

It is Time to Cancel Medicine's Social Contract Metaphor

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Abstract

There is agreement that the complex relationship between medicine and society is best described as a metaphorical social contract and that professionalism is the medical profession's contribution to this contract. Metaphors can help clarify abstract concepts, but they can also be abused if the counterfactual attributes of a metaphor become attributed to its subject. This seems to be happening with medical professionalism, which has sometimes been reduced to a contracted deliverable and a bargaining chip. The undesirable attributes of the social contract metaphor may be hindering efforts to understand and teach medical professionalism.

Despite its theoretical weaknesses, the social contract metaphor has historical credibility because of its alleged association with the 1847 *Code of Medical Ethics* and the subsequent ascension of regular (allopathic) medicine in the early twentieth century. However, the record does not support an argument that the intended purpose of the 1847 *Code* was to create a social contract or that one ever arose. The alternative account that a contract did arise, but physicians were poor partners, is neither satisfying nor explanatory.

As now used, medicine's social contract metaphor has serious theoretical and historic weaknesses. Medical educators should remove this narrow and overworked metaphor from their discussions of professionalism. By doing this, educators and the profession in general would only lose the ability to threaten themselves with the cancellation of their social contract.

In return they would open the door to a more complex and fruitful consideration of medical professionalism and medicine's relationship with society.

Medical philosophers and medical educators generally agree that the medical profession's relationship with society is best described as a social contract and that, however it may be defined, medical professionalism is the profession's contribution to this contract.¹⁻⁴ The Charter on Medical Professionalism,⁵ a document prepared by U.S. and European leaders in medicine and published in 2002, begins, "Professionalism is the basis of medicine's social contract with society." Cruess and Cruess⁶ remind physicians of the terms of their social contract:

Society granted physicians status, respect, autonomy in practice, the privilege of self-regulation, and financial rewards on the expectation that physicians would be competent, altruistic, moral, and would address the health care needs of individual patients and society. This 'arrangement' remains the essence of the social contract.

Likewise, Kurlander et al¹ tell physicians of the compelling historic durability of their social contract:

The social contract has long been the basis of statements of medical professionalism, starting with the American Medical Association's (AMA's) 1847 *Code of Medical Ethics*.

The term *social contract* is, of course, a metaphor, one that provides a lens for visualizing the complex and abstract concept of medicine's relationship with society. A metaphor brings clarity to its subject by creating an illuminating counterfactual statement. Thus, one of the cardinal features of an effective metaphor is that its literal interpretation produces absurdity. As Berggren⁷ suggests, to say that King Richard was a lion is not to make the meaningless assertion that he was a four-legged feline. Rather, the intent is to permit a revealing comparison between certain features of King Richard and lions. The danger of metaphors is that they can be

transformed into myth when counterfactual attributes of the metaphor are attributed to the subject. The viewer loses the distinction between the metaphorical viewing lens and the subject.^{7,8}

The social contract metaphor has been used by philosophers from Plato to Rawls⁹ to express the concept that, all of us being equal, we implicitly consent (or agree) to collectively enforced social arrangements. This act of mutual, uncoerced, and metaphorical consent/agreement solves the philosophical problem of the justification for societal structures and norms.⁹⁻¹¹ The social contract metaphor describes a thought experiment, not how organizations, societies, or other societal systems actually originate and function.⁹

There can be a transformation of the medical profession's social contract metaphor into myth if the metaphor's contractual concepts are too literally applied to medical professionalism. This may be happening. For example, a 2004 article entitled "Professionalism and Medicine's Social Contract with Society"⁶ applied a literal characteristic of contracts to medical professionalism:

A contract involves obligations from both parties, so it is reasonable for medicine to expect certain deliverables from society.

In this context, the abstract concept of medical professionalism has acquired the metaphor's attributes of a bargaining chip.

Theoretical Problems with the Social Contract Metaphor

Canadian bioethicist Lynette Reid¹² has argued that five attributes of the social contract metaphor have become improperly attached to medical professionalism:

- it presents the status quo as the result of a nonexistent negotiation and agreement,
- it assumes a position of privilege for the parties,
- it encourages the view that ethics and self-interests should coincide,
- it fosters an expectation that appearance and reality coincide in morality, and
- it presents prima facie ethical obligations as merely conditions of a reciprocal arrangement.

Others have seen these negative attributes in their discussions of medical professionalism, whether they are framed as challenges—in the hidden curriculum—to humanism, the tension between new and nostalgic professionalism, or the conflicting ethics of physician entitlement.¹³⁻¹⁶ Thus, it is quite possible that some of the vexatious issues with medical professionalism are due to the social contract lens through which it is being viewed.

As Reid also noted, the social contract metaphor has one theoretically attractive behavioral property. It encourages doctors to preserve their side of the social bargain. In her words,

...it functions as a reminder that while you may not personally be inclined towards empathy, the financial rewards in which you are interested depend on the profession as a whole having a reputation for empathy.

There is some evidence for this assertion. One experiment by business ethicists found that salespeople who identified as part of a group were less likely to engage in an act that was seen as a breach of the group's implicit social contract.¹⁷

Unfortunately, this potentially beneficial property of the metaphor also exposes a failure of the metaphor. The linkage of a specific type of professional behavior to personal reward, as if by contract, creates the image of a single, or at least a dominant, arrangement. But what if there are actually multiple arrangements, each one with a set of favored behaviors that are necessary to preserve the profession's financial rewards? As Castellani and Hafferty¹⁶ have noted, the physician ruling class has its version of "nostalgic professionalism," which favors altruism, opposes commercialism, and presumably rewards empathy. However, other physicians have alternative professionalisms, such as "lifestyle professionalism," which accepts a certain amount of commercialism and resists self-denial.¹⁶ Those who ascribe to alternative professionalisms have to reject the purported nostalgic professionalism social contract quid pro quo for their own two-way social bargains. Given the reality of multiple social contracts with different terms, none can bind the profession as a whole. For that reason, a medical educator cannot rely on a single version of the metaphorical contract's bargain to encourage ethical behaviors.

And what if professionalism, as Wynia et al¹⁸ write, is not a set of defined behaviors at all, but a general belief system that binds multiple types of health practitioners in a common purpose?

How does one reduce this to a clear, financially-rewarded deliverable, a possibility implied by the social contract metaphor? This cannot be done, which shows that the metaphorical contractual relationship between reward and behavior does not provide clarity or insight in a diverse environment where medical professionalism is a complex system rather than a clear set of rules.¹⁹

Historical Problems with the Social Contract Metaphor

Although there are theoretical reasons why the social contract metaphor is a poor viewing lens for medical professionalism, the metaphor has persistent historical salience. For some, it is barely a metaphor at all. The AMA currently states on its Web site, in reference to the 1847 *Code*, "...this founding document—the first uniform code of ethics of its kind—is still the basis of an explicit social contract between physicians and their patients."²⁰ To philosopher Robert Baker the AMA's 1847 *Code* "...transform[ed] the underlying logic of American medical ethics into that of a social contract."²¹

But a critical examination of the history of medicine's putative social contract, beginning with the 1847 *Code*, does not support the notion that an explicit or implicit social contract, as the term is now used, was ever intended or ever arose. The 1847 *Code* clearly used contractual language, but its authors could not have intentionally chosen this language to promote the "explicit social contract" referenced by today's AMA. In 1847, the social contract metaphor only referred to the theories of government developed by Hobbes, Rousseau, and Locke, theories

proposing that individuals sacrificed some of their natural rights to form a collective civil society.^{10,22} The contemporary social contract metaphor used by medical ethicists, one that describes a relationship between society and organized groups of individuals, was not clearly developed until Donaldson used social contract theory to present a moral justification for corporations in 1982.^{23,24}

Then what purpose was served by the 1847 *Code's* contractual wording? The language came from an 1805 medical school lecture, "On the Duties of Patients to Their Physicians,"²⁵ by the American physician Benjamin Rush. In 1847, AMA Ethics Committee chairman John Bell²⁶ expanded upon Rush's language in his introduction to the *Code*:

Every duty or obligation implies, both in equity and for its successful discharge, a corresponding right. As it is the duty of a physician to advise, so has he a right to be attentively and respectfully listened to.

The 1847 *Code's* author, Isaac Hayes, distilled his text from earlier writings by Rush and, mostly, by English physician Thomas Percival.^{21,27} Hayes presented the *Code* as if it were three sections of a contract: (1) duties of physicians to their patients and the obligations of patients to their physicians, (2) duties of physicians to each other and to the profession at large, and (3) duties of the profession to the public and the obligations of the public to the profession.²⁶

Hayes removed Percival's idiom of social privilege and replaced it with Rush's idiom of reciprocal duties and rights. According to Baker,²¹ Hayes did this to create a more democratic,

American-sounding document. However, it is hard to see how the *Code* was more democratic and less noblesse oblige-sounding because of its contractual language. As an example:

The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them...²⁶

Many prominent physicians at the time did not accept the *Code's* enumeration of their supposedly common goals or its self-serving language of reciprocal rights and duties. There was little dispute with the Hippocratic principles of trust, benevolence, and loyalty, but there was considerable disagreement that anything more was necessary.^{28,29} In 1869, the editors of the *New York Medical Gazette*³⁰ blasted Bell and Hays's contractual concept of reciprocal rights and duties as ludicrous:

...there is something almost pitiably ludicrous in impotent declamations concerning the "sacrifices of comfort, ease, and health" voluntarily assumed by the physician, and his "right to expect and require" that those who "avail themselves of his services" should entertain a just sense of the duties which they owe to their medical attendants.

The more likely purpose of the *Code's* contractual structure was to create a sense of earned entitlement that could bind physicians together in a common struggle.³¹ This motive was revealed in 1855 when the *Code* became a loyalty oath. Responding to an attempt by the State Medical Society of Ohio to modify the *Code*, delegates to the 1855 AMA annual meeting voted to require adoption of the *Code*, without modification, as a requirement for local society membership.³² One AMA president, Charles Reed, observed in 1903 that this unfortunate act

converted the *Code* from ethics, “the science of right conduct,” to law, “a rule of conduct prescribed by authority.”³³

Although the record shows that the *Code*’s authors and the AMA members who approved it often had laudable objectives, it also confirms that they sought to achieve their objectives *in spite of* society, not in collaboration with it. Paul Eve³⁴ presented the AMA’s position in his 1858 presidential address:

Eschewing politics, proposing to control medicine alone, taking its management from unprofessional trustees, and seeking no aid from State or Church, we should become a law unto ourselves, or rather act above all law save the divine, since it is quite certain we alone must protect the honor of the medical profession.

Whatever intentions underlay American medicine’s first ethical codes, there can be little argument that, as the twentieth century unfolded, the country’s regular physicians did enjoy increasingly broad latitude in their exercise of professional judgment, higher incomes, enhanced societal deference, and virtually complete control of their profession’s medical education, licensure, and discipline processes.^{28,35,36} For many, these combined achievements offer unimpeachable evidence that an implied social contract eventually arose, one based on physician professionalism defined as “altruism, civic-mindedness, devotion to scientific ideals and a promise of competence and quality assurance through self-regulation.”³⁷

But a defining feature of a contract, even an implicit social contract, is mutual, uncoerced agreement. Uncoerced agreement requires a conscious choice between alternatives. When there are no viable alternatives, or choice is coerced, then a valid contract cannot exist.^{9,38} If

there were historical evidence that early twentieth-century physicians achieved unique benefits that accrued to those who professed their values, but not to others, then one might conclude that the parties mutually agreed to an implicit social contract based on those values, rejecting other available options.

What actually happened was that many other groups, some with very different values from the medical profession, acquired the same rights as physicians. For example, physicians asserted that they needed the rights to set fees and control advertising in order to maintain professional quality and dignity. They were granted these rights, but so were other professional organizations, including trade unions.^{39,40} Physicians asserted the value of scientific medicine and, in order to reduce the amount of poorly trained practitioners, they demanded the rights to control their education and licensure. They received these rights, as did osteopaths, homeopaths, and eclectics, despite their “unscientific” dogmas.⁴¹⁻⁴³ It is hard to argue that the legislative accomplishments and rewards the medical profession attained in the early twentieth-century evolved from an implicit social contract based on the profession’s *unique* values and accomplishments, since similar rewards for other professional organizations were also achieved during this time, based on different values and accomplishments.

Rather than arising from a successful social contract, it is much more likely that the medical profession’s gains in the early twentieth century occurred because physicians and their organizations were, for a short while, in the right place at the right time. There was an unprecedented confluence of professional and public interests in early twentieth-century

America. For instance, as part of the wider progressive movement, two persistent physician issues, quackery and medical education, finally caught the public eye.⁴⁴⁻⁴⁶

Organized medicine rushed to meet the newly identified public needs of drug safety and educational quality. During this period the AMA was the primary source of scientific information on drugs and a close ally of federal agencies responsible for drug safety.⁴⁵ Likewise, because there was no other option, the AMA Council on Medical Education became the de facto accrediting body for medical schools.³⁵

With declining internal competition, a congenial relationship between organized medicine and the public interests, a growing public faith in medical science, and, not the least, an overall increase in affluence following World War I, physicians and the public got along. But, harmony does not mean a contract existed. The purpose of a contract is to assure cooperation when times are difficult.

In 1934 the AMA responded to economic stresses facing its members by adopting a new ethical precept that any organizational form that provided “solicitation of patients directly or indirectly” or interfered with “reasonable competition” and “free choice of physician” in a community was unethical. Accordingly, the AMA publicly opposed hospital employment of physicians, group practice, and many forms of health insurance as unethical.⁴⁷ Alarmed by these actions, scholars delved into the AMA’s inner workings and showed that it often acted to

preserve the hegemony of solo-practice, fee-for-service, white, male physicians rather than foster the public's welfare.⁴⁸

Organized medicine continued down this path for generations. Using the ethical reasoning that no outside force should interfere with physician decision making, the AMA vigorously and unsuccessfully opposed the Kefauver amendments to the Food, Drug, and Cosmetic Act from 1961-1962^{45,49} and Medicare/Medicaid from 1961-1965.⁵⁰ The public was not a partner. It was the enemy, as if the AMA had never left 1858.

The public fought back. In 1975 the Federal Trade Commission filed suit against the AMA's restrictions on advertising. The AMA contested the suit, but lost its final appeal in 1982.⁵¹ In 1982 the United States Court of Appeals upheld a ruling preventing medical organizations from setting fees for individual members.⁵² Lawyers lectured doctors that "to survive challenge under the Sherman Act, ethical standards and regulations should serve the purpose for which the profession exists, i.e., to serve the public."⁵³

Any myth of individual physicians as good "social contract" partners also unraveled. Here, too, society took matters into its own hands. In 1966, Henry Beecher⁵⁴ published 22 examples of serious ethical shortcomings in the research reported in published studies, including three examples of withholding effective treatment and eight of performing risky procedures on patients without their consent. This report added to a growing body of literature that American

physicians had knowingly misused patients in the name of science.⁵⁵ In the 1980s the new field of bioethics, in which physicians were mere participants, was born.⁵⁶

In 1974, Robert Derbyshire, a former president of the Federation of State Medical Boards, asked whether hospital committees, medical societies, and state licensing boards were upholding the ethical standards of the medical profession. Looking at governing laws and regulations, along with histories of disciplinary actions, he concluded that none of these physician-led entities was meeting its responsibilities.⁵⁷ Despite considerable objections from organized medicine, state medical boards were increasingly required to accept non-physician members.⁵⁸

In summary, the historical relationship between American physicians and the larger society was never intended to look like a social contract and it never functioned like a contract. One depressing explanation could be that physicians were and are simply not cut out to be good contractual partners. A more realistic conclusion is that the social contract metaphor did not, and does not, describe the relationship(s).

Cancel the Current Social Contract Metaphor

...if professionalism fails to ensure trustworthiness, if the public no longer believes in professionalism, it can be revoked in favor of substitute belief systems that rely less on patient and public trust in health practitioners.

—Matthew K. Wynia et al, 2014¹⁸

...the codicils in the social contract with society are always at risk of unilateral modification by the public.

—Jordan J. Cohen, 2015⁵⁹

The undesirable attributes of the social contract metaphor may be hindering efforts to understand, discuss, and teach medical professionalism. Overall, the risks and dangers of the social contract metaphor far exceed its benefits. The metaphor has serious theoretical flaws and no historical justification. It needs to go. When the metaphor does go, when we have either chosen to frame medicine's relationship with society in another manner or accepted Veatch's recommendation to stop trying to separate the two,^{60,61} all we will lose is the capacity to threaten ourselves with the cancellation of medicine's social contract.

Inside the self-imposed viewpoint of a social contract, such threats twist the complex relationships between health practitioners and everyone else into a nonexistent either-or dichotomy. Outside the metaphor, those threats have no meaning. By getting rid of the social contract metaphor, we would open the door to a more complex and fruitful consideration of medical professionalism and medicine's relationship with society.

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