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A social contract
Innovation in health professional Education for establishing
trans disciplinary professionalism for health

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I have been asked to reflect on what I have heard about a social contract in health and perhaps flavor it with my experience as student, patient, medical educator, medical practitioner and health administrator over many years. At the outset, let me declare that I am not a professional ethicist nor have I carried out research on professionalism although I have had to reflect on it on several occasions over the years-often more about the breach than the observance as I sat on Medical Council. I will frame my comments within the context of the workshop's aim which is on innovation in health professional education with a focus on establishing trans disciplinary professionalism for health. Is it possible to educate health professionals in a trans disciplinary manner so as to inculcate the elements of a shared contract?

Let me begin by saying that while I am no intellectual Luddite as far as medical education is concerned, I have always needed to be convinced of the merits of any radical change as evidenced by the change in the functioning of the product. This is because I have seen many attempts at change in methods and content of educational instruction in my time and have not always been convinced of the value of the effort. I also believe that changes in areas such as education are more likely to have traction when they are evolutionary rather than revolutionary and give the comfort of building on continuity.

I start with the concept of a social contract and I deliberately asked that the title not have the definitive article and I have to admit to some doubts about there being a single social contract and some ambivalence about the possibility of enforcing it. When I was very young I held to the notion of a social contract in the political sense-in the sense used by Plato and then Hobbes, Locke and Rousseau. It was a contract in which a group or individuals give up some degree of individual benefit or autonomy in order to achieve some greater social good or to ensure protection of themselves. According to Rousseau, a social contract reduces itself to the following terms:

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“Each of us puts his person and all his power in common under the supreme direction of the general will, and in our corporate capacity, we receive each member as an indivisible part of the whole”.

I know fairly well of the Caribbean experience in which the Heads of Government identified specific social sectors and posited that there could not be progress in terms of human development without some contract of some or all of these with government. In times of economic stringency the successful social contract between organized labor and government was held up as a sign of social maturity. I have followed peripherally the debate as to whether the growth of social protest is some reflection the weakness of the social contract and the inability of the state to protect the freedoms of individuals who had as it were, given up some of their autonomy for that protection. In this sense social as applied to contract implied an arrangement with and for the benefit of society.

If I am to propose a contract that is trans disciplinary and trans professional, then at least I should give my concept of that professionalism. Yesterday the Creusses defined a profession brilliantly as:

“An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and to the promotion of the public good within their domain”.

I cannot better that, and only add that professionalism obviously embraces the exercise of a profession. Health professionals have almost by definition a formal relationship with three critical groups-patients; other health workers and society at large and the organization of these relationships and the rules to order them in a formal sense go back about 150 years on both sides of the Atlantic. These relationships or parts of them can be seen in the origins of medical practice, appear in many different cultures and are always hedged around by strict rules and regulations. The area with which I am most familiar is the relationship of the health worker, primarily the physician with patients.

But despite this history of codification and regulation of relationships and firm establishment of regulatory frameworks, I still recall as a young physician hearing that much of the angst for a formal code or contract stemmed from the need to protect the physician and was another manifestation of the old dictum of emptor caveat-let the buyer beware. Contracts were less necessary when there was genuine professionalism. A President of the General Medical Council of Great Britain–Sir Graeme Catto in a recent lecture admitted to being sympathetic to the words of Lord Phillips in a deposition to the Royal College of Physicians as he decried the growth of moral minimalism leading to emphasis on regulation. Lord Phillips said:

“It seems self-evident to me that the essence of professionalism is to be able to call upon the honor, probity and principled judgment of the practitioner. A self-respecting, fully functioning profession would surely profess just that, and deal with the inevitable failures.”

However, on the basis of this contract primarily with the patients, physicians acquired the power, authority and the degree of compensation that set them apart from many other professions. Medicine moved away from being closeted and cosseted by the notion of a guild, physicians were highly regarded, trusted and remunerated and they often acquired influence outside their area of competence, based on the degree to which they were trusted. Today, the nature of the contract with the patient is changing or has changed for several reasons.

But I think there would be general agreement that as far as the individual patient is concerned, there is still the fundamental responsibility to achieve what Daniel Callahan refers to as the core goals of medicine.

These are:

The prevention of disease and injury and promotion and maintenance of health

The relief of pain and suffering caused any maladies

The care and cure of those with a malady and the care of those who cannot be cured

The avoidance of death and the pursuit of a peaceful death.

Parenthetically it is the last of those which is most often ignored in modern medicine. But really these are not enough and have to be complemented by inclusion of values such as trust, respect, confidentiality and compassion.

Medicine is infinitely more complex and is becoming more complex every day. As the eminent medical academic Cyril Chantler said pithily “*Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous.*” This increased complexity has resulted from the vertiginous growth of science and our increasing understanding of the basis of disease and illness. The advances in the basic sciences have made it impossible for any single discipline within the profession to have the knowledge and expertise to address the whole range of illnesses that may present. Hence there has arisen a large number of disciplines that are necessary to deal with the health problems of medicine.

It is this complexity of care and the changes in the world’s disease profile that have brought to the fore the second of these relationships, that between health workers in different disciplines. The chronic noncommunicable diseases have now surpassed the acute communicable diseases as causes of death in most parts of the world. The number

of deaths from NCDs has increased by 30% over the past 20 years while those for communicable diseases have fallen by 17%. Even HIV/AIDS is now becoming a chronic disease. Thus the world has to be adopting models of continuous care which essentially involve the patient, the family, the community and the care services at different levels. Given the chronicity of care, patients will be seen by a variety of health professionals and it therefore becomes fundamentally important that there be respect, understanding, trust and fluid communication between them. Thus, codes of practice and behavior must of necessity incorporate the need for relationships among widely different disciplines exercised by different professionals.

The availability of information has changed the nature of the physician/patient relationship. The degree of informational asymmetry was once so great that this induced a paternalistic approach by physicians and placed them in the difficult situation of having to ensure that they did not take advantage of the asymmetry to advance their own utility. With the increased availability of information the degree of symmetry has decreased although it has not disappeared. Also, the access to health information that will decrease the asymmetry is not necessarily a global phenomenon.

There are tools available to effect change in the health of populations and the classic work of Geoffrey Rose showed the nature of the interventions that are needed. In addition there is now better understanding and appreciation of the social determinants of health at the individual and population level and the acceptance that many of the levers to be pulled are outside the competence of the health sector. Indeed this appreciation of the social determinants of health has called into question whether such disciplines as sociology and economics should not be legitimately counted among the health professions. But a more critical question is whether the interventions needed for improving the health of populations should be part of the social contract involving individual health workers, or should it be under the exclusive purview of the state to effect these changes. Tobacco use is a good example. As part of the compact that involves individuals, the physician has a responsibility to set a good example by not smoking and to advise his patients not to smoke, but it is the state that has the authority and responsibility to raise taxes on tobacco as the best method of reducing smoking.

This brings into question the role of the health professional as an advocate for change. Should it be part of professional responsibility to advocate for the change in the social determinants of health? The great German physician Rudolf Virchow wrote in 1848:

“Doctors are the natural advocates of the poor, and social problems are largely within their jurisdiction”.

It is in terms of the relationship between medicine and society that I see the great need for a social contract which as the Creusses explained, embraces the expectations and contribution of both. The societal expectations of the physician include the services of a healer whose competence has been guaranteed by some formal process of education, credentialing and certification. Society also expects morality, integrity and accountability. The trust given to medicine depends in large measure on the degree of

morality and integrity on the part of medicine. Accountability can be problematic, as on occasion the fiduciary responsibility to an individual patient may run counter to the social purpose of medicine.

Medicine in turn expects that society will grant the autonomy necessary for the discharge of the essential functions. Medicine also expects trust from society, a monopoly on practice and a reasonable measure of status and financial compensation. Medicine also will expect of society a health system that enables medicine to be practiced efficiently, although it may be claimed that this is a shared responsibility between medicine and society.

Now, is it possible to envisage a contract, perhaps not a social contract, that is trans disciplinary in the sense that it cuts across all health disciplines? First, there is already a great deal of similarity in the codes of practice of the various health professions. Examination of the code of ethics of Pharmacy for example shows great similarity with the code of ethics of physicians and laboratory workers. I believe that one will find in all these professions three essential processes that ensure the fitness to practice—a corpus of standards and ethics, a system of registration and a system of education and instruction. I can envisage the elements of relating to patients, to other members of the profession and to society as a whole having a degree of commonality across all the health professionals. The relationship between a physician and a patient is not fundamentally different from that between a pharmacist and a patient or a dentist and a patient. It is these core elements that might form the basis of a commonality of approach with regard to a contract that is across disciplines and does not relate to the science of the discipline as opposed to the art or personal affective interaction. This would have to be complemented by separate contracts with individual disciplines which embraced both their science as well as their art. This commonality of relationship has little to do with teamwork. Teamwork is clearly useful, but I would doubt that it should be the focus of any arrangement that is genuinely trans disciplinary.

What would be type of pedagogy that would enhance this trans disciplinary approach? The Report of the Commission on Medical Education points out the nature and evolution of the instructional reform needed in the 21st Century. Instruction has moved from informational learning to formative learning and now it is transformational learning that is necessary. While emphasis has been put on this last one as being about developing leadership, I view it through a wider lens. This learning is about acquiring the knowledge and skills in disciplines beyond those traditionally given in health with a view to transforming health from being considered uniquely as constitutive and mainly of intrinsic value to being also instrumental for human development. The innovation will be not only in the form of education driven by the new technology, but also in the content of the material. It will also be innovative in the formal incorporation of the mentoring and role-model exposure which has often been at random, as indeed the traditionalists will posit that it is the mentoring and following of role models that does most to inculcate the form of relationship to patients, other health workers and to society that has to be the bedrock of good health care.

Thus, I believe that there can be a contract with society that embraces all health disciplines with such a contract being at the level of that art that is common to all health professionals. In addition, it is possible to develop the kind of innovative pedagogy that can contribute to the formulation of such a trans disciplinary contract. Such a pedagogy would incorporate fully the aspect of mentoring and formal exposure to role models that could be truly transformational.