to multiple variables, it would be difficult to separate these out. However, we think it is fair to say that changes at the curriculum level are, at the very least, not enough to make a difference, and as Dr. Sandroni implied, might be in some cases counterproductive. There probably needs to be a change in the marketplace before we will see a substantial improvement.

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**Cover Note**

**THE SOCIAL CONTRACT**

What is the “social contract” that people talk about in academic medicine institutions? The term comes up in policy discussions, debates about mission, and disputes about planning. Although it is sometimes a mere rhetorical flourish, often it clearly represents a deeply held value that influences leaders’ thinking and decisions. But what is it?

Academic medicine people in the United States use the term to signify a special arrangement between the biomedical community and society as a whole. Government, on behalf of society, gives enormous financial support to academic medicine, and in return the institutions and individuals supported by this money provide services that benefit the whole society.

Such an arrangement is comparatively new, arising only in the latter half of the 20th century. Before then, physicians and medical researchers had quite different relationships with the larger society. Specifically, physicians as healers considered it a virtue to give their services to the poor and other unfortunates. Medical researchers often felt strongly that they were working for the good of mankind. The history of medicine is replete with stories of physicians and researchers working among the sick and dying under appalling conditions during epidemics, often succumbing themselves. Likewise, the informal history has almost as its norm the physician who in all weathers left home to care for patients who would never be able to pay for their services. But physicians undertook such acts of charity from a private sense of obligation, not because they were required to. True, physicians who did more were considered more virtuous, and those who did a great deal were considered by many to be almost saintly. But those who did no charity work could still be considered good physicians and good citizens. The obligation followed from moral tenets of contemporary religion. In North America the Judeo-Christian tradition put great emphasis on charity and caring for the poor, as well as on the greater obligation of those with the most (including skills) to share. The physician and society did not have a “contract,” nor did medicine and society.

Many individual physicians and researchers are still motivated by this ethos today, feeling the same personal desire to ease suffering or aid mankind. However, they often work within institutions that are part of a general, diffuse arrangement between government and medicine. Through this arrangement, their work is done in ways that benefit society in partial repayment for government’s financial support of medical schools, teaching hospitals, and research programs.

Yet the “contract” between medicine and society is not carefully defined, nor does it spell out each party’s responsibilities. How can either side expect to get what it wants? It might be tempting to see “social contract” as only a metaphor. But it is not. Instead, it is a facet of the larger social contract within whose terms we all function. We live in a web of mutual connections that are the glue of society. We must trust that our consensus values are held and the rules we have agreed on will be followed by the other members of society. What makes an oath, a contract, or any agreement important is that we are able to trust that it holds true—trust our fellows to be truthful, just as they can trust that we will be. We must trust that most of us will adhere to our principles and meet our obligations in spirit as well as to the letter. Otherwise, we can have nothing to depend on in our dealings—no law, no enforcement can take the place of mutual obligations freely met.

In the larger social contract we must be able to trust that every day, in ordinary decisions as well as momentous ones, our fellow citizens—and our colleagues in academic medicine settings—are trying to do the right thing, and we must do the same. We must trust that over space and over time, even over generations, our decisions and actions will work together to the benefit of us all. Inherent in academic medicine’s social contract with society is the mutual trust that all are working together for the good. And we as individuals and as institutions must do the good.

—ADDEANE S. CAELLEIGH