REVISITING MACKLIN'S ARGUMENTS AGAINST THE COMPLETE-LIVES PRINCIPLE

REVISITANDO OS ARGUMENTOS DE MACKLIN CONTRA O PRINCÍPIO DE VIDAS COMPLETAS

To Maruxa, a Galician woman

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RESUMO
Em junho de 2020, Ruth Macklin publicou um ensaio crítico contra um guia do Conselho Geral de Saúde do México em que o uso da idade é recomendado como critério de desempate para distribuir recursos terapêuticos escassos. O guia baseia esta recomendação no princípio de vidas completas. Neste artigo eu reconstruo e rejeito os três argumentos formulados por Macklin contra o princípio das vidas completas. Subseqüentemente, formulo três objeções de minha autoria a esse princípio.
Palavras-chave: Preconceito de idade; Triagem; Alocação; Recursos.

ABSTRACT
In June 2020, Ruth Macklin published a critical essay against a guideline from the General Health Council (Consejo de Salubridad General) of México that recommends using age as a tie-breaking criterion to allocate scarce therapeutic resources. The guideline bases this recommendation on the complete-lives principle. In this paper I reconstruct and reject the three arguments presented by Macklin against the complete-lives principle. Subsequently, I formulate three objections of my own to this principle.
Keywords: Ageism; Triage; Allocation; Resources.

I - Introduction

The COVID-19 pandemic brought to the forefront the need to publicly discuss important issues in medical ethics. Among these, it reemerged the question of the moral relevance of people's age in making certain decisions to allocate scarce resources. In June 2020, at a time of enormous uncertainty about the development of the pandemic and the potential availability of vaccines, Ruth Macklin published an essay opposing an early version of the Mexican General Health Council (CSG for its acronym in Spanish) "Bioethical Guide for Allocation of Limited Critical Medical

Resources in Emergency Situations", that justifies the use of age as a tie-breaker for allocating ventilators and other scarce therapeutic resources. The first version of the guideline holds that in the face of a tie, a "complete-lives principle" (CLP) should be adopted, which mandates a tie-breaker in favor of the younger patient. The younger patient is at a greater disadvantage in this situation because he or she has gone through fewer life stages. The guideline establishes the following age ranges: 0-12, 13-40, 41-60, 61-75, and +75. In the event of a tie, the scarce resource should be allocated to the patient in the youngest age range.

Macklin offers three arguments against CLP. My goal will be to analyze these three arguments and show that none of them is acceptable. This is not to say that one should accept CLP in particular or ageism in general. I share with Macklin (and with other authors who have denounced the injustice of ageism), that the use of age as a relevant variable in itself is morally arbitrary. [2]   Therefore, I will raise three objections against the defense of ageism raised in this first version of the guideline.

The article is structured as follows. In section II, I present a series of clarifications that allow us to delimit the discussion and understand the scope of Macklin's arguments and of my critique. In section III, I present the characteristics of CLP. In section IV, I reconstruct and critically analyze Macklin's arguments against CLP. In section V, I introduce an alternative way to reject CLP.

II – Preliminary clarifications

II.a - Context of Macklin's essay

Macklin's essay begins by noting the controversy that resulted from the publication of the first version of the "Bioethical Guide for Allocation of Limited Critical Care Resources in Emergency Situations" by the CSG, a collegiate body under the President of Mexico that has the status of a federal health authority, in April 2020.

This first version identifies a series of characteristics that should not be taken into account in deciding how to break the tie between two or more patients who immediately need a ventilator (or any life-saving resource) at the same time and who meet the medical criteria to receive it. These characteristics are: political affiliation, religion, head of household, perceived social value, nationality or immigration status, gender, race, sexual preference, and disability. The non-consideration of these characteristics is in line with international law, which postulates that all people are of equal value and that their health care should not depend on

arbitrary traits. The first version of the CSG guideline did not include age as a characteristic to be disregarded. On the contrary, it made a case for the use of age as a tie-breaker.

The ageism of this first version was criticized by human rights organizations. A few weeks after the controversy, the CSG approved and published a new version of the guideline that removed the ageist defense and included age in the list of characteristics that should not be considered in allocating ventilators. However, this new version offered no justification as to why ageism had been abandoned. Precisely, Macklin's essay seeks to offer a justification for this abandonment.

As will become apparent, the discussion of Macklin's arguments is not limited to the context of the controversy generated by the first version of the CSG guideline. It is not even limited to the context of the COVID-19 pandemic. Her arguments seek to reject a way of justifying the use of age as a criterion for allocating scarce resources that may appear in other contexts.

Although the specific characteristics of the SARS-CoV-2 virus are worthy of attention when determining which resources might be insufficient or which groups would be most affected, the COVID-19 pandemic did not add a distinctive and novel conceptual dimension to the problem of scarce resource allocation. Once the universe of competing resources has been delimited, the question is, after all, the same one that health professionals must face in other contexts of scarcity (e.g., allocation of organs for transplantation, contexts of acute structural poverty, war, other pandemics).

This clarification explains the importance of discussing CLP and Macklin's arguments for rejecting it. Although the COVID-19 pandemic seems to be a matter of the past, it is likely that similar situations will occur again in the future, putting the capacity of health systems at risk. It is conceivable that, if that were to occur, new triage guidelines would be written, some of which might appeal to CLP (or a similar principle) to justify the use of age as a criterion for allocating scarce resources. Even if that does not happen, the central problem of allocating scarce resources is a perennial challenge in medical ethics beyond circumstantial emergencies (PERSAD *et al*., 2009).

II.b – Different types of resources

It seems implausible to claim that a single moral criterion can be established for distributing different medical resources such as vaccines,

viral tests, respirators, beds, and qualified human resources. The distribution of some scarce medical resources may raise specific moral issues. For example, the debate on the distribution of vaccines at the global level has its own characteristics that must be considered by virtue of its production context (in terms of patents, international law, economic inequalities, and pressure between states, among others) and that are not replicated in the debate on the distribution of other resources, nor are they replicated in the debate on the distribution of the same resource (vaccines) at the local level. Likewise, specific moral problems may arise due to the characteristics of the resource under consideration. There is no reason to assume that the morally justified criteria for distributing a therapeutic resource will be identical to those that should govern the distribution of a preventive or palliative resource. In fact, unlike what happened with the allocation of respirators (a therapeutic resource), in many countries, the policy of distributing vaccines (a preventive resource) against COVID-19 prioritized the elderly, a group particularly vulnerable to possible contagion. In any case, if this difference in the characteristics of the resource itself is believed to be morally irrelevant, it must be proven on the basis of a solid independent argument (the same would apply to any attempt to dismiss as morally irrelevant the characteristics of the context of production of certain resources, such as vaccines).

Therefore, it seems more sensible to limit the analysis to a specific type of resource. Macklin's paper specifically analyzes the use of age as a criterion for distributing ventilators. However, her analysis can be extended to the distribution of scarce therapeutic resources in general. By "therapeutic" should be understood any resource aimed at treating and/or curing an already acquired disease. In turn, therapeutic resources should be distinguished from preventive and palliative resources. By "preventive" should be understood any resource aimed at preventing the patient from getting a certain disease. By "palliative" should be understood any resource aimed at alleviating the suffering and improving the quality of life of patients suffering from a serious disease that, in principle, cannot be treated and/or cured.[3]

I believe that the conclusions that can be reached regarding the (non)permissibility of ageism in the distribution of scarce therapeutic resources (such as ventilators, beds, and qualified human resources) may be important when defining the (non)permissibility of ageism in the distribution of scarce preventive resources (such as vaccines, masks, sanitizers). It does not seem sensible to assert that the discussion on the criteria for distributing resources that prevent the acquisition of a disease is completely independent of the discussion on the criteria for distributing

resources that make it possible to treat and/or cure that disease once it has been acquired.[4] However, each discussion must recognize the morally relevant characteristics of each resource. That said, in the present essay I will limit myself to considering, as Macklin does, the use of age to allocate scarce therapeutic resources.[5]

II.c – Prioritization and tie-breaking

The first version of the CSG guideline holds that age can be used only as a criterion to break the tie between patients. This means that age could only enter as a relevant consideration in a situation where all medical criteria have been exhausted to distinguish between patients and allocate the resource.

The authors (and triage guidelines) tend to agree that the relevant medical criterion for allocating a scarce therapeutic resource among equally needy persons should be the probability of survival of each of them if they receive the resource. This should not be surprising. If we consider that every life is equally valuable, we should opt for a criterion that allows us to save the greatest number of individual lives possible.[6]

Arguably, this use of the probability of survival also operates as a tie-breaker between people equally in need of the resource (both are tied with respect to the need to receive the resource). However, defining it in this way prevents us from recognizing the difference between the use of the probability of survival and the use of age between people with an equal probability of surviving if they receive the resource. To distinguish between these criteria, it is convenient to refer to the use of probability of survival as a prioritization criterion and the use of age as a tie-breaker.

The use of a characteristic as a prioritization criterion is distinguished from the use of a characteristic as a tie-breaker by virtue of the importance attached to it within a triage procedure. Prioritization criterion operates as the first and most fundamental filter within triage. It makes it possible to distinguish between patients based on one (or more) characteristics that are considered highly relevant. The tie-breaker, on the other hand, operates as a second filter, once the highly relevant characteristics do not allow distinguishing between patients and allocating the resource.

Thus, the first version of the CSG guideline, by accepting the use of age only as a tie-breaker, is giving age a lesser importance with respect to other patient characteristics, namely, their probability of survival if they receive the ventilator.

As I mentioned above, the most widely accepted prioritization criterion is that of the probability of survival. This is a characteristic that is

presumed to be neutral and does not incorporate considerations that could undermine the principle of equal value of all patients.

However, other prioritization criteria can be formulated. The challenge for triage guideline developers who believe that there is more than one highly relevant characteristic to consider is to express these characteristics in the form of mutually consistent and applicable prioritization criteria. For example, in the midst of the COVID-19 pandemic, some authors argued for giving preference to physicians and healthcare workers. This priority was often justified on instrumental grounds (we need them to continue fighting the pandemic) and/or reciprocity grounds (we owe them preferential treatment because they were exposed to contagion more than other citizens). One way of operationalizing this preferential treatment is by incorporating the characteristic of "being a healthcare worker" as a tie-breaker. So, in a situation where two people need the same scarce therapeutic resource, both have an equal chance of survival, but one of them is a healthcare worker, we should allocate the resource to the healthcare worker. In this way, "being a healthcare worker" would operate as the age in the CSG guideline.

However, we might want to give even more preferential treatment to the healthcare workers group. Perhaps merely incorporating it as a tie-breaker does not reflect the duty of reciprocity we have towards them or the degree of the health emergency that requires all possible medical resources. In that case, "being a healthcare worker" could be incorporated as a prioritization criterion. Thus, a doctor or nurse could have priority over another citizen, even if he or she has a lower probability of survival.[7]

The same thing can happen with the use of age. Some people may believe that age is such a relevant variable that it should be operationalized as a prioritization criterion and not just as a tie-breaker. Thus, a young person should be prioritized over an old person and receive the resource, even if he or she has a lower probability of survival. Put in these terms, the use of age as a prioritization criterion is hardly acceptable. However, the use of metrics that link different variables, such as QALYs (Quality-adjusted Life Years) or DALYs (Disability-adjusted Life Years), can incorporate age as a disguised prioritization criterion.

In general, the use of age is more explicitly accepted as a tie-breaker. Only once a non-ageist prioritization filter has been applied can age be considered as a tie-breaker. As with the distinction between using age to distribute therapeutic resources and using age to distribute preventive resources, I believe that the use of age as an exclusively tie-breaker is difficult to sustain. The arguments usually advanced in favor of such use, if they were correct, would seem to justify a more widespread use of age,

namely as a prioritization criterion. In practice, this is probably what happens covertly. The discourse that claims that a tie must be broken in favor of the youngest can, in the manner of a slippery slope, permeate medical practice and lead to considering age as a prioritization criterion, hindering an objective analysis of the prognosis of elderly patients (FISHER, 2013).

That said, in this paper, I focus on the use of age as a tie-breaker. That is the type of use that seeks to justify the CSG guideline using CLP and it is that justification that is the subject of Macklin's critique. It is also the use that seems most difficult to reject. If the use of age as a tie-breaker does not hold, *a fortiori*, its use as a prioritization criterion will not hold.

III – Complete-lives principle

CLP can be found for the first time in a paper by Persad, Wertheimer, and Emanuel (2009). [8] Strictly speaking, these authors propose a "complete-lives system" that seeks to combine five distributive principles that capture morally relevant considerations. The complete-lives system incorporates a prioritarian principle that prioritizes the younger patient as the one who is worse off in the eventual distribution of a lifesaving resource. Comparatively, the younger patient has had less of a very valuable good, namely, years of life. Therefore, if he did not receive the resource and died, he would be deprived of a good that the other patient has already enjoyed.[9]

This principle, which the authors call the "youngest first principle," implies prioritizing infants over any other patient. Persad, Wertheimer, and Emanuel consider this to be a counterintuitive consequence of the principle to be avoided, since they argue that the death of an adolescent is worse than the death of a three-year-old child, which in turn is worse than the death of an infant.[10] Therefore, they propose a modified version of the principle ("modified youngest first principle") and give priority to young adults and adolescents not only over older adults, but also over infants.

Likewise, the complete lives system, as its name indicates, aims to produce the greatest possible number of complete lives. Therefore, it considers the patient's medium- and long-term prognosis. It is important to know whether the patient will be able to reach the threshold of a "complete life" or whether he or she has comorbidities that are likely to cause early death. For example, between a 10-year-old patient who will live to 12 and a 65-year-old patient who will live to 90, Persad *et. al*. might assert that the unfavorable prognosis of the former should be considered and prioritize the patient who could live many additional years or allocate the resource randomly. This is true, although the 10-year-old patient is the one who is

worse off and should be prioritized from the perspective of the modified youngest first principle.

The Persad et al. proposal, as the authors themselves later acknowledge (PERSAD *et al*., 2010), is a framework for incorporating morally relevant considerations in the context of allocating scarce medical resources and not an algorithm that provides a precise answer to every conceivable situation. For this reason, they do not offer a definitive answer to the aforementioned situation between a young patient with a poor prognosis who will not reach the threshold of a complete life, even if saved, and a patient who has had a complete life but who, if saved, will live many more years. They merely point out that the poor prognosis in young patients is a consideration to be taken into account and must be weighed against the modified youngest first principle.

The CSG guideline, on the other hand, is a triage protocol and consequently has the advantage of clearly distinguishing between prioritization criteria and tie-breakers. Two prioritization criteria are presented in the guideline: the probability of survival if the resource is received and the short-term survival prognosis. The first criterion evaluates a patient's likelihood of survival if the resource is received by applying the *sequential organ failure assessment* (SOFA) scoring system. The second criterion evaluates the patient's future prognosis if he or she survives the clinical condition that leads to the need for the resource. With respect to this second criterion, the guideline contemplate two options: the patient may present serious comorbidities that substantially affect his or her probability of survival in the short term, or he or she may present a terminal condition due to another disease and have a high probability of death within one year. Both criteria are incorporated into a common scoring scale ranging from 1 to 8. Only if the application of these criteria would be insufficient to determine which patient should receive the resource, is the use of age as a tie-breaker recommended.

Although the guide cites the work of Persad *et al*. as a reference, they are clearly different from each other. First, in the complete-lives system the goal is to produce as many complete lives as possible, not to save as many lives as possible. Thus, within the system, it may be justified to allocate a resource to a young patient, although that same resource could save several patients who have already had a complete life (for example, because they would need less time using the resource to survive).[11] In contrast, the guideline sets a goal to save the most lives. If X time of use of a resource can either save one person or save several, several should be saved. It is not relevant how long these people have lived, nor how many

years they will live in the future (as long as they exceed a short-term survival threshold).

Secondly, in the CSG guideline, the probability of survival (and short-term prognosis) as a prioritization criterion takes lexical priority over the age of the patients. Therefore, if patient A has a worse SOFA score than patient B, patient B should be prioritized, regardless of his or her age. The principle of distributive justice in favor of the young does not come into discussion in this type of case. Persad *et al.* instead argue that the age of patients should be weighted in conjunction with the probability of survival, although they are not precise about how this should be done (a way of doing this is proposed in KERSTEIN & BOGNAR, 2010).

Third, the CSG guideline distinguishes between age ranges (0-12, 13-40, 41-60, 61-75, and +75) and mandates a tie-breaker in favor of the patient belonging to the younger age range. Thus, it does not adopt the modified youngest first principle, since infants (0-12) would have priority over adolescents. Likewise, by incorporating ranges, it does not apply a strict version of the youngest first principle. Within each age range, there is no priority. In case of a tie between two patients belonging to the same age range, a random method of allocation should be chosen. This seems reasonable. Prima facie, there is no reason why a person of 15 should be prioritized over a person of 20. The age ranges attempt to identify "stages" or "life cycles" of people (childhood, adolescence, adulthood, and old age). It makes sense to state that a person in the 61-75 range has passed a stage of bio-psycho-social development that someone in the 13-40 range has not.

In summary, CLP, as presented in the CSG guidelines, is a version of the youngest first principle rejected by Persad *et al.* that uses age ranges to identify stages or life cycles of people and sets a tie-breaker in favor of the patient who belongs to the youngest age range. Unlike the Persad *et al.* proposal, age is only considered as a tie-breaker.

IV – Macklin's arguments

IV.a – Non-guarantee argument

Macklin presents three arguments against CLP. The first of these, which I will call the "non-guarantee argument," argues that CLP rests on the false assumption that its application in the context of triage guarantees a fair outcome, namely, that the beneficiary will be able to live a normal number of years (considering, for example, the average life expectancy of

the population). However, Macklin argues that, unlike other principles of fairness, the application of CLP cannot guarantee a fair outcome. The prioritized person may not receive the benefits that are due to him or her.

> But a child between 0 and 12 may develop leukemia or die in an automobile accident. A woman under 40 may have the BRCA gene and die of invasive breast cancer at 25. A man between 41 and 50 may die from an overdose of opioids. Individuals from 65 to 75 may drop dead of a heart attack even if they do not have prior heart disease or other co-morbidities at the time they are evaluated with Covid-19. At the other end of the life span, an increasing number of people live well into their 90s and even reach 100. People's physiological age can be lower or higher than their chronological age. In sum, the complete-lives principle is applied without any possible reference to real-life circumstances that can cause death at any age. The 75-year old who lives to 100 has more life years left than the 40-year old who dies in 10 years from colon cancer (MACKLIN, 2020, 591).

Certainly, the death of a person can occur at any age for different reasons. But this fact does not allow us to reject CLP as an incorrect principle of distributive justice.

It is useful to begin by drawing a key distinction between "unfair" and "unfortunate" (RIVLIN, 2000). Problems of fairness emerge in contexts in which human agency is involved and moral rights are involved. Thus, it makes no sense to say that it is unfair for a 20-year-old to die at age 25 of cancer (although this is an expected statement in such a tragic situation). To say so implies that this person has a moral right not to die of cancer and that this right was violated by human agency in a certain way. It is correct to assert that that person's death is "unfortunate."

Although no one has a moral right to live a certain number of years (and so it is incorrect to claim that it is unfair for him to die before reaching that number), it may be correct to claim that it is unfair that when faced with the allocation a life-saving resource to a 20-year-old or an 80-year-old, it is not allocated in favor of the younger one. This is what CLP advocates argue.

The dimension of fairness may enter into that decision because what is being evaluated is the response of whoever must allocate the resource in the face of the fact that one person has lived a certain number of years and another person has not. If the person of 20 years died unexpectedly at the age of 25, that does not imply that the decision to allocate the saving resource was not fair. The allocation of the saving resource was fair, in light

of CLP, and his death, which is outside the scope of our agency, was simply unfortunate and does not affect the fairness of the allocation. Consider the following example to illustrate this distinction.

Funfair: A funfair has come to town and will be open for two days only - Saturday and Sunday. Juan, who was looking forward to going to the funfair and had bought his ticket to go on Sunday, has the flu and has fallen into bed on Friday, so he will not be able to go. Juan must decide what he will do with the ticket he has purchased. He has two options. He can give it to Carla, who had bought a ticket for Saturday, but lost it, or he can give it to Maria, who went to the funfair on Saturday. Juan has no special reason to prefer one option or the other (he is either friends with both or neither).

It is not unfair that Juan has the flu and cannot go to the funfair. His situation is simply unfortunate. Juan's decision of what to do with his ticket can be evaluated as fair or unfair. For example, if he decided to give it to Maria, his decision could be evaluated as unfair. Juan had the option of allocating a resource (his ticket) to favor the person who was worse off and decided to favor the one who had already enjoyed the funfair. This is true even though Carla did not have a moral right to go to the funfair regardless of Juan's decision. In fact, that Carla lost her ticket is not unfair but unfortunate (in the same way that Juan's condition is unfortunate). However, it is reasonable to say that Carla has a moral right to receive the ticket from Juan. Ultimately, Maria has already gone to the funfair and it is up to Juan to allow her to go. [12]

CLP in the context of triage can function analogously. It is not unfair per se for the younger person to be in a position to need a lifesaving resource. It can be considered unfair, and this is what advocates of CLP argue, that he or she should not be allocated the resource versus a patient who has already lived a "complete life" (whatever this means). Not breaking the tie in favor of the younger patient is analogous to not giving the ticket to Carla (and, for example, drawing lots between Carla and Maria, who has already visited the funfair).

That said, it could happen that Carla again loses the ticket given to her by Juan or gets a similar flu-like condition, or twists an ankle while entering the funfair and does not enjoy any of the rides. Any of these unfortunate possibilities does not affect the assessment of Juan's action as fair. Juan's action was intended for Carla to enjoy the funfair, but the scope of his agency is limited to the allocation of the ticket. In principle, Juan will not be able to prevent Carla from losing her ticket, getting a flu-like

condition, or twisting her ankle. The fairness of his action does not depend on what subsequently happens to her.

Thus, Macklin's claim that CLP cannot guarantee a fair outcome is an error in the object of moral evaluation. CLP guarantees a fair outcome regarding to whom a resource should be allocated. That decision, and the outcome it produces, can be evaluated as fair or unfair. In contrast, the years that the person benefited by CLP will live are not the subject of a fairness analysis, since they do not depend on the human agency of the resource allocator and there is no moral right to live a certain number of years.[13]

Beyond this error, Macklin seems to introduce two independent criticisms that are worthy of attention. First, we might ask about the moral relevance of the fact that a person will not reach the threshold of a complete life. This fact can be known *ex ante*. For example, we could ask how to decide between a 30-year-old patient A who will live to 45 because of other comorbidities and a 50-year-old patient B who will live to 80. According to the age ranges established in the guideline, patient A will not pass two age ranges (61-75 and +75) and, consequently, will not live a complete life. Patient B, on the other hand, will be able to pass all age ranges, will live a complete life, and would lose many more years of life if he or she were to die.

Second, Macklin argues that a person who has passed all age ranges may have more years of future life than a person who is in a younger age range. For example, a 40-year-old may live to 50 and a 75-year-old may live to 100. Again, this information may be known *ex ante* by those who have to allocate the lifesaving resource.

Under the "no guarantee argument", Macklin does not develop these objections. However, I think they are interesting in showing the problems with a perspective that adopts CLP. I will return to these types of decisions involving a patient who will not be able to achieve a complete life in Section V.

IV.b – Borderline cases argument

Macklin's second argument, which I will call the "borderline cases argument," argues that the age ranges proposed in the CSG guideline can lead to arbitrary outcomes when the lifesaving resource is contested by the oldest patient in one age range and the youngest patient in the next age range.

> The younger person who falls within these brackets when a tie exists: 0-12, 13-40, 41-60, 61-75 and +75. Let us assume

that the two people arriving at the same time and with the same medical eligibility for treatment are age 40 and 41. The 40-year old gets the ventilator but not the 41-year old. The same holds for any age groups that cluster around the first and last ages in each bracketed group. What is suggested as a principle to save the most remaining years of life becomes no better than a lottery at the edges of these age Brackets (MACKLIN, 2020, 591).

Macklin is right that allocating the lifesaving resource to the 40-year-old and not to the 41-year-old, simply because the former belongs to the younger age group, is arbitrary. There is no morally relevant difference between the two on the basis of age that should be taken into account in the allocation of a lifesaving resource. However, the scope of his objection is very limited and the CLP advocate could easily answer it.

The borderline case problem pointed out by Macklin is intrinsic to the use of age group distinctions. For example, when a minimum voting age is set, a distinction is made between two age groups: the group of those at or above that age and the group of those below that age. Let us assume that the minimum age to exercise the right to vote is 18 years old. One might ask why a person of 17 is denied the right to vote and a person of 18 is guaranteed the right to vote.

To answer this type of concern, it is worth distinguishing between the arbitrariness of the chosen age (e.g., 18) and the arbitrariness of the act of setting an age (GOSSERIES, 2013). Let us stay with the example of the right to vote to illustrate this difference.

In the case of voting, age is not intended to operate as a relevant datum in itself to grant the right to vote, but as an indicator or proxy of another datum that is relevant to grant the right to vote, namely, the ability to make reasoned decisions in political matters. Arguably, no matter how this ability is defined, there will be people who are above any reasonable age threshold, have no serious cognitive disability, and have no ability to make reasoned political decisions. This is true, but these are presumed to be exceptional cases and in the absence of an uncontroversial test to individually assess such ability the right to vote of such persons cannot be denied. Conversely, children are presumed to lack the ability to make reasoned decisions in political matters and such inability is often linked to a lack of development in their cognitive functions. It is not reasonable to allow a 5-year-old child to exercise the right to vote and it is reasonable to allow a 45-year-old adult to exercise the right to vote. But where should one draw the threshold at which one has the right to vote?

Since life is a continuum and the development of the cognitive functions that allow us to make reasoned policy decisions does not magically

occur at a certain age, any threshold chosen will be somewhat arbitrary. But that does not imply that it is arbitrary to set some threshold and that there are no distinctions regarding the arbitrariness of possible thresholds. A threshold can be established on the basis of the contributions of cognitive sciences that allow us to define approximately the age at which most people reach the adequate development to make reasoned decisions in political matters. There will be young people who develop the ability before that threshold, but it is presumed (as well as adults who do not develop it) that these are exceptional cases. Ideally, and in the absence of a non-controversial test to individually assess the ability to make reasoned political decisions, the threshold should be established based on the contributions of cognitive sciences and seeking an appropriate balance between false positives (people who did not develop the ability, but are recognized the right to vote) and false negatives (people who did develop the ability, but are not recognized the right to vote).

Age discrimination has a special nature that distinguishes it from other types of discrimination (e.g., racial or sexual). Although age escapes our will, we will all pass, at best, through all age groups before we die (DANIELS, 1988; BIDADANURE, 2017). This is the reason why the determination of the threshold for the right to vote does not produce too much discussion. Given that those who are 17 and cannot vote (although perhaps they have the ability to make reasoned decisions in political matters) will be 18 and will be able to do so, the discrimination they suffer is not equally severe as that suffered by people on the basis of their sex or race and is compatible with diachronic equality among all people (all will be, at best, discriminated against in the same way before the age of 18).[14]

Macklin is arguing about the decision to allocate a resource on which patients' lives depend. The consequences of (not) allocating a lifesaving resource by virtue of age group membership are more serious than those of disallowing the exercise of the right to vote. It is difficult to accept that such an important decision should be made on the basis of a threshold that could have been set differently. If the age ranges were defined differently than the guideline proposes (e.g., 13-39 and 40-60), the allocation of the lifesaving resource between the 40-year-old and the 41-year-old would have to be resolved by a random method, which prima facie seems more appropriate.

The problem with Macklin's argument is that it is limited to questioning borderline cases between contiguous age groups. Macklin's objection does not address the central problem about the arbitrariness implicit in the definition of any age group. There is a very simple way to incorporate age ranges and defend CLP from the borderline cases argument

as Macklin puts it. It would be sufficient to introduce subdivisions between age groups and allow tie-breaking in favor of the younger patient only between non-contiguous groups. Instead of 0-12, 13-40, 41-60, 61-75, +75, the ranges could be divided as follows: 0-10, 11-20, 21-30, 31-40, 41-50, 51-60, 61-70, 71-75, +75. Thus, CLP would not apply to break the tie between a patient of 40 and a patient of 41, but, for example, between a patient of 40 and a patient of 51. I think many CLP advocates would find this proposal more convincing than that of the guideline, which within the 13-40 group includes patients in very different life stages from each other (adolescents of 15 years, young adults of 25, and adults of 40).

Although this solution defuses Macklin's argument, it shifts the problem of borderline cases to the oldest person in the youngest group or the youngest person in the oldest group. If there were a tie between a 40-year-old and a 51-year-old, one might ask why the tie should be broken in favor of the younger person. The 51-year-old does not belong in an age group contiguous to the 40-year-old just because the contiguous group was arbitrarily defined as 41 to 50. The borderline problem is intrinsic to the very use of age groups and does not depend on the closeness in age of the patients involved as Macklin argues.

Macklin's argument does not address the central problem of the use of age ranges in the context of triage. The central problem is about the very nature of age ranges. In the discussion of voting rights, age operates as an imperfect proxy for the ability to make reasoned political decisions. In the discussion on the allocation of scarce therapeutic resources, it is not clear whether age range membership operates as a proxy or as a relevant datum in itself. As I will argue in Section V, both options are problematic.

IV.c – Undesirable consequences argument

Finally, Macklin argues that CLP can produce undesirable consequences. To prove this, she presents the following example.

> Suppose a 4-year old child arrives at the hospital at the same time as her 32-year-old mother. The guidance says give the ventilator to the child. But that child has five older siblings and the mother is the sole parent caring for all six children. She dies, and six children are without a parent and few, if any, resources. It is patently clear that such situations could not possibly be discovered and resolved on a case-by-case basis by taking into account the various life circumstances of patients who arrive at the hospital in an emergency. Selecting the recipient by chance could, of course, have the same result: chance could favor the child as well as the mother. But that's "the luck of the draw", not some presumption of

fairness, which the complete-lives principle purports to ensure." (MACKLIN, 2020, 591-592)

By referring to the death of the 32-year-old mother (and the orphaning of six children) as an "undesirable consequence," Macklin seems to be asserting that it is an outcome that if known in advance would affect the fairness of resource allocation. The question is whether the allocator of a lifesaving resource should take into account the relevant features of this example. Should it be taken into account, for example, that one of the patients performs caregiving duties and/or is the provider of a family? This is a question that runs through the debate on allocation of scarce therapeutic resources from its inception and is, in a sense, independent of the moral relevance of age. The tie could be posed between the 32-year-old mother in Macklin's example and another 32-year-old childless person.

The undesirable consequences argument does not raise an objection to CLP but to membership in different age ranges being the only morally relevant variable to break the tie. The trait "being a caregiver" or "being the only family member caring for dependents" can be incorporated as a tie-breaker along with age.

It remains to be clarified how both tie-breakers can be consistently incorporated into a triage. This is especially the case in examples such as Macklin's, where CLP mandates saving the youngest person and the criterion "being the only family member caring for dependents" mandates saving the mother. A possible solution could be to opt for a randomized method when the fulfillment of both criteria is considered equally important. This is compatible with stating that sometimes CLP is morally more important than saving the caretaker. This could occur, for example, if the tie were between the 4-year-old child in Macklin's example and an 85-year-old grandparent who is the sole caretaker of his grandchild. Also, as Macklin intends to show with his example, the criterion "being the only family member caring for dependents" may be morally more important than CLP. The random method should be the option used when the patients who need the resource do not have morally different traits from each other or when they have morally different traits from each other, but neither is more important than the other all things considered.

In his example, Macklin proposes the use of a random method because the family situation of the patients cannot be known in a triage. The lottery may produce the outcome Macklin considers incorrect (saving the child of 4 and leaving his mother to die), but it does so randomly and not on the false assumption that the right decision is being made. This proposal by Macklin would imply discarding CLP and applying only the random method as a tie-breaker, since we could always be faced with a

patient whose death would be worse all things considered. This solution is clearly implausible if one accepts that CLP is morally relevant, since it implies not making a decision on the basis of a known morally relevant trait (age), because of the possible existence of another morally relevant trait that is more important (being the only family member caring for dependents). This is compatible with recognizing, if the latter trait is subsequently ascertained, that the result of the allocation was unfair. But the allocation must be made in the light of the information known *ex ante*. In this sense, it is advisable to distinguish between the fairness of the allocation outcome and the fairness of the allocation.

In short, the undesirable consequences argument does not concern CLP per se, but its inclusion as the only tie-breaker in a triage. Since the other tie-breaker implicit in Macklin's example (being the only family member caring for dependents) is difficult to be known in the context of a triage, that leaves only CLP as the sole tie-breaker or the use of a random method in all cases (even in those where CLP seems more plausible: for example, in the tie between a 4-year-old child and an 85-year-old elderly person).

Although it exceeds the limits of my analysis, I am interested in pointing out two reasons for not incorporating the relevant features of Macklin's example in a triage.

First, the fact that a person does not have children does not imply that he or she does not perform caregiving tasks and that his or her death does not affect dependents in his or her care. A person may care for a disabled family member, or assist people in a community center. The existence of these tasks is even more difficult to know in the context of triage and, in turn, it is difficult to compare their importance with that of care tasks for one's own children. Secondly, tie-breaking in favor of those who perform caregiving tasks may imply a bias against the group of people who are considered, sometimes erroneously, as incapable of performing caregiving tasks and mere beneficiaries of the care of others. The allocation of scarce therapeutic resources is an area of decision-making that is highly conducive to these ableist biases that mask a distinction between more and less valuable lives, and any risk of encouraging them should be avoided.

V – Against CLP

CLP is a type of fairness-based argument in favor of ageism. [15] Fairness-based arguments frame the discussion of the relevance of age as a problem of distributive justice in which the currency is years of life. Unlike consequentialist arguments in favor of ageism, fairness-based arguments

do not focus on the years of life that a person has ahead of him or her, but on those that he or she has already lived. In this sense they are centrally backward-looking rather than forward-looking.[16]

This can be illustrated by an example. The tie between a 40-year-old patient A who will live to 50 and a 75-year-old patient B who will live to 90 would be solved very differently by a consequentialist approach that seeks to maximize the years of future life and by a fairness-based approach that seeks to fairly distribute the years of life between the patients. The consequentialist approach would break the tie in favor of patient B, who will live 5 years longer than patient A. The fairness-based approach would tie in favor of patient A, who would have lived fewer years than patient B if he had died.

There are different ways to implement this fairness-based approach and each carries different implications. One simple way to implement it is through the youngest first principle (mentioned in section III). The problem with this principle is that it introduces age as a tie-breaker even when it is counterintuitive to do so. For example, to tie-break between a 40-year-old and a 41-year-old patient.

There is no morally relevant difference by virtue of age between these patients that should be considered in allocating a lifesaving resource. An alternative way to implement a fairness-based approach is to establish a threshold at which the age difference between patients is relevant. Let us call this approach "threshold ageism." Threshold ageism can mandate tie-breaking in favor of the younger patient only when there is an age difference that is above a threshold (e.g., 10 years difference). Thus, tie-breaking could be ordered in favor of the 40-year-old patient when competing for a lifesaving resource with a 50-year-old patient, but not when competing with a 45-year-old patient.

Threshold ageism is more plausible than the youngest first principle. However, it is not clear why a ten-year difference is sufficient to break the tie in favor of the younger patient. Consider, for example, a tie between patient A age 10 and patient B age 20. Although patient B has enjoyed a good that patient A has not, it is reasonable to assert that both are equally bad off in the face of early death. That B has lived 10 years longer than A, in this case, is not sufficient to claim that it would be unfair not to allocate the resource to A. The correct thing to do seems to be, prima facie, to break the tie by a random method.

Much of the intuitive force in favor of using a random method in this case lies in the fact that A and B are young people who arguably have not yet lived long enough. Allocating the resource to A would be equivalent to giving a funfair ticket to Carla just because Maria has been inside for five

minutes (to return to the example in section IV.a). In such a scenario we would say that both people are in similar conditions, that neither of them has been able to enjoy the funfair and that the ticket should be allocated randomly between them.

Perhaps 10 years is not a large enough age difference to resolve a tie. Could an age difference of 20 or 30 years be sufficient? The central question is not where the threshold should be set but what that age difference indicates. The age ranges used by CLP are not morally relevant in themselves, but are intended to operate as a proxy for "life stages" (childhood, adolescence, adulthood and old age).

There are two ways of interpreting this idea of "life stages". In one interpretation, age ranges do not function as a proxy, but are the way of defining life stages. In this interpretation, childhood, for example, is defined as the period from 0-12. Belonging to this age range does not indicate something different from what that range seeks to define. This interpretation presents the problem of arbitrariness pointed out in Section IV.b. In a tie between a 10-year-old patient A and a 15-year-old patient B, CLP would order a tie-breaker in favor of A because he has not completed a life stage that B has already completed. But this results from having defined the life stage of childhood as 0 to 12 years. [17] This interpretation does not offer an explanation as to why having gone through a life stage is morally relevant.

There is another interpretation according to which age ranges are linked to certain life experiences considered valuable. Thus, the 65-year-old (who is in the 61-75 range) has enjoyed the valuable life experiences of the three previous ranges (0-12; 13-40; 41-60). Under this interpretation, the age ranges are not relevant in themselves but operate as a proxy or indicator of having gone through certain valuable experiences. This interpretation has great intuitive appeal. Normally, ages are associated with certain experiences. It is estimated that a 30-year-old has lived through certain experiences that a 10-year-old is still waiting to live through. The problem with this interpretation is that it assumes an overly structured view of human life and its stages. Consider the following life experiences that are recognized as valuable and that people often perceive as giving meaning to their lives: falling in love, having children, discovering a vocation, starting a family, seeing one's loved ones develop, having friends, influencing the political life of the community in which one lives. Each of these significant life experiences can occur at any chronological stage of a person's life.

A possible response to this objection could be that patients in the first age range (0-12) did not have those life experiences while patients in subsequent age ranges at least had the opportunity to have them. Age

ranges then function as a proxy not for "having had valuable life experiences" but for "having had the opportunity to have valuable life experiences". This brings CLP closer to another fairness-based argument, namely the fair innings argument (FIA), which, as its name suggests, seeks to distribute opportunities (innings).

This version of CLP escapes the above objection. It does not assume that each age range has its own set of significant life experiences. However, it does present problems.

First, in this version of CLP there is no reason to justify the use of age ranges. Belonging to an age range is not a good proxy for having or not having had certain opportunities. Especially when comparing patients who are reaching the end of the youngest age range and patients who are entering the next age range. It is more convenient for that purpose to appeal to "threshold ageism" and establish an age difference threshold (e.g., 30 years) that functions as a proxy for whether one patient has had more opportunities to have valuable experiences than another. For example, a 40-year-old patient can be said to have had more opportunities to have valuable experiences than a 10-year-old patient, regardless of establishing fixed age ranges containing one and the other. [18]

Second, even if the use of age ranges is retained, CLP presents the same problem as FIA, namely, it takes age as a sufficient indicator of having had opportunities. To know whether a person has had opportunities to have valuable life experiences it is necessary to know what the years he or she has lived have been like (JECKER, 2022, 6). The importance of this analysis can be illustrated by returning to the example of the funfair in section IV.a. Suppose Juan must decide whether to give his ticket to Carla or Maria. Maria went to the funfair on Saturday, but twisted her ankle on the way in and spent her entire time in the funfair sitting on a bench and did not enjoy any of the rides. The fact that Maria suffered this unfortunate event is a morally relevant datum for choosing a random method for allocating the ticket.

Similarly, the same can be said of those older people who for various reasons have not had enough opportunities to have valuable life experiences. Imagine the situation of a 75-year-old person in a country that has just emerged from a 30-year war. Undoubtedly, we would say that this person has had fewer opportunities to have valuable life experiences than a 75-year-old person who spent the last 30 years in a country without war.

This is compatible with saying that the 75-year-old who has lived through war has had *some* opportunities to have valuable experiences. Indeed, he or she may have fallen in love, had children, and formed friendships with others even in the midst of the horror of war. However, it is plausible to claim that those opportunities were either not enough or too

inconvenient to allocate the resource to the younger person. This consideration can be replicated in many other cases: people who have been unjustly imprisoned for a long time, people who have escaped from very oppressive environments (for example, the abused women in the Amish community in Manitoba, Bolivia, whose story is portrayed in Sarah Polley's film "Women Speaking") or from violent interpersonal relationships, people who wake up from a very prolonged coma (exceptional cases such as Jan Grzebski, Munira Abdulla, Terry Wallis and Miguel Parrondo) or who have gone through long incapacitating illnesses.

Chronological age is too imperfect a proxy for the opportunities a person has had in life. Especially when the allocation of a life-saving resource depends on it.

However, it is arguably an adequate proxy when seeking a tie-breaker between very young people, who are in the first CLP age range, and very old people, who are in the last age range. For example, a tie between a 10-year-old patient and a 75-year-old patient. In that case, there is a sufficiently large age difference that the older patient has had some opportunities and the younger patient is worse off in the face of the possibility of an early death (RIVERA LÓPEZ et al., 2020, 50). This solution would reduce the practical application of CLP considerably. CLP would only apply in case of a tie between pediatric and geriatric patients. Although this option is reasonable, the discussion remains open as to where to establish the thresholds above which this restricted application of CLP makes sense. [19]

Finally, CLP presents some internal inconsistency when it mandates a tie-breaker in favor of younger people who will not be able to go through all age ranges. CLP rests, as its name suggests, on the idea of a "complete life". This idea, like that of "fair innings" in FIA, assumes that after a certain age it can be reasonably asserted that a person has already had (or has had the opportunity to have) a significant set of valuable experiences: they have completed their life projects, have found their vocation, have developed professionally, among other experiences.

As we have seen, this assumption is open to at least two criticisms: it assumes an excessively structured view of life and takes age as a sufficient indicator of having had certain opportunities. Here I am interested in pointing out a third problem. If it is desirable for a person to complete his or her life (however that is understood), then priority should be given to the person who can go through all age ranges and not necessarily to the youngest person. Let's imagine the case of a tie between a 10-year-old patient A who will live to 50 and a 70-year-old patient B who will live to 90. A has forty years ahead of him but only patient B will be able to "complete

his life" and go through all age groups. Although CLP is a type of fairness-based argument and as such is centrally backward-looking, in these types of cases it has to incorporate a forward-looking perspective. This is a difficult consequence to accept for an argument in favor of ageism.

In summary, I have presented three objections to CLP. The first can be called the "structured view objection" and is directed against the version of CLP that uses age ranges as a proxy that people have had certain valuable life experiences. The second can be called the "oversimplification objection" and points against the CLP version that uses age ranges as a proxy that people have had opportunities to have valuable life experiences. This objection also reaches FIA. The third objection can be called the "internal inconsistency objection" and points out that in cases of a tie between a young patient who will not reach the threshold of a complete life and an older patient who can reach it, CLP should break the tie in favor of the older patient.

VI - Conclusion

In this paper, I have reconstructed and criticized the three arguments formulated by Macklin against CLP. The "no guarantee argument" mistakes the object of moral evaluation in the allocation of a scarce therapeutic resource. CLP, if correct, can guarantee a fair outcome on who should receive the resource, but it cannot prevent unfortunate outcomes. The "borderline cases argument" criticizes the arbitrariness of a tie-breaker in favor of the oldest patient in the youngest age range when he or she contests the resource with the youngest patient in the next age range. This criticism is correct but limited. Macklin does not advance the arbitrariness of establishing any age range and does not question the nature of age ranges as proxies. The "argument from undesirable consequences" does not reject CLP per se but its exclusivity as a tie-breaker. Macklin proposes the characteristic " being the only family member caring for dependents " as a relevant trait to be incorporated as a tie-breaker. I offered two reasons for rejecting this proposal.

Subsequently, I raised three objections to CLP. First, I argued that one version of CLP assumes an overly structured view of life, assigning each age range its own life experiences. Contrary to this assumption, life experiences usually regarded as valuable or meaning-giving to life can occur at any chronological age (structured view objection). Second, I asserted that age is too imperfect a proxy for the opportunities a person has had throughout his or her life to have valuable experiences (oversimplification objection). At best, age can operate as such a proxy only to break the tie

between pediatric and geriatric patients. Third, I argued that CLP must accept a counterintuitive outcome when it must resolve a tie between a young patient who will not reach the threshold of a complete life and an older patient who may reach it (internal inconsistency objection).

Notas

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[2] Authors rejecting ageism in the distribution of scarce therapeutic resources include RIVLIN (2000), FISHER (2013), GULLETTE (2020), INOUYE (2021), and JECKER (2022). For a defense of ageism see BOGNAR (2015), EMANUEL *et al.* (2020), MILLER (2020), SINGER (2020), among others. In the context of the COVID-19 pandemic, in addition to the CSG guideline, the following triage guidelines were published that accept ageism to distribute scarce therapeutic resources: OBD (2020), SIAARTI (2020) and UP (2020). In fact, the CSG guideline is, as far as prioritization criteria are concerned, a copy of the UP guideline.

[3] This distinction is merely analytical for the purpose of clarifying the discussion. In practice, the same resource can be considered therapeutic, preventive and palliative. For example, a hospital bed can be considered as a therapeutic resource or as a palliative resource. The same can be said of the working hours of a health professional. In any case, if the moral criterion for allocating a given resource is being discussed, it is important to know whether it is being considered as a therapeutic, preventive or palliative resource, since there is no reason to assume that the moral criterion should be the same for allocating any medical resource.

[4] There may be an implicit trade-off between "risk of getting X disease" and "risk of dying if get X disease". For example, it can be estimated that the risk of a young person becoming infected and dying is not so high that the elderly (who are at a higher risk of dying if they become infected) should not be vaccinated as a priority. This is compatible with stating that once both are infected, the decision is different. Here I am only pointing out that discussions on the distribution of preventive resources and on therapeutic resources cannot be completely independent. If it is believed for prioritarian reasons that the young are worse off than the old in terms of the possibility of dying, the moral importance of the risk of the young becoming infected and dying is greater.

[5] It should be noted that I am referring to indivisible resources (PERSAD *et al.,* 2009). Indivisible resources are those that cannot be divided between two or more patients without losing their effectiveness (to a significant degree). For this reason, it does not make sense to ask how much of the resource belongs to each one, but rather who should receive the entire resource.

[6] This is certainly a consequentialist approach. In another text, I argued that this consequentialist approach should only apply to decisions to allocate scarce

therapeutic resources. For reallocation decisions, a deontological constraint should be incorporated, even at the cost of, at the end of the day, saving fewer lives.

[7] The challenge is to define how the different prioritization criteria can be made compatible. RIVERA LÓPEZ *et al.* (2020) propose different ways of incorporating the characteristic "being a healthcare worker" as a prioritization criterion according to the importance that is intended to be given to it.

[8] When CLP is introduced in the CSG guideline, PERSAD *et al.* (2009) is cited as a reference.

[9] A distinction is usually made between "lifetime prioritarianism" and "time slice prioritarianism" (NIELSEN, 2022, 236). The former focuses on a person's entire life to see if he or she is worse off than someone else. The second focuses on how much worse off a person is at any given time. In the debate about the moral relevance of age in allocating scarce resources, the prioritarianism under consideration is lifetime prioritarianism.

[10] PERSAD *et al.* propose this for two reasons (2009, 428). First, adolescents and young adults have received education and parental care while infants have not yet. This is an odd reason as it focuses not on the patients but on the efforts that others made. In addition, there may be adolescents who have not received such parental education and care. Following this rationale, a distinction should be made between adolescents who have received parental education and care and those who have not. This is clearly implausible. Persad *et al.* try to avoid this in an *ad hoc* way, considering all adolescents in the same way, even if they have not received parental education and care. Second, Persad *et al.* argue that, unlike infants, adolescents have a developed personality to the point of forming long-term plans. The problem with this reason is that it may involve an ableist bias. There are adolescents who lack the capacity to develop long-term plans due to a disability. The "modified youngest-first principle" has been subject to criticism (KERSTEIN & BOGNAR, 2010; GAMLUND, 2016) and defense (TALLMAN, 2012).

[11] I consider that this possible implication of the complete-lives system should be seen as a *reductio ad absurdum* of the whole proposal. However, BOGNAR (2015, 254) believes that this implication, or some close version, is perfectly reasonable. Bognar claims that the position according to which the principle of saving the most lives should take lexical priority over any other consideration is counterintuitive and replicates a consequentialist aggregation problem (SCANLON, 1998, 235).

[12] An anonymous reviewer pointed out that the fact that Carla may have lost her ticket by being careless may be relevant in assessing who should receive the ticket (just as it may be relevant that a person is a heavy smoker when in need of a second lung transplant). This is true. But the example poses a situation between a person who lost his ticket (perhaps by being careless) and a person who already went to the fair. In any case, to avoid any kind of distortion, I assume that Carla lost her ticket for reasons that cannot be attributed to her irresponsibility.

[13] There is a biblical reference that some have interpreted as the affirmation of a right to live at least 70 years (Psalm 90: 10). However, a complete reading of this psalm shows that it does not refer to a right, but to a fact ("Our days may come to seventy years, or eighty if our strength endures"). Moreover, the general tone

of the psalmist is one of devaluation of human years in the face of God's greatness ("A thousand years in your sight are like a day that has just gone by, or like a watch in the night.").

[14] For reasons of space, I cannot dwell on this point. But, it should be noted that this compatibility between age discrimination and diachronic equality is not sufficient to accept age discrimination. Compatibility simply points to a feature of the nature of age discrimination but says nothing about its justification. Age discrimination can be unjust, even if we all experience it in the same way. Moreover, it is not true that all people experience age discrimination in the same way. In certain contexts, poor people, for example, suffer from ageism in the allocation of scarce resources at a certain age, while rich people will not suffer from it because they can afford their own resources.

[15] The category "fairness-based argument" is taken from BOGNAR (2015). Under this category, Bognar includes the fair innings view of John Harris and the prudential lifespan account of Norman Daniels. He then presents his own hybrid position, which combines consequentialist (maximizes future years) and prioritarianist (gives different weight to each year depending on the patient's age) considerations.

[16] This is compatible with asserting that future years should have some weight in the allocation of resources, but this weight should be less with respect to the fair distribution of years of life among people. This is a classic difference between consequentialist and deontological approaches, as originally pointed out by Prichard when referring to the inability of utilitarianism to account for the moral importance of keeping promises.

[17] In addition, there is the issue of patients who are finishing one stage and patients who have just started the next stage. Following the age ranges of the CSG guidelines, the 10-year-old patient is about to finish the first life stage and the 15-year-old patient has just started the next life stage.

[18] The use of age ranges can be maintained and a tie-breaker can be proposed in favor of the younger patient when the older patient belongs to a non-contiguous age range (as I proposed in section IV.b). However, this proposal maintains the problem of the arbitrariness of the ranges already pointed out.

[19] I believe that the previously noted cases of older people who have not had sufficient opportunities to have valuable life experiences for various reasons (illness, war, oppressive context) maintain their strength in cases of a tie between pediatric and geriatric patients. Such cases may be exceptional to the point of maintaining the usefulness of the pediatric (0-12) and geriatric (+75) age ranges as a proxy. Since the allocation of the lifesaving resource must be assessed ex ante and information about the opportunities a person has had in his or her lifetime is controversial and difficult to know, age may operate as an imperfect proxy that those opportunities were had. A similar point I made in analyzing the characteristic "being the only family member caring for dependents" in section IV.c. However, unlike what I argued in analyzing the undesirable consequences argument, I believe that if information about a person's lifetime opportunities is known ex ante,

it should be incorporated into the triage and that it does not present the problems of consequences noted by Macklin as relevant to the fairness of resource allocation.

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