# Saving People from the Harm of Death

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With a Foreword by Jeff McMahan

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# Health Care Rationing and the Badness of Death

## SHOULD NEWBORNS COUNT FOR LESS?

Tim Campbell

### 1. Introduction

According to the *Deprivation Account* of the badness of death, an individual's death is bad for her to the extent that it deprives her of goods she would otherwise have had. The Deprivation Account implies that the death of a healthy newborn is worse for her than the death of a healthy young adult is for him, insofar as death deprives the former of more good life than it does the latter. Jeff McMahan (chapter 8, this volume) and several other philosophers have argued that the Deprivation Account gets the wrong answer here.[1] McMahan thinks that typically the death of a young adult is worse for him than the death of a newborn is for her, even if death deprives the newborn of substantially more (e.g., twice as much) full-quality life. In support of this claim, he points to the vast difference in psychological development between a normal healthy newborn and a normal healthy young adult. The young adult is much more psychologically developed than the newborn, who lacks self-awareness and is barely sentient. Thus, McMahan argues that for the young adult the burden of death is substantially greater.

In their respective contributions to this volume, McMahan (chapter 8, Espen Gamlund (chapter 5), John Broome (chapter 7), Joe Millum (chapter 4), Andreas Mogensen (chapter 3), and Ben Bradley (chapter 9) argue that the two opposing views of the badness of death mentioned above have different implications for how we should ration health care. For example, Millum

[1] See, e.g., Millum (2015), DeGrazia (2012, 33), Mogensen (chapter 3, this volume), and Norheim (chapter 2, this volume).

writes, "If [the Deprivation Account] is true, then the younger one is, the worse one's death and, all else equal, the greater priority preventing that death should receive."[2] But if a young adult's death is worse for him than a newborn's death is for her, even when death deprives the newborn of twice as many years of full-quality life, then it seems our health policy should reflect this. We should accept

> *Young Adults over Newborns*: All else equal, we ought to save a certain individual, A, from dying as a young adult rather than save some other individual, B, from dying as a newborn, even if the latter intervention would give B twice as many years of full-quality life as the former intervention would give A.[3]

In this chapter, I show that if we accept Young Adults over Newborns, then we must reject at least one of the following three claims:

> *Saving Newborns from Death*: All else equal, we ought to save a newborn rather than let it die, even if saving it entails that it will die at age 30.[4]
>
> *Weak Life Extension*: All else equal, we ought to extend the life of a certain newborn from age 0 to age 80 rather than extend the life of some other newborn from age 0 to age 70, provided that for either individual the additional years of life would be full-quality.
>
> *Acyclicity*: The relation 'ought to choose rather than,' as it applies to pairs of health interventions, is acyclic: for any three alternative health interventions *a, b*, and *c*, if *a* ought to be chosen rather than *b* when *a* and *b* are the only options, and *b* ought to be chosen rather than *c* when *b* and *c* are the only options, then it is not the case that *c* ought to be chosen rather than *a* when *a* and *c* are the only options.

I will suggest that Young Adults over Newborns is less plausible than each of the three claims listed above and that this constitutes a strong reason to reject Young Adults over Newborns.[5]

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[2] Millum (2015, 280).

[3] I assume throughout this chapter that a year of full-quality life for a given individual would have the same quality as a year of full-quality life for any other individual. The term "full-quality" picks out the same quality level for all individuals. For my purposes, the term "individual" just refers to a *being* that might be the target of a health intervention.

[4] I am assuming that if the newborn were to survive, each year of its life would be full-quality.

[5] Young Adults over Newborns isn't the only principle that is in tension with an acyclic ranking of health interventions. For example, Beckstead and Ord (2013) show that a principle of allocation that prohibits discrimination on the grounds of disability is in tension with the requirement that one's *preferences* over a set of options (health interventions) be acyclic—that is, the requirement that if one prefers A to B, and B to C, then one must not prefer C to A. More generally, many principles seem to be in tension with an acyclic ranking of outcomes or actions. For discussion of this topic, see Temkin (2012).

TABLE 18.1 } **Three-Option Case**

| | *X* | *Y* | *Z* |
|---|---|---|---|
| Alex | Dies at 0 | Dies at 30 | Dies at 70 |
| Ben | Dies at 80 | Dies at 80 | Dies at 0 |

## 2. The Problem

To see that accepting Young Adults over Newborns forces us to reject at least one of the three claims stated above consider the following example.

> *Three-Option Case*: Alex and Ben are both newborns. Each suffers from a disease that will be fatal unless treated. We do not have the resources to cure both of them fully. However, there are three alternative life-saving interventions available to us—*X*, *Y*, and *Z*. I outline the outcomes of these interventions for Alex and Ben in table 18.1.

Henceforth, I shall assume that when a health intervention would give some individual some number of additional years of life, each of these years of life would be *full-quality*. I will not consider cases in which it is possible to extend the life of an individual whose quality of life would be less than full.

Here are the details of the case. Due to a lack of resources, we can deliver only one of three medicines to an emergency clinic: Med *X*, Med *Y*, or Med *Z*. Physicians are awaiting our arrival at the clinic; once we arrive, they will treat Alex and Ben using whatever medicine we provide. Med *X* would fully eradicate Ben's disease, giving him the "full" life span of 80 years, but would have no effect on Alex. Med *Y* is more powerful than Med *X*; it would fully eradicate Ben's disease *and* would have at least some positive effect on Alex—specifically, it would extend Alex's life by 30 years. Med *Z* would extend Alex's life by 70 years, but would have no effect on Ben.

Now consider the three possible interventions: *X, Y*, and *Z*. First, imagine that *X* and *Y* were the only options. For *Ben*, there is no difference between *X* and *Y*, and for *Alex*, the only difference is that in *X* he dies as a newborn, whereas in *Y* he dies as a young adult after enjoying 30 years of full-quality life. Therefore, Saving Newborns from Death implies that we ought to choose *Y* rather than *X*: we ought to prevent Alex from dying as a newborn even if this means that he will later die at age 30.

Next, imagine that *Y* and *Z* were the only options. Ben's death in *Z* deprives him of 80 years of life while Alex's death in *Y* deprives him of only 40 years. However, Alex's death in *Y* occurs when he is a young adult, a 30-year-old, whereas Ben's death in *Z* happens when he is just a newborn. Therefore, Young Adults over Newborns implies that we ought to choose *Z* rather than *Y*. We ought to save Alex from dying as a young adult rather than save Ben from

dying as a newborn, even if the latter intervention would give Ben twice as many years of life as the former intervention would give Alex.

It is important to emphasize that saving a patient from dying as a young adult doesn't require that the action that saves him occur *when* he is a young adult. For example, suppose we know that a certain newborn has a condition that, if untreated, will cause him to die at age 30. Furthermore, suppose that if we were to treat his condition now, this newborn would not die at age 30 but would instead die at age 70. Treating this individual's condition *now* would save him from dying *as a young adult* since it would prevent him from dying at age 30. According to McMahan and Millum, the fact that this individual is *now* a newborn, and not a young adult, is irrelevant. What matters is whether he would be a young adult *at the time of his death*. The badness of death for an individual and, hence, the strength of the reason that one has to prevent this death are determined relative to the time at which the death would occur—*not* relative to the time at which one must act to prevent it.[6]

Returning to our evaluation of the three options, let us suppose that *X* and *Z* were the only available options. The only relevant difference between *X* and *Z* is that *X* gives 80 years of life to Ben (extending his life from age 0 to age 80), whereas *Z* gives only 70 years of life to Alex (extending his life from age 0 to age 70). Therefore, Weak Life Extension entails that we ought to choose *X* rather than *Z*.

We are now left with a cycle: we ought to choose *Y* rather than *X* (when *X* and *Y* are the only options), *Z* rather than *Y* (when *Y* and *Z* are the only options), and *X* rather than *Z* (when *X* and *Z* are the only options). This cycle violates Acyclicity, which states that the relation 'ought to choose rather than' as it applies to pairs of health interventions is acyclic.

We cannot consistently accommodate all four claims: Young Adults over Newborns, Saving Newborns from Death, Weak Life Extension, and Acyclicity. We must reject at least one of these seemingly plausible claims.

I think we should reject Young Adults over Newborns. While this claim may seem plausible, the other claims—Saving Newborns from Death, Weak Life Extension, and Acyclicity—seem even more plausible. Moreover, as I will now argue, it is hard to think of a convincing rationale for rejecting any of these other claims.

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[6] See Millum (2015, 270–271). John Broome points out that if the strength of our reason to prevent a particular death is determined relative to the time at which we must act to prevent it, then we will exhibit diachronically inconsistent behavior. See Broome (2004, 250–251), as well as Greaves (chapter 13, this volume). Mathias Barra (personal conversation) has suggested that the strength of our reason to prevent a particular death might be determined *in part* by how bad this death would be for the individual and *in part* by the individual's degree of psychological development at the time when we must decide whether to prevent her death. I suspect that this approach would also be vulnerable to Broome's criticism.

One possible rationale for rejecting Saving Newborns from Death appeals to the idea that for a typical individual, it would be worse to die as a young adult than as a newborn. McMahan and Millum both defend this idea. On McMahan's view, as well as on Millum's, the badness of one's death is "a function of the future goods of which one is deprived *and* the degree of psychological unity one has with the future self that would otherwise experience these goods."[7] As an individual develops physically and mentally, she becomes more psychologically unified with her future self. When she is a young adult, she is fully psychologically developed.[8] From young adulthood on, assuming there is no weakening of the psychological connections between the different parts of her life (e.g., as a result of dementia), the badness of her death for her is determined by the amount of good it deprives her of. Hence, from young adulthood on, it is worse for her to die sooner rather than later, and so from this point on, the Deprivation Account and McMahan's account will usually give the same result.

Even if we agree with McMahan that it is worse to die as a young adult than to die as a newborn, we shouldn't reject Saving Newborns from Death. Indeed, McMahan doesn't reject it. This is because he thinks that, typically, preventing a particular individual from dying at age 30 by ensuring that she instead dies at age 0 would make her *worse off*, even though her death at age 30 would be worse for her than her death at age 0.[9] This aspect of McMahan's view may seem puzzling. Isn't it always *better* to avoid a *worse* death? Perhaps not. Suppose that you prevent me from dying at time $t_1$ and that, as a result, I live another 10 years and die at time $t_2$. Next, suppose that if I had not died at $t_2$, I would have lived another 20 years. In this case, we can say that my death at $t_2$ deprived me of 20 years of life (i.e., in the nearest possible world in which I do not die at $t_2$, I live for another 20 years). But if you had let me die at $t_1$, this would have deprived me of only 10 years of life. In this respect, one could argue, my death at $t_2$ is worse for me than my death at $t_1$.[10] However, clearly it would not make sense for you to prevent this worse death by allowing me to die at $t_1$. The explanation is that I would not have been better off if I had died at $t_1$ since I would have had fewer years of good life.

To sum up: It is hard to think of a compelling reason to reject Saving Newborns from Death.

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[7] Millum (2015, 279).

[8] On Millum's view, an individual becomes fully psychologically developed well before young adulthood.

[9] For further discussion on this point, see McMahan (2002, 185–188), as well as Norheim (chapter 2, this volume) and Greaves (chapter 13).

[10] For example, the Deprivation Account of the badness of death would imply this, since it treats the badness of death for an individual as a function of the amount of good life that she would have had if she hadn't died when she did.

## 3. Weak Life Extension

It is even harder to think of a compelling reason to reject Weak Life Extension. Some philosophers argue that living longer doesn't necessarily entail living better, even if the health-related quality of one's life doesn't diminish as its duration increases.[11] Defenses of this sort of view are surprisingly common in philosophical discussions of immortality, in which we are asked to consider what it would be like to live for hundreds, or thousands, or millions of years. Many seem convinced that life would become meaningless if it were to continue for so long. I don't think there is much justification for this belief. But in any case, when we focus on people with "normal" maximum life spans (e.g., 80 years), it is very hard to resist the idea that for such people living longer—and at full quality—entails living better.

Another possible reason to reject Weak Life Extension is that giving more years of life to one person rather than fewer years of life to another creates more inequality in the distribution of health-related goods.[12] However, I don't think one can appeal to considerations of inequality in order to reject Weak Life Extension. This is because we can stipulate that the "all else equal" clause in my statement of Weak Life Extension takes inequality into account. For example, we can assume that if giving more years of life to one patient rather than fewer years of life to another would produce an inequality between these two patients, it would also eliminate some other inequality (e.g., between the first patient and some other unidentified individual in the population).

To sum up: It is *very* hard to think of a compelling reason to reject Weak Life Extension. To reject this claim would seem to express a morally perverse preference for shorter lives over longer ones.

## 4. Acyclicity

If we want to accept not only Young Adults over Newborns but also Saving Newborns from Death and Weak Life Extension, we must reject Acyclicity. That is, we must admit that there are at least three health interventions, *a, b*, and *c*, such that we ought to choose *a* rather than *b* when *a* and *b* are the only options, *b* rather than *c* when *a* and *b* are the only options, and *c* rather than *a* when *a* and *c* are the only options.

If we allow a cyclic ranking of alternative health interventions to guide our decision-making, we might exhibit cyclic choice behavior. This would make

[11] See, e.g., Williams (1981, 1–19).

[12] The phrase "distribution of health-related goods" could refer to well-being, health, or whatever sort of good matters within the sphere of health care.

us vulnerable to a "money pump." If we thought it was important to choose *Y* from the set of options {*X, Y*}, then presumably we would be willing to pay some amount of money to exchange *X* for *Y* in this case. If we had the same attitude about choosing *Z* from the set {*Y, Z*} and choosing *X* from the set {*X, Z*}, then again, we would be willing to pay some amount of money to exchange in each of these cases. That would leave us with *X*—the very same alternative that we started with—but with less money. Moreover, if our dispositions remained stable, we would be willing to continue trading in this manner until we had traded away all our money, with nothing to show for it. Intuitively, rational individuals will not freely exhibit cyclic choice behavior.[13]

Cyclic rankings would not *inevitably* lead to cyclic choice behavior. There might be principled ways of avoiding such behavior through strategic reasoning.[14] Moreover, it may be hard to see how a money pump would occur in cases that are more realistic than the highly simplified Three-Option Case that I have presented. However, as I will now argue, embracing Acyclicity gives rise to other problems.

## 5. Contraction Consistency

Intuitively, where *X, Y*, and *Z* are the only options, one of these options is what we ought to choose *all things considered*.[15] Those who accept Young Adults over Newborns, Saving Newborns from Death, and Weak Life Extension but reject Acyclicity can agree. However, they must then accept one of the following three claims:

> Claim 1: We ought to choose *Z* if our options are *X, Y*, and *Z*. However, if *X* and *Z* are our only options, then, as Weak Life Extension says, we ought to choose *X* rather than *Z*.
>
> Claim 2: We ought to choose *Y* if our options are *X, Y*, and *Z*. However, if *Y* and *Z* are our only options, then, as Young Adults over Newborns says, we ought to choose *Z* rather than *Y*.
>
> Claim 3: We ought to choose *X* if our options are *X, Y*, and *Z*. However, if *X* and *Y* are our only options, then, as Saving Newborns from Death says, we ought to choose *Y* rather than *X*.

[13] Beckstead and Ord (2013) show that those who follow a principle of health care allocation that prohibits discrimination on the grounds of disability may also be vulnerable to a money pump.

[14] For instance, Edward F. McClennen (1990, sec. 10.2) argues that an agent with intransitive *preferences* can avoid being money-pumped under certain conditions by using backward induction.

[15] This assumption is, in fact, stronger than what I need to establish my argument. I need only the weaker assumption that with respect to at least one of *X, Y*, and *Z* it is false that we ought *not* to choose this option over the others.

Each of Claims 1–3 violates a version of *Contraction Consistency*, according to which if one ought to choose a given option *A* from a given set *S* of options, then one ought to choose *A* from any subset of *S*.[16] There are instances in which violating Contraction Consistency seems entirely unreasonable. In these instances there is no plausible explanation of how adding or removing some option changes the ranking of the other options. I suggest that each of Claims 1–3 is such an instance.

According to Claim 1, if our only options are *X* (Alex dies at age 0 / Ben dies at age 80) and *Z* (Alex dies at age 70 / Ben dies at age 0), then we ought to choose *X*. But if option *Y* (Alex dies at age 30 / Ben dies at age 80) becomes available, then we ought to switch our choice to *Z*. The problem is that there is no apparent explanation of how the availability of *Y* could justify switching our choice to *Z*. When *X* and *Z* are the only options, choosing *Z* rather than *X* would violate Weak Life Extension. It would demonstrate a morally absurd preference for shorter lives over longer ones. But choosing *Z* rather than either *X or* Y would seem to demonstrate the same kind of morally absurd preference. In either case, choosing *Z* rather than *X* would give 70 years of life to one person (Alex) rather than 80 years of life to another (Ben). This seems morally absurd whether or not we have an *additional* option, *Y*, which gives Alex *even fewer* years of life (30 years, to be exact). In other words, the availability of *Y* does not seem to change the ranking of *X* and *Z*, since it does not appear to change the normative considerations that are relevant to a choice between *X* and *Z*.

According to Claim 2, if our only options are *Y* (Alex dies at age 30 / Ben dies at age 80) and *Z* (Alex dies at age 70 / Ben dies at age 0) then we ought to choose *Z*. But if option *X* (Alex dies at age 0 / Ben dies at age 80) becomes available, then we ought to switch our choice to *Y*. But, again, it is hard to see how switching our choice to *Z* could be justified in this case.

Let us suppose that initially our only options are *Y* (Alex dies at age 30 / Ben dies at age 80) and *Z* (Alex dies at age 70 / Ben dies at age 0). Because we accept Young Adults over Newborns, we intend to choose *Z*. That is, we intend to deliver Med *Z* to the clinic, where the physicians will then administer this medicine to Alex. But suppose that just as we are retrieving Med *Z* from its storage container, option *X* (Alex dies at age 0 / Ben dies at age 80) becomes available. According to Claim 2, now we ought to choose *Y*. Suppose we acknowledge this, and so we place Med *Z* back in its storage container and proceed to retrieve Med *Y*. This behavior seems irrational.[17] This is because the availability of *X* appears to be irrelevant to how we should rank *Y* and *Z*.

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[16] Sen (1993, 500).

[17] For a discussion of similar violations of contraction consistency in a health care context, see Beckstead and Ord (2013).

McMahan has suggested that the availability of *X* might change the ranking of *Y* and *Z* in the following way. When *Y* and *Z* are the only options, at age 30 Alex will have a very strong time-relative interest in continuing to live. This strength of this time-relative interest will be a function of how strongly psychologically connected Alex at age 30 would be to his future self if he were to continue to live. The existence of this strong time-relative interest does not depend on which option we choose—*Y* or *Z*. (If we choose *Y*, then this time-relative interest exists and it is frustrated; if we choose *Z*, then this time-relative interest exists and it is satisfied. In either case, it *exists*.)

On the other hand, when *X* becomes available, the existence of the strong time-relative interest that Alex would have at age 30 *does* depend on which option we choose. This time-relative interest would exist if we were to choose either *Y* or *Z*, but it would not exist if we were to choose *X*. If we were to choose *X*, then the only time-relative interest Alex would ever have in continuing to live would be the one he would have as an infant. This time-relative interest would be very weak since, as an infant, Alex is only weakly psychologically connected to his future self. According to McMahan, there is reason to satisfy (or avoid frustrating) an individual's time-relative interest in future benefits if the existence of this time-relative interest *does not depend* on our actions. But McMahan also suggests that there may be little or no reason to satisfy (or avoid frustrating) an individual's time-relative interest in future benefits when the existence of this time-relative interest *does depend* on our actions.[18]

If McMahan's suggestion were plausible, it would provide a solid defense of Claim 2. However, the suggestion is implausible. To see this, consider the following example. Suppose we can either create a new person or refrain from doing so. If we create the person, we can give her either 70 years of full-quality life or only 30. If we give her only 30 years, this will frustrate the strong time-relative interest she will have at age 30 in continuing to live. The existence of this time-relative interest depends on our actions since we have the option of not creating this person. However, it seems obvious that we have a very strong reason *not* to frustrate this time-relative interest. Allowing the person to die at age 30 rather than age 70 cannot be justified merely in virtue of the fact that the strong time-relative interest she has in avoiding death at age 30 exists only because of our choice. We should reject McMahan's suggestion as well as Claim 2.

According to Claim 3, If *X* and *Y* are our only options, then, as Saving Newborns from Death entails, we ought to choose *Y* rather than *X*. But if *Z*

[18] McMahan suggested this to me in conversation. Also, see his discussion of what he calls the *Asymmetric Interest Account* in section 5 of chapter 8, this volume.

becomes available, then we ought to choose *X*. To explain how the availability of *Z* changes the ranking of *X* and *Y*, one might reason as follows.

> Suppose our options are *X*, *Y*, and *Z*. In this case, if we were to choose *Y*, Alex would have a very strong complaint against us, since we would have caused him to die at age 30 rather than age 70. The ground of Alex's complaint would be that his death at age 30 is a grave misfortune for him and that *we could have avoided this death* by extending his life to age 70. The fact that Alex would have this strong complaint is sufficient to explain why, in the Three-Option Case, we ought not to choose *Y*. However, in the case in which our only options are *X* and *Y*, Alex would have no complaint against us for choosing *Y*. It is true that choosing *Y* would cause Alex to die at age 30, and this would be a grave misfortune for him. However, if our only options are *X* and *Y*, then we cannot avoid Alex's death at age 30 by extending his life to age 70. Alex would have a very strong complaint against us for causing him to die at age 30 *only if* we had the option of causing him to live to age 70.

This is only a *partial* defense of Claim 3. It explains why we ought not to choose *Y* from the set {*X, Y, Z*}. But it doesn't explain why we ought to choose *X* rather than *Z* from the set { *X, Y, Z* }. To complete the defense of Claim 3, one could appeal to my earlier claim that choosing *Z* rather than *X* from the set { *X, Y, Z* } is morally problematic because it demonstrates a morally absurd preference for shorter lives over longer ones. One could then conclude that in the Three-Option Case, the only unobjectionable choice is that of *X* (Alex dies at 0 / Ben dies at 80).

I doubt whether Alex would have a complaint against us for choosing *Y* in the Three-Option Case. Even if he would have such a complaint, it is implausible that in order to avoid giving Alex grounds for this complaint, we should choose *X* rather than *Y*. After all, as should be clear from our earlier discussion of Saving Infants from Death, *X* is *worse for Alex* than *Y*, since in *X* Alex has fewer years of full-quality life than he has in *Y*. And it is implausible that in order to avoid giving Alex grounds to complain, one can (or should) choose an option that is *even worse* for him.

In sum: It is doubtful whether those who reject Acyclicity can justify violating Contraction Consistency, as they must if they are to offer any plausible story about what we ought to choose in my Three-Option Case.

## 6. Conclusion

I have argued that we have reason to reject Young Adults over Newborns, which states: All else equal, we ought to save a certain patient, A, from dying as a young adult (e.g., at age 30) rather than save some other patient, B, from dying as a newborn, even if the latter intervention would give B twice as many

years of full-quality life as the former intervention would give A. Our reason to reject this claim is that accepting it would force us to reject at least one of three other more plausible claims: Saving Newborns from Death, Weak Life Extension, and Acyclicity. This reason is strong. Further examination of the issues discussed in this volume is needed before we can say whether it is decisive.

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