READINESS FOR DEATH: SYBIL SPEAKS

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While life has been increasing in length an increasing proportion of that life is in a state of poor health and decrepitude. Indeed, an increasing proportion of life is in that poor state because of its increased length. Medicine always fails to catch up, and increasingly so in providing a life of good health overall set by the end point of inevitable death. This requires a change in attitude from the zealous concentration on medical interventions whose chief aim is to increase the length of life, and a move to being able to consider more readily refusing some medical treatments, along with a more resigned attitude to our death, which must come anyway.

He who would teach men to die would teach them how to live.

> Montaigne, 'That to Philosophize is to Learn How to Die'

That he would be glad to find a hole to creep out of the world at.

Thomas Hobbes

1

Sybil of Cumae appears as an epigram to T. S. Eliot, *The Wasteland.* Sibyl of Cumae was a prophetess (who failed to see her own doom coming) in service to Apollo and a great beauty. Apollo wished to take her as his lover and offered her anything she desired. She asked to live for

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as many years as there were grains in a handful of dust she held. Apollo granted her wish, but still she refused to become his lover. Although she was mortal Sibyl lived for a thousand years. In time, Sibyl came to regret her wish as she grew old but did not die. Apollo had granted her long life but not eternal youth. Each year she becomes smaller and frailer. A mere tourist attraction, kept in an ampule – tiny, ancient, confined, with only her voice left, and longing to die.

This article is not about the well-trodden debate about life having meaning and value being dependent on mortality and the corresponding utterly debilitating effect on our lives having meaning that would result from immortality. That may or may not be so, but it is irrelevant here and not the subject. What this article is about is longevity running ahead of a life worth living.

It will be argued that there is a need for a change of culture, a philosophical change, in our attitude to death, to our own death in particular, so that it applies to each individual. It is perhaps a return to a previous cultural attitude. Perhaps a more resigned and accepting attitude rather than a coy turning away from the inevitable. That it is such a return, if it is, is a mere fact with no normative implications taken alone. However, it does make it more likely, justified or not, that such a cultural change if it was once something people found possible could again be something that might come about and not something that would fight futilely against an ineluctable feature of human nature. When one hears that a 'cultural change' is 'needed' and it is clearly something that is an entrenched feature of human nature, you can only admire the idealistic hubris. But I think this is not the case with what I'm normatively suggesting here. Of course not everyone will wish to make such a change, nor indeed find it possible, even if they think it normatively justifiable, for themselves or those closest to them. But there is no implication in what follows that anyone will be forced to adopt a new attitude towards death. Rather the shift in cultural background in respect of death will have a tendency

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to make the attitude something thinkable and adoptable by those who feel able and are willing to be drawn to it.

There is an overall cultural background issue here, whereby some doctors have a tendency to ignore Hume's dictum that you cannot get an 'ought' from an 'is'. Very swiftly on the basis presumably of assumed, unquestioned, and perhaps thought to be unquestionable (or that no-one would surely want to question) assumptions, prescription, proscription and treatment proceed directly from diagnosis, without considering that the move from medical facts to what someone ought therefore to do is essentially conditional and normative. As with other aspects of one's life such normative matters – how one wants to live one's life – are in liberal societies normally, and should be, regarded as a private matter for individual decision. The tendency of medical treatment is to suppose that this is not so, and that it is obvious what anyone would want to do given the medical facts. But this imposes a forceful hegemony of values on individuals that they may therefore find difficult to question, even though they would like to and then choose more freely from a range of possible actions driven by their own normative evaluations. There might be some warrant for this if medical practitioners were somehow more expert or sophisticated than most people in normative evaluative matters concerning the choices we might make about how to live, given whatever the facts are. But clearly there is no reason to suppose that they are. Indeed, the very notion of an expert in this matter at all is justifiably regarded as dubious, which is part of the reason liberal thinkers argue that normative pluralism should, within certain constraints of avoiding mutual harm, be maximized.

As a footnote it is worth mentioning this. It is indicative of the sloppy thinking here that we often hear medical practitioners talking of steps that would 'avoid a premature death'. This presumptively elides the factual and the evaluative. So, if one thinks about it, it's hard to know what 'premature' means here, particularly as applied to an individual, since it is loaded with qualitative and not just quantitative

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considerations. Did Ernest Dowson, or Mozart, or Beethoven (died 57) have 'premature deaths'? Well, it depends on how you look at it.

2

Empirical evidence indicates that we are generally living longer. It is also the case that we are living during that life in proportionately ever-longer states of poor health and decrepitude (dotage or senility). The reason for this is that medical interventions, which might give us a non-decrepit life, are being outstripped and increasingly, perhaps exponentially, so by longevity, some of which is a result of those very same medical interventions. This variation on Malthusian thought is what underpins this article. The proportion of decrepit life is getting ever longer as life gets longer. We are not dying soon enough to avoid decrepitude or to experience only a short dose of it. We spend an ever-increasing period of our lives as decrepits where once we would have been dead already.[1]

'Decrepit' is defined here as a condition which typically many people would consider wretched or piteous, and such that whether, in their own person or in being considered by another, the question of whether it is worth living in such a state might naturally and properly arise, whatever answer one gives to the question. Thus 'decrepit' is not defined by reference to any particular illness (although many conditions are age related: live long enough and one will go blind and deaf, for example), but to the state of the person and will involve aspects of that state as viewed both objectively and subjectively in the way others see us and the way we see ourselves. Characteristically these states typically involve objectively extreme or to the person unacceptable levels of dependency on others, chronic pain, loss of dignity, being unable to enjoy most of the things that one once loved that may have given point and meaning to one's life, or at the very least helped one through it, and in

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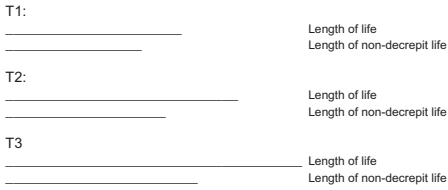
addition, mental decline and dementia, not to mention fear, pitiless anxiety, engulfing timidity, loss of dignity, feeling pathetic, depression and madness. While all the time there is the contrasting mockery facilitated by memory and other records of the person one once was compared to one's state now. The *OED* includes in its definition of decrepit 'worn out or ruined because of age'. 'Ruined' is highly apposite here. To be a ruined building is a building that is no longer fit to be a building. A ruined person is one who is no longer able to be anything like the person they once were. Complex interlocked layers of what doctors prosaically call comorbidities. People usually not working, regarded as useless, marginalized, and, most notably, if you wonder why you do not see them, invisible, unless they happen to be a friend or relative of yours.

There has been much talk in philosophy about the good life. The subject here is the *bad life*. Just as, I would argue, there is no universal prescription for the good life, there is none for the bad life either. The case of each person should be judged individually. But in each case, although there might always be consolations, they are for the decrepit typically wildly insufficient to compensate for the bad features of the life without downgrading one's aspiration grotesquely. Arguably no death qua death is good, especially one's own, and so cannot be better or worse – it simply is. But this should not be confused with the how and when of its not being something worth considering as being better or worse.

William Shakespeare ends 'All the world's a stage' with seven ages of man:

> Last scene of all,
> That ends this strange eventful history,
> Is second childishness and mere oblivion,
> Sans teeth, sans eyes, sans taste, sans everything.
>
> *As You Like It*, Act II Scene VII

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The gap between the onset of decrepitude, the serious loss of quality of life, and death is ever widening as time goes by. Arguably length of life facilitation will always outrun the cures to decrepitude. If it does, there is something that needs dealing with in how we approach the latter years of our lives. Yet it is the case that the push from both the providers of medical intervention, prevention, and treatment and the receivers of them, except *in extremis*, is that you cannot have too much medical intervention, prevention, and treatment. Conditions need always if possible to be dealt with and if possible cured. Prevention extended to the point of the unreasonable and unrealistic. This, however, not only exacerbates the state already described of more older and yet older people, but more and yet more of them in terrible states with incredibly poor qualities of life. Expectations for treatment and its effectiveness go ever upwards as indicated both by the resources put into medical research and by the demands of patients who receive it. Yet the unintended consequence of this is a reduction in the quality of their lives in older age, perhaps if bad enough a reduction in the quality of their life overall summated (although that would be contentious) simply because of still being alive.

Looked at like this, medicine, although it can improve people's lives temporarily and even substantially, is a matter of the finite postponement of death; that is, until one gets something they can't treat. Sometimes you get the impression that if only you do what you're told you'll live forever, and if you don't it's probably your fault.

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However, as the truistic old adage goes: we all have to die of something. Let us set aside the idea that death itself might be eliminated. In so doing we do not have to explore the colourful world of what life would be like under that counterfactual. No-one supposes that it is remotely possible, let alone that anything in current medical research will one day lead to our immortality. But there is some kinship in the way our lives are developing to that of the Struldbruggs so vividly portrayed by Jonathan Swift in *Gulliver's Travels*. They had discovered the secret of eternal life, but not of eternal youth, or even eternal good health. We have discovered the secret of a longer life (like Sibyl) and moreover an ever-longer life, without also similarly discovering the secret of good health during an increasing proportion of it, let alone eternal youth while we live. And to some extent the same lessons apply as Swift would teach us. Swift contrasts other kingdoms to that where the Struldbruggs live.

> That whoever had one foot in the grave, was sure to hold back the other as strongly as he could. That the oldest had still hope of living one day longer, and looked on death as the greatest evil, from which Nature always prompted him to retreat; only in this island of Luggnagg, the appetite for living was not so eager, from the continual example of the Struldbruggs before their eyes.
>
> Jonathan Swift, *Gulliver's Travels* (London: Penguin, 1985), Part III, Chapter 10, p. 256

Medical treatment currently assumes and depends upon this appetite. We do not have examples of Struldbruggs before our eyes, but we have something like it and increasingly like it.

As we are all going to die, and die of something, the question naturally arises whether some times and ways of

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dying are better than others. At least the question should arise.

3

The main contention here is to suggest that a change in cultural attitude to news of our possible death might not produce as now a desperate scramble for treatment that might only marginally postpone the death or propel us beyond into a wretched state where few would want to be despite being alive, but bring about rather an acceptance of the death that is to come, and, it cannot be emphasized too much, is going to come anyway sooner or later.

At the moment the desperate scramble attitude tends to prevail, and often to the detriment of the life of the person involved. It is currently very hard to walk away from offered treatment. The social and cultural pressure to take any treatment on offer that may increase one's life expectancy is enormous. Sometimes it is said that the aim is to improve the quality of someone's life. This of course is an unobjectionable aim. But it is also not one that can be perpetuated forever since eventually, as we all die, there is no life left to improve the quality of. There is no guarantee that, if the life is extended, the period leading to death and inevitable death later won't be worse than if the person had died earlier, and that moreover the life overall in sum isn't worse.

This of course does not even include the often life-wrecking process of getting the treatment, including the time involved, the tedium, the anxiety, along with sometimes life-destroying side-effects from treatment.

There is no necessary implication here supporting voluntary euthanasia, for the issue is what would make it the case that our death, which will come, is a better death and involve less suffering leading to it than otherwise, and euthanasia might not be the best way in all cases if

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that is the aim. But a change in attitude such as the one suggested makes voluntary euthanasia something which it is more natural to consider because it might be one way, and the optimum way, in some cases, of bringing about the result of a better death with less suffering. Note that the 'suffering' referred to here is not only the immediate process leading to death, but also that which would have occurred in a life not lived because it has been curtailed by euthanasia.

However, if the idea of medicine universally is to treat bodily and mental conditions and in so doing improve people's lives, making things better for people, then perhaps the bad conditions caused by an excessively long and protracted life, some as a result of earlier treatments, should be addressed as one such treatable condition.

Everything is culturally skewed to our not walking away from treatment even when the effectiveness is only marginal and transitory, or as prevention merely probabilistic and uncertain. But that is not the chief problem, which is that it often only briefly postpones the inevitable – and at some intrinsic cost – something that is going to come anyway, and may turn out to be much worse than if we had died earlier. Of course it may be hard to tell when this is true: whether dying now or later would make the period that is the precursor to death worse or better. There is nothing in what is said here that suggests it must be better or worse one way rather than the other. But at the moment the point is that the prevailing cultural attitude really fails to let in at all the idea that an earlier death might be better, or if considered it is poorly so, and as things stand incredibly difficult to act upon unless one has an iron will and a capacity to run against the crowd and cast off cultural conformity.

To make the point, consider the following case, a true case, related to me by a Senior Medical Oncologist. A farmer, as it happens, attends a meeting with the oncologist. He is offered treatment that may prolong his life no more than six months or a year, and during that time his

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quality of life would be better than it would be without any treatment. But of course after that we may hypothesize he will be just as badly off in terms of quality of life and life expectancy as though he had had no treatment. He might even be worse off. He is going to die, and soon, in any event. He refuses any treatment. Is he just stubborn? Or has he found a way of reconciling himself to his death and making his peace with the world, and seeing that as his chief objective now, rather than undergoing arduous treatment that will only postpone the imminently inevitable? Think of the pressure he is currently under, certainly if not sensitively handled (in fact it was sensitively handled in this case), to undergo the treatment – to let the doctors do what they can for you – rather than walking out of the door against advice. Think also of the cultural pressure from his family when he gets home and he tells them he was offered treatment but refused it. 'But you must!', is most likely to be the response. But if cultural attitudes were different, it would be so much easier for the farmer not only to say no, but to carry it through feeling that he had done the right thing. As it is it would be hard enough to it carry it through without feeling the guilt that it is the wrong decision too.

The overall contention is that people might have better ends to their lives and better lives in the period leading up to their ends if they died earlier. But in order for this to be brought about there would have to be a cultural change accepting this as a reasonable attitude. The price of not doing so is, so it seems, more suffering in death and more suffering in the period leading up to death. This is before one considers the economic impossibility of pursuing the current policy where resources are never able to meet demand because the numbers of those requiring treatment will grow ever greater, as people live longer and longer, but in longer states requiring expensive and ever more medical treatment, and the proportion of those able to supply the resources for such treatment will dwindle and dwindle yet more, as they are inevitably outrun in number by the ageing decrepit. Even to put it like that, the shock it

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evokes, the uncomfortableness of it, shows how culturally entrenched and taboo the idea is. The taboo is no better exposed by the discomfort of saying simply: in many cases people would be better dying earlier than when they actually die.

A change in cultural attitude would make it easier for people to say one has had enough, and go through with it, and for other people (those who love you and doctors) to accept that as reasonable and support it. 'Enough', because of how they are now and because of what with some certainty they see coming. It wouldn't be for everyone. But for those who wished it, it would be a real possibility – for many now feel pressured to carry on when they don't want to, when they have had enough – and it would mean that they have a better death and a better life leading up to that death.

There is a balance here: that between a preparedness to die, a readiness for death, a resignation to die, as opposed to an avoidance of it at pretty much all cost – except in extreme do-not-resuscitate cases. The philosophical-cultural attitude has very much swung towards the latter these days, giving little chance for the former to be recognized, discussed, and be formed as an attitude – an attitude that might indeed help one's eventual death. After all it's not as if a choice is avoiding it forever. Such an attitude could be supported by new mental habits, prevailing attitudes, and open discussion.

Some final thoughts in point and counterpoint.

As Kingsley Amis said: 'No pleasure is worth giving up for the sake of two more years in a geriatric home at Weston-super-Mare.'

Jean Sibelius on reaching his 85th birthday (he lived to 92) said: 'All the doctors who wanted to forbid me to smoke and drink are now dead.'

This might be thought to balance things up in sentiment, but rather I think it shows that there would be no precipitous chase for death: resigned to if not longed for. Tennyson:

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Whatever crazy sorrow saith,
No life that breathes with human breath
Has ever truly longed for death.

The Two Voices

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Note

[1] Evidence supporting the empirical claim here is given in *The Times* and the *Office of National Statistics* below.

> Life expectancy has edged up slightly for both men and women, but we are all likely to spend longer in poor health, according to official projections. A baby boy born in 2013–15 can expect to live 79.2 years, compared with 78.5 in 2009–11. For girls, life expectancy rose from 82.5 to 82.9 years. However, healthy life expectancy remained static for women and increased by 0.4 years for men over the same period, according to the Office for National Statistics (ONS). Women can now expect to spend 19 years of their lives in poor health (up 0.4 years). Men should prepare for 16.1 years of poor health, up 0.3 years.
>
> *The Times*, 30 November 2016.

And from the *Office of National Statistics*:

> 'Healthy life expectancy at birth and age 65 by upper tier local authority and area deprivation: England, 2012 to 2014.' *Office of National Statistics*.
>
> https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthylifeexpectancyatbirthandage65byupertierlocalauthorityandareadeprivation/england2012to2014

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Males at birth in England could expect to spend a higher proportion (79.7%) of their remaining lives in 'Good' health, compared with females (76.9%).

On the basis of mortality and health status rates in 2012 to 2014, a boy born in England could expect to live on average for 79.5 years, of which they could expect to spend 63.4 years in 'Good' health. Whilst for a girl, life expectancy (LE) was 83.2 years, of which they could expect to spend 64.0 years in 'Good' health.

Therefore, the gender gap between the number of years males and females could expect to spend in 'Good' health was narrower at 0.6 years compared with LE at 3.7 years. Despite males expecting to live shorter lives on average compared with females, they could expect to spend a higher proportion of their remaining lives in 'Good' health (79.7% compared with 76.9%).

When comparing the 2012 to 2014 data with the latest non-overlapping time period 2009 to 2011, the healthy life expectancy (HLE) estimate at birth for males increased by 0.2 years from 63.2 years to 63.4 years. Although HLE at birth increased for males, it did not keep pace with the increase in LE. Males born in 2012 to 2014 could expect to live a further 0.6 years than those born in 2009 to 2011. For females, HLE at birth declined by 0.1 years, from 64.2 years to 64.0 years whilst LE increased by 0.3 years.

This shows that there has been an expansion of morbidity (the number of years in 'Not Good' health) for both males and females as there were larger increases in LE compared with HLE. This results in an increase in the number of years lived in 'Not Good' health. Where there are larger increases in

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HLE compared with LE, this is referred to as compression of morbidity.

The higher increase in both LE and HLE at birth observed for males suggests that over time, the gender gap between males and females for LE and HLE has narrowed.

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