Is Dying Young Worse Than Dying Old?

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Often we experience the death of a very young person differently than the death of an older individual. We may be disposed to feel not only greater sorrow, anger, despair or bitterness, but also a greater sense of injustice when death strikes a very young child. Is there any ethical justification for these divergent feelings? Or are such tendencies prompted by false stereotypes that should be shed? Furthermore, what practical difference might our responses to death make? If we are warranted in feeling comparatively worse in response to the death of a very young person, does this mean that we are also warranted in recognizing a greater duty to avert such a death? For example, should we measure the call upon medicine to preserve the life of people in different age groups as different? Should scarce medical resources be used first to save the life of younger patients even when this entails letting elderly patients die? Should health professionals exert a greater effort to defeat the odds and apply futile treatments when the patient is very young, while avoiding “heroics” on behalf of older patients?

Giving Feelings Their Due

To begin to answer these questions, we first consider the weight that ethical argument should give to ordinary moral feelings. Ethical argument is more than a description of moral feelings or beliefs, but instead involves reflecting critically on competing moral claims in order to clarify their nature and underlying basis of support. Thus we ask: Is there anything that is uniquely of ethical importance about responding differently to different deaths? One line of thinking is that our feelings surrounding death are more amenable to psychological, than to ethical or philosophical, justification. According to some views, reasoners should not assign special weight to ordinary moral sentiments, but should strive to be wholly impartial. Feelings cloud judgment, it is said, and render ethical reasoning suspect if not spurious.

Should we then resist the pull of emotion and sentiment? Does ethical reasoning demand this? Against this approach we note that the different psychological reactions to death we observe often present themselves not simply as feelings, but as normative truths. That is, we not only feel sharper regret when a small child dies, but feel that sharper regret is merited because such a death constitutes a greater injustice. Likewise, we sometimes sense that a lesser injustice takes place when an older person dies and so feel that a lesser degree of anger or bitterness is appropriate. Understood in this light, our different reactions to death may prove helpful to ethical reasoning because they may point to underlying ethical reasons.

Yet some might challenge the assumption that having certain moral feelings automatically shows that those feelings are backed by valid ethical norms. Perhaps our moral feelings are instead instincts that we are innately programmed to feel. Or perhaps they are the product of crude indoctrination by our parents and teachers. These suggestions await empirical analyses, and are more properly the domain of the social sciences (psychology) than the humanities (philosophy). However, ethical reasoning might take as its starting point what the philosopher Thomas Nagel (1986; see also Gibbard, 1990) has described as a middle ground view. Rather than either automatically debunking common moral sentiments as coarse and unfounded, or trusting them blindly and uncritically, Nagel suggests that we place enough faith in moral feelings to inquire what more precisely they involve and whether or not they are ethically...
justified. In support of this approach it can be said that ethical inquiry is not infrequently rewarded by tentatively trusting moral sentiments and letting them navigate inquiry in the direction of underlying norms. For instance, when moral feelings and critical ethical analysis are at odds, letting feelings guide reason may induce us “to continue looking beyond the proposed arguments, to keep searching and broaden the review. Later we may ... feel profoundly grateful that we were not carried away by abstractions” (Callahan, 1988, p. 12).

Let us consider our response to death’s timing in light of Nagel’s model. We will attempt to clarify the content of our response, lay bare the underlying reasons that might support it, and explore alternative responses. Throughout, our inquiry will be limited to specific Western attitudes toward death and to current and ancient time frames; a more complete analysis of attitudes toward death must address a fuller range of cultural and historical perspectives.

Our Response to Death’s Timing

In characterizing our response to death’s timing, Daniel Callahan (1987, 1993) has written that when we view people’s deaths in distant retrospect, we tend to regard the deaths of very young persons with sharp regret, while seeing the deaths of older individuals as sad, but relatively acceptable, events. For example, recalling the death of a young child who could not raise the money needed to pay for a bone marrow transplant may still arouse in us bitter disappointment and the feeling that death was cruel and unnecessary. But we may feel comparatively less regret upon learning of the death of a 70-year-old who failed to obtain kidney dialysis due to age-based rationing of this technology. Extending this point, we may also find that the anticipation that death is imminent, and that there is nothing medicine can do to forestall it, is frequently met with deeper resistance in those treating small children as opposed to those treating elderly patients. Thus, a medical team may be more inclined to press for aggressive interventions, despite low odds of success, when the dying one is a child, rather than someone age 80. Extending this point still further, we may discover that many people find the actual event of death harder to witness in patients whose lives have barely begun to unfold than in those with many years behind them. Death in an elderly patient may be deemed “peaceful,” implying “free from strife or commotion,” “undisturbed, unruffled, calm, tranquil, quiet” (Compact Oxford English Dictionary, 1971). By contrast, a child’s death may be called “senseless,” which indicates it is “without sense or meaning . . . purposeless” (Compact Oxford English Dictionary, 1971).

Suppose, for the purpose of this article, that such observations are roughly true. That is, suppose that we as a matter of fact feel worse when we recall, anticipate, or witness the deaths of very young persons than when we recall, anticipate, or witness the deaths of elderly persons. (Actually validating this assumption would require collecting empirical evidence which we do not attempt, although others have done so [Reynolds, 1979]). These divergent feelings and attitudes toward death would not yet suffice to show that dying at a very young age is genuinely worse than dying late in life. After all, our psychological responses may be underlaid by illusions and false stereotypes about old age and youth. Or they may be backed by nothing more than an arbitrary cultural bias of Western industrialized societies that favors youthfulness and disparages old age. Should the death of a very young person truly merit the deeper resistance we apparently feel, we should be able to produce the reasons that support our feelings and attitudes.

One consideration that lends credence to the view that death is more acceptable when it occurs in old age is that “the elderly have lived a full life, have done what they could, and thus are not victims of the malevolence of the forces either of divinity or of nature” (Callahan, 1987, p. 72). By contrast, the death of a very young person may strike us as evidence that cruel forces govern the universe, and that responsible adults have failed to shield defenseless children against these forces.

Yet even when we assign no one responsibility for a person’s death, we may still undergo more profound or bitter regret when the dying person is quite young. For example, the fact that the instrument of a small child’s death is seen as an accident or fluke, rather than the product of divine will, does not necessarily make it seem less senseless or cruel. Even when God and nature are exculpated, we may continue to hold that death occurring early in the lifespan is particularly unfair.

A different justification for thinking death worse when it befalls a young child is simply that such a person has more potential years ahead to lose. What’s more, when many future years are forgone, the individual is likely to miss major stages of life in their entirety. Thus, unlike the 65-year-old, the 5-year-old will never grow up to become an adult, or experience the events typically associated with this, such as falling in love, becoming a parent, developing and fulfilling life ambitions, and sustaining and deepening close relationships over time.

A related point holds that losing very young persons is a greater blow because younger persons have more potential contributions to make to society. Older persons, by contrast, have fewer years remaining to contribute. Moreover, beyond a certain age, older persons as a group may have contributed most of what they will contribute in areas such as economically productive labor, science and technology, or art and culture.

A further reason why the loss of a very young person may be harder to bear is that to lose such a person is tantamount to losing the future. Not infrequently, we refer to children as “our country’s future.” In contemporary American society the ideal of perpetual progress for each new generation continues to inspire us. This inclines us to invest special meaning in the welfare of our children: children stand for the improved life toward which our present labors are leading. By contrast, our nation’s elderly
may symbolize a past that will inevitably be improved upon and surpassed.

On a more personal level, the death of one's own child may convey what psychiatrist Irvin Yalom (1989, p. 132), has called "project loss": the loss of "what one lives for, how one projects oneself into the future, how one may hope to transcend death." By contrast, the death of an aging parent is not the loss of a life project but of an "object" or figure who has played an instrumental role in the constitution of one's personal past. Thus, with the loss of a parent one's personal future remains viable, even enlivened. Robert Jay Lifton and Eric Olson (1974) convey a similar thought, noting that offspring can represent a kind of "symbolic immortality" for parents. Lifton and Olson describe "symbolic immortality" as a psychological process of creating meaningful concepts, imagery, and symbols that fulfill the human need for a sense of historical connection beyond the individual life. Offspring afford parents symbolic immortality not only through continuing their physical/genetic material, but also by virtue of showing the imprint of parents' values and attitudes in the way they lead their lives. Parents may feel that their influence on children connects them to humankind as it enters "into a general human flow beyond the self" (Lifton & Olson, 1974, p. 77).

Finally, our attitudes toward death's timing may reflect our underlying attitudes toward time and temporal passage (Mellor, 1981). Although an individual's personal past grows more distant with the death of those (i.e., the elderly) who store its memory, the loss of the past may already be perceived as inevitable. Thus, the forward march of time makes the past appear increasingly temporally distant, further and further away from present reality. By contrast, we perceive the future as perpetually approaching, rather than slipping away. Parents fully expect their children to be represented in the future, even if they themselves are not. Thus, when death befalls children, parents feel deprived of something they did not expect to lose. The future that they imagined, and that seemed to be moving closer and closer to fruition, is now gone forever.

An Alternative Response

Are the above considerations compelling? Are our different responses to death in children and the elderly indeed warranted? It is instructive to juxtapose the response to death elaborated above with an alternative response. This approach features the aging process from youth to maturity as adding to the individual's capacity to appreciate life, and so heightening one's capacity to experience loss and deprivation of tragic dimension.

The response that treats the death of a mature adult as a greater hardship is particularly salient in the philosophy and literature of ancient Greece. Greek tragedies, for example, often take as their subject great men brought low. A great man's fall aroused compassion by leading the audience to put themselves in his place and feel empathy for his tremendous suffering. Thus, Sophocles takes Oedipus, a good man and king, as his subject and depicts Oedipus' downfall; the audience is drawn into Oedipus' despair and led to feel his upheaval and horror upon learning that he has killed his father and slept with his mother. Similarly, Aeschylus tells the tale of an eminent and morally blameless man, Orestes, who is ordered by Apollo to kill his mother. The audience is made to experience Orestes' torment as the Eumenides (which symbolically represent the fury of Orestes' mother) pursue him relentlessly.

Whereas Greek playwrights expected the losses of great men to excite compassion, they did not consider compassion equally applicable when similar harms were visited upon children. In contrast to our contemporary ethos, the ancient Greeks apparently regarded the death of small children as beneath tragic dimensions. This was perhaps because the infant or very small child lacks the adult's capacity to appreciate what is happening. An infant whose death is imminent may coo and wiggle; a toddler, not comprehending the import of a terminal diagnosis, may appear bored or listless. When Greek literature portrayed a child's death, the implications that the child's death carried for others received greatest emphasis. Thus, in Medea, Jason's wife seeks revenge against Jason by maliciously killing the children she bore him. Euripides treats the tragedy as befalling King Jason, rather than his murdered children, and makes the climactic moment the moment when Jason's fury erupts in the aftermath of his children's murders:

[...]

The point of view described here places our contemporary perspective in sharper focus. To begin with, whereas our forebears regarded maturing as heightening tragic potential, our contemporary ethos treats maturing as limiting tragic possibility. Contemporary attitudes tend to regard the death of young children as representing a greater injustice because the younger one is, the more innocent and blameless one is thought to be. According to contemporary thinking, maturing spoils purity and innocence, so it inevitably lessens the tragedy of death by inviting the possibility that one is somehow responsible for one's own downfall. The mature man is considered "worldly" and accountable, in contrast to the babe in arms who is considered naive and good.

A second contrast concerns the distinct emotions that ancient and modern attitudes call forth. Whereas the ancients underscored the adult's travail to summon empathic concern, contemporary views highlight the child's defenselessness and vulnerability to awaken a sense of responsibility that triggers protective impulses. We view a mature man as strong and self-reliant in the face of danger, but feel disposed to nurture and protect an imperiled child from harm.
Finally, our modern thinking envisions aging as consuming and reducing a person's entitlement to a finite resource, namely, the lifespan. The older people become the more they have "had their share" and depleted their entitlement to further existence. Whereas a newborn possesses the greatest entitlement to life, an aged person, like a gentle but lame horse, has already "drunk from the trough," and now it is time for her to let the next horse drink. Switching metaphors, some invoke a "fair innings" concept to convey that early in life people have not yet played the game, but once they have had their turn at bat playing further innings is no longer a strict entitlement (Somerville, 1986).

Notwithstanding these differences, certain affinities exist between ourselves and ancient Greeks. Thus, both we and our predecessors may anticipate with excitement the birth of a healthy baby, take special care in choosing names, feel pride in our children's development, and enjoy nursing and caring for our young. Despite notable differences then, the Greeks' intuitions are not exactly in counterpoint to our own. For all that is said here, the Greeks may well support the claims of children over very old persons, even if they subordinated the claims of both to the mature man. Or they may regard the death of a mature person of base character as less significant than the loss of a very young child from a good family who promises well.

Yet why should we even take Greek views about children seriously? Perhaps the Greeks simply became inured to child death because the survival of children was so precarious. Rates of childhood mortality were high, and in contrast to our society the survival of infants and small children was unpredictable. What's more, for all their vaunted tragedies, the Greeks had less than admirable views about women and non-native Greeks. Why should we expect their attitudes toward children to be any better? The answer here, as before, is that even if Greek views about children turn out to be unfounded, we cannot dismiss them outright. Instead, we ought to examine their views critically, and learn whether or not they are supported by ethical considerations that reason can come to discern and defend.

The response that treats the death of a small child as a more catastrophic event might gain an initial foothold from the observation that as one becomes a mature adult, the greater becomes one's capacity to comprehend the nature and import of catastrophe and so to experience and feel wounded by misfortune. Recognizing this, onlookers rightly perceive a mature adult's death as more potently tragic than the death of a young child.

In reply, however, it can be said that we recognize misfortunes as befalling persons who do not experience suffering and who are even wholly unaware of their condition. Thus, we count betrayal and deception as evils even when those betrayed or deceived remain ignorant of their situation. And we consider a disease process that results in gross mental deterioration as a tragic misfortune to its victim, even when the victim does not understand or mind the condition (Nagel, 1979). These reflections seem to indicate that tragedy can also befall an infant or small child who cannot comprehend tragedy's dimensions.

Yet the viewpoint that takes death as worse when it befalls a mature adult might spring from an alternative set of premises. A mature adult's death may be thought more tragic because mature persons are in the prime of life: they are at the height of their physical strength, and many of the life goals they have set may, for the first time, appear within reach. Hence, there is more reason to shake one's fist at the world when death takes a mature adult, since it brings to an end a more fully realized perfection.

The conviction that death qualifies as a greater evil for the mature person also may be accounted for on the ground that the death of an adult cancels the realization of goals and projects already underway. As the philosopher Ronald Dworkin observes, the frustration of desires and aspirations that death produces "is greater if it takes place after rather than before the person has made a significant personal investment in his own life..." (1993, p. 88). Thus the mature adult, unlike the infant or small child, has dreams for the future and death deprives such a person of the chance to realize hoped-for possibilities.

A further reason for regarding the death of a mature person as worse than the death of an infant or small child is that by maturity a person has entered into more relationships with others, and these relationships have grown more meaningful over time. For example, the Akamba people of Kenya treat the death of a mature person as worse for this reason. According to their view, "the more personally intertwined a person becomes with others through time, the greater the damage done to the social fabric when that person is torn away by death" (Kilner, 1990, p. 88).

Finally, persons may feel greater aversion to the death of mature adults because more than children, mature persons have earned our respect and honor. As a group, they merit respect merely by virtue of having lived through life. According to Jonsen, "Living a life is an achievement. Some persons do it with great vigor and style; others barely make it; yet everyone who survives accomplishes it. The accomplishment deserves acknowledgement" (1991, p. 346).

**Implications for Health Care Decision Making**

So far we have provided some basis for questioning our contemporary response to death by setting it alongside an alternative view gleaned from our own historical past. To summarize what has been said, the contemporary conception that a youthful death is a more tragic event may stem from a variety of sources. When a very young person dies we may feel that that individual has not yet lived a full lifespan or has not yet had an opportunity to make lasting contributions to society. Further, contemporary observers may find the loss of a young child less acceptable because the young stand for the future and seem to afford us the opportunity for progress and for exerting an enduring influence on humankind.
An alternative response toward death's timing is provided by the ancient Greeks, who portrayed tragedy in terms of a mature man brought low through death or personal devastation. Unlike the child, the mature individual understood his predicament and experienced the anguish it occasioned. He felt the loss of a hoped-for future as he found his plans and desires disappointed. To the extent that ancient Greeks considered a mature man to be an exemplar of the human species, the mature man's death or ruin was a greater loss than the death or devastation of a small child.

With this background, we now proceed to show that even if we continue to find contemporary attitudes compelling, their scope of practical application is limited. It might at first glance be thought that how we regard death carries immediate practical implications in many areas, including health care. Thus, ancient Greek attitudes toward death are apparently reflected in that society's treatment of newborns. The Greeks routinely "exposed" infants to the threat of death by abandoning them when they were born with deformities or were healthy but unwanted. Reflecting the ethos of ancient Greek society, caring for sick or defective newborns "was not a medical concern in classical antiquity"; moreover, no laws existed to prohibit either the killing of defective newborns or the exposing of healthy ones (Amundsen, 1987, p. 15). Philosophers, including both Plato and Aristotle, generally accepted the morality of exposing infants for the purposes of selective breeding or on purely economic grounds (Rist, 1982). Nor does Greek civilization stand alone in permitting the active or passive killing of infants. According to Post, "the Netsilik, an Eskimo society that placed importance on having enough sons as hunters to ensure food for its members, practiced female infanticide because suckling a female infant for several years would prevent the mother from having a son" (Post, 1988, pp. 14-17). Other societies, including the !Kung of the Kalahari and the Tikopia of Polynesia, apparently practiced infanticide due to the difficulty of providing food for children.

If contemporary responses to death are justified, does it follow that our society should take an opposite tack? Should we, for example, devote great resources in medicine to saving the lives of children while investing comparatively few resources to saving the lives of older persons? Should we engage in heroic efforts to beat the odds on behalf of the tiniest babies, while refraining from exerting extraordinary efforts to benefit older patients? To address such questions we explore several possible claims one might be led to make on the basis of the view that death is worse when it happens to a very young person. Although we continue to focus on attitudes toward death at different ages, it is important to note that age is but one of several factors that informs our contemporary conception of "valuable-person-want-to-keep-alive." A more complete analysis would place attitudes toward age in the broader context of attitudes toward race and ethnicity, gender, economic status, and other factors.

Resource Allocation. — In considering possible ramifications of contemporary attitudes toward death, one set of issues relates to how we should distribute finite lifesaving resources among different age groups in society. It might be assumed that if the death of very young persons is worse than the death of very old persons, for example, then the young merit comparatively more lifesaving resources than the old. Callahan has argued for rationing publicly financed lifesaving resources on the basis of old age (as well as other criteria). He claims that by old age, people have passed the marker of a natural life span and their death may then be viewed as a sad, but relatively tolerable event (Callahan, 1987).

However, even assuming that our attitudes concerning death in old age are warranted, there are other reasons that tell against old age-based rationing. First, it might be argued that the young and old alike deserve equal access to basic health care because unequal access signals unequal respect for persons. Persons treated with lesser respect doubt their own value as persons and find their sense of self-worth and self-respect undermined (Gutmann, 1983).

Second, old age-based limits on medical care might be opposed because they violate the moral thrust of Judaic and Christian religions. Both traditions emphasize the equal worth and dignity of human beings. Both regard human dignity as age-transcendent rather than age-influenced (Post, 1991).

Special duties to the old might also follow from the fact that older persons as a group have made substantial contributions to society. Society therefore owes the elderly a debt of gratitude, and this debt cannot be paid unless the elderly have access to basic forms of medical care, including lifesaving care. Old age-based rationing represents, in this view, an ungrateful response to all that the elderly have given us.

Finally, old age-based rationing may be challenged on the ground that it affects women disproportionately. Women live longer than men, and so would be affected by ageist policies in greater numbers. Moreover, the deprivation of life-saving medical care in old age would be a greater deprivation for women because they have on average more years ahead to live (Jecker, 1991).

In light of these remarks, we conclude that it is wrong to suppose that old age-based rationing is justified just because death in old age is less tragic than death early in life. Even assuming it is correct to feel that an older person's death is relatively acceptable, it does not follow that the old can be ethically deprived of scarce life-saving medical resources so that such resources may be distributed to young age groups. Instead, a host of other considerations emerge as relevant.

Medical Futility. — A different set of issues is at stake when the tragedy associated with the loss of a small child disposes health care providers to pursue medical interventions against all odds in order to rescue a small child from death. Whereas rationing has to do with treating different groups fairly in the allocation of scarce resources, futility concerns
the likelihood and quality of benefit that medical treatment affords for a single individual (Jecker & Schneiderman, 1992). By calling a life-saving treatment futile, we mean that the likelihood that it will in fact prolong life is exceedingly low or the quality of life thereby gained would be exceedingly poor (Schneiderman, Jecker, & Jonsen, 1990). Under such circumstances, some may insist that even when the chance of a successful outcome is slim, health professionals have a stronger duty to attempt beating the odds on behalf of very young patients. The reasoning here may be that the death of a small child is a more terrible thing, and so more effort must be expended to prevent it from occurring.

Yet this reasoning breaks down once the odds of success approach a very low threshold. When the odds of success become exceedingly slim, attempting to defy them is not in the patient's best interest, but instead functions as a means for health professionals, patients, and family to evade hard choices and flirt with fantasies of omnipotence. Clinging relentlessly to the life of a very small child by pursuing aggressive medical treatments may even add to the patient's or parents' misery by creating an emotional roller coaster of raised, then dashed, hopes. In addition, efforts to beat the odds through medical means may only increase suffering by prolonging the dying process; entailing the use of painful and invasive methods; and leading the medical team to dwell on pointless therapies rather than focusing their attention on truly beneficial measures, such as palliative and comfort treatments (Jecker & Schneiderman, 1993). In light of this, we urge health professionals who care for very young patients to move beyond the relentless pursuit of futile technologies to an ethic of care (Schneiderman, Fager-Lange-Deon, Jecker, in press).

There is a slightly different objection one might raise in defense of making a greater effort to forestall death in the young. It might be claimed that even if health professionals have no ordinary duty to provide an intervention that is very unlikely to succeed, they should be more inclined to make an exception on behalf of the very young patient on the basis of compassion. In other words, empathizing with the very small child should prompt health professionals to exceed their ordinary duty and do everything possible to ward off death.

Yet this reasoning does not withstand careful scrutiny. Compassion involves an attempt to "be in" the patient's persona and experience the suffering the patient does. As suggested already, a very small child may feel immediate pain or fear, yet lacks the deeper understanding and capacity for suffering we attribute to an adult. Thus, when the physician "steps into" a very young patient's shoes, the physician is unlikely to find there a stronger basis for compassion. When compassion is stirred in response to some harm that befalls a small child, it is often more properly directed toward the child's parents than the child. For example, when a small child's life is in peril, the child's parents are more likely to grasp the moment's finality and recognize an incalculable loss. The life that is lost may even be perceived as theirs (the parents'), as much as the child's. The parents, like the protagonist in Euripides' Medea, may sense that they have been "broken" and are "as the dead."

Conclusion

We submit that the response of deeper anger, despair and bitterness in the face of a youthful death is not universal. Following Nagel's model, we have placed enough faith in these sentiments to inquire what more precisely they involve, and the reasons that can be advanced to support them. The juxtaposition of ancient and contemporary attitudes has made evident that the various norms that underlie contemporary attitudes are subject to alternative interpretations. Thus, the impending death of an infant or very small child will seem less cruel when it is emphasized that the infant or child does not comprehend the magnitude of the situation. On the other hand, the imminent death of a mature adult will appear more tragic when the mature adult is portrayed as innocent of wrongdoing, e.g., when death is attributed to the malign acts of others, or to genetic causes beyond the person's power to control or influence.

Finally, even assuming that contemporary responses to death's timing are justified, it does not immediately follow that the ethical obligations of physicians toward very young patients are more stringent. Nor does it follow that a tendency to "write off" elderly patients more readily, or feel absolved sooner of responsibility toward them, is warranted. Instead, justice standards are far too complex to reduce to a single rationing criterion, such as age. With regard to medical futility, it is clear that the boundaries of medicine apply to young and old alike, and even death's specter cannot undo medicine's ineluctable limits.

References


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