Social contracts and health care

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Résumé : Il y a 16 ans, le Dr Doug Waugh a rédigé un article sur le contrat social et ses répercussions dans le bulletin publié par l'Association des facultés de médecine du Canada. Étant donné les événements qui sont survenus en Ontario cet été, lorsque les négociations sur le contrat social entre la province et les employés du secteur public, y compris les médecins, dominaient les grands titres de l'actualité, le Dr Waugh a décidé de remanier son article. Il dit ne pas avoir été surpris du degré de mésentente en Ontario parce que, forcément, les tensions augmentent dans toute situation de contrat social.

In 1977, Dr. Douglas Waugh wrote an article on social contracts for the Forum, *published by the Association of Canadian Medical Colleges. Given events in Ontario this summer, when social-contract talks involving physicians, public employees and the Ontario government dominated the news, the article Waugh wrote seems as relevant today as it did 16 years ago. He has revised the article and broadened its scope to include all the health professions, not just the country's physicians.*

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For most, the word *contract* conjures up the picture of a dry legal document full of whereases that specify which of the contracting parties will do what, and with what and to whom. Contracts also tell of the dire penalties in store for the party that fails to honour its obligations. These penalties are reinforced by a body of common law to which recourse can be sought in cases of real or perceived breaches in the terms of the contract. The entire business is, if one can ignore the cumbersome, often arcane language of the contract, rather neat and tidy.

The expectations and requirements of the contracting parties are clearly set forth, and neither is expected to go beyond them. Also, neither party is expected to read the other's mind and anticipate or respond to requirements that are not specified in the contract.

Of course, contracts are not rigid, unchangeable documents. They can be altered, modified, or even terminated through more or less ponderous procedures that are set forth in the original agreement. As I said, it's all neat and tidy and, apparently, an essential part of most societies.

Lately, we've been hearing a great deal about another kind of contract, the social contract. This concept was elaborated in the 17th and 18th centuries by Hobbes, Locke and Rousseau, although the idea was presented even earlier by the Greek Sophists. In its simplest form the social contract consisted of an agreement between groups in a society, or between them and their government for their mutual protection.

Social contracts lack all the precision and most of the sanctions that are implicit in legal contracts. In the first place, social contracts are not written down, and by their very nature usually cannot be. It is difficult even to give a precise definition of a social contract that would cover all situations. The best I can do goes something like this: A social contract may be said to exist when two groups within a society, between which a state of mutual dependence exists, recognize certain expectations of one another and conduct their affairs according to those expectations.

Probably the best example of a social contract is the British Constitution, that unwritten body of expectations that is mutually recognized between the government and the governed in Great Britain.

It is implicit in my definition

and in others that expectations might change from time to time, as may the responses to them by both parties. It is also implicit that trouble arises when one side tries to impose a social contract on another, as Premier Bob Rae of Ontario discovered this summer.

Tensions are bound to arise in a social-contract situation. The expectations of one party might be ignored by the other, or might be responded to in a way that is thought inappropriate. Indeed, the only thing that keeps the entire business going is the state of mutual dependence: no matter how severe the tensions or conflicts that arise, each party knows that it cannot get along without the other. Each recognizes (most of the time) that it cannot, at least for long, take over the function of the other and, thus, cancel the contract. For example, in a political coup a new dictator might liquidate the police force of his predecessor and thereby cancel his contract for the protection of society (and of himself!). If, however, he and his government are to survive he must quickly enter a new contract with a new police force. The faces may change, but the essential features of the social contract persist.

In the concept of the social contract that I have outlined, I perceive each of the health professions, the medical schools, medical students and residents as corporate parts of society as a whole, brought into being initially in response to society's expectations and continuing to exist because of the mutual dependence between each group and society at large. This type of social contract is between society as a whole and corporate entities within itself.

Society, and particularly Canadian society, cannot be looked on as a single, homogeneous "thing" with a simple, monolithic and definable set of expectations of its present and future health care providers. For instance, different levels of government permit or require a galaxy of social expectations from their health care professionals, and within that galaxy we can be sure that some of the stars will be on a collision course; others might be on their way out of the solar system!

For this reason, we in the health care professions can expect to continue to find ourselves beset by conflicting and/or confused expectations from our diverse Canadian society. It is, in fact, not hard to find examples of the conflicting expectations of the federal government, provincial and territorial governments, and communities and regions. Indeed, different branches of the same level of government might hold conflicting expectations for the same group of professionals.

How then can each of our groups hope to satisfy the terms of its social contract? We must recognize the existence of the contract and attempt to define the obligations of the partners to that contract. This will not be easy and many obligations are likely to remain vague and subject to disagreement or differences of interpretation. This is as it should be in a nonhomogeneous, pluralistic society. Nevertheless, in attempting to define its obligations each group will need to engage in dialogue with the elements in society with which it has a social contract, seeking either agreement on definitions or, at least, a mutual understanding of disagreements. Such a process should help define the terms of the contract and make it possible to progress toward the settlement of problems.

This process is neither easy nor always perceived as a partnership undertaking. On one hand we have professional groups saying: "We are the ones who should define and prescribe for society's health care ills." On the other, we find parliamentarians or bureaucrats responding: "We are the guardians of our society and it is our job to see to it that the health care professionals meet the needs we have defined — and we'll see to this through our control of the flow of funds."

The positions I have described may be caricatures, but there is enough truth in them to interfere seriously with the effective operation of the social contract. The fundamental flaw in both attitudes is the failure of both sides to recognize the state of their mutual dependence. Society cannot dictate to the health professions any more than the professions can lay down the law to the society they serve. All that such posturing achieves is the frustration of objectives and aspirations on both sides.

In a further refinement of the social contract, it is both possible and necessary to recognize the existence of a series of subcontracts. Thus, while one can identify certain expectations that apply to one professional group and its community, there are others that derive from regional, provincial, national and even global relationships, each of which can have a bearing on one or more of the professional groups in a highly individual and specific manner, and each with its own capacity to generate tensions.

In talking of expectations, it is important to recognize that the term is not necessarily synonymous with objectives. In the conventional sense within the health care professions we tend to think of objectives as targets we ourselves have chosen for our programs. In the context of the social contract, expectations are objectives that have been mutually agreed to by the parties to the contract and might differ in important ways from the expressed objectives of one side or the other.

If the concept of the social contract has value for the health professions (and I wouldn't be talking about it if I didn't think it did) it is in drawing attention to the need for a more cooperative approach to problems of health education, service and research by each professional group and by the various levels of society that it is committed to serve.

An essential first step is establishing open and easily accessible routes of communication between the parties to the various contracts. ■