La profession médicale : TIME FOR A NEW SOCIAL CONTRACT

Discussion Paper

QMA

Doctors IN ACTION

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« 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.

These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served, to their colleagues, and to society. »

CRUESS, JOHNSTON AND CRUESS (2004).
Teaching and Learning Medecine.

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PREFACE

This document aims to set in motion a broad reflection, initiated by the Quebec Medical Association, on medical professionalism and the need to reconsider the foundations of the social contract between the medical profession, healthcare organisations, patients and the State.

Effective healthcare has become an essential element of civilized society. As healthcare has advanced, it has transformed from an artisanal practice to a major part of every developed country's gross domestic product. During this transition, healthcare has come to be viewed as a fundamental human right.

In almost every country, governments have changed in order to guarantee the quality and availability of healthcare services. Until a few decades ago, doctors operated in private practices and were only held accountable to their patients. Now they are required to function within complex systems that are controlled by third parties from both federal and commercial sectors. The Canadian system has created a complicated relationship between medical professionals and the provincial and federal governments. It has been necessary to preserve the doctor-patient relationship while individual physicians—and the medical profession as a whole—became an important part of a growing social contract that reflects the country's values.

The idea of a 'social contract' dates back more than 300 years, originating from the fields of philosophy and political science. Even today, people use the idea to explain how contemporary society, including the healthcare sector, is organized. It is generally understood that the nature of the social contract varies somewhat, both between and within countries. The social contract in the United States insists that individuals are responsible for their own care, although people in Boston and Dallas may disagree on some of the finer points within the contract. Meanwhile, in Canada the social contract is based on the idea of caring for all citizens' well-being, so the social support network is much stronger and includes the provision of universal healthcare. However, there are regional differences between, say, Alberta and Quebec.

The general social contract (macrocontract) in a country or area reflects the values and beliefs of that country. Healthcare is a microcontract; its overall parameters are aligned with the moral boundaries established in the macrocontract.

There are several advantages to including healthcare in the analysis of the social contract. This idea has a long and rich history that does not need to be reinvented. In an almost primordial way, the social contract grants rights and responsibilities to all parties. The expectations of medicine and society are therefore important factors. The term 'contract' also presupposes that there will be negotiations, that all parties will be known and that an agreement will be reached. If one party does not fulfil its obligations towards the other, the second party will react.

Canada and Quebec have been negotiating their healthcare social contract for more than half a century. The laws establishing the Quebec healthcare system are the result

of national and provincial negotiations between medicine and society, the latter of which has elected representatives. The numerous changes made since those laws were put in place have resulted in modifications to the social contract. Many of these modifications have been made as a result of dissatisfaction with the status quo, usually on the part of society.

There are written and unwritten elements of the healthcare social contract. The unwritten components are fundamentally important. After all, you cannot legislate kindness, compassion or integrity; these qualities can only come from each individual doctor. The written components of the contract involve codes of ethics and conduct, as well as legislation that describes the characteristics, financing and controls of the healthcare system. They determine many of the working conditions for the medical profession and, by the same token, the details of the social contract. We need to take an enlightened approach to the ongoing negotiations surrounding the social contract and examine the consequences of modifications for both society and medicine. In doing so, we need to remain aware of both sides' expectations of the contract.

Richard L. Cruess, M.D.
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FOREWORD

The discussion on which this report is founded is the result of an initiative by the Quebec Medical Association. However, since this paper prioritized collaboration, it was equally made possible by the participation of numerous partners. We thank them sincerely for their participation.

More specifically, this document aims to provide an understanding of the creation, maintenance and transformation of the medical profession over time, both in Quebec and around the world. The research team was therefore asked to document doctors' professionalization process within the current social context. Hopefully, this process will initiate critical reflections within the medical community. Given that the practice of medicine is transforming so profoundly, we hope that this report will aid in the evaluation of the relationship between doctors, healthcare organizations, patients and the State. It now seems essential that we redefine the bases of the social contract that unites these parties. In doing so, we need to provide services that are professional, high-quality and respectful of the wishes of all involved.

Finally, we wish to note that this report looks at the evolution of the medical profession from an Anglo-Saxon point of view. While the French perspective defines professions as any job or occupation that requires specific training, the Anglo-Saxon perspective states that a profession is a group that organizes itself into professional associations. It also maintains that professions have standardized and scientific training, strong morals and regulated professional, ethical and legal responsibilities.[1] Although both perspectives are highly influential, the Anglo-Saxon point of view is used in this report because it is better suited to reflecting on the essence of the medical profession.

CONTEXT FOR DISCUSSIONS ON THE FUTURE OF THE MEDICAL PROFESSION

Traditionally, the medical community has benefited from significant respect from members of other professions and the population in general. However, there have been significant changes to the medical community's contexts over the past years. These changes have had a profound impact on the roles of healthcare professionals, including doctors. Certain controversies have also led to media coverage, which in turn has contributed to society's deteriorating view of the medical profession.

Doctors' social responsibilities are more and more often becoming the focus of debates about the future of the medical profession. Doctors benefit from a high social status; they also control access to the medical profession by determining its norms and required skills. However, the other facet of the "social contract" means that doctors are also responsible for serving their patients and society in general.

A doctor may certainly, in good faith, provide diagnostic or therapeutic services that appear to be valid within the confines of a standard doctor-patient relationship, but that may provide few benefits on a social level. For example, how does a doctor go against the will of an individual who wants to undergo certain screening procedures, even though they have not shown to be effective and their potential harms may outweigh their potential benefits?

[1] Many classic works on the sociology of professions are based on an Anglo-Saxon point of view. Officially, it was introduced in the literature by Flexner in 1915. For more information, consult the book by Dubar, C., Tripier, P. and Broussard, V. (2011). Sociologie des professions (3rd ed.). Armand Colin, Paris, 376 p.

A doctor's social responsibility is based on a delicate balance between the patient's best interests and those of the community. Technological advancements have also drastically changed how medicine is practiced, and organizational methods are still trying to catch up. The medical profession is faced with many technological challenges, such as the use of information and communications technologies by doctors and patients alike, the patient's role in monitoring their own health (through portals, DCIs, the Internet, etc.) and the reach and effectiveness of at-home testing.

Finally, our healthcare system was designed and organized to provide short-term, acute care. It is therefore ill-adapted to providing effective care for chronic illnesses. Clinical intervention models are undergoing gradual changes, leading to a fundamental reconsideration of the role doctors could and must play within changing organizations.

SUMMARY OF THE MEDICAL PROFESSION

The study of the medical profession, which is categorized under the larger studies of philosophy and sociology, has ancient roots. Professions have been established since the medieval period. During this era, doctors were organizing into professional groups in order to build the foundations of their practice. The purpose of these professional groups was to maintain the clinical autonomy of their members, ensure excellence for the benefit of their patients, guarantee the sharing of scientific knowledge throughout the community, normalize university education and establish a strong code of ethics.[2] Because organizing professional bodies was so complicated, only a few professions were legally recognized. In fact, only three professions hold a **distinct social status** according to the State: medicine, law and clergy. [3]

For the longest time, the medical profession has been perceived as a uniform group. Many authors have stated that the medical community was made up of professionals who shared the same ideologies, values, roles and interests for their profession.[4] However, modern studies (such as the study by Hodges et al.) show that there was a considerable variation in the values held by the medical community. Like other professional groups, **the medical community** is actually a **diverse group** that contains many unique individuals. Although there are differences between individuals, **we still expect this** community to share and respect the values related to strong medical professionalism.

Professionalism is a central aspect of the medical profession. Until very recently, "professionalism" referred to the individual characteristics, traits, behaviours or cognitive processes related to a professional community. In the medical profession, this is reflected in the Hippocratic Oath.[5] Among the dominant traits of this type of professionalism, objectivity was seen as essential to maintaining a service ethic, clinical autonomy and self-regulation. Along the same lines, equality, safety and patient health were defining traits of medical professionalism. However, during a major international conference on the evolution of the medical profession in 2010, significant differences in the medical community were noted. It appeared that fundamental values, seen as characteristic of the practice of medicine, were not always shared by all members of the profession. Moral values like altruism, self-regulation for the common good, trust and selflessness no longer define the practice of modern medicine. That said, those traits form the moral foundation of the medical profession; they even give the medical community its prestige and social status. Without a strong, shared sense of medical professionalism, the medical community risks losing certain privileges.

To that effect, current studies are showing that medical professionalism varies with each individual. **Doctors function in complex environments where real-life situations are varied and unpredictable.**[6] The attitudes, codes of conduct and professional practices

[2] Andrew Abbot is one of the first modern authors to treat professions as a system. He states that professions cannot be seen as closed systems. Many authors believe that the professional system is implicated in a much larger system.

[3] The concept of distinct social status is a central part of the study of professions. Social status encourages professionals to respect the terms of a social contract that grants them privileges as well as duties. This idea will be outlined elsewhere in the report.

[4] Durkheim believes that a professional is different from other people because they are part of a "moral group" (Mauss and Durkheim, 1937).

[5] The Hippocratic Oath likely originated from the 4th century BC. This oath, which has been updated over the past century, exists mainly to remind doctors that they have legal, moral and ethical obligations.

[6] Eliot Dodson's Professional Dominance brilliantly explains the complexities of the practice of medicine.

learned during training are only suitable in a few situations. The new perception of professionalism assumes that the medical community changes its attitudes and behaviours according to situations encountered. For example, a 2011 study by Kirkpatrick et al. showed a considerable change in medical professionalism. The authors concluded that modern professionalism reflects not only the clinical nature of medical practice, but its psychosocial and medical traits as well. The borders between the different professional groups are more flexible than they appear. **While we believed** that professional practices were stable, rational and belonging to **a single group, we are now realizing that they are constantly evolving.** Medical professionalism is not pure, as we once believed. Instead, it is a hybrid, changing depending on the context Medical professionalism is not only a matter of personal traits, but also **of content.** Professionals must possess the scientific knowledge, the know-how and the **skills necessary to practice their profession.**

Throughout their careers, doctors are required to adapt their skills to suit the needs of their patients. Practicing medicine requires reflection, judgement and strong morals in order to ensure that it is motivated by the well-being of others. Professional actions are defined by the code of ethics, but doctors are still required to adapt their practices to suit the circumstances at hand.

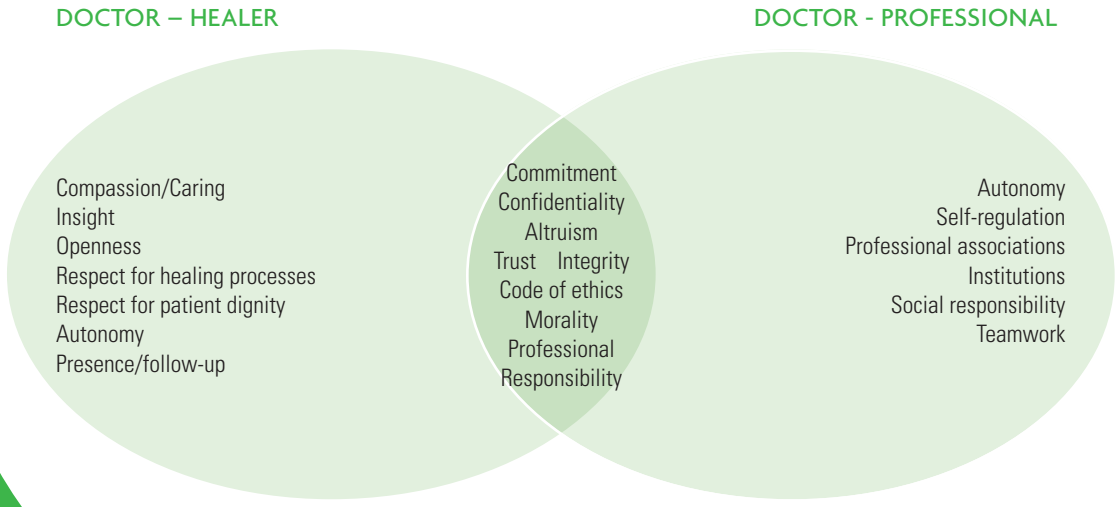
DOCTORS: BETWEEN HEALERS AND PROFESSIONALS

According to Cruess and Cruess, we must reconsider medical professionalism. Historically, medical professionalism was viewed as a function of a doctor's role as healer. However, research has shown that practicing medicine relies on the fact that doctors are professionals as well as healers. These are distinct but complementary roles. Doctors must find a balance between the two, even though they are sometimes in opposition. The diagram developed by Cruess and Cruess shows just how fragile that balance is. This diagram lists the traits associated with the roles of healer and professional. In the middle are certain skills that make the medical profession unique. Notable among them are professional skills such as commitment, confidentiality, altruism, trust, integrity, ethics, morality and professional responsibility. The requirements for medical professionalism are numerous. The link between professional values and individual interests is simply a matter of size. Nevertheless, the status quo is no longer an option. As a medical community, we can no longer tolerate division amongst our members.

REFLECTION ON CONTEMPORARY MEDICAL PROFESSIONALISM

Over the past few years, the medical community has been receiving an unprecedented amount of attention from scientists, the media and society in general. This attention is sometimes positive, sometimes negative. Despite the significant reputation of the medical community, the profession seems to be in the hot seat. It is therefore imperative that we understand the reasons behind the uproar, although doing so will be an unprecedented undertaking.

In fact, this questioning approach shows that the medical community is interested in developing the profession and maintaining its status in society. In the face of the increasingly rapid changes to the healthcare environment, an evaluation of medical professionalism is not only desirable, it is necessary. The current changes do not only pose challenges. They also provide opportunities that we can use to our advantage.



UNDERSTANDING THE SOCIAL CONTRACT FOR THE PRACTICE OF MEDICINE

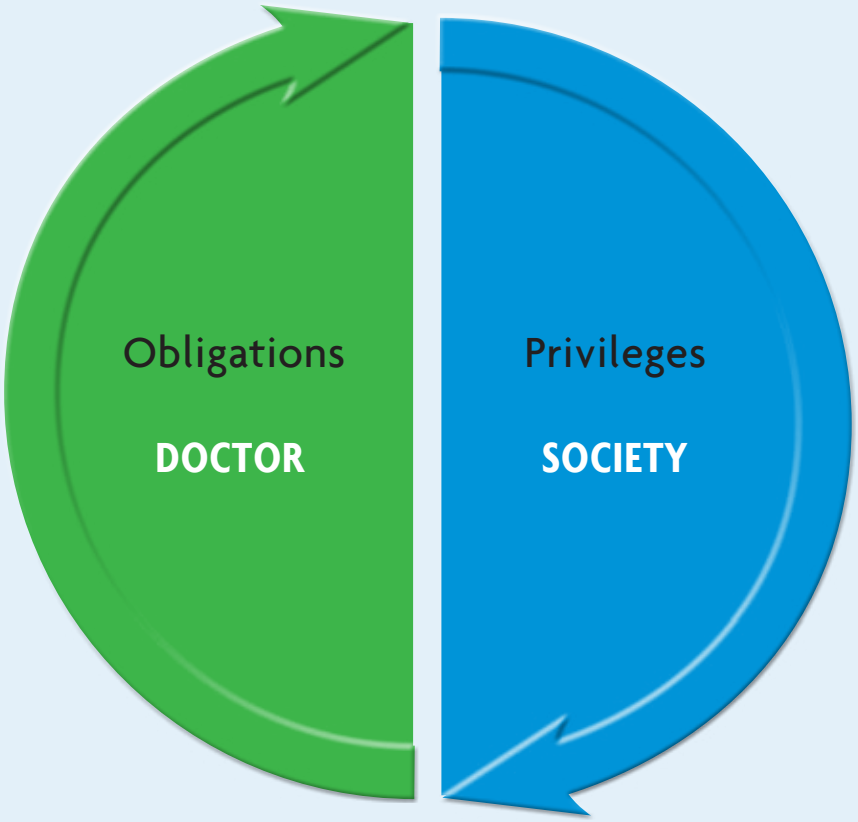
Over the past few years, the medical profession has been undergoing unprecedented changes. The reform movement in the 1990s, which was inspired by the New Public Management movement, caused many upheavals. As a matter of public interest, consultants, officials and academics are attempting to determine which management tools and techniques can guarantee high-quality public services at low prices.

However, this desire to improve the performance and efficiency of the healthcare system is having a considerable impact on the medical profession. Because of new requirements such as accountability, optimal use of resources, creation of specific organizational goals, updating performance measures and achievement of results, the medical community's influence and clinical autonomy are being eroded. There are multiple underlying causes for these reforms. Many agree that the evolution of pathologies, the diversification of patient needs, the advances in technology and medical research, access to information and new governing models have contributed greatly to these changes.

NEOLIBERAL IDEOLOGY DEFINES MODERN SOCIETIES
Accountability
Optimal use of public resources
Meeting organizational goals
Measuring performance
Transparency

A number of authors (including Paul Starr, Sylvia Cruess and Richard Cruess) believe that the changes to the medical environment have changed modern professional dynamics. More specifically, the terms of the **social contract** have changed. This unspoken contract assumes that there is an agreement between society and the medical community. As with official agreements, the contract confers **rights and responsibilities** on all parties.

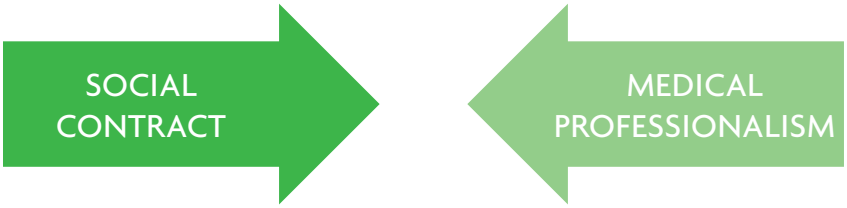
Although the idea of a social contract can be applied to society as a whole, it can also be understood on an individual scale. The terms of this moral engagement apply both on the macro (medical community-society) and micro (doctor-patient) level. The same obligations and privileges guide the provision of care and services on any scale.



THE SOCIAL CONTRACT

Finally, the changes to the basis of the social contract are reflected in medical professionalism. In Cruess and Cruess' words, medical professionalism "rests" on the terms of the social contract between doctors and society. As a result, any changes in the social contract will lead to changes to professionalism as well. It is a sine qua non equation. It is naïve to think that medicine - its norms, values, code of ethics and the practice itself - can remain unchanged while the rest of society is evolving and transforming. As such, a famous author named Hafferty states that medical professionalism has sometimes been idealized. Some doctors embody a type of professionalism that he calls "nostalgic."

These doctors believe that medical professionals must be free from social pressures, accountable only to patients, free from any constraints imposed by authorities, completely independent and trustworthy because of the powers given to them. This type of professionalism, insofar as it can exist in such a pure manner, has been put to the test over the past few decades. As we explained above, the imperatives of the neoliberal economy have incurred profound ideological changes. This puts the terms of the social contract in jeopardy.



PRACTICING MEDICINE: PRIVILEGES AND EXPECTATIONS

Belonging to the medical community, and the resulting medical professionalism, grants doctors many privileges. As was discussed earlier in the paper, medical professionals are granted job stability, higher pay, recognition of their expertise, the clinical autonomy necessary for the determination of professional activities, and the privilege of self-regulation through professional associations. These privileges are substantial and limited to a very small group of people in our society. The Collège des médecins adopted a code of ethics in 1860, followed by the Canadian Medical Association in 1868. In doing so, they reinforced just how important these privileges are to medical authorities.

In a 2004 article, Cruess and Cruess elaborated on this idea of privilege. They wanted a detailed view of the situation, so they reviewed scientific literature in order to determine the main privileges related to the practice of medicine. According to their findings, doctors' privileges fall under six (6) headings:

- **Clinical autonomy:** Practicing medicine is both an art and a science. Clinical autonomy is necessary because of the complexity and diversity of situations doctors encounter. The knowledge and experience gained through training and years of practice give the medical community cutting-edge expertise. Clinical judgement must be free from obligations or constraints that could threaten the doctor-patient relationship .

- **Trust:** The doctor-patient relationship is based on a significant imbalance in terms of information and expertise. However, this imbalance can be mitigated by mutual trust between both parties. That trust is the basis of the professional relationship. Traditional systems such as codes of ethics, graduation, continuing education and moral commitments are intended to ensure the quality of medical services and allow patients to keep a high level of trust in doctors.

- **Exclusivity:** Exclusivity is a central tenet of the medical profession. The practice of medicine is strictly regulated. Doctors must maintain exclusivity in order to guarantee the quality of medical practice. The practice of medicine—the training, expertise, norms, values and professional practices—must be protected from external pressures.

- **Social status and compensation:** Originally, doctors formed professional associations because they were "the only moral power capable of containing individual egos, ensuring solidarity and preventing 'survival of the fittest' from taking hold." [translated] (Dubar et al. 2011, p. 73) From then on, the medical community was granted a distinct social status. Despite the importance of this status, the medical community believes

that commitment and devotion to patients also merit fair and equal pay.

- **Self-regulation:** Since medieval times, the medical profession has been self-regulating in order to prevent inequalities in practice, a proliferation of "quack" doctors and variable work ethics within the community. Self-regulation is one of the foundations of the medical community's excellence. Many authors state that in order to ensure the well-being of patients, doctors must remain independent but beholden to the influence of the State, as well as the institutions and organizations within which they evolve.

- **Functioning of the healthcare system:** There are many different professional groups in the healthcare system. This network of relationships requires strong links between all partners in order to guarantee integrated care and services to patients. More than ever, doctors are asked to meet this major challenge. This assumes that the medical community is invited to share its skills and points of view in order to create organizational management strategies that prioritize the patient's experience.

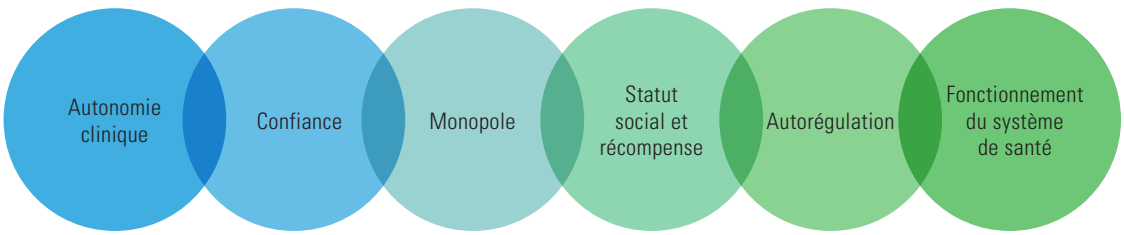
Privileges and expectations related to the practice of medicine

It is important to note that these principles are privileges, but also expected of the medical community. This is an important distinction to make. Once society recognizes these privileges, they become institutionalized and set in stone. In fact, while society still sees them as privileges, the medical community has come to expect them. Some are trying to remind the medical community that their advantages stem from privileges granted to them by society, but the medical community is claiming that they have the right to those advantages. The balance between rights and privileges is a delicate one.

PROVISION OF MEDICAL SERVICES: SOCIETY'S EXPECTATIONS

Questions about the definition of professional duties, like those surrounding the provision of medical services and the practice of medicine, are becoming more and more central in modern societies. Throughout the work on medical professionalism, we are seeing an update to society's expectations of the medical community. Because of the benefits (both financial and non-financial) that come from practicing medicine, people expect that doctors will honour their commitments. Over the past few years, the media has published many editorials showing that doctors wish to respect the terms of the social contract.

The expectations of the medical community are not defined by legal missives or official rules, but by general moral requirements. Yes, the oaths sworn upon graduation outline some of the medical community's duties to patients. But these oaths vary depending on the university or professional association.



« 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... »

Medical Education, 2009
in Cruess and Cruess

Despite the medical community's desire to appear coherent and trustworthy, there are still some disparities. However, an editorial in the journal Medical Education highlighted how important it is that recently-graduated doctors know the terms of their professional commitment. The concept of vocation seems to be obsolete. Instead, the concrete nature of professional practice dominates modern medical ideology.

Cruess and Cruess suggest that society expects seven things from the medical community. Although each of these elements are distinct, they share a common goal: promoting the medical community's engagement with and devotion to patients' well-being. These expectations, while well-intended, are demanding and sometimes contradictory. Therefore we need to examine them separately in order to understand the terms of the social contract.

- **Healer's availability:** One of society's primary expectations of medical practitioners is the **professional's availability.** Because doctors have such a critical role (as healer and professional), **availability** is seen as sacred. Doctors have many responsibilities and the right to exclusive professional acts. As a result, people need to see them for clinical procedures. The population wants appropriate, respectful, confidential, dignified care to be provided within a reasonable time frame. Certainly, many other professionals work alongside medical teams or offer related services. However, these services do not replace medical expertise. Therefore, a fundamental element of the doctor-patient relationship is the doctor's availability.

- **Advanced clinical competence:** There are two very different ways to understand the doctor-patient relationship. On one hand, **doctors may be viewed as qualified medical professionals—the only ones able to make judgements for the benefit of the patient.** On the other, doctors can be seen as healthcare professionals who provide expertise, clinical judgment and skills in order to work together with their patients. These patients may be well-informed, capable of making judgments and free to decide which services and care they receive. They are important agents who want to be fully part of the doctor-patient relationship. However, they still expect their doctor to be qualified, trained and ethically responsible enough to guide them in their decisions.

- **Altruism:** The practice of medicine is focused on one essential virtue: the best interests of the patient. Medical professionals must prove themselves worthy of the privileges and status given to them by going outside of their own best interests. Doctors must be diligent and honest enough to recognize potential conflicts of interest. If a doctor is faced with a valid moral dilemma, it is their responsibility to see to the patient's best interests and take action accordingly. Altruism must always supersede personal interests.

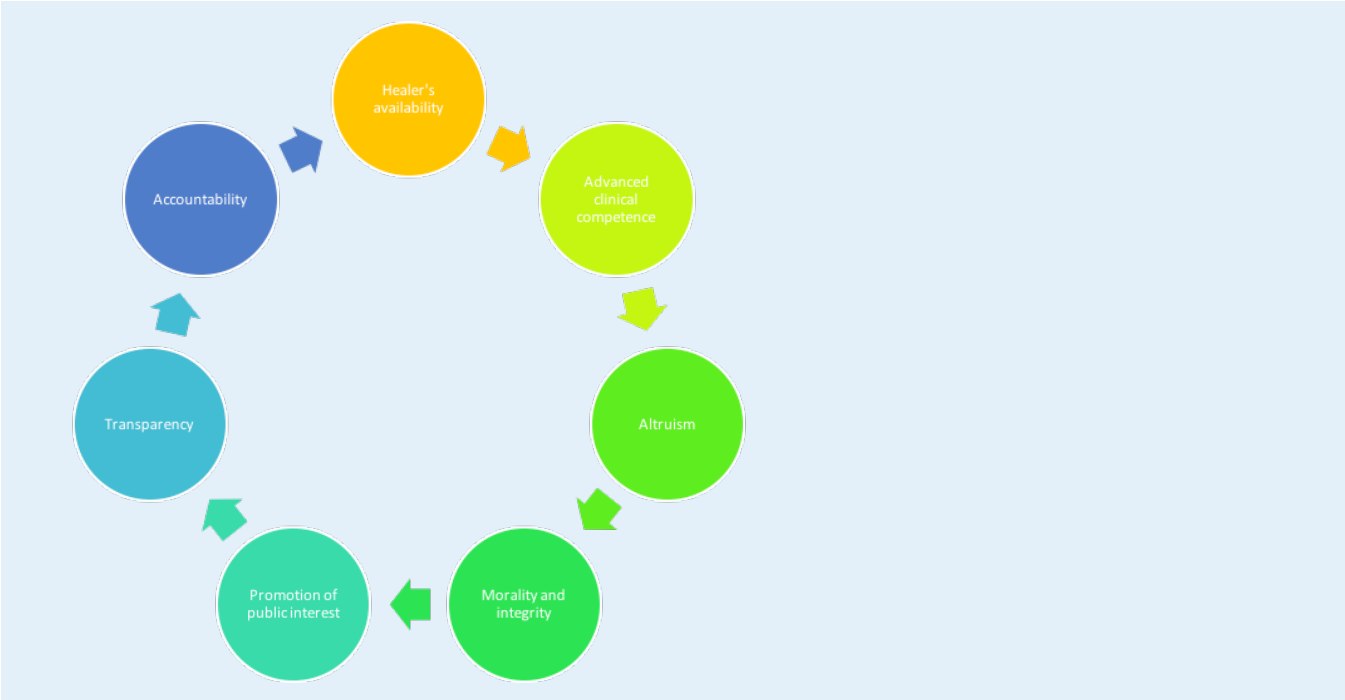
- **Morality and integrity:** The powers granted to professional groups go well beyond the practice of the profession itself. Society expects members of the medical community to set a standard for morality and integrity in all aspects of their lives. Not only are morality and integrity important while practicing medicine, they must also influence doctors' everyday lives. Doctors who violate these unspoken rules do significant harm to the entire medical community. The public's trust is a key element of the social contract. Doctors who erode that trust pose a threat to the medical profession.

- **Promoting public interest:** The practice of medicine does not only involve a privileged relationship between doctor and patient. In fact, society expects the medical community to invest in and defend the best interests of their patients. The medical community, as well as most patient rights groups, must actively participate in debates about major social issues. It must focus on something other than simply practicing medicine as it has always been practiced. Of course, this assumes that these other commitments meet the aforementioned terms of the social contract.

- **Transparency:** Before the 1960s, when the Quebec healthcare system became a national asset, the medical community was independent and free to practice as they wished. Now, doctors must be in direct contact with the medical community, the public and the State. They must ensure a reconciliation between norms and medical and social values, and see to the enforcement of rules of conduct that ensure a sort of collective legitimacy. Such an undertaking can only be successful if it is done transparently. Society no longer allows professions to isolate themselves from social life. More than ever, the medical community must be completely open in order to cooperate with society and build the foundations of medical practice. The recent public debate surrounding doctor-assisted death is an example of this paradigm shift.

- **Accountability:** The medical community may be largely independent and self-regulating, but it must still meet the public's expectations of their use of public resources in a coherent, transparent and effici ent manner. As members of society, doctors must reconcile their interests with their professional needs, taking into account the resources available and the patient's best interests. The growing tension resulting from this situation cannot be ignored. Doctors' practices must be transparent due to the nature of the healthcare system in which they operate

Recent changes to the healthcare environment have reaffirmed the link between the medical community and society. Social changes mean that doctors are depending more and more on public resources to function. They are also treating their new closeness with society as an essential ingredient of good professional practice. In addition to contributing to new synergies, these changes have improved the doctor-patient relationship and the quality of care. Essentially, society's expectations of the medical community, while demanding, clearly define the terms of the social contract.



ENVIRONMENTAL PRESSURES CHANGE THE NATURE OF THE SOCIAL CONTRACT

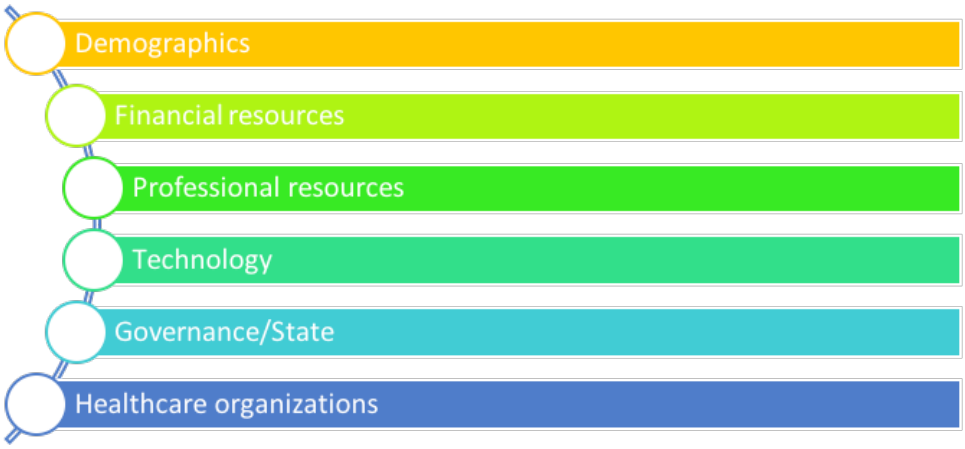
In order to understand the basis of the social contract, we need to look at the idea of negotiated order. Professionals are locked in constant negotiations with society. Despite the medical community's best efforts, its members cannot completely avoid pressure from healthcare organizations, other professional groups and the State. The social contract is therefore transforming constantly. Stability is an illusion; the social contract is never completely stable. Its construction is a continual process that involves renewal, adaptation and change.

Like the social contract, the construction of professionalism is also an ever-changing process. This means that medical professionalism varies as a result of changes to the general environment. In that sense, we can say that the social contract and the resulting professional standards are temporary because of the strong link between the development of the medical profession and the development of society as a whole.

In order to understand the transformation of medical professionalism and the social contract, we need to look closely at the changes to the healthcare environment. To this end, we cannot ignore that the Quebec population—not to mention the Canadian population as a whole—is undergoing major changes. While people are living longer, healthier lives, the demand on the healthcare system is still increasing. In addition, human and financial resources are becoming more difficult to obtain as costs continue to skyrocket. Furthermore, several cutting-edge technologies are entering the market, putting an increasing amount of pressure on the healthcare network. Finally, pathologies are evolving, forcing the medical community to adapt quickly. These changes are going to upset the delicate balance between doctors and society.

Demographics

Over the past century, Quebec's demographics have changed rapidly. One of the biggest influencing factors is undoubtedly that of the baby boomers. The postwar period resulted in a population explosion, not only



in Quebec but in all of North America. The demographic shift started in 1950. In that year alone, there were 121,842 births in Quebec (Institut de la statistique du Québec). That number represents a 4.1% increase (5018 births) over the previous year. This baby boom lasted around 15 years, during which time 2,036,635 children were born in Quebec. Compared to the previous 15 years (1935 to 1949), that's an increase of 30.48%. Now that these people are adults, they are responsible for more than 70% of Quebec's healthcare consumption. This is putting a considerable strain on the medical community.

Financial resources

In general, public hospitals in Quebec and Canada are facing a changing—and therefore uncertain—financial environment. Annual investments are not always distributed consistently. Instead, they are made on a non-recurring basis, which causes some uncertainty not only in healthcare establishments, but in the medical community as a whole. For example, the total budget for the Ministère de la Santé et des Services Sociaux was $29,341,367,000 in the 2011–12 fiscal year. In 2012-13, the budget was raised to $30,147,923,700. The recent healthcare budget cuts announced by the Liberal government indicate that total investments will be lower in 2013-14 and 2014-15.

Additionally, the increase in healthcare investments is offset somewhat by increased inflation of consumer prices. The result is a minimal net profit for healthcare organizations and the medical community. The Canadian Institute for Health Information has this to say on the matter: "After a brief dip in the mid-1990s, public sector spending per person, adjusted for inflation, rose steadily. The result was that we spent $16.3 billion "more" on health care (48% of overall growth) through the public sector in 2002 than in 1997. [...]Inflation accounted for about $8.3 billion or 25% of the growth in total spending."

Doctors are constantly aware of the problems arising from so many changes to the budget. Changes to budget allocations sometimes force the medical community to change or reorganize its clinical activities in order to adapt to budgetary constraints.

Professional resources

The healthcare system is currently experiencing changes to its pool of professional resources. Although this issue

is not exclusive to the Quebec healthcare system, it is nevertheless going to have an effect on the professional system and the social contract. In fact, as the 2012 CMA Presentation to the House of Commons Committee on Human Resources, Skills and Development and the Status of Persons with Disability: Addressing Existing Labour Shortages in High-Demand Occupations says, "Addressing health human resource shortages is critical to ensuring a sustainable, accessible and patient-centred health care system." The environment is transforming, and it is going to require a change in attitude from agents in the healthcare system. Once again, change is necessary because human resources, especially medical professionals, are indispensable to healthcare and related services.

Technology

Medicine has changed drastically over the decades. The desire to improve the quality of service, ensure that the system meets patients' needs and guarantee service to a targeted population has had a strong impact on professional practices, skills development and evolution of knowledge. In this sense, medical advances did not previously allow such a large number of patients to be saved. Research has yielded considerable progress. It is now possible to give or at least prolong life for many patients. For example, 25 years ago the survival rate for premature (26 weeks of gestation) infants was only 20%. Today, a preemie's chance of survival is around 80%.

All of these innovations—whether they be in diagnostics, telemedicine, invasive techniques or outpatient services—are completely changing the healthcare environment. The evolution of medical technologies, which increase the growth of medicine in general, is encouraging professionals to specialise and change the services they offer. The end result is a transformation of the professional environment.

Governance and the State

Since the 1970s, the Quebec government has been passing more legislation on the organization, governance and structure of the healthcare system. The State has been forced to rethink its methods because of the desire to improve the healthcare system's performance and efficiency. With this in mind, Gaétan Barrette, Minister of Health and Social Services under Premier Philippe Couillard, adopted Bill 10 in the fall of 2014. This bill decreed the creation of integrated health and social services centres (CISSS). As a result, individual health and social services agencies were closed and fused into regional establishments.

During the same timeframe, Barrette revealed an outline of Bill no. 20, the Act to enact the Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation. As the Ministry of Health and Social Services website explains, this bill aims to "optimize the use of medical and financial resources according to the population's needs and taxpayers' ability to contribute[...], to establish guidelines so that general practitioners' and specialists' time is spent wisely (in other words, doing consultations and follow-ups for patients), and better regulate professional activities." This bill is major; it will require much reflection and some major commitments. The change to patient management is more than a simple numbers game. It will regulate medical

practice, review the services offered by doctors and ultimately transform the practice of medicine.

The introduction of these laws is changing the healthcare environment. Many doctors are seeing few advantages to the proposed legislation. Instead, it is being treated as a series of additional barriers to the practice of medicine.

Over the past 15 years, many commissions and working groups have studied the problems with the Quebec healthcare and social services network. They have proposed solutions that often received a muted response from various governments over the years.

However, they have been very active when it comes to legislation, as evidenced by Hudson's census. The census inventoried all legal actions concerning medical practice from 2001 to 2008. The following table sums up this legislation.

Healthcare organisations

Healthcare organisations are very complex. This is due in part to the nature of the independent relationships between various professional groups. According to Mintzberg's theory, professional bureaucracy is developing within a dynamic healthcare system. More specifically, the system is based on premises established by the Canadian government in the 1950s and modified in 1984. They reflect the population's most profound wishes of the healthcare system. As a result, healthcare organizations must find a balance between equality, individual freedoms and efficiency. At the same time, they need to respect the five basic principles of the Canadian healthcare system: universality, comprehensiveness, accessibility, portability and public administration.

YEAR (N)	LAWS (NUMBERS AS LISTED ON ORDER PAPER)
2008 (3)	An Act to amend the Professional Code and other legislative provisions (Bill 75) An Act to amend the Act respecting health services and social services, the Health Insurance Act and the Act respecting the Régie de l'assurance maladie du Québec (Bill 70) An Act to amend the Act respecting medical laboratories, organ, tissue, gamete and embryo conservation, and the disposal of human bodies (Bill 95)
2007 (6)	An Act to repeal the Act respecting the provision of health services by medical specialists (Bill 4) An Act to amend the Act respecting prescription drug insurance (Bill 24) An Act to amend the Act respecting health services and social services for Cree Native persons (Bill 25) An Act to amend the Act respecting the Régie de l'assurance maladie du Québec and to amend other legislative provisions (Bill 26) An Act to amend the Professional Code and the Pharmacy Act (Bill 12) An Act to amend the Act respecting the Régie de l'assurance maladie du Québec, the Health Insurance Act and the Act respecting health services and social services (Bill 51)
2006 (3)	An Act respecting the provision of health services by medical specialists (Bill 37) An Act to amend the Professional Code as regards the issue of permits (Bill 14) An Act to amend the Act respecting health services and social services and other legislative provisions (Bill 33)
2005 (4)	An Act respecting the Health and Welfare Commissioner (Bill 38) An Act to amend the Act respecting health services and social services and other legislative provisions (Bill 83) An Act to amend the Act respecting prescription drug insurance and other legislative provisions (Bill 130) An Act respecting conditions of employment in the public sector (Bill 142)
2004 (1)	An Act to amend the Professional Code (Bill 41)
2003 (1)	An Act respecting local health and social services network development agencies (Bill 25)
2002 (6)	An Act to amend the Act respecting prescription drug insurance and other legislative provisions (Bill 98) An Act to amend the Professional Code and other legislative provisions as regards the health sector (Bill 90) An Act respecting pre-hospital emergency services and amending various legislative provisions (Bill 96) An Act to ensure the continued provision of emergency medical services (Bill 114) An Act to amend the Act respecting health services and social services as regards the safe provision of health services and social services (Bill 113) Loi modifiant la Loi sur les services de santé et les services sociaux concernant les activités médicales, la répartition et l'engagement des médecins (Bill 142)
2001 (4)	An Act to amend the Professional Code and other legislative provisions as regards the carrying on of professional activities within a partnership or company (Bill 169) An Act to amend the Act respecting health services and social services and other legislative provisions (Bill 28) An Act respecting the Health and Social Services Ombudsman and amending various legislative provisions (Bill 27) Public Health Act (Bill 36)

Source: Raymond Hudon, Rachel Mathieu and Élisabeth Martin. 2009. Pouvoir médical et interventions législatives au Québec, 2001-2008. Recherches Sociographiques 50 (no. 2), 255-281..

SYNTHESIS

Given the various elements (demographics, financial resources, professional resources, technology, governance and the State, and healthcare organizations) discussed in this section, we can deduce that the Quebec medical community's current environment is not very stable. Many transformations—some more prominent than others —are occurring or have occurred over the past few years. They have had a definite impact on the practice of medicine. While some changes are more predictable than others, doctors must still adapt and change their practices in reaction to their environment. All of these elements **add up to change the terms of the social contract.**

More specifically, **environmental changes, the evolution of society and the transformation of medical practice are all contributing to a breech in the social contract.** By establishing the terms of the social contract, doctors and society have agreed to respect the resulting privileges, but also the obligations. This agreement must be demonstrated on an individual (doctor-patient) and general (medical community-society) level.

Moreover, recent upheavals have changed the way the practice of medicine is perceived. On both sides, it seems that the rights and responsibilities attached to the social contract have been rethought and sometimes even arbitrarily changed. For example, the Ministère de la Santé et des Services Sociaux's Bill 20 is questioning the medical profession's privileges of self-regulation and clinical autonomy, even though the medical community has had these privileges for a long time. Furthermore, some of the obligations related to the practice of medicine have been left behind. Some doctors are turning away from their social obligations and restricting their availability to suit their own interests. Others are ignoring their obligation to remain accountable to the healthcare system. These points of contention are dividing doctors and society, leading to an erosion of the social contract. **In other words,** if the medical community or society doesn't respect the terms of the contract, it will inevitably lead to a complete breakdown of the social contract as we know it.

We need to relieve this pressure in order to ensure high-quality medical care that favours patients' well-being and respects the wishes of all involved. **The medical community, and society as a whole**, must focus on these pressure points so that they can better understand the consequences of a breech in the social contract.

POINTS OF CONTENTION: PRIVILEGES AND DUTIES BEING QUESTIONED

Society has always seen medicine as a distinct profession that is worthy of their trust because of the reputation of its teachings, its members' commitment to the population, the excellence of its practice, the strength of its professionalism and the

strong morals and ethics that have been confirmed by the community. However, several events over the past few years have shaken this confidence. Here is a summary of a few of the points of contention caused by this situation.

Accessibility

Doctors' accessibility is undoubtedly one of society's main concerns. After all, people need medical services. Researcher André-Pierre Contandriopoulos suggests that availability is a major concern for contemporary societies because of the competing need for balance, fairness, individual freedom and efficiency.

If accessibility issues persist, the State may decide to **implement mechanisms to regulate or control professional practice.** For example, over the past few years Quebec has implemented information systems like SIMASS (for surgery) and SIGDU (for emergency departments). Among other things, these systems allow the State to monitor and control professional work by setting standardized goals.

The monopoly of medical practice is also under significant pressure because some part of the population is always experiencing accessibility issues. To cope with the shortage of medical resources, strategies such as delegations of professional acts have been adopted. Essentially, society is giving itself the right to rethink and even redefine the fields of professional practice. While these strategies may be relevant, they are still resulting in the **medical community's loss of monopoly, to the benefit of other professional groups.**

Medical professionals' ability to attend to the needs of the population, along with their mastery of advanced clinical skills, guarantee them sufficient compensation and distinct social status. The lack of medical resources emphasizes the discontent of the population. In fact, society may even start questioning the medical community's privileges. People may believe that doctors have broken the contract if they keep their privileges without providing the services that society thinks are owed them. Society believes that the State must negotiate the terms of medical contracts with the unions. The resulting dynamic means that **the medical profession is "deprofessionalizing" and becoming a function of the State or a career.** As is the case in England, the medical profession appears to be losing its autonomy, monopoly and capacity for clinical governance, all for the benefit of the State.

On the other end of the spectrum, the College of Physicians and Surgeons of Manitoba sets the province's codes of ethics regarding medical availability. As a result, the practice of medicine in Manitoba comes with a legal responsibility to be available; all medical clinics must guarantee a 24/7 response, 365 days per year.

In Quebec, choices need to be made. If the medical community cannot regulate itself and find a solution to the public's need for accessibility, the State may decide to increase the number of legal or regulatory actions.

QUESTIONS TO CONSIDER

Which professional conditions will allow doctors to guarantee availability of medical services?

Which strategies can we use to maintain society's trust in the medical community while keeping the longtime privileges of reputation, autonomy and self-regulation?

Does the reality of modern medical practice require a change in the medical community's privileges?

Does the reality of modern medical practice mean that the population's expectations of the medical community must change?

Morality and integrity

Because of the privileges granted to members of the medical community, society assumes that they will demonstrate integrity and morality not only in their practice, but in their personal lives as well. However, **certain** events, such as financial compensation for services that never happened or operating rooms being used for doctors' private interests, are leading to **an erosion of society's trust in doctors.** While most doctors' practices are beyond reproach, some members of the medical community are engaging in unprofessional conduct. The behaviour of a small part of the community can lead people to doubt the selflessness of the entire profession.

In the same vein, the way the healthcare and Quebec legal systems work lead, in some ways, to a shift in the public perception of the medical community. To some, State organizations and medical colleges are protecting doctors instead of the population, especially when it comes to medical errors. The complexity of legal proceedings, long wait times and associated costs are all contributing to a loss of confidence in members of the medical profession. Even though they make up only a small percentage of cases, controversies create a lasting impression on the general public. The relationship between doctors and society is therefore becoming strained.

Even if medical professionalism is always seen as trustworthy, it remains that negative incidents can have serious consequences for the medical profession. One such consequence is that society may be more likely to invest in regulation in order to ensure that their best interests are being respected. As such, some medical colleges are introducing legislation that involves more non-professionals than doctors on their administrative councils. **Eroding confidence** is causing a significant decline in the medical community's autonomy and ability to self-regulate, to society's detriment.

For the first time in the history of the medical profession, the sovereignty of medical ethics seems to be weakening.

QUESTIONS TO CONSIDER

Morality and integrity are a large part of the medical community's reputation. What steps can we take to make sure those values are respected?

Are society's expectations of the medical community realistic? Can they be reconsidered?

Does a doctor, as a professional, have a responsibility to society?

Duties and responsibilities

Historically, the medical community has been fully involved in clinical governance. Over the years, interests have evolved and doctors have turned away from managing healthcare organizations. Although there have been numerous efforts to maintain or reassert strong medical leadership in healthcare organizations, actual management (sometimes even in clinical settings) has become the responsibility of managers.

As a result, recent reforms to the healthcare network (especially Bill 20) are aiming to maintain the population's access to healthcare services. However, in the name of user satisfaction legislators are introducing provisions that guide the medical profession and may lead to a decrease in the quality of care.

Reformists, inspired by practices in the private sector, are attempting to measure, standardize and optimize performance in medical practice. To do so, they are rethinking and renewing regulatory mechanisms. Traditional accountability models no longer appear to guarantee the profession's excellence. In sum, the control exercised by peers—a form of control that was legitimized by the knowledge, standards of practice, moral values and reputation—no longer appears to be valid enough to ensure the efficiency of the medical community. Because its members are becoming less invested in clinical governance, the medical community may be contributing to the decline in its clinical autonomy and ability to self-regulate..

QUESTIONS TO CONSIDER

If applicable, what strategies can be used to reconcile the roles of professional, healer and manager?

Are the State's expectations of the medical community realistic? Can they be reconsidered?

CONCLUSION

The practice of medicine as we know it is under close scrutiny. The characteristics that make it so prestigious are being questioned by society, the State and even the medical community itself. Because of the current climate, it is a good time to start a reflection process that will cause medical professionals to reconsider what professionalism is to them. The new form of professionalism should honour the doctor's roles as healer and professional while ensuring that both of those roles are performed adequately and realistically. In doing so, they can help renegotiate or even change the terms of the social contract that link doctors to society. We need to leave the past behind in order to redefine the rights and responsibilities related to the practice of medicine and bring them more in line with the current realities of society.

The medical community has succeeded over the centuries because it has believed in the improvement and perfection of its relationships with society. The community has constantly questioned itself in order to adapt to the complexities of its environment. Nevertheless, the profession's current environment requires that all agents collaborate to renegotiate the terms of the new social contract. Drastic changes are needed to ensure the continuation and success of the doctor-society relationship. Knowing this, we need to start an in-depth process that will allow us to update this social project at the same time. In that sense, we will be moving from the status quo to a renewed situation. In fact, a paradigm shift is necessary.

Finally, redefining the social contract will require certain skills and dynamic leadership. The renewal should promote the mobilization of all agents to support important and necessary changes to the maintenance of medical excellence. The social contract should be updated to suit the conditions of the new environment while remaining somewhat flexible and adaptable. In doing so, we will need to avoid unequivocally standardizing the medical profession's practices and operating rules in order to respect the different but complementary cultures of all agents. That way we will be able to preserve medicine's undeniable contributions to society and make progress for the betterment of the profession.

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