

**Sylvan short debate**  
**16th June 2025**

Ye Olde Cock Tavern  
*Detailed summary powered by AI*

**The motion:**

***we should not try to extend human lifespans.***

The speaker: I'm for the proposition. My motif will be quality, not quantity—quality of life, not quantity of life. We have to be incredibly careful, and this broad motion needs to be defined with precision. Let me read the motion again: we should not try to extend human lifespan. I will go through each term. Who is "we"? For the purposes of this debate, I'm going to say an individual, surrounded by their community, should not try to extend their lifespan. What does "trying" mean in this context? I'm saying unnatural, highly damaging medical intervention should not be used when individuals are severely ill, or there should be the option for people not to use that kind of intervention when they're ill. This leads us to the question of extension. What does it mean to extend a human life naturally? Is there a finite human lifespan? Is there a particular amount of units of human life that we should live? I'm going to say there is not. What I'm arguing is that an individual should not try to extend their lifespan beyond what is natural in the circumstances they find themselves in. A life well lived is a life with dignity. There is no meaning in life without finitude. A narrative, like a life, needs a beginning and an end. The notion of trying to extend one's life forever is a fantasy, a fiction, and is impossible. It is simply unrealistic that one should continually try to extend one's life. We must be careful when we discuss extending people's lives. We have to guard against totalitarian state intervention. We must ensure safeguards around protecting human life, and that depends on the individual and their natural lifespan. We must guard, as we have seen in debates about euthanasia, that decisions are well-informed, carefully protected in law, and well understood by those who make them. Only with those safeguards can someone truly take an informed decision with dignity about when they should extend their life. Within that is the logical motion that one should not try to extend their life beyond what is natural, beyond what allows them to live with dignity in a way they choose. There are other points an earlier speaker might raise around the social and financial cost of extending life when we live in an economy and a healthcare system that are stretched. Philosophically, a life cannot be extended forever; there is a moment when a life must end. One cannot keep intervening in someone's life when there is ultimately no end goal. I resist utilitarian arguments that it is more efficient financially not to extend someone's life, but I say that there has to be a point where medical intervention is not helpful for the individual, not helpful for society and not helpful for the dignity of a person. To finish: quality, not quantity.

Another speaker: I anticipated the life-in-good-health or bad-health argument. I agree with many of your points. We all value health, and we should prioritise it as a society. This is why healthcare is important and why we cherish the NHS. Health is linked dramatically to another ethical value—life. You can have bad health and still be alive, but you cannot have good health

while being dead. If we cherish health, we should cherish life as well. This is a purely deductive argument. Now I will consider the threshold of health below which life is not worth living. Many people imagine situations, like paralysis, in which they would refuse life, yet when they are actually in that situation they often change their minds. Ethical priorities may be conditioned by experience. To end life should not be only a subjective decision; it should also be objective, with a panel of doctors confirming that the pain endured is not worth living. I advocate increasing lifespan, but not vainly. We have limited resources and must act sustainably, yet reducing lifespan for sustainability alone is a form of austerity. We have to be optimistic and humanist and believe that solutions lie within people. If we educate them and trust their ethical priorities, they will make good use of their extended time.

Chair: We move to floor speeches, three minutes each. Questions are welcome.

Speaker: The assumption is that the current system works well, doctors always get diagnoses correct and treatments always work. That's an illusion. Doctors get about 50% right. The chief researcher for GlaxoSmithKline once said, "Our drugs do not work on most people." If drugs did work, perhaps there would be fewer sick people and they would live longer. End of story.

Another speaker: Data from simple societies show a high but constant risk of death, producing two triangles of age distribution with the apex at about ninety years. Civilisation turns those triangles into rectangles, but people still rarely live past ninety. Over sixty, the risk of death jumps and then stays constant. I see life like a car: eventually it is not economic to keep repairing it. Medicine cannot put all faults right. Have a good life while it lasts.

Another speaker: We have focused on medical extension, but we also need to look at preventative policy. Predicted lifespans differ widely by demographic and location. Morally, we should extend lifespans for groups where early death is inequitable.

Another speaker: In Glasgow the average lifespan is shorter than the rest of the UK. An extreme trend among the very rich seeks to live to 200, taking young-blood transfusions and so on. Extending lifespan changes the human life cycle, leadership refresh rates and politics. Do we really want that?

Another speaker: The word "not" confused me. Increasing lifespan involves environment, health and access to medicine; many here have had antibiotics or an appendix removed. Human inventions protect our species, but the planet has limited resources. Extending lifespan means more people and strain on Earth. Have another glass of wine and eat more cake.

Another speaker: I'm sixty-eight. My friend's mums and my mums wanted to die after losing the ability to do what they enjoyed. I'd like to reach eighty or eighty-eight, perhaps ninety, but not necessarily one hundred unless my health allows me to stay active. I go with the motion.

Another speaker: Many breakthroughs follow wars, but the primary cause is mankind's desire to live and thrive. Extending life means improving quality. We may never live forever, but in seeking it we create breakthroughs that improve life for everyone.

Another speaker: Were Aubrey de Grey right that ageing is a disease? Even if technology could let us live two hundred healthy years, I wouldn't want to see the same people for that long.

Another speaker: I'm in my eighty-eighth year with several ailments, but I'm still alive and kicking. Compared with my relatives' ages of death, I'm doing well.

Another speaker: Since the 1990s there have been no radical life expansions. We haven't passed the mortality ceiling of ninety. Healthspan differs from lifespan. Precision medicine seeks the right drug for the right patient. Even with the best research, maximum lifespan may be 117–125. At some point the body breaks down. To anti-age fully you'd have to stop eating and breathing, but then you'd be dead.

Audience member: What about integrating into machines?

Response: Perhaps, but that is another discussion.

Philosophical speaker: Once dead, you no longer know you ever existed. Whether you live forty years or a thousand, death erases awareness. Lucretius and Wittgenstein note that death should cause no fear; myth and religion create the illusion of continued existence.

Chair: Growing old terrifies me, but I want the choice. I dislike seeing people forced to carry on because of others' feelings.

Another speaker (closing): I stress the optimistic side. Not wanting to extend life arises from pessimism and lack of self-love. If you have a treatment, it is unethical to withhold it. We must believe in humanity and work on solutions. We cannot do it if we are dead.

The speaker (closing): You cannot cherish life without an ending. One should not be encouraged to live beyond realistic limits. Going on for two hundred years sounds exhausting. Society should understand that one does not have to extend life. Empowering the individual mitigates inequality. My point is dignity and quality. It should not be society's aim to extend life endlessly.

Chair: Thank you to all contributors. The motion again: we should not try to extend human lifespans. The proposition carries.

### **AI analysis of the result:**

#### **1. Framing and definition**

- The proposition seized the initiative by tightly defining key terms ('we', 'try', 'extend') and narrowing the motion to "unnatural, highly damaging medical intervention" once severe illness has set in.

- This definition shifted the discussion away from everyday public-health measures and towards heroic, late-stage procedures, making the motion easier to support.

## 2. Ethical centre of gravity: quality versus quantity

- The proposition's repeated refrain—"quality, not quantity"—gave a clear moral anchor: dignity in death is preferable to marginal, burdensome survival.

- Personal stories from the floor (the 68-year-old, the mothers who had "had enough", the 88-year-old who still feared frailty) reinforced this intuition.

- The opposition's claim that "if you cherish health you must cherish life" sounded abstract by comparison and did not directly rebut worries about futile treatment.

## 3. Limits of medicine and resources

- Several floor speakers cast doubt on medicine's power ("our drugs do not work on most people", "eventually it is not economic to keep repairing the car"), bolstering the idea that extension efforts are often ineffective.

- Resource strain—on the NHS, on the planet—was cited repeatedly. While the opposition warned against "austerity", the proposition's camp convinced enough voters that there is a practical stopping point.

## 4. Fear of social consequences

- Concerns about entrenched elites living to 200, stalled leadership turnover and population pressure surfaced more than once. These anxieties aligned naturally with the proposition and were never fully neutralised by the opposition.

## 5. Psychological resonance of finitude

- The proposition's philosophical claim that meaning requires an ending, and that limitless life would be "exhausting", resonated emotionally.

- The opposition's optimism—"Not wanting to extend life arises from pessimism and lack of self-love"—risked sounding accusatory and may have alienated undecided listeners.

## 6. Structure and rhetorical advantage

- Primacy and recency effects mattered in a small room: the proposition opened and closed the formal speeches, bracketing the debate with its narrative of dignity.

- The opposition, though measured and logical, occupied the middle slots and never wrested control of the framing.

## 7. The abstentions

- Three voters could not endorse either extreme. Their reasons (complexity, confusion over "not", case-by-case nuance) indicate that a more modest or conditional motion might have swung the outcome.

Why the motion carried

The decisive factors were the proposition's tight framing, its morally compelling emphasis on dignity and natural limits, scepticism about the real efficacy of life-extension medicine, and latent fears about social, economic and environmental costs. The opposition's broader, more idealistic appeal to human potential was respected but did not sufficiently allay practical and existential worries. With a small group, these combined considerations delivered a narrow but clear victory for the proposition.