January 2021

> *"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."*
>
> *— Ludwig Wittgenstein*

Upcoming Events

- Ethics Committee Consortium Webinar Series: KS/MO Coronavirus Vaccine Allocation and Distribution Update (Thu 01/14 @ 12PM Central)
- Webinar: Safety & Efficacy in Emergency Authorization: Getting it to those who want it, responding to those who don't (Fri 01/29 @ 12PM Central)
- 2021 Annual Event: Humility, Health & Healing: Where do we go from here? (Thu 02/25 @ 6:30PM Central)

Hot Topic: Language Matters

Is it possible to have thought without language?

This is a deeper question related to the nature of the relationship between language and thought. Some have argued that language and thought are indeed separate, with language serving as a means of communicating thought. This is the opinion of Bertrand Russell who wrote, "Language serves not only to express thoughts, but to make possible thoughts which could not exist without it. It is sometimes maintained that there can be no thought without language, but to this view I cannot assent: I hold that there can be thought, and even true and false belief, without language. But however that may be, it cannot be denied that all fairly elaborate thoughts require words" (Russell, Human Knowledge).

Different Language, Different Meaning

This opinion is not shared by all. In the hypothesis of linguistic relativity, also known as the Sapir-Whorf hypothesis, the main notion is that language is not only a means of communicating ideas, but that the language of a person shapes also how that person views the world. A famous example comes from a 2003 study by Boroditsky, Schmidt, & Phillips in which researchers questioned German speakers and Spanish speakers who were asked to describe different objects. Comparisons and contrasts then were made of answers given.

Take the words *key* and *bridge*. *Key* is masculine in German and feminine in Spanish. They found "German speakers in the study tended to describe 'keys' as *hard, heavy, jagged, metal,* and *useful*. Spanish speakers, on the other hand, used words such as *golden, intricate, little, lovely*, and *tiny* when describing keys." Compare that to the word 'bridge' which is feminine in German and masculine in Spanish. Sure enough, German speakers described bridges as *beautiful, elegant, fragile, pretty,* and *slender,* while Spanish speakers said they were *big, dangerous, strong, sturdy*, and *towering"* (p.70). From this study, we can see how the language itself influences how speakers think about the world, affecting how they create opinions, expectations and thoughts. This is to say that we think in language rather than use language to think.

Language in Healthcare

Whether or not one agrees with that conclusion, the main point is uncontroversial fact: our language matters. The way we use language is particularly challenging for healthcare situations, manifesting itself specifically in how we discuss illness and treatments. For example, healthcare practitioners, and patients too, have adopted a semantically militaristic approach to treatment plans. This is shown in statements like: "He's losing the battle to cancer" or "She's a fighter, so keep doing everything!" or "We are going to fight this together." While militaristic language might be helpful to demonstrate the difficulties patients, families, and providers are facing, it also creates

a combative binary approach, which can be more harmful than helpful when disease progresses and the patient declines.

A common phrase tangential to healthcare militaristic terminology is one that becomes especially difficult, psychologically and otherwise. How many times have we said or heard said that so-and-so is "giving up"? When a patient has a poor prognosis and is in a pattern of decline, it is ethically and medically appropriate to discuss involvement of palliative medicine, perhaps moving towards "full comfort measures" and hospice. However, this can easily be interpreted by patients and their families—by some healthcare providers also—as "giving up." This is understandable especially if the patient has had their condition discussed in binary militaristic terms throughout treatment. If a patient is not "fighting," then they are "giving up." Aren't they? It could seem so for one described as "a fighter" involved in "combatting the cancer," or whatever.

Returning to the previous discussion of language and thought, if people (patients, families, providers) in fact do think *within language* and not just *with language*, then they will understand their condition within the language used to describe what's going on. If militaristic binary language is used descriptively, thoughts will arise to shape that healthcare experience, possibly in ways less than helpful, regardless of good intent by those who linguistically framed the experience of treatment or being treated. Language matters.

Words Determine Response

Problems are encountered in patient care when the language that some providers use with patients and family is inconsistent with that used by others. But consistency must be of the sort of language that helps and doesn't harm. For example, medical providers consistently have used the phrase, "withdraw care," when discussing the stopping of life-sustaining treatments and involving palliative medicine. As O'Connor, Davis, & Abernethy (2013) state: "…referrals to palliative care are often for reasons of 'stopping treatment' or because 'there is no further treatment'. Therefore, palliative care becomes the 'no treatment' but care or 'management' service; whereas, in fact, individuals may be simultaneously receiving palliative care while continuously receiving treatment, which may include radiation and/or chemotherapy" (p. 70). In other situations, it may indeed be that aggressive and curative treatments are no longer helpful but only harmful, and wasteful too. As many clinical ethicists have noted, in such cases, it is a *treatment* modality that is being stopped or withdrawn or withheld, not *care.* We ought never to stop caring for and about our patients. Indeed, truly caring for a patient means offering what is beneficial and effective and not what is not. If optimal care is full comfort measures only, then we are not stopping or withdrawing care in the transition to CMO, and saying so is stating a falsehood. Do we think that doesn't matter? Of course it does. Language matters.

Medical professionals need to understand that the words and language used to discuss a patient's diagnosis and prognosis go a long way to determining how that patient will approach and respond to treatment. Patients and their families look to providers to clarify information, address ailments, and provide both physical and emotional care as they navigate through the journey of illness. And notice the language here of "navigation" and "journey". Might these be terms of a sort that are more helpful than harmful? Whether or not we "think in language rather than use language to think," it is ethically fitting to think about the language we use in healthcare, because it matters.

Bioethics in the News

- LA County Paramedics Told Not To Transport Some Patients With Low Chance Of Survival
- Must Catholics refuse a COVID-19 vaccine made with a cell line from an abortion?
- What the Chaos in Hospitals is Doing to Doctors
- Triage according to standard tests of frailty, says Oxford bioethicist
- Bioethics met its COVID-19 Waterloo: The doctor knows best again
- What if autonomous weapons are more ethical than humans?

Case Study

The patient is a 73 year old individual who identifies as female and is suffering from metastatic colon cancer. While an inpatient, she is cared for by her longtime oncologist, hospitalists and ultimately a critical care team. While she initially does have decision-making capacity, this patient makes decisions with her family (husband and two adult children). When discussing treatment options and goals of care, the patient inconsistently makes decisions based on who is present in the room. When the patient is by herself, she says that she knows she is very sick and is tired; and at this point, all she cares about is being comfortable. But when her family, particularly her husband, is in the room, she will default to saying that she wants to "continue to fight."

Multiple physicians have noticed the difference between what their patient says in private and when family is present. Family discussion centers on those militaristic notions of "fighting" the cancer. "Mom, you don't want to give up, do you?" and "Let's just keep fighting a little more, Honey." Then when the patient is alone with her providers, she says, "I really just want to make sure that I am comfortable and not in pain."

During the night shift, this patient coded and was resuscitated per her Full Code status. She was transferred to the Medical ICU and seems now to have more pain and discomfort than previously. Her decisional capacity is unclear, and transient at best due to sedation and possibly anoxic injury. A family meeting is scheduled to discuss decisions to be made, including code status going forward. ICU physicians, residents in particular, state a perspective that attempting resuscitation again would be "futile" and it is time to move to comfort measures only. The attending oncologist believes that it is too early to stop aggressive treatment and "withdraw care." She wants to keep her patient Full Code and obtain consent for at least another round of chemotherapy. Both teams have requested that Ethics join the family meeting.

Ethical Musings: What is Good?

What is the meaning of the word *good*? This is a fundamental question that needs to be addressed in both metaethics and medical ethics. Medical providers are held to the principle of beneficence, an obligation to do and promote good. But how is one able to do and promote good if one is not able to know what *good* is? Would it be futile and unproductive to hold medical providers to undefinable standards? This has been a recognized problem in ethics and metaethics for some time, with philosophers attempting to define *good* so as to create ethical systems addressing it.

The Reductive Approach

A common approach to think about *good* is to reductively define the term in natural properties, using such terms as *pleasant* or *desirable*. This was the approach taken by British philosopher Jeremy Bentham, seen as the founder of the philosophy that would go on to be known as Utilitarianism. Bentham argued that moral terms such as *right*, *good* and *obligation* can only be understood in natural and perceptible terms such as *pains* and *pleasures*. Humankind understands morality only through these terms, and the creation of additional terms only confound matters. In his introduction to the Principles of Morals and Legislation, Bentham begins by stating, "Nature has placed mankind under the governance of two sovereign masters, *pain* and *pleasure*. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand, the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne. They govern us in all we do, in all we say, in all we think: Every effort we can make to throw off our subjection will serve but to demonstrate and confirm it. In words a man may pretend to abjure their empire: but in reality he will remain subject to it all the while."

The Naturalistic Fallacy

This attempt to deconstruct the nature of *goodness* into more understandable terms has been attempted by many philosophers. But it was strongly argued against by G.E. Moore in *Principia Ethics* in 1903, in which Moore lays out

the "Naturalistic Fallacy." Moore argues that any attempt to ground *goodness* in naturalistic language is futile. *Goodness* exists in a different understanding than naturalistic language. Moore lays out his argument thus:

(1.1)

> For any naturalistic or metaphysical "*X*", if "good" meant "*X*", then (i) "*X* things are good" would be a barren tautology, equivalent to (ii) "*X* things are *X*" or (iii) "Good things are good."

(1.2)

> For any naturalistic or metaphysical "*X*", if (i) "*X* things are good" were a barren tautology, it would not provide a reason for action (i.e., a reason to promote *X*-ness).

(1.3)

> So for any naturalistic or metaphysical "*X*", *either* (i) "*X* things are good" does not provide a reason for action (i.e., a reason to promote *X*-ness), *or* "good" does not mean "*X*".

To put it another way, Moore encourages thinking about *goodness* in the same way we think about the nature of *yellow*. He states:

> Consider yellow, for example. We may try to define it, by describing its physical equivalent; we may state what kind of light-vibrations must stimulate the normal eye, in order that we may perceive it. But a moment's reflection is sufficient to shew that those light-vibrations are not themselves what we mean by yellow. They are not what we perceive. Indeed, we should never have been able to discover their existence, unless we had first been struck by the patent difference of quality between the different colours. (§10)

Outside Normal Experience

You cannot describe *yellow* in terms that do not contain their own self-reference. Think to yourself, how would you describe the color yellow without referring to yellow itself? You may describe things that are yellow, but that is exemplifying or showing yellow, not actually defining yellow. This does not mean that there is not a definition of yellow, but only that that definition cannot exist with naturalistic language. You cannot say that yellow is that which brings pleasure. While this may be true to some observers, it is itself not a universal truth, thus not a definition.

This is the mentality and approach we need to have towards *goodness.* We can observe *goodness*, give examples of *goodness,* identify it, and even develop better definitions. But we have to ensure that the language used in those definitions is different than naturalistic mentalities, such as pleasure. *Goodness* exists outside of normal experience of people and is much more complicated than the understanding used by Bentham. *Goodness* and *pleasure* are not one-to-one equal terms. This is demonstrated often in medical ethics, as acts that are *good* are not always those that bring pleasure. Sometimes the right or *good* action is one that brings unhappiness and displeasure, but it is *right* based on a higher understanding.