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Professionalism, Communities of Practice, and Medicine's Social Contract

Richard L. Cruess, MD and Sylvia R. Cruess, MD

While medicine's roots lie deep in antiquity, the modern professions only arose in the middle of the 19th century after which early social scientists examined the nature of professionalism. The relationship between medicine and society received less attention until profound changes occurred in the structure and financing of health care, leading to a perception that medicine's professionalism was being threatened. Starr in 1984 proposed that the relationship was contractual with expectations and obligations on both sides. Other observers refined the concept, believing that the historic term, "social contract," could be applied to the relationship, a concept with which many agree. There was general agreement that society used the concept of the profession to organize the delivery of essential services that it required, including health care. Under the terms of the contract, the medical profession was given financial and nonfinancial rewards, autonomy, and the privilege of self regulation on the understanding that it would be trustworthy, assure the competence of its members, and be devoted to the public good. In examining how the social contract is negotiated, it has been proposed that physicians belong to a "community of practice" that they voluntarily join during their education and training. In joining the community, they accept the norms and values of community members and acquire the identity prescribed by the community. The leaders of the community are responsible for negotiating the social contract on behalf of the medical profession. In so doing, they must ensure that they recognize the importance of devotion to the public good in the maintenance of medicine's professional status. (J Am Board Fam Med 2020;33:S50–S56.)

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Implicit: *implied though not plainly expressed.*

Explicit: *explicitly stated or conveyed; stated in detail.*[1]

Introduction

Throughout the ages there have been healers who were given responsibility for caring for the sick and infirm in society.[2] At least from the time of Hippocrates, it was understood that these individuals constituted an identifiable community characterized by collegiality.[3] The word profession[4] was later applied to their collective activities, and some of their obligations to patients and society were outlined, thus indicating that some form of relationship existed between the community and the society that it served. Codes of ethics formalized the behaviors expected of physicians in their dealings with patients and each other,[5] but the exact nature of the community of medicine and its relationship to society remained largely unexamined until the modern medical profession emerged in the middle of the 19th century and medicine was granted a monopoly over the diagnosis and treatment of human disease.[5,6] Medicine had convinced societal representatives that it should be granted a privileged position in the delivery of health care and that it could be trusted to put the interests of both individual patients and society above its own, carry out its actions with honesty and integrity, and assure the competence of its members through self regulation. In retrospect, it is clear that a social contract existed between medicine acting as a community and society, but the exact nature of both the social contract and of the

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Corresponding author: Richard L. Cruess, MD, Institute for Health Sciences Education, Lady Meredith House, McGill University, 1110 Pine Ave. W., Montreal, Quebec, H3A 1A3 Canada (E-mail: richard.cruess@mcgill.ca).

community remained largely implicit. This was true despite early interest in both subjects by social scientists, and in particular by early sociologists examining the structure and organization of work in modern societies.[7]

The scientific revolution had given credibility to the claims of the superiority of allopathic medicine in the 19th century, and in the latter part of the 20th century it transformed health care from a cottage industry into an activity consuming a significant portion of the wealth of the developed world.[5,6] Health care became essential to the well-being of individual citizens, leading to the entry of the state and the corporate sector into the health care field. This led to profound changes in the structure and financing of health care and alterations in the practice of medicine, that posed an existential threat to the traditional values of the medical profession encompassed in the word professionalism.[8] One result was an examination of the nature of contemporary professionalism and of the evolving relationship between medicine and society.[9] What had been implicit now needed to be made implicit.

The Healer and the Professional

While in practice, physicians unconsciously fulfil the roles of healer and professional simultaneously, their historic origins and evolution are different.[7] Healers have been present throughout history,[2] answering a basic human need. While the word profession can be traced to antiquity,[4] the modern professions emerged from the guilds and universities of medieval England and Europe in the middle of the 19th century.[6]

An early observation was that society used the concept of a profession as a means of organizing the complex services that it requires.[9] In the case of health care, these essential services are provided by the healer.

If medicine's professionalism is to be addressed directly, its nature must be understood. While many complain that profession or professionalism are difficult to define, the many definitions proposed are all remarkably similar, with their content changing depending on the context of the discourse.[10] For the purposes of examining medicine's relationship to society, the definition proposed by Starr,[6] based on his summary of the opinions of sociologists, seems to be the most useful. "An occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation enshrined in its codes of ethics."

Figure 1. The attributes traditionally associated with the healer are shown in the left hand circle and those with the professional on the right. As can be seen, there are attributes unique to each role. Those shared by both are found in the large area of overlap of the circles. This list of attributes is drawn from the literature on healing and professionalism.

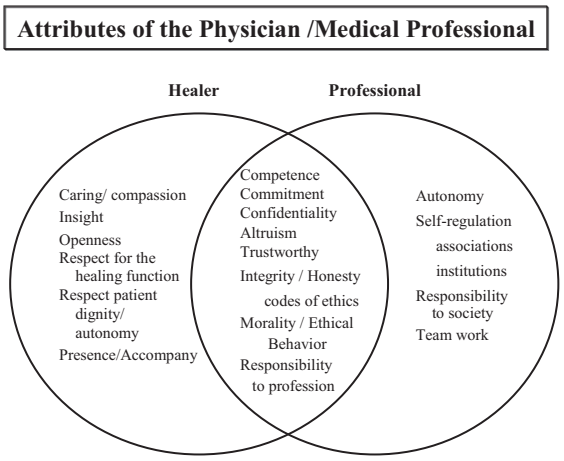


Figure 1 is a schematic representation (as derived from the literature) of the complex relationship between the healer and the professional, along with the attributes of each. It is possible to separate the attributes of each, with a significant area of overlap. The attributes of the healer seem to be relatively timeless and to transcend national and cultural boundaries. Those of the professional are not universal, evolving over time and being influenced by the structure and organization of both society and health care as expressed in their social contracts.[9,10] In addition, there are documented differences in the nature of medical professionalism in countries heavily dependent on Judeo-Christian traditions and values[10] and those based on other philosophical approaches such as Buddhism, Confucianism,[11,12] or the Muslim faith.[13]

The Social Contract

While healers as a group have always enjoyed a privileged position in society, this relationship was not defined until an evolving and complex health care system led to both professional and societal

dissatisfaction.[9] Starr[6] was the first to describe the relationship as contractual, stating that the contract "was being redrawn, subjecting medical care to the discipline of politics or markets or reorganizing its basic institutional structure." Subsequently, many observers turned to the term, social contract, whose origins can be traced to the early philosophers, Locke (1689) and Rousseau (1762), who addressed the relationship between citizens and the state at a time of absolute monarchies.[14] They proposed that a series of reciprocal rights and duties existed between citizens and the state. The concept has had a continuing existence in philosophical discourse until the present time, with John Rawls being its most prominent contemporary proponent.[15] The social contract can be considered in global terms, in which all services required by citizens are included. It has also been suggested that there are mini-contracts that apply to selected essential services such as health care.[16] These mini-contracts must conform to the "moral boundaries" laid down by the global contract. Thus, the American health care system places much more emphasis on individual responsibility in line with its global contract, while the mini contracts in those countries which have comprehensive national health care systems rely more on the collective responsibility of society to care for its vulnerable members.[17]

A definition of social contract appropriate to the health care field can be found in the Oxford Dictionary of Philosophy: "A basis for legitimating legal and political power 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 nature of the obligations, each to the other."[18]

A comprehensive legal document does not exist.[14] However the actions of both medicine and society seem to be organized "as if" one did. Both legal and political power are present, and a set of perceived reciprocal obligations exist. Essentially, the social contract represents "a bargain" in which society grants the medical profession prestige and substantial rewards, autonomy in practice, and the privilege of self regulation. In return, individual physicians and the profession are expected to carry out their activities with honesty and integrity, place the interests of patients and society above their own, address issues of concern to society within their domain, and assure the competence of practicing physicians through rigorous self regulation.[19] These broad aspects of the bargain constitute an outline of the expectations of both parties to the contract[14] (Table 1).

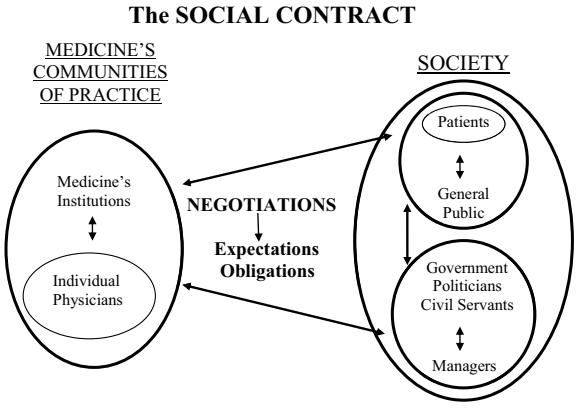
Table 1. The Expectations of the Two Major Parties Involved in Medicine's Social Contract

Patients/Public Expectations of Medicine	Medicine's Expectations of Patients/Public
Fulfill the role of the healer	Trust
Assured competence of physicians	Autonomy sufficient to exercise judgment
Timely access to competent care	Role in public policy in health
Altruistic service	Shared responsibility for health
Morality, integrity, honesty	Self regulation
Trustworthiness	Balanced lifestyle
Codes of ethics	Monopoly
Accountability: performance, productivity, cost effectiveness	Rewards: non-financial
Transparency in decision making and administration	Respect
Respect for patient dignity and autonomy	Status
Source of objective advice on health matters	Rewards: Financial
Team health care	
Promotion of the public good	

A part of the mini contract in health care, including such things as legislation establishing the national health care system and documents delegating authority to the profession, is written. However, important elements such as honesty and integrity, caring and compassion, cannot be legislated. They must arise from within each individual healer as they have acquired a professional identity that causes them to "think, act, and feel like a physician."[20]

The social contract is established and altered through what Daniels has described as "social negotiations", consisting 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."[21] The "specific legal arrangements" can vary from the establishment or alteration of a national health system to the creation of an approved fee schedule. Of equal importance are the day-to-day negotiations that take place in national, regional, or local settings that establish the formal and informal rules governing the daily work of physicians. The evolution of the doctor–patient

Figure 2. A schematic representation of medicine's social contract with society. Neither medicine nor society are monolithic, with each arriving at a negotiating position after an internal discourse between the various internal stakeholders.



relationship from a paternalistic model to one emphasizing patient autonomy is an example of social negotiations that took place over a prolonged time frame.[22] The negotiations that establish the contract are thus a mix of formal and informal negotiations that take place in a wide variety of settings and result in a contract that is a mix of the implicit and the explicit A schematic representation of the relationship between medicine and society is presented in Figure 2.

Medicine's Community of Practice and Social Negotiations

Medicine has long been recognized as a community. The Hippocratic oath emphasized its collegial nature[3] and it has been termed a moral community because of the nature of the medical act.[23]

The emergence of the social learning theory "community of practice" helps to clarify the complex nature of medicine's many roles and organizations.[24] The term was coined by Lave and Wenger[24] in 1991 and they and others have expanded on the concept in recent years, applying it to many occupations including the professions. A community of practice can be defined as "a persistent sustaining social network of individuals who share and develop an overlapping knowledge base, set of beliefs, values, history, and experience focused on a common practice."[25] While the concept may be new, it is clear that such communities have always been present. Indeed, Lave and Wenger[24] stated that communities of practice have existed since "man lived in caves." Individuals, in the case of medicine, medical students, and residents, voluntarily wish to join medicine's community of practice. In so doing, they gradually move from "legitimate peripheral participation" (legitimate as they have been accepted as novice members) to full membership in the community, becoming proficient in its practice, acquiring the identity prescribed by the community, and accepting its values and norms, organization, and governance.[26] In doing so they develop a sense of belonging to the community that in return provides support.[24,26] The community is dynamic, being constantly renewed as members progress from junior to senior status and older practitioners retire.[24] In addition its knowledge base is recreated as it is acquired by those moving to full participation.[26]

As an individual moves to full participation, a professional identity is superimposed on the existing identity.[24,26] It is clear that an individual can possess multiple personal identities depending on their gender, sexual orientation, and multiple national and cultural influences.[26] In addition, an analysis of medicine as a community indicates that it also is not monolithic, consisting of what has been termed a "landscape of communities."[27] The medical profession as a whole can be termed a macrocommunity with an identity based on the universal values of the healer.[28] Each specialty or subspecialty constitutes a meso-community, each with its own unique identity related to their specific professional activities that exist in parallel with their identity as a healer. Finally, there are microcommunities such as the community, university, or hospital-based departments and units in which physicians work on daily basis and which also constitute professional communities of practice, each with their own identities and often intense loyalties.[29] It is believed that the strongest influence on the professional identity of a physician is exerted during their postgraduate training and that the greatest sense of community is found within their specialty or subspecialty of choice.[29] In addition to establishing the expected values and norms and providing a very important sense of belonging, Wenger has pointed out that communities have been mandated to act on behalf of their members, "engaging in joint activities: negotiation of mutual relevance, standards of practice, peer recognition, identity and reputation and commitment to collective learning."[30]

Since the emergence of the modern medical profession the details of medicine's social contract

have been established and maintained through negotiations between the profession and society as outlined in Figure 2.[14] Whether the issue is large or small, individuals representing the medical community, working in institutions established by the community of practice, are mandated to negotiate on its behalf. To be credible, they require the tangible and public support and trust of individual physician members. National medical associations fulfilled this role in the 19th century as medicine claimed a dominant position and the modern social contract was being established.[5,6] They have continued to maintain an important role in many countries.[31] Originally, they were concerned with negotiating the macro contract on behalf of entire profession at a national level. However, the growth of specialty and subspecialty medicine has given increasing importance to the associations representing these groups who constitute mesocommunities of practice that often enjoy higher levels of loyalty and commitment than do the national associations.[32] Many physicians consider that their dominant professional identity is based on their specialty choice and the leaders of their specialty community of practice negotiate the details of social contracts within their domain.[32] Finally, local issues have always had great relevance to the day-to-day activities of the practicing physician, and social negotiations at this level have been and remain important with local microcommunities assuming responsibility for negotiations at the local level.[33]

It should be obvious that communities of practice arise because of the presence of both opportunity and need.[27,30] They can continue to exist only when these conditions are present. and they will either undergo substantial change or can actually disappear because of the presence of external circumstances. The changing role of the national medical associations is an example of such a transformation. They are not now the sole bargaining agents for the medical profession.[5,6] A lack of leadership can lead to a dysfunctional community that fails to meet the needs of its members[27] and external threats that include substantial changes to the social contract can impede the ability of the community to actually meet its member's needs.[30] Without question the intrusion of marketplace values to the health care domain is illustrative of such a change.[6]

Not everything about communities of practice is positive and it is important to emphasize some negative aspects. The process of socialization through which the community exerts its influence on identity formation has a strong impact. There is a resulting tendency toward homogenization within the community, as it seeks to impose a uniform identity on those wishing to join, rather than encouraging them to develop their own individual identities that are compatible with the norms and values of the community.[34] Bourdieu[35] has emphasized this, pointing out that in so doing communities tend to reproduce themselves, perpetuating existing hierarchies, power structures and inequalities. The history of medicine's community is certainly compatible with this viewpoint, having for generations systematically excluded women, minorities, and anyone "thought to be different."[36] If these palpably harmful consequences are to be avoided, medicine must be conscious of their existence and conduct the internal affairs of the community in such a way that they are eliminated.

What Principles Should Guide Social Negotiations?

The major reason for making explicit our understanding of medicine's community and its social contract is to illuminate the issues in hopes that those negotiating on behalf of both medicine and society have a clearer understanding of both the nature of the dialog and of the issues at stake. Some general principles can be developed to guide them in their deliberations.

1. It is important to be explicit about the nature of medicine's relationship to society. Consciously employing the term social contract places the negotiations between medicine and society within a theoretical framework that has been developed over the past two centuries and is widely understood. Employing the concept of community of practice, along with the legitimate presence of multiple communities within medicine's macro community adds both clarity and structure to the negotiations.
2. Collaboration between the multiple organizations having responsibility for these negotiations is clearly essential if there is to be an integrated approach to negotiating the social contract. It is particularly important for each community to establish goals and objectives

that do not in conflict with either medicine's macro contract or other communities within the family of medicine.

3. The leadership of each community is responsible for establishing and maintaining its own legitimacy by ensuring the allegiance of its members and gaining recognition from both its members and society as the accepted bargaining agent at the appropriate levels.[30] This is heavily dependent upon the presence of a trusting relationship between the community members and its leadership.[33] Openness, transparency, and communication with the community thus become essential.
4. Each community of practice should specifically accept responsibility for the health and well-being of its individual members by initiating actions aimed at promoting and maintaining a sense of belonging, including both educational and social activities as well as support for individuals experiencing difficulty.[37] This is particularly true at the present time because of the prevalence of disillusionment and burnout.[38]
5. In the complex modern world of healthcare, where dominance has shifted from the medical profession to the state or the corporate sector.[5,6] It is essential that the medical profession have strong representation as it negotiates the details of the social contract. However, those negotiating on behalf of medicine must understand that they are representing professions and professionals, one of whose fundamental duties is a devotion to the public good. While to the casual observer, negotiations in the healthcare sector may resemble those that take place in the commercial world as they often deal with levels of remuneration and conditions of work, the moral nature of the medical act[23] and foundational elements of medicines bargain with society[19] impose limits on both the public stance and the tactics employed by the community leaders. It is fundamental to understand that professional status is granted to medicine by society and its maintenance is dependent upon society believing that its needs will be placed above those of the profession. Medicine's professional status will be altered if society comes to believe that the profession is abusing its privileged status.[39]
6. Finally, those negotiating on behalf of the medical profession must have two equally important goals in mind. First they must prepare for the future by negotiating a social contract that actually embraces change, as change will occur. However, and of equal importance, at the same time they must respect the past by actively ensuring that the contract preserves the traditional values of the healer that have existed for centuries. In so doing, they will be serving both society and the medical profession.

In closing, it is appropriate to quote Elliot Freidson,[40] a perceptive sociologist who spent his lifetime studying medicine. In analyzing the profession's response to threats to its status, he concluded that those defending the profession rely "primarily on a rhetoric of good intentions which is belied by the patently self-interested character of many of their activities. What they almost never do it is spell out the principles underlying the institutions that organize and support the way they do their work and take active responsibility for their realization."

It has been the intent of this article to address the issues raised by Freidson[40] by attempting to "spell out" some of these principles, making them explicit to provide a framework for the ongoing discourse between medicine and society.

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