

COMMENTARY

Linking the teaching of professionalism to the social contract: A call for cultural humility

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Abstract

Professionalism, which is fundamental to medical practice, must be taught explicitly. It is the basis of medicine's relationship to society, which most observers call a "social contract." The social contract serves as the basis for society's expectations of medicine and medicine's of society. It therefore directly influences professionalism. The role of the healer is universal, but how professionalism is expressed will differ between countries and cultures due to differences in their social contracts. When professionalism is taught, it should be related to the different cultures and social contracts, respecting local customs and values.

Introduction

Professionalism has always been fundamental to medicine's relationship to society, something which, while understood, was articulated only recently (Cruess RL & Cruess SR 1997a; Ham & Alberti 2002; Rosen & Dewar 2004; Sullivan 2005). In his seminal work, "The Social Transformation of American Medicine," Paul Starr stated that the evolution of contemporary healthcare and its delivery had led to "redrawing the 'contract' between the medical profession and society, subjecting medical care to the discipline of politics or markets or reorganizing its basic institutional structure" (Starr 1984, p. 380). While he described events occurring in the United States, it is apparent that this process is universal. As a result, individual physicians and their organizations, health care planners, and medical educators throughout the world have been attempting to cope with the consequences of the changes in the contract that he documented. An important part of the response of the medical profession in a changing world has been devoted to trying to preserve those historic values that foster the healing role of physicians that are usually encompassed in the word "professionalism" (Cruess RL & Cruess SR 1997a).

Until the mid-1990s, there was essentially no literature on professionalism in medical journals. Since then it has been defined, methods for teaching and assessing professionalism and professional behaviors have been developed, and virtually all of medicine's associations and institutions have initiated activities designed to promote the professionalism of physicians. From the beginning, it was clear that an important component of medicine's response had to be the explicit teaching of professionalism throughout the continuum of medical education (Cruess RL & Cruess SR 1997a, 1997b; Cruess R & Cruess S 2006). What to teach and how best to teach it to the current generation of learners became pressing issues. What had worked in previous decades was no longer as

effective. "Today's students frequently need the purpose and meaning of activities spelled out for them...most young people no longer respond to appeals to duty; instead, they want to know exactly *why* they are doing something" (italics ours; Twenge 2009, p. 404).

Both social scientists and physicians have concluded that professionalism serves as the basis for medicine's relationship with society (Ham & Alberti 2002; Rosen & Dewar 2004; Sullivan 2005) and most have termed this a "social contract" (Cruess RL & Cruess SR 2008). In so doing, they link the relationship to a concept which has a long history in philosophy and political science and which stresses the importance of reciprocal rights and obligations (Sullivan 2005). Essentially, the contract consists of a "bargain" between medicine and society (Klein 1995). Medicine is granted prestige, autonomy, a monopoly, the privilege of self-regulation, and rewards on the understanding that it will be altruistic, self-regulate well, be trustworthy, and address the concerns of society. Parts of the contract are written (health care legislation, codes of ethics, mandates of licensing, and accrediting bodies, etc. (Cruess RL & Cruess SR 2008), and outline many of the obligations of the parties to the contract: individual physicians, medical organizations, and society. But other fundamental parts represent moral imperatives that must be present if the relationship is to function. Caring and compassion, altruism, and commitment cannot be legislated. The trust of patients and of society, which are so fundamental to the art of healing, cannot be mandated or created artificially.

Arising out of this implied contract is a series of expectations of the various parties to the contract. For medicine, the expectations of individual patients and of society constitute a working definition of professionalism (Cruess RL & Cruess SR 2008), but implicit in the concept is the belief that physicians also have legitimate expectations of society. As an example, the ability to self-regulate (the setting and maintenance of standards for education, training, and

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practice) has been an important privilege of the profession and hence represents an expectation in most jurisdictions.

Finally, there is agreement in the literature that professionalism is not static. While the role of the healer with its roots in antiquity appears to be relatively stable, social scientists have commented that professionalism does change over time as society, health care, and the associated social contract evolve (Freidson 2001; Sullivan 2005; Hafferty 2006).

Linking the teaching of professionalism to the social contract

Linking the teaching of professionalism to the social contract provides a logical basis for the presence of medicine's professional obligations – an answer to the “why” posed by today's learners (Cruess RL & Cruess SR 2008). It also provides an incentive to meet the legitimate expectations of both physicians and the public. As an example, if medicine fails to meet an important societal obligation, society will change the contract and hence medicine's professional status. Recent events in the United Kingdom in which the profession failed to self-regulate with sufficient rigor have led to major changes in the regulatory process and consequently in medicine's professional status (Secretary of State for Health 2007). The commodification of medicine in the United States has forced physicians to become entrepreneurs in a competitive marketplace and has changed their behavior (Starr 1984; Relman 2007). Without question, there has been a change in the social contract and in the nature of medical professionalism.

National and cultural differences

There has been a surprising degree of agreement on the nature of professionalism in the medical literature on teaching and evaluating professionalism, the majority of which has come from Western countries and cultures. This is undoubtedly due to the fact that most Western countries share common roots in Judeo-Christian culture. Most observers in medicine have assumed that professionalism represents a relatively stable value system, which is common, at least in the Western world. The social science literature would suggest otherwise. Hafferty and McKinley (1993) and Krause (1996) compared professionalism in 14 and 5 different countries, respectively. While there were certainly many commonalities, there were also significant differences in the nature of professionalism across national boundaries. We have suggested that those aspects of professionalism, which relate to the doctor–patient relationship, and which we refer to as the healer role, are relatively stable across cultural lines. Those aspects of professionalism, which concern the interface between physicians and the medical profession and society are the ones which vary, sometimes considerably (Cruess RL & Cruess SR 1997a, 2008). This should not be surprising as the role of the physician is subject to cultural differences and is also heavily dependent upon the nature of the health care system in which medicine is practiced. As an example, the United States and Canada share a continent and, until the middle of the twentieth century, had

very similar health care systems. Canada introduced a national health insurance plan and the United States opted for reliance on a market-oriented system. The two countries now have significantly different social contracts in health care, the threats to the professionalism of their physicians come from different sources, and the expectations of the parties to the contract on the two sides of the border are significantly different (Tuohy 2009).

The implications for teaching

Linking the concept of the social contract to professionalism helps to provide a rational basis for medicine's professional obligations, an obvious pedagogic advantage for those instructing the current generation of students and trainees. In addition, it provides a logical explanation for many of the differing expectations which have been noted in both patients and physicians from different countries, cultures, and health care systems. Significant differences are found both between countries and cultures in the Western and non-Western world and between the large geopolitical and cultural global communities (Hafferty and McKinley 1993; Krause 1996; Cruess et al. 2010). Both medical educators and practicing physicians should be sensitive to these differences. They are generally a part of the heritage of each community and they must be respected. One culture or country may not impose its value system on another. This includes the nature of the social contract in health care and of the professionalism derived from it.

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