What's Wrong With Our Social Contract?

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LIVE WELL. DIE WELL. GRIEVE WELL.

The old contract

We Americans seem to have an unspoken social contract with our healthcare institutions. It goes something like this:

> *I'll live as I like, and I expect you to take care of me, doing all you can to keep me alive.*

We can see the evidence of this contract in behaviors on both sides of the agreement. It is rare, in general, for people to take personal responsibility for their health. As we have moved from an active agrarian society to a sedentary information age, weight has become an issue for more than a third of us, including children, bringing with it greater incidences of heart disease, diabetes, troubled hips and knees, and other chronic conditions.

The irony is that health problems are good for the healthcare business, especially in procedure-driven economic models. With the rapid expansion of technological possibilities medicine has produced in the past few decades, there is always more that CAN be done to keep us alive.

Functional, but flawed

This social contract has been functional in many ways. It has resulted in dramatically extending our life expectancy throughout the last century, and new medical developments continue to give us hope for further extensions in the current century. The healthcare industry has become one of the most resilient and lucrative job markets in America, even as manufacturing and other jobs have gone overseas. Healthcare buyers love to complain about costs rising faster than general inflation for the past four decades, but for the most part, we like our social contract.

But this contract is heading for disaster.

The dysfunctional qualities of our current social contract become glaringly obvious when we focus on end-of-life care. We may have the technology and therapies to live longer, but without making intentional decisions about how we should access and use our healthcare system, we're likely to live longer *with costly chronic diseases*. The probability of death from cancer reaches its peak in

Quality of life AND cost

our mid-sixties. Heart disease claims most of its victims by their mid-seventies. If we live into our eighties and beyond, there is a high likelihood that we'll be frail, and about a 50/50 chance that we'll suffer some form of cognitive impairment like dementia, with all its painful social and financial burdens. It's a daunting scenario.

As we approach the end of life, the cost of care often goes up dramatically. Pacemakers, chemotherapy, invasive surgeries, and dialysis consume extraordinary resources, but do they actually extend life in ways that you would consider worth living? Medicare spends about 32% of its total budget caring for people in the last two years of their lives (Dartmouth Atlas of Health Care). We're quick to devote resources to extend our days, but often at the significant deterioration of the quality of the time we have left. Death is still a 100% probability. Only the timing seems negotiable, and quality of life, to a large extent, is in fact within our control.

Better options

That's why we need a new social contract, maybe something like this:

> *I'll be responsible for my choices, even at the end of life. I ask that you honor them, even if it means that I choose medical interventions short of what may be technically possible.*

This may be a radical departure from current norms, but let's examine the implications and consequences before dismissing it prematurely.

- It changes the doctor-patient relationship immediately. Patients will look to doctors for coaching rather than decision-making. When they're healthy, they need to learn how to stay that way. When they're sick, they need to learn enough about their disease and their options to make informed choices. The weight of the decision – and all its consequences – becomes the responsibility of the patient rather than the doctor. Patients, not doctors, will choose how they will live, and how they will die.

- When facing end-of-life issues, physicians and patients can focus on the quality of life rather than negotiating for one more month, or week, or day that may include enhanced suffering, produced only as a result of those choices.

- It conserves resources that might otherwise go toward futile interventions, which could have positive results for patients

and their families, but negative financial implications for healthcare institutions.

Facing the barriers

Moving toward this new social contract will be daunting in its own way. It requires us to face our mortality and come to grips with it. It invites us to grieve in anticipation of the inevitable, to plan for uncomfortable scenarios so as to avoid shocking crises, and to engage our loving families in conversations about end-of-life issues.

It also invites challenges from the special interest groups that seek to preserve the status quo. The proponents of extensive medical interventions will not accept this lightly, and their voices will be commanding. Expect to hear about advocacy for “standards of care” and “quality of care,” which is not necessarily the same as “quality of life.” This new social contract could put some people out of business. They’re not going to go without a fight.

Is it worth it? I think so. As I talk about these issues with people around the world, I find that it resonates deeply with most people. None of us wants to outlive our vitality or our resources. We want to live well, and then when death comes, to die well. Living well and dying well may require us to learn also how to grieve well, for then we can renegotiate our contract with death itself. We can let it come in its own time.

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