the contract, perhaps withdrawing some of medicine's privileges as happened in the United Kingdom. However, the converse is true. If physicians feel that their legitimate expectations are not met, individual physicians and the profession will react. One possible response is a change in physician behaviour. As an example, the physician entrepreneur may emerge (Hafferty & Castellani, 2010).

Finally, the concept of the social contract can be beneficial in teaching professionalism to current students, trainees and practitioners who no longer respond to justifying obligations on the basis of "thou shall" or "thou shall not". They wish to know why they must behave in a certain way (Twenge, 2009), and framing the discourse terms of a social contract provides a logical answer.

William Sullivan (2005), a social scientist who is a firm believer in the presence of a social contract between medicine and society, is worth quoting:

> The expectations of high standards of competence coupled with public responsibility have been established in large measure through the profession's own efforts during the past century to establish secure social contracts with the public. The contract has been worked out gradually in statute and custom. In the process professionalism has evolved as a social ideal (p. 3).

Negotiating the social contract within this context should be a principal objective of the medical profession and can assist the profession as it attempts to meet the ideal.

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