



UK Health Alliance on Climate Change

Cite this as: *BMJ* 2022;377:e01415<http://dx.doi.org/10.1136/bmj.o1415>

Published: 07 June 2022

Death and the bogus contract between doctors and patients

Richard Smith *chair*

Perhaps medicine is best understood when it confronts death. “That distinguished thing,” as Henry James called it, highlights misunderstandings, confusions, and contradictions.

Until the 16th century it was not an aim of doctors to try and hold back death. God, in all his and her various manifestations, decided when people should die. It was not for doctors to get in the way of death. Indeed, to try and do so would be to insult God.

The Renaissance philosopher and scientist Francis Bacon (1561-1626) was the first to argue that it should be one of the tasks of doctors to battle with death. But it was not until the middle of the 20th century that medicine developed effective means to delay death. Since then, medical research has been much more concerned with diseases like cancer and cardiovascular disease that are major causes of death than with conditions like depression and musculoskeletal and skin diseases more associated with suffering than death. (I remember hearing an American psychiatrist argue that psychiatry made a strategic mistake in not emphasising more that severe mental health problems are an important cause of premature death.)

Death attracts more research funding than suffering. Ironically, the medical specialty most associated with death, palliative care, attracts only paltry research funding because it is concerned with accepting death not defeating it. Is medical research out to defeat death? Certainly, large sums are being invested in dramatically extending life if not in defeating death altogether. Much of this investment is on the West Coast of the US where all of life's problems, including death, are seen as soluble with enough money and genius. Conventional medical research is not aiming explicitly at defeating death, but implicitly it seems to be: it is aiming at curing all diseases.

Medicine's implicit mission to defeat death provides the context when a doctor meets a patient with a life-threatening disease. This is when the bogus contract between doctors and patients may be at its most pernicious. I've written several times about the bogus contract, and at its heart is patients thinking doctors to have greater powers than they actually possess and doctors being painfully aware of the limitations of their craft but being reluctant to be fully open about those limitations.¹ For patients it's wonderful to believe that doctors can fix most of their ills. For doctors the gap between what patients wish they could do and what they can do is uncomfortable, but doctors may worry that a full confession may limit their therapeutic power and perhaps their status and income. The media contribute to the bogus contract in that they prefer tales of what look like medical miracles to medical disasters.

When patients with life-threatening illnesses consult doctors, they hope, or may even believe, that the doctors will be able to hold off, or defeat death. The doctors make their assessment and let us suppose for this discussion that they think that there is a 10% chance that they can keep the patients alive for five years. The doctors know that the patients will suffer great discomfort during the treatment and have a 90% chance of dying within a few years or even months.

What should the doctors say? To the rational person, perhaps an economist, it seems simple: the doctors should present all the options with as much information as possible. If a patient says, “You do what you think best, doc,” the doctor should say, “I can't do that. This is your life. You are a unique individual you must decide, probably after talking to family and friends.”

Such conversations are rare. These are emotionally-charged encounters with death watching both patients and doctors. Patients want to hear that doctors can cure them, quickly and with minimal pain and discomfort. The doctors know what the patients want to hear, but will know that cure is highly unlikely, probably impossible, and that the treatment will be prolonged and involve much discomfort. The doctors wish that they could do more and may be attracted by new treatments of uncertain benefit.

The conversation that needs to happen has been called “the difficult conversation,” although others prefer “the anticipatory or essential conversation.” We know that it often doesn't happen, and the *Lancet Commission on the Value of Death* (which I cochaired) lists many reasons why the conversations don't take place: busy clinics; fear of extinguishing hope or creating despair; difficulties finding the right language; the fix-it, protocol-driven culture of much of medicine; lack of clarity about whose job it is to start and hold the conversation; and perhaps even cowardice.²

It is easier for both doctors and patients to launch into a conversation about the treatments available and how they will be given and then begin the treatment. One result is that patients can be days or even hours from death without either the patients or their families aware that the patients are about to die. Another possibility is that the palliative care team is asked to come and hold the conversation that should have taken place weeks or month before.

The bogus contract where patients believe that doctors can do more than they can and doctors go along with the belief is highly—attractive to both patients and doctors. But ultimately it causes excess suffering for patients and infantilises them, while doctors are left with the

discomfort of being evasive, dishonest, or cowardly. The bogus contract also explains why, as the Lancet Commission found, 10% of annual health expenditure is spent on the 1% who die in that year.²

It takes courage from both patients and doctors to move beyond the bogus contract in all of healthcare, but especially when death is close, but everybody—patients, doctors, other health professionals, citizens, and taxpayers—stand to benefit.

Competing interest: RS was a cochair of the *Lancet Commission on the Value of Death*, which argued for the demedicalisation of death and it becoming much more a partnership among patients, families, communities, and health professionals with health professionals as supporters rather than leaders.

Provenance and peer reviewed: not commissioned, not peer reviewed.

- 1 Smith R. Why are doctors so unhappy? There are probably many causes, some of them deep. *BMJ* 2001;322:1073-4. doi: 10.1136/bmj.322.7294.1073, pmid: 11337419
- 2 Sallnow L, Smith R, Ahmedzai SH, et al. Lancet Commission on the Value of Death. Report of the Lancet Commission on the Value of Death: bringing death back into life. *Lancet* 2022;399:837-84. doi: 10.1016/S0140-6736(21)02314-X, pmid: 35114146