11. Contract or Covenant?
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... While criticizing the ideal of philanthropy, I have emphasized the elements of exchange, agreement, and reciprocity that mark the professional relationship. This leaves us with the question as to whether the element of the gratuitous should be suppressed altogether in professional ethics. Does the physician merely respond to the social investment in his training, the fees paid for his services, and the terms of an agreement drawn up between himself and his patients, or does some element of the gratuitous remain?

To put this question another way: Is covenant simply another name for a contract in which two parties calculate their own best interests and agree upon some joint project in which both derive roughly equivalent benefits for goods contributed by each? If so, this essay would appear to move in the direction of those who would interpret the doctor-patient relationship as a legal agreement and who want, on the whole, to see medical ethics draw closer to medical law.

The notion of the physician as contractor has certain obvious attractions. First, it represents a deliberate break with more authoritarian models (such as priest or parent) for interpreting the role. At the heart of a contract is informed consent rather than blind trust; a contractual understanding of the therapeutic relationship encourages full respect for the dignity of the patient, who has not, because of illness, forfeited his sovereignty as a human being. The notion of a contract includes an exchange of information on the basis of which an agreement is reached and a subsequent exchange of goods (money for services); it also allows for a specification of rights, duties, conditions, and qualifications limiting the agreement. The net effect is to establish some symmetry and mutuality in the relationship between the doctor and patient.

Second, a contract provides for the legal enforcement of its terms—on both parties—and thus offers both parties some protection and recourse under the law for making the other accountable for the agreement.

Finally, a contract does not rely on the pose of philanthropy, the condescension of charity. It presupposes that people are primarily governed by self-interest. When two people enter into a contract, they do so because each sees it to his own advantage. This is true not only of private contracts but also of that primordial social contract in and through which the state came into being. So argued the theorists of the eighteenth century. The state was not established by some heroic act of sacrifice on the part of the gods or men. Rather men entered into the social contract because each found it to his individual advantage. It is better to surrender some liberty and property to the state than to suffer the evils that would beset men apart from its protection. Subsequent enthusiasts about the social instrument of contracts have tended to measure human progress by the degree to which a society is based on contracts rather than status. In the ancient world, the Romans made the most striking advances in extending the areas in which contract rather than custom determined commerce between people. In the modern world, the bourgeoisie extended the instrumentality of contracts farthest into the sphere of economics; the free churches into the arena of religion. Some educationists today have extended the device into the classroom (as students are encouraged to contract units of work for levels of grade); more recently some women's liberationists would extend it into marriage and still others would prefer to see it define the professional relationship. The movement, of the whole, has the intention of taking the authority, legalizing relationships, activating self-interest, and encouraging collaboration.

In my judgment, some of these aims of the contractualists are desirable, but it would be unfortunate if professional ethics were reduced to a commercial contract. First, the notion of contract suppresses the element of gift in human relationships. Earlier I urged on denying the importance of this ingredient in professional relations, when I criticized the medical profession for its concept of philanthropy, for its self-interpretation as the great giver. In fact, this earlier criticism was not an objection to the notion of gift but to the moral pretension of a professional whenever it pretends to be the exclusive giver. Factually, the professional is also the beneficiary of gifts received. It is unbecoming to adopt the pose of spontaneous generosity when the profession has received so much from the community and from patients, past and present.

But the contractualist approach to professional behavior falls into the opposite error of minimalism. It reduces everything to tit for tat. Do no more for your patients than what the contract calls for. Perform specified services for certain fees and no more. The commercial contract is a fitting instrument in the purchase of an appliance, a house, or certain services that can be specified fully in advance of delivery. The existence of a legally enforceable agreement in professional transactions may also be useful to protect the patient or client against the physician or lawyer whose services fall below a minimal standard. But it would be wrong to reduce professional obligation to the specifics of a contract alone.

Professional services in the so-called helping professions are directed to subjects whose needs are in the nature of the case rather unpredictable. The professional deals with the sickness, ills, crimes, needs, and tragedies of humankind. These needs cannot be exhaustively specified in advance for each patient or client. The professions therefore must be ready to cope with the contingent, the unexpected. Calls upon services may be required that exceed those anticipated in a contract or for which compensation may be available in a given case. These services moreover are more likely to be effective in achieving the desired therapeutic result if they are delivered in the context of a fiduciary relationship that the patient or client can really trust.

Contract and covenant, materially considered, seem like first cousins; they both include an exchange and an agreement between parties. But in spirit, contract and covenant are quite different. Contracts are external; covenants are internal to the parties involved. Contracts are signed to be expeditiously discharged. Covenants have a gratuitous, growing edge to them that spring from ontological change and are directed to the upbuilding of relationships.

There is a donative element in the upbuilding of covenant—whether it is the covenant of marriage, friendship, or professional relationship. Tift for tat characterizes a commercial transaction, but it does not exhaustively define the vitality of that relationship in which one must serve and draw upon the deeper reserves of another.

This donative element is important not only in the doctor's care of the patient but in other aspects of health care. In a fascinating study of The Gift
Relationship, the late economist, Richard M. Titmuss, compares the British system of obtaining blood by donations with the American partial reliance on the commercial purchase and sale of blood, without the exploitation of the indigent, which the American system has sanctioned and which our courts have encouraged when they refused to exempt non-profit blood banks from the antitrust laws. By court definition, blood exchange becomes a commercial transaction in the United States. Titmuss expanded his theme from human blood to social policy by offering a sober criticism of the increased commercialism of American medicine and society at large. Recent court decisions have tended to shift more and more of what had previously been considered as services into the category of commodity transactions with negative consequences he believes for the health of health delivery systems. Hans Jonas has had to reckon with the importance of voluntary sacrifice to the social order in a somewhat comparable essay on Human Experimentation. Others have done so on the subject of organ transplants.

The kind of minimalism that a contractualist understanding of the professional relationship encourages produces a professional too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with his patients along the road of their distress.

Contract medicine encourages not only minimalism, it also provokes a peculiar kind of maximalism, the name for which is "defensive medicine." Especially under the pressure of malpractice suits, doctors are tempted to order too many examinations and procedures for self-protection. Paradoxically, contractualism simultaneously tempers the doctor to do too little and too much for the patient—too little in that one extends oneself only to the limits of what is specified in the contract, yet, at the same time, too much in that one orders procedures useful in protecting oneself as the contractor even though not fully indicated by the condition of the patient. The link between these apparently contradictory strategies of too little and too much is the emphasis in contractual decisions on self-interest.

Three concluding objections to contractualism can be stated summarily. Parties to a contract are better able to protect their self-interest to the degree that they are informed about the goods bought and sold. Insofar as contract medicine encourages increased knowledge on the part of the patient, well and good. Nevertheless the physician's knowledge so exceeds that of his patient that the patient's knowledgeability alone is not a satisfactory constraint on the physician's behavior. One must at least, in part, depend upon some internal fiduciary checks which the professional (and his guild) accept.

Another self-regulating mechanism in the traditional contractual relationship is the consumer's freedom to shop and choose among various vendors of services. Certainly this freedom of choice needs to be expanded for the patient by an increase in the number of physicians and paramedical personnel. However, the crisis circumstances under which medical services are often needed and delivered does not always provide the consumer with the kind of leisure or calm required for discretionary judgment. Thus normal marketplace controls cannot be relied upon fully to protect the consumer in dealings with the physician.

For a final reason, medical ethics should not be reduced to the contractual relationship alone. Normally conceived, ethics establishes certain rights and duties that transcend the particulars of a given agreement. The justice of any specific contract may then be measured by these standards. If, however, such rights and duties adhere only to the contract, then a patient might legitimately be persuaded to waive his rights. The contract would solely determine what is required and permissible. An ethical principle should not be waivable (except to give way to a higher ethical principle). Professional ethics should not be so defined as to permit a physician to persuade a patient to waive rights that transcend the particulars of their agreement.

The Donative mode seems to provide for a more satisfactory analysis than the philanthropic or the contractual, but it shares their flaws. Analysis based on Donative elements suggests that the professional fulfills his contract, lives up to his specified technical code, and then, gratuitously, throws in something extra to sweeten the pot. All of these tools of analysis allow the analyst to evade the uncomfortable and demanding ontological implications of profession as transformation. A profession of a mystery, in theological terms changes one from damned to saved; in professional terms, from a man who studies medicine, to a man who at all times embodies the virtues of a good doctor. A profession is characterized by what one eats to heal, drives to heal, reads to heal, comforts to heal, rebukes to heal, and rests to heal. The transformation is radical, and total. The Hippocratic Oath, under this ontological aspect, can be summarized: aut medicus aut nihil: from this moment, I am a healer or I am (literally) nothing. He takes his identity from that which he professes, and that which he professes, to which he is covenanted, whose code he will embody, transcends him and transcends his colleagues.

Two characteristics of covenantal ethics have been developed in the course of contrasting it with the ideal of philanthropy and the legal instrument of contracts. As opposed to the ideal of philanthropy that pretends to wholly gratuitous altruism, covenantal ethics places the service of the professional within the full context of goods, gifts, and services received; thus covenantal ethics is responsible. As opposed to the instrument of contract that presupposes agreement reached on the basis of self-interest, covenantal ethics may require one to be available to the covenant partner above and beyond the measure of self-interest; thus covenantal ethics has an element of the gratuitous in it.

Covenant ethics shies back from the idealist assumption that professional action is and ought to be wholly gratuitous and from the contractualist assumption that it be carefully governed by quotidian self-interest in every exchange.

A transcendent reference may also be important in laying out not only the proper context in which human service takes place but also the specific standards by which it is measured. Earlier we noted some dangers in reducing rights and duties to the terms of a particular contract. We observed the need for a transcendent norm by which contracts are measured (and limited). By the same token, rights and duties cannot be wholly derived from the particulars of a given covenant. What limits ought to be placed on the demands of an excessively dependent patient? At what point does the keeping of one covenant do an injustice to obligations entailed in others? These are questions that warn against a covenantal ethics that sentimentalizes any and all involvements, without reference to a transcendent by which they are both justified and measured.

FURTHER REFLECTIONS ON COVENANT

So far we have discussed those features of a covenant that affect the doctor's conduct toward his patient. The concept of covenant has further consequences for the patient's understanding of his role as patient, for the accountability of health institutions, for the placement of priorities within other national commitments, and, finally, for such collateral problems as truth telling.

Every model for the doctor-patient relationship establishes not only a certain image of the doctor, but also a specific concept of the patient. The image of the doctor as priest or parent encourages dependency in the patient. The image of the doctor as skillful technician encourages the patient to think
of himself as passive host to a disease. The doctor and his technical procedures are the only serious agent in the relationship. The image of the doctor as covenanter or contractor bids the patient to become a more active participant both in the prevention and the healing of disease. He must bring a will-to-live and a will-to-health to the partnership.

Differing views of disease are involved in these differing patterns of relationship to the doctor. Disease today is usually interpreted by the layman as an extraordinary state, discrete and episodic, disjunctive from the ordinary condition of health. Illness is a special time when the doctor is in charge and the layman renounces authority over his life. This view, while psychologically understandable, ignores the buildup, during apparent periods of health, of those pathological conditions that invite the dramatic breakdown when the doctor "takes over."

The cardiovascular accident is a case in point. Horacio Fábrega has urged an interpretation of disease and health that respects more fully the procreative rather than the episodic character of both disease and health. This interpretation, I assume, would encourage the doctor to monitor more continuously health and disease than ordinarily occurs today, to share with the patient more fully the information so obtained, and to engage the layperson in a more active collaboration with the doctor in health maintenance.

The concept of covenant has two further advantages for defining the professional relationship not enjoyed by models such as parent, friend, or technician. First, covenant is not so restrictively personal a term as parent or friend. It reminds the professional community that it is not good enough for the individual doctor to be a good friend or parent to the patient, it is important also that whole institutions—the hospital, the clinic, the professional group—keep covenant with those who seek their assistance and sanctuary. Thus the concept permits a certain broadening of accountability beyond personal agency.

At the same time, however, the notion of the covenant also permits one to set professional responsibility for this one human good (health) within social limits. The professional covenant concerning health should be situated within a larger set of covenant obligations that both the doctor and patient have to other institutions and priorities within the society at large. The traditional models for the doctor-patient relationship (parent, friend) tend to establish an exclusivity of relationship that obscures these larger responsibilities. At a time when health needs command $120 billion out of the national budget, one must think about the place that the obligation to the limited human good of health has among a whole range of social and personal goods for which men are compacted together as a society.

NOTES

2. [Richard M. Tilmuss, The Gift Relationship (New York: Pantheon, 1970)] Tilmuss does not acknowledge that physicians in the United States have helped prepare for this commercialization of medicine by their substantial fees for services (as opposed to salaried professors in the teaching field or salaried health professionals in other countries).