

The compact we **never renegotiated**



John M. Hwang, MD, FRCSC

The relationship between physicians and the institutions they serve has long been understood as a compact: an exchange of expectations and obligations. These compacts are rarely written down but strongly felt. This concept has deep roots in the organizational behaviour literature on psychological contracts and has been applied specifically to medicine by several authors. Empirical work shows that breaches of this contract measurably affect physician satisfaction and well-being. This viewpoint argues that the traditional, largely implicit physician compact was built for conditions that no longer fully hold. Further, the practice of medicine is demanding and, by most accounts, becoming more so, while the practice of physician leadership specifically is becoming increasingly critical to navigating that difficulty. For physician leadership to be sustained, both physicians and the institutions they serve need to regard it as worth the investment it requires. If the investment on both sides is worthwhile then a subsequent question should be what would make physician leadership sustainable, meaningful, and effective? Drawing on the wider compact literature, this piece argues that an explicit compact, built through genuine dialogue rather than declared unilaterally, is a necessary but insufficient step, and that the real work lies in naming, concretely, what sustains physician leadership over time.

KEY WORDS: physician leadership, psychological contract, organizational compact, physician well-being, leadership development



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The relationship between physicians and the institutions they work within has long been described, informally, as a compact: a set of mutual expectations and obligations that shapes behaviour often without ever being fully written down. The concept has a well-established academic lineage. Organizational scholars have studied what is often called the psychological contract for decades, describing it as the implicit beliefs held by both parties to an employment relationship about what each owes the other.¹ Several authors have applied this idea to medicine, and empirical work on doctors themselves has found that breaches of this contract, particularly around training, career development, and organizational support, are measurably associated with lower job satisfaction and well-being.² The compact, in other words, is not merely a useful metaphor. It has real, documented consequences when it is not honoured.

Physicians from earlier generations, myself among them, often inherited a version of this compact without ever negotiating it directly. Loss of personal time and autonomy, submission to regulation, the weight of fiduciary duties intrinsic to the practice of medicine, and the emotional vulnerability of practice were exchanged for public trust and high standing, meaningful and sustainable work, and autonomy over our work environments. For many of us, that trade has felt worth it. But an inherited compact of this kind depends on conditions holding roughly steady across generations, and there is good reason to doubt that they still do.

A compact built for different conditions

The practice of medicine itself has become more demanding, and most available evidence suggests that this trend is continuing rather than leveling off. Administrative burden, workforce pressures, and the sheer complexity of modern health care systems have all intensified in ways that earlier generations of physicians did not face to the same degree. A compact built for a less complicated set of conditions cannot simply be extended to a harder one by assumption. If the terms of the original exchange assumed a certain baseline of manageability in clinical practice and that baseline has shifted, the compact needs to be renegotiated rather than quietly stretched to cover conditions for which it was never designed.



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At the same time, the practice of physician leadership has become more critical to navigating this complexity, as health systems increasingly require functions that are difficult for anyone but a physician to perform well: mobilizing peers around difficult change, distinguishing a technical fix from a deeper adaptive problem, and carrying clinical judgement into administrative and political rooms where it does not otherwise travel. Yet the health systems that depend on this kind of leadership often seem to be ill-equipped to develop and sustain it reliably. This raises the stakes of the compact considerably. It is no longer enough for physicians and institutions to share an implicit understanding about clinical practice in general. The compact needs to speak directly to physician leadership as its own distinct domain, with its own demands and its own requirements for support.

What would make leadership sustainable?

This leads to the central question this piece is trying to raise. Both physicians and the institutions asking them to lead need to regard physician leadership as worth the investment it requires rather than assume that is still the case. If worth the investment, then what makes the practice of physician leadership sustainable, meaningful, and effective over time? These are three separable questions, worth naming individually rather than folding into a single vague commitment to support. Sustainability concerns whether physician leaders can continue this work over a career without burning out or being quietly replaced by attrition. Meaning concerns whether the work itself remains connected to why physicians took it on in the first place, rather than being reduced to administrative process. Effectiveness concerns whether the leadership physicians provide is equipped, through training and support, to produce the outcomes it is meant to produce.

Building the compact well

The wider literature on organizational compacts, including work addressed specifically to medicine, converges on a crucial point: the document that eventually describes a compact matters far less than the process that produces it. Jack Silversin and Mary Jane Kornacki, whose account of physician–organization compacts remains among the more practically useful in this space, argue that a compact drafted centrally and handed to physicians for endorsement is not a genuine compact at all, regardless of what the document says.³ What matters is sustained dialogue, patience, and institutional leadership demonstrating that it is not exempt from the

trade it is asking physicians to make. That is, the process of coming to a compact is as important, if not more important, than what is in the compact itself. Indeed, a compact-building process conducted this way is, in a sense, itself an exercise in the same adaptive leadership that physician leaders are often asked to practise elsewhere: bringing people with different values and interests into sustained dialogue rather than imposing a solution from either side.⁴

There is a legitimate objection to formalizing something that has functioned, however imperfectly, as an implicit understanding. Writing a compact down risks reducing a relationship built on judgement and context into a checklist, inviting disputes over compliance rather than the kind of genuine partnership an unwritten understanding can sometimes sustain. This concern deserves to be taken seriously rather than dismissed, and it is likely correct wherever an institution treats the writing of a compact as a substitute for the dialogue that should produce it. But it is not an argument against an explicit compact that is built well. A written compact that emerges from genuine engagement with physicians is evidence that the underlying trust was strong enough to survive being articulated, not proof that the trust has been replaced by paperwork.

A different objection is that this is fundamentally a training problem rather than a compact problem: physicians have simply not been taught to lead, and if health care systems built the right infrastructure, physician leadership would follow without needing anything as abstract as a renegotiated compact. This objection is not wrong, and building that infrastructure is necessary work in its own right. But infrastructure alone does not explain why capable, well-trained physician leaders step back from leadership roles or why physicians who could lead choose not to. Training can teach someone how to lead well; it cannot, by itself, convince them that leading is worth what it costs. That judgement depends on whether the exchange behind the training, what is given up and what is received in return, still holds. Training answers whether physicians can lead. The compact answers whether they will keep doing it.

This work does not need to start from nothing, and it can happen at more than one level: between a ministry of health and a provincial medical association, between a health authority and its medical staff association, or between an individual hospital and its physician staff collectively. Canadian precedent already exists at the hospital level. The Ottawa Hospital, working



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with front-line physicians and physician leaders, developed a Physician Engagement Agreement defining the mutual principles, interactions, and expectations of the hospital and its medical staff, now built into the privileging process itself.⁵ It does not resolve every tension raised here, but it demonstrates that an explicit, negotiated compact is achievable in a Canadian setting, not merely a theoretical prescription borrowed from elsewhere.

Limitations

This viewpoint draws on a selective, narrative review of the compact and psychological contract literature rather than a systematic one, and pertinent work, including material outside the English-language and North American literature, may not be represented here. The Ottawa Hospital's Physician Engagement Agreement is offered as a single Canadian precedent rather than a representative or exhaustive survey of comparable efforts, and its outcomes have not, to this author's knowledge, been independently evaluated in the published literature. Finally, the argument here is conceptual, built from established theory and secondary sources, rather than from new empirical data on how physicians or institutions currently perceive the compact between them. Generating that primary evidence, ideally through direct engagement with physicians and institutional leaders, is a natural next step for this line of work rather than something this piece attempts to supply.

Conclusion

The question of whether physician leadership has been worth it for any individual physician will always be answered privately. But whether it remains worth it for the profession and the institutions that depend on it, as medicine grows more demanding and physician leadership grows more necessary, is not a private question and cannot be answered by assuming that an inherited, unwritten compact will simply continue to hold. What is required, from both sides, is a genuine accounting of what would make physician leadership sustainable enough to last a career, meaningful enough to be worth choosing, and effective enough to justify the investment institutions are asked to make in it. That accounting has not

been done with much rigour so far. It is worth doing properly now, before the next generation of physician leaders must decide, largely on inherited faith, whether to accept terms nobody actually renegotiated.

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Author

John M. Hwang, MD, FRCSC, is chair of the Board of Directors at Doctors of BC. He also holds leadership roles in the Fraser Health Authority, including regional medical director of Home Care and Home Support and co-chair of the Health Authority Medical Advisory Committee Quality Subcommittee.

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Correspondence to:

john.hwang@fraserhealth.ca

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