Ireland PAS Margaret Battin testimony for Oireachtas Joint Committee on Assisted Dying
10-2-23

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To the Joint Committee:

The structure of the argument over medical aid in dying (MAID) looks roughly like this:

FOR	**AGAINST**
Autonomy	Permits killing
	Threats to the integrity of the physician
Relief of suffering	The slippery slope

The items in the left column, the "for" arguments, represent basic principles of morality, defended by proponents of medical aid in dying, MAID. They are often appealed to in tandem: the person must be freely choosing MAID but enduring or about to endure serious, unrelievable suffering. The items in the right column, the "against" column, represent predicted outcomes of a permissive MAID policy, typically used to oppose legalization.[i]

You've heard all these arguments from all quarters already, though I'll be happy to discuss them further if you wish. Instead, especially in light of the religious and cultural history of Ireland, I'd like to address an issue about MAID that is rarely if ever raised. It's a values/empirical issue.

Consider our historical legacy about how people died—these aren't representative cases but the ones that still underlie contemporary cultural traditions:

Ancient Hebrew

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Jacob on his deathbed, giving blessings and prophecies to his twelve sons (*Genesis* 49).

Ancient Greek: Socrates about to drink the

hemlock.

Medieval Christian:

The medieval practices of *Ars moriendi* and Holy Dying involve the effort to avoid sudden death, hoping to be conscious and alert at the time of death, to be able to confess, repent, and receive absolution.

"Death and the Miser" by Hieronymus Bosch (circa 1450-1516).[ii]

The dying man, a miser, must choose between a demon with a bag of gold and an angel pointing to the crucifix, as Death comes in the door.

Early American:

George Washington on his deathbed, with family and attendants, December 14, 1799.

In each of these situations, the dying person is conscious, alert, capable of communication. Consider, in contrast, how dying is often managed in contemporary medicine: with pain relieving medications, often narcotics like morphine, that can produce drowsiness, sleepiness, obtundation. Specific strategies used in hospice and palliative care include withholding or withdrawal of care that is perceived as burdensome or thought to be futile, foregoing nutrition or both nutrition and hydration (known as VSED, for voluntary stopping of eating and drinking), and terminal sedation. Hospice and palliative care can often provide extremely effective pain

and symptom relief. And some patients may prefer such strategies for a variety of social, personal, or religious reasons.

But these strategies may also come at the cost of consciousness, and with it, the possibility of continuing communication and human interaction. What MAID grants a person is a way of dying that is conscious, alert, communicative, and can be timed to allow visits from family and others, communication with religious advisors, and self-reflection. Of course MAID will not be chosen by everyone—even where it is legal. Rates of dying with medical aid are rising in some places, as for instance in Canada, but it in fact remains rare—yet is deeply meaningful to many. It is sometime described as “dying on one’s own terms.”

It most important to recognize that the tradeoffs are *new,* that is, new in the history of human dying, roughly since the beginning of the epidemiologic transition in the 1850s and in particular since the development of antibiotics in the 1940’s. In earlier periods of human history people died primarily of infectious and parasitic diseases:

influenza
pneumonia
diarrhea
smallpox
tuberculosis
malaria
cholera
typhoid
diphtheria
typhus
pertussis
plague
yellow fever
measles

and becoming bedridden could lead fairly quickly to death. As the well-known Hospice physician Joanne Lynn MD put it, in those earlier times, when you fell ill, within a week you were either recovered or dead.

What the contemporary patient faces is different: We die of diseases with long downhill courses, cancer, heart, stroke, and other cardiovascular disease, various forms of organ failure,

and neurological diseases, which may extend over months or years, with trajectories like this:

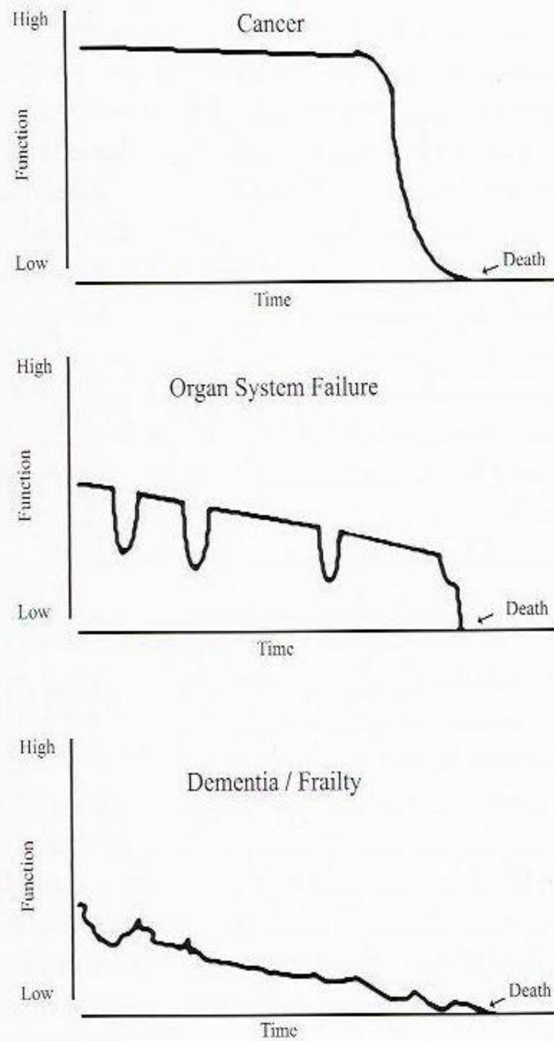

Figure I.
Three General Trajectories of Function and Well-Being over Time in Eventually Fatal Chronic Illnesses

Source: Joanne Lynn, MD

The rapid deaths our cultural forebears faced are no longer the likely outcomes for us, and many of our contemporary dying processes end in prolonged courses of deep functional impairment. The lessening of consciousness that aggressive pain and symptom management may involve, or the gradualness eclipse of the self in the process of dying, or the ending of human interactive capacity in deep or terminal sedation may appeal to some patients and/or their families, especially if this slow process is perceived as gentler, as easier for the patient, and as permitting the family more time to absorb the reality of their loss.

But other people would welcome the freedom to die as Jacob did, distributing blessings; or as Socrates did, delivering an extended philosophical discussion that would be preserved for posterity; or as the medieval religious believer hoped to, still able to pray, confess, repent, and receive absolution that they trusted would bring them closer to God; or as George Washington did, alert until the end. All of these figures (except Socrates) would probably have died within a week; in our current times, they might remain in a medicalized situation for an extended period of time. That's the modern dilemma.

Many philosophical and policy-oriented defenses of MAID rest on one of the two basic moral principles mapped above—autonomy and relief of suffering. Defenses of MAID are particularly often focused on escaping from terminal suffering, the second of these principles: *you don't want to die badly; the option of MAID means you don't have to fear a prolonged, horrible death; you don't have to suffer at the end of life. .*

This note, in contrast, stresses a point rooted primarily in autonomy, something a person might meaningfully choose when confronted with medical situations they cannot otherwise

control: the freedom to shape as much as possible the circumstances of their own dying. *You can choose the timing of your death. You can choose what family, friends, spiritual advisors and others will be present at your bedside. You can, in most jurisdictions, choose the mechanism of your death, whether orally administered or by IV, or perhaps other modalities. And you can choose whatever rituals, ceremonies, and memorializing activities you want, it is all up to you.*

Presupposed in all of these is the importance of protecting one's capacity for clear thought and communication, a choice in dying that runs counter to some of the ways we now deal with the long downhill courses of contemporary causes of death—cancer, cardiovascular disease, neurological conditions—deteriorative processes often involving symptoms than require consciousness-dimming management that some patients do not wish to endure. I believe it is morally essential to recognize these choices, even if they are not frequently made. The increasing legalization and social acceptance of MAID is, I think, the recognition that there are more person-respecting ways of dying than, as some have called it, being obliterated by disease.

[i] . Reference to killing in this argument depends on how "killing" is understood: if it is understood as the involuntary taking of a person's life, that is clearly wrong but not relevant in MAID, which is required to be voluntary; if it is understood as "taking measures that result in the end of a life," then all occasions of legal and noncontroversial withdrawal of treatment, discontinuation of treatment, and refusal of treatment, ubiquitous in modern medicine, would also be problematic. The "threats to the integrity of the physician" and "slippery slope" arguments involve empirical claims about who dies and whether they have been forced or pressured, and there is virtually no empirical evidence to support these claims. After all, where MAID is legal, rates of dying in this way range from less than 1% (in the US) to a handful of percent (in the Netherlands) of the annual mortality, meaning that some 99% (US) of people who die don't die in this way, and more than 99% don't die in this way in the Netherlands, a country in which MAID is widely accepted. (Current figures available from other witnesses)

[ii] "Death and the Miser" by Hieronymus Bosch (circa 1450-1516),[ii] oil on panel, painted about 1485-1490, housed at the National Gallery of Art, Washington, D.C. In the painting, a demon appearing from behind the bed curtain tempts the miser with a bag of gold, while an angel kneeling at right encourages him to regard the crucifix in the window, with its divine light streaming downward. Death enters from the door at left, ready to lance the man with his arrow. The work is a *memento mori,* intended to remind its viewers of the inevitability of death and the futility of pursuing material wealth. Bosch was influenced by the "Ars Moriendi" of the Middle Ages, which instructs Christians to live rightly, so as to deliberately prepare to die.