DOWNLOAD PDF WELL-BEING AND DEATH

Chapter 1 : Well-Being and Death eBook: Ben Bradley: blog.quintoapp.com: Kindle Store

Well-Being and Death addresses philosophical questions about death and the good life: what makes a life go well? Is death bad for the one who dies? How is this possible if we go out of existence when we die?

But death remains a rich source of philosophical questions. This book attempts to answer some of those questions. Is death bad for the person who dies? Under what circumstances is it bad? What makes it bad? How bad is it? Does the badness of death have a timeâ€"is it bad for us at some times but not others? Is it worse to die as a baby, a child, or an adult? Is it bad for animals to die? Is death less bad for someone who had a good life? Is there anything at all we can do to make our deaths less bad for us? If so, should we do it? There is something weird about these questions. We would not ask these questions about other things we think are bad. Nobody could get away with writing a book about whether it is bad to stub your toe, what makes it bad, whether it is worse to stub your toe when you are a child or an adult, or whether we can make toe-stubbings less bad for us. Then how can I get away with writing this book? The answer is that, as we will see, the answers to these questions are somewhat less obvious concerning death than concerning toe-stubbings. Death is an evil of deprivation. Dying keeps us from having more of a good life. So thinking about death leads us to think about what we think makes our lives go well for us. In Chapter 1 I attempt to develop some new arguments about the good life. These arguments tend to support hedonism, or the view that pleasure is what is good 1 Plato, Phaedo, 64a. They support hedonism only indirectly, by posing problems for its main competitors, such as the view that what is good for a person is that she gets what she wants. Hedonism is often taken to have been thoroughly discredited. The arguments given here also undermine the possibility that events that take place after a person dies can affect her well-being. According to the deprivation account of the evil of death, death is bad because it deprives us of a good life. Like most people, I accept that death is bad, and I accept the deprivation account of its badness. But there are versions of the deprivation account that differ in philosophically interesting ways. In Chapter 2 I argue for a difference-making account of deprivation, according to which the badness of a death is determined by a comparison between the life its victim actually lives and the life she would have lived had that death not occurred. Death, I will assume, causes a person to go out of existence. How can a nonexistent thing be the subject of a misfortune? Such questions do not arise when we talk about the evils of toe-stubbings; this is the most important difference between the two sorts of misfortune. Chapter 3 is largely concerned with questions about death and existence. In this chapter I argue against a view that I think has been rather dogmatically and uncritically accepted: You might get lucky and never stub your toe as long as you live. But death is inevitable. Thus it is a universal object of fear. Socrates argued that philosophers in particularâ€"but presumably everyone else tooâ€"should be unafraid of death. But this is because he thought 2 Gettier Introduction xv we survive our deaths, and that death is good for us. This thought can be terrifying. Is this terror rational? It is obviously rational to have an occasional worry about stubbing your toe. But is it true, in general, that it is rational to fear or otherwise have bad feelings about something that is bad for us, even if it causes us no pain? I say a few things about this question in Chapter 2. But my main concern is the badness of death, and there is no necessary connection between the badness of an event and the rationality of fearing it. There is at least this connection though: Likewise, and more importantly, if something would be bad for you or someone else, then you have some defeasible reason to do something to prevent it. Most would agree that death in old age is less bad for its victim than death as a young adult. But is it worse to die as a young adult than to die in infancy? This is another question that does not arise when thinking about toe-stubbings; nobody could really be puzzled over whether how bad it is to stub your toe depends on how old you are. In Chapter 4 I argue that death is typically worse the earlier it occurs, and so it is worse to die in infancy than as a young adult. Again, this seems to be a somewhat unpopular view based on my informal quizzing of philosophers and their reactions to things I say , but the principles that philosophers have used in arguing for the opposite view are unsupportable. Supposing death is a bad thing: Is there anything we can do to make our deaths less bad for us? This is another way in which death is unlike toe-stubbing. Nobody worries about whether it is possible to defeat toe-stubbings. Unfortunately, those people

are wrong. I 3 Plato, Phaedo, 67d â€”e. He makes the astonishing claim that this would actually be pleasant for the nonexistent dead person, since it would be like a dreamless sleep, which we all recognize to be pleasant. It does turn out that there are things we can do to make our deaths less bad, but those are either things we have independent reason to do anywayâ€”the fact that they tend to make our deaths less bad being irrelevant to whether we should do themâ€—or things that would be obviously crazy to do. So the main highlights of the book are as follows. I defend a straightforward deprivation account of the evil of death. This account has a controversial implication: I also defend two views about well-being that very few people seem to hold: Establishing the latter view enables me to defend another controversial view: Death is bad for its victim at some time after the person has died. There is an important question about death that I say absolutely nothing about in this book: I will take it for granted that we have enough of a grasp on the concept of death to get by. I will just make one assumption: This assumption might well be false. One way it would be false would be if people continue to exist as corpses after they die. This would make little difference to the arguments of this book. If anything, the assumption that death marks the end of existence puts more pressure on my arguments in Chapter 3. On the other hand, perhaps people survive in some other form. Perhaps, as Socrates thought, people are composed of a body and a spirit, and the spirit survives the death of the body. Introduction xvii put the arguments of this book in a different light. It would also make a big difference to the way we ought to feel about death, depending on what the afterlife is like. But if this is true, then why is it so seriously wrong to kill people? In fact, why is it not frequently obligatory to kill people? For the purposes of this book I assume that there is no afterlifeâ€”no souls, no resurrection, no reincarnation. But even those who believe in such things can endorse the general principles about value I defend here. They will just draw different conclusions from those principles. While I think the principles entail that death is usually very bad for people, those who believe in afterlives might think the opposite. What we say about the value of life and the evil of death may be relevant to many other topics. First, our views about the good life help determine what we take to be prudent behavior. See, for example, Kagan and Vallentyne Thanks to James S. Taylor for discussion here. As Simon Keller pointed out to me, not all those who hold such views about well-being will give such advice. One of the tasks of moral philosophy is to explain why killing is wrong, when it is wrong. The badness of death seems relevant to this question. Suppose it is much worse to die in adulthood than in infancy. One might well think that it is even less bad to die as a fetus or an embryo. In that case, one might think abortion is not so bad. On the other hand, if it is worse to die as an infant than as an adult, it might be even worse to die as a fetus. If so, we might think abortion is seriously wrong. I think it may be extremely bad for a fetus to dieâ€”much worse than for an adult. This does not, however, show that aborting a fetus is wrong.

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This book addresses philosophical questions about death and wellâ€•being. It defends two main theses. The first is hedonism, or the view that pleasure is what has intrinsic value for us.

Find articles by Ajai R. Singh Find articles by Shakuntala A. This article has been cited by other articles in PMC. Abstract The problems of the haves differ substantially from those of the have-nots. Individuals in developing societies have to fight mainly against infectious and communicable diseases, while in the developed world the battles are mainly against lifestyle diseases. Yet, at a very fundamental level, the problems are the same-the fight is against distress, disability, and premature death; against human exploitation and for human development and self-actualisation; against the callousness to critical concerns in regimes and scientific power centres. While there has been great progress in the treatment of individual diseases, human pathology continues to increase. Sicknesses are not decreasing in number, they are only changing in type. Poverty is not just income deprivation but capability deprivation and optimism deprivation as well. While life expectancy may have increased in the haves, and infant and maternal mortality reduced, these gains have not necessarily ensured that well-being results. There are ever-multiplying numbers of individuals whose well-being is compromised due to lifestyle diseases. These diseases are the result of faulty lifestyles and the consequent crippling stress. So, the prescription pad continues to prevail over lifestyle-change counselling or research. The struggle to achieve well-being and positive health, to ensure longevity, to combat lifestyle stress and professional burnout, and to reduce psychosomatic ailments continues unabated, with hardly an end in sight. We thus realise that morbidity, disability, and death assail all three societies: For those societies afflicted with diseases of poverty, of course, the prime concern is to escape from the deadly grip of poverty-disease-deprivation-helplessness; but, while so doing, they must be careful not to land in the lap of lifestyle diseases. For the haves, the need is to seek well-being, positive health, and inner rootedness; to ask science not only to give them new pills for new ills, but to define and study how negative emotions hamper health and how positive ones promote it; to find out what is inner peace, what is the connection between spirituality and health, what is well-being, what is self-actualisation, what prevents disease, what leads to longevity, how simplicity impacts health, what attitudes help cope with chronic sicknesses, how sicknesses can be reversed not just treated , etc. Studies on well-being, longevity, and simplicity need the concerted attention of researchers. The task ahead is cut out for each one of us: Each one must do his or her bit to ensure freedom from disease and achieve well-being. Those in the developed world have the means to make life meaningful but, often, have lost the meaning of life itself; those in the developing world are fighting for survival but, often, have recipes to make life meaningful. This is especially true of a society like India, which is rapidly emerging from its underdeveloped status. It is an ancient civilization, with a philosophical outlook based on a robust mix of the temporal and the spiritual, with vibrant indigenous biomedical and related disciplines, for example, Ayurveda, Yoga, etc. It also has a burgeoning corpus of modern biomedical knowledge in active conversation with the rest of the world. The means that the developed have could combine with the recipes to make them meaningful that the developing have. That is the challenge ahead for mankind as it gropes its way out of poverty, disease, despair, alienation, anomie, and the ubiquitous all-devouring lifestyle stresses, and takes halting steps towards well-being and the glory of human development. While individual diseases have to be tackled, patient welfare safeguarded, and scientific progress forwarded, it also has to address the social forces that impinge on, regulate, modify, and at times derail many an earnest effort at disease control. Socioeconomic and political factors, along with public awareness, are three crucial areas that cannot be neglected if the fight against disease and for positive health, well-being, and human development has to succeed. The main culprits here are poverty in the have-nots and lifestyle stresses in the haves, and both are interlinked with callousness in those who have the power to change things. The problems of the haves differ substantially from those of the have-nots. Their concerns are different, as are their diseases. The social issues, interpersonal problems, and cultural ethos in the two groups are markedly different. Yet, at a very fundamental level, their problems remain the sameâ€”both fight against

distress, disability, and premature death; they struggle against human exploitation and for human development and self-actualisation; and they struggle against callousness to critical concerns in regimes and scientific power centres. The haves are not any better off than the have-nots on these parameters, although they may appear to be so. It is only that the issues of disease, well-being, development, and the fight against callousness adopt different forms in these two groups. We will see later how this is true. Also worth noting is the fact that the number of people falling sick has not reduced. While individual disease treatment is progressing, so also is human pathology; sicknesses are not reducing in number; they are only changing in type Singh and Singh, Health awareness has increased. So has average life expectancy. Medical science boasts of a vast array of treatment modalities for an equally vast array of diseases. Distress has been ameliorated, disability curtailed, death postponed. And yet, if the booming medical practice and pharma industry are any indication, the patient population has not reduced. In fact, it has multiplied. Not all of this is because of increased health awareness. While individual distress may have been reduced, individual disability curtailed, and individual death postponed due to better treatment facilities, the number of distressed have not reduced. Neither have the number of disabled, nor that of the dead. What does this signify? It signifies, if nothing else, that while individual disease treatment is progressing, so also is human pathology. Newer and more ingenious ways of falling ill are seeing the light of day, and the body is finding newer ways of getting out of order. Sicknesses are not reducing in number. They are changing in type. If infectious diseases and malnutrition took their toll in the earlier centuries and in certain sections of the world even today , lifestyle diseases, chronic conditions, and neoplastic disorders are taking their toll in the present. It is almost like changing fashions in the world of disease Singh and Singh, Hence, it indeed is an unrelenting struggle to keep disease at bay and ensure human development and well-being. In all such struggles, both in the haves and the have-nots, people from all strata of society-high, middle, or low-and in different types of societies-Asian, European, African, American, or Australian-are perennially involved. Those who consider themselves immune to such considerations only cloak their ignorance in false bravado. Let us see first the problems of the have-nots, then of the haves, and then of societies and people in transition. We could then analyse the essential factors that impact all three, their commonalities and differences, and what could be the action plan to meet them head-on. Add measles, pneumonia, and diarrhoeal disease, and you have the whole panorama of the diseases of poverty-six in all, according to the WHO. These, along with complications of childbirth, kill 14 million people a year Results, These are individuals and societies which have neither the economic resources nor the technical expertise or manpower to handle the epidemic proportions that these, and related, diseases and disabilities assume in such vulnerable groups. This is in spite of the fact that all these six diseases of poverty can be prevented or treated for a small amount of money. For instance, medicines to treat acute malaria cost just pennies, and a measles vaccine costs just 26 cents Results, Poverty and disease are involved in a vicious downward spiral, each aiding and abetting the other. Poverty is an inveterate consequence and cause of ill health Klugamn, Diseases of poverty increase poverty, and poverty, in turn, increases the chances of developing the diseases of poverty. Often the hapless patient, and his eager but resourceless caregiver, is sucked into this vortex with no redemption in sight-and it does not take very long for an eager-resourceless caregiver to become an indolent-resourceless one. The interplay of these diseases of poverty is substantial and can hardly be overlooked. TB and HIV are synergistic infections: We also know how malnutrition compounds TB. Infectious, communicable and deficiency diseases, which are aplenty in such populaces, further add to the agony. The social dimension of poverty can hardly be discounted. Alcoholism, drug abuse, chronic mental disorders, sociopathy, beggary, violence in family and neighbourhoods, child labour, physical abuse and neglect of the female especially the female child , commercial sex-all these, while they may impact any strata of society, leave their greatest trail of devastation among the impoverished. A greatly reduced self-esteem, with a feeling of being trapped in a helpless situation, with no succour in sight, adds to the crippling effect of poverty-disease-deprivation on human existence. Poverty is not just income deprivation but capability deprivation as well Sen, ; p There is a distinction between lack of income and lack of capacity Sen, Poor people acutely feel their powerlessness and insecurity, their vulnerability and lack of dignity. Rather than taking decisions for themselves, they are subject to the decisions of others in nearly all aspects of their lives.

Their lack of education or technical skills holds them back. Poor health may mean that employment is erratic and low-paid. Their very poverty excludes them from the means of escaping it. Their attempts even to supply basic needs meet persistent obstacles, economic or social, obdurate or whimsical, legal or customary. Violence is an ever-present threat, especially to women. The poorest use what resources they have, and considerable resourcefulness, in their struggle to survive. For the poor, innovation means risk, and risk can be fatal. Equally importantly, along with income and capability deprivation, poverty also means optimism deprivation. Let us explain what we mean thereby. The will or motivation to fight poverty, the urge to escape its shackles, the hope that the fight will succeed one day-this optimism is lost due to subsistence living and the daily fight for survival. There seems to be no cause for cheer, no redemption around the corner, no way out, howsoever much the person struggles. A trapped helpless feeling, which grows on the person, aided and abetted at every step by the life situation around-this is what mainly sustains the poverty-disease-deprivation spiral. It is this optimism deprivation that may be a salient feature of the depression that overwhelms such individuals, adds to resource deprivation and income deprivation and, finally, does the person in. It is only those who do not suffer from optimism deprivation, in spite of suffering from the other two forms of deprivation, who manage to break free of the shackles of the poverty-disease-deprivation spiral and the concomitant depression. The examples of those who do break out of these shackles are few, but they are worthy exemplars in poverty eradication awareness programmes. The examples of those who do not escape these shackles are umpteen and they only add to the optimism deprivation in the rest. A striking example of this phenomenon is the recent spate of farmer suicides in various parts of India. It is overtly the result of crippling poverty and loan recoveries by blood-sucking moneylenders and others. Things could be a lot worse after June. But more importantly, it is a state of feeling cornered and alienated, with no hope of escape except by escape from life itself.

Chapter 3 : Well-being and Death // Reviews // Notre Dame Philosophical Reviews // University of Notre Da

Well-Being and Death not only captures the full flavor of the contemporary debate on death but also moves it forward in a stimulating and engaging way" --Walter Glannon, Journal of Value Inquiry 21/09/

Midcourse Review Data Are In! Check out our interactive infographic to see progress toward the Health Related Quality of Life Well Being objectives and other Healthy People topic areas. Goal Improve health-related quality of life and well-being for all individuals. Overview Health-related quality of life HRQOL is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life. Well-being is a relative state where one maximizes his or her physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life. Researchers today agree that HRQOL is multidimensional and includes domains that are related to physical, mental, emotional, and social functioning and the social context in which people live. Measures of life expectancy and healthy life expectancy HLE were used to report on this goal for several populations, which relied on self-reported data related to health, including global health status, prevalence of certain chronic diseases, and activity limitations. For Healthy People , quality of life is integral to each of the 4 overarching goals. Over the decade, Healthy People is approaching the measurement of health-related quality of life and well-being from a multidisciplinary perspective that encompasses 3 complementary and related domains: Self-rated physical and mental health Overall well-being Participation in society Although none of these domains alone can fully represent the concept of health-related quality of life or well-being, when viewed together they will provide a more complete representation to support monitoring of the health-related quality of life and well-being of the U. All items were tested in large and diverse samples. Individual items include fatigue, pain, emotional distress, and social activities. Back to Top Well-Being People with higher levels of well-being judge their life as going well. People are satisfied, interested, and engaged with their lives. People experience a sense of accomplishment from their activities and judge their lives to be meaningful. People are more often content or cheerful than depressed or anxious. People get along with others and experience good social relationships. Personal factors, social circumstances, and community environments influence well-being. Physical well-being relates to vigor and vitality, feeling very healthy and full of energy. Social well-being involves providing and receiving quality support from family, friends, and others. Healthy People is exploring measurement of these concepts at this time. Underlying this participation measure is the principle that a person with a functional limitation â€” for example, vision loss, mobility difficulty, or intellectual disability â€” can live a long and productive life and enjoy a good quality of life. Participation in society includes education, employment, and civic, social, and leisure activities, as well as family role participation. An evaluation of well-being scales for public health and population estimates of well-being among U. Health and Well Being. Healthy People Framework. WHO Definition of Health. Soc Sci Med ; 41 Definitions and conceptual models of quality of life. Outcomes assessment in cancer. Medical Care ; Journal of Clinical Epidemiology ; Monitoring Population Health for Healthy People Quality of Life Research ; Evaluation of item candidates: Psychometric evaluation and calibration of health-related quality of life item banks. Well-Being for Public Policy. Oxford University Press, Inc. Soc Sci Med ; The dilemma of measuring perceived health status in the context of disability. Disability and Health Journal ; 2: A population health framework for setting national and state health goals. JAMA ; Arch Phys Med Rehabil ;

Chapter 4 : Diseases of Poverty and Lifestyle, Well-Being and Human Development

Well-Being and Death addresses philosophical questions about death and the good life: what makes a life go well? Is death bad for the one who dies? How is this possible if we go out of existence when we die? Is it worse to die as an infant or as a young adult? Is it bad for animals and fetuses to.

Such theorists face three Epicurean challenges: Everyone now agrees that the subject of mortal harm is the very person who dies. Nearly everyone also agrees that death harms us by depriving us of goods, but precisely what the relevant goods are remains a matter of contention. The third challenge has generated more controversy; it is not clear when mortal harm is accrued, or even that it is accrued at some time. Nevetheless most theorists agree on this much: In Well-being and Death Ben Bradley addresses these challenges. He accepts the standard answer to the first, but his approaches to the other two are anything but standard. His solutions to the second and third, respectively, are hedonism and subsequentism, and he defends them resourcefully, mostly by criticizing the alternatives, in the first three chapters of his book. In Chapter 4 he argues that usually it is worse to die in infancy than later, and that, while the demise of a fetus might be the worst death of all, abortion may be permissible. In the last chapter he argues that there is nothing sensible we can do to make our deaths less bad for us. Bradley defends a version of the standard comparativist account of interests in Chapter 2. He says that an event or state of affairs E is overall good bad for a subject, S, just when, and to the extent that, the intrinsic value of the actual world for S is higher lower than the intrinsic value of the closest possible world in which E does not occur or hold. As for the intrinsic value of some world W for S, it equals the value of the intrinsic goods S attains in W together with the dis value of the intrinsic evils S attains there. Comparativism does not tell us what is intrinsically valuable. In Chapter 1 Bradley supplies an account, opting for the hedonist view that the state of affairs of our getting pleasure is the only thing that is intrinsically good for a subject S, while pain is the only thing that is intrinsically bad for S. Unlike the former, which is defined in terms of the intrinsic value of a world, the latter is defined in terms of the intrinsic value of a time T in a world W, which equals the value of the intrinsic goods S attains in W at T together with the dis value of the intrinsic evils. The overall value of E for S in W at T equals the intrinsic value of T in W minus the intrinsic value of T in the nearest world in which E fails to occur. I refuse to move to Tahiti; each day of my remaining fifteen years is unpleasant; had I moved, I still would have died fifteen years later, but the first fourteen would have been pleasant, and the last extremely unpleasant. Comparativism says my decision is bad for me. Bradley adds that it is bad for me during the next fourteen years but good during my final year. To bolster his view that the dead have a welfare level, Bradley discusses two cases: Does Marsha or Greg have a welfare level? I think that Greg does. Bradley says my response "just seems wrong"; both "have a well-being level of zero" p. Suppose Bradley is correct. What gives Marsha a zero welfare level? Is it her inability to attain intrinsic goods or evils? As far as I can tell, claiming that something has a zero welfare level on the grounds that it cannot accrue goods or evils is like saying that something has a temperature of zero because it is incapable of having a mean molecular kinetic energy. The number 5 can have no such mean, but it does not have a temperature. Having no temperature or welfare level is not the same as having a zero temperature or welfare level. Many things, such as shoes and the number 5, are unresponsive like Marsha yet have no welfare level. So what gives normal people and not shoes a welfare level? I would say it is responsiveness itself: S has a welfare level at T iff S has the capacity to attain intrinsic goods or evils at T. Even at times when they are asleep or in reversible comas, normal adults have this capacity, while corpses and shoes never do. Sleep and comas can temporarily block people from exercising a capacity without removing it. Bradley admits but see p. He insists, however, that dead people and Marsha do. So what explains the difference? A person, he says, is the sort of thing that can be benefited or harmed. So perhaps the difference between a dead person and a shoe is this: The same cannot be said of a shoe, which seems to be the sort of thing that could not possibly have a welfare level p. Bradley appears to reason as follows: S is the sort of thing that can be benefited or harmed at some time iff it is metaphysically possible for S to attain goods or evils at some time. S has a welfare level at T only if S is the sort of thing that can be benefited or harmed at some time. So S has a welfare level at T only

if it is metaphysically possible for S to attain goods or evils at some time cf. Shoes cannot possibly have a positive or negative welfare level at some time. So at no time do shoes have a welfare level. So at no time do people lack a welfare level. This reasoning has a hole, of course; while 5 follows from 3 and 4, 6 does not. Unlike 6, 3 is compatible with A. Just because something is the sort of thing that is such that its attaining goods or evils at some time is not impossible, it does not follow that it has a welfare level at some given time, or at every time. Still, there is an obvious fix; we can convert 2 and 3 into biconditionals: S has a welfare level at T iff S is the sort of thing that can be benefited or harmed at some time. S has a welfare level at T iff it is metaphysically possible for S to attain goods or evils at some time. Now we have a valid argument for 6. Consider arguing that people never lack a temperature on the basis of the following unsound argument: S is the sort of thing that can have a temperature at some time iff it is metaphysically possible for S to have a positive or negative temperature at some time. S has a temperature at T iff S is the sort of thing that can have a temperature at some time. So S has a temperature at T iff it is metaphysically possible for S to have a positive or negative temperature at some time. Numbers cannot possibly have a positive or negative temperature at some time. So at no time do numbers have a temperature. So at no time do people lack a temperature. For something actually to have a temperature level at all times, it hardly suffices that it be the sort of thing that can have a positive or negative temperature level at some time, or even that it does have a temperature level at some time. People and shoes have temperatures but not before they exist or after they are annihilated. Are 2a and 3a any more plausible than b and c? On 3a welfare levels are very strange things indeed. If something could ever have a welfare level it cannot lack one, even while nonexistent. The following proposal seems more promising than 3a: S has a welfare level at T iff it is metaphysically possible for S to have a positive or negative welfare level at T. On 3a, anything that ever has a welfare level has one throughout the eternity that precedes its existence -- even if it could not possibly have a positive or negative level then. At least 3b does not imply that. But why should we accept 3b? Why is the claim it makes about welfare more plausible than the corresponding claim about temperature; viz. Why prefer it over A? Bradley concludes Chapter 4 with a "positive argument" for his view that the dead have welfare levels p. He thinks his view is supported by the fact that it is reasonable for a person, say Kris, to be prudentially indifferent as between two futures that might follow his being struck by an anvil at T: F1, being killed instantly, or F2, being made comatose for the ten years prior to death. However, I suggest that we can make good sense of F1 and F2 having the same value for Kris even though he has no welfare level while dead. In fact, we can assess the times during which F1 and F2 unfold, and we can do this in terms of what Bradley calls their intrinsic value. During F1, Kris fails to exist, and attains neither goods nor evils, so the sum of their values is 0. During F2, he exists, but still attains neither, so the sum is again 0. For any time T, the value for my shoe at time T, measured in terms of the goods and evils it has at T, is always 0, but it never has a welfare level. The upshot is this: Presumably the claim that E makes S worse off at T than S otherwise would have been means that S has a welfare level at T that is not as high as the welfare level S would have had at T had E not occurred. That T is, in this sense, less valuable for S does not imply that S has a welfare level at T. It advances the scholarly debate about death and its harmfulness. Anyone who contributes to or follows that debate will want to read Well-being and Death.

Chapter 5 : Health-Related Quality of Life and Well-Being | Healthy People

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Get this from a library! Well-being and death. [Ben Bradley] -- "Ben Bradley defends the following views: pleasure, rather than achievement or the satisfaction of desire, is what makes life go well; death is generally bad for its victim, in virtue of depriving.

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Chapter 7 : Well-Being and Death By Ben Bradley | Analysis | Oxford Academic

BOOK REVIEWS Bradley, Ben. Well-Being and Death. Oxford: Oxford University Press, Pp. $ (cloth). Many philosophers writing about death have adopted a strikingly cheery and.

Chapter 8 : Well-Being and Death by Ben Bradley

WELL-BEING AND DEATH This page intentionally left blank Well-Being and Death Ben Bradley CLARENDON PRESS Â· OXFORD 1 Great Clarendon Street, Oxford ox2 6dp Oxford University Press is a department of the University of Oxford.

Chapter 9 : Well-Being and Death (ebook) by Ben Bradley |

Bradley rejects this, arguing that a non-existent person can have a level of well-being and so can be harmed after death. In order to evaluate the harm that death brings to a person, p, one must calculate what would have happened to p had p lived.