



# “The Danger of Words”: Language Games in Bioethics

Michael A. Ashby

Published online: 19 April 2023  
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To most doctors and health workers who haven't studied philosophy, the works of Ludwig Wittgenstein are hard to approach. Many of us outside the philosophical academy will tend to know more about him through the landmark biography by Ray Monk (1991): the irascible genius who is alleged to have waved a poker at Bertrand Russell, corrected musical performers from memory of the score, retreated to teach in an obscure school in Austria during his philosophical career, and moved in with his Cambridge doctor when dying of prostate cancer in 1951. Medical readers might be interested to know that one of his best friends was Maurice Drury, a Dublin trained psychiatrist, described by Monk as having written in *The Danger of Words and Writings on Wittgenstein*, “the most truly Wittgensteinian book published by any of Wittgenstein's students” (Drury 1996). Drury describes how language can both consciously and unconsciously lead to confusion, error, and misunderstandings. In this issue, Riisfeldt (2023) tackles what he sees as taxonomic confusion with the terms “euthanasia” and “assisted dying” by locating them within an all-embracing contingency table based on six factors relating to causality, consent, capacity, and intention. He thereby offers what he describes as an unambiguous, value-neutral taxonomy of “end-of-life practices.”

There have been many attempts to clarify language in the long ongoing debates about euthanasia that have culminated in permissive legislation and/or court decisions in North America, Europe, Australia, and New Zealand. For instance, Somerville drew attention to the way language was used in euthanasia debates in the 2000s, pointing out that the words used could be deployed tactically, particularly, in this argument against permissive legislation, the use of euphemisms to avoid naming of the act of killing itself (Somerville 2003).

The Greek derivation of the word “euthanasia,” literally good death, is unhelpful in nailing down what is really at stake. Despite its many definitions in the various literatures and many societal debates, the common themes it seeks to convey are: (i) an intentional ending of life involving human agency (yes, killing oneself or being killed in bald forensic terms), (ii) justified by an unacceptable state of being due to illness, usually based on pain and suffering and violations of notions of human dignity. Causation and human agency are not in dispute, and self-willed death is permitted provided that a process is followed in which the autonomous nature of the request is tested and the contingent qualifying medical facts are confirmed.

“Passive” euthanasia as a term has been largely abandoned as unhelpful and a misrepresentation of medical treatment abatement, a normal part of good everyday medical practice when treatments are not working or are too burdensome. The terms involuntary and non-voluntary both refer to situations where consent is absent, either where it could be and is not sought or where it cannot be due to lack of mental

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M. A. Ashby (✉)  
Sub Acute, Aged & Community Services, Royal Hobart Hospital, Tasmanian Health Service, and School of Medicine, University of Tasmania, Hobart, TAS 7000, Australia  
e-mail: ashbyjbin@gmail.com

capacity but occurs nonetheless. Euthanasia as practiced in Nazi Germany (Burleigh 1994; Aly, Chroust, and Pross 1994; Annas and Grodin 1995) constituted crimes against humanity, and is hopefully not advocated by anyone. However, access to euthanasia for those with dementia will become a major issue as this becomes one of the most common pathways to death across the world as populations age. People who might anticipate wanting it when competent, will usually lack mental capacity at the time assistance to die is desired as the dementia process progresses. Reorientation of health systems to provide palliative care in dementia is now a health policy priority in most countries. (Brennan et al. 2023). We know that changes to mental capacity and loss of independence are fundamental to many people's dignity constructs and their anticipated loss is widely feared. Assisted dying has to be continuously willed until the moment of death. The only way to address this will presumably be to allow some form of advance direction for assisted dying, as in Belgium, although even there the law does not cover the dementia contingency. In addition to the capacity challenge, the trigger points for activation of such requests would be tricky to pin down, for example something like "when I can no longer recognize my family and friends, feed and toilet myself."

There is no doubt that "assisted dying" is a euphemism, and that legislation has favoured self-administration to emphasize the autonomy of the person concerned and reduce the causal burden for practitioners. In bald language terms, yes, it is killing and suicide at stake here, but this is consciously dealt with by making it clear that subject to clinical situation and prescribed procedure, these are permitted in law and indeed in legislation these matters can be dealt with in the definitions, by stating, for instance, that for the purposes of the act, an assisted death, following the procedures prescribed, does not constitute a suicide. Those availing themselves of these legal provisions, and those who conscientiously assist them, would certainly not use such language, and one would only do so as a tactic to argue against the legal provision. If we employ the word "kill" in everyday speech there is usually an implication that it is death inflicted against the person's will, otherwise we say they died (or in latter years the bizarre euphemism, they "passed away" rather than they were killed in a road accident, for example).

For those who work in palliative care outside the setting of legally sanctioned assistance to die, the issue of

causation is well addressed by a set of clinical and ethical characteristics promulgated by the Ontario coroner and submitted to the Canadian senate in 1997 (Parliament of Canada 1995; Dr James Young 1997). It captures the essence of the basic underlying principles of therapeutic interventions in palliative medicine by laying down four conditions that need to be satisfied for palliative care interventions to be legal in his jurisdiction:

- (1) The care must be intended solely to relieve suffering;
- (2) it must be administered in response to suffering or signs of suffering;
- (3) it must [be] commensurate with that suffering;
- and (4) it cannot be a deliberate infliction of death. Documentation is required, and the doses must increase progressively.

This "mainstream" palliative care practice defence that might be termed "causal neutrality" (neither hastening nor prolonging the dying process) is reasonably well established (although still susceptible to intellectual challenge) in ethics and law for cancer pain relief with opioids, based on double effect reasoning and clinical intention. This causal position cannot of course be empirically verified one way or the other and has been contested during the euthanasia debate (see Singer 1995). It cannot however be assumed that the same defence applies to sedation practices, particularly in aged care, where the excessive and inappropriate use in non-dying persons has led to public policy discouragement of the use of sedative drugs at all in aged care settings (Australian Government 2021). Sedation for terminal restlessness in the last hours or days of life is widely used but practices vary considerably between jurisdictions, cultures, and indeed individual practitioners (Douglas, Kerridge, and Ankeny 2013). As the world faces a huge increase in deaths from dementia, it will be increasingly important to ensure that dying people who are experiencing resistant and persistent "behavioural and psychological symptoms of dementia" (BPSD) have adequate sedation necessary to preserve dignity and relieve suffering (aggression, disinhibition, incontinence of every kind, and repetitive anguish, for example). This will need to be skilfully deployed, with expert specialist aged psychiatry input on the variable length journeys of individual natural history, and then with palliative care input and experience as death approaches where sleep and calm will be the endpoints. If we fail to deal with fears of pharmacological intervention and death

causation during the imminent dying process, many people will literally “rave their way to the grave.”

So rather than engage in language games, we might be better served by acknowledging clinical realities, recognize the dying process for what it is, abandon euphemism, and ensure that with good communication and transparency, doctors and nurses can relieve suffering without lingering causal doubt and fear of ethical, regulatory, or legal censure. This can only happen with broader community understanding of what dying is like, including both the therapeutic possibilities and limitations in any given clinical situation, set in a medico-legal framework that moves beyond mere forensic causation in terminal care. If you are dying in pain or distress, and especially if your last act is to hit a nurse or abuse a much-loved relative, will your final question be about causality? So, in the end, precision and common understanding of word meaning is necessary in any discourse but language will also often be deployed to euphemize the real issues for political and tactical reasons.

Assisted dying in Australia is a state-by-state matter, and one by one they have been passing permissive legislation, based largely on the laws originally enacted in two west coast states of the United States (Oregon and Washington) (University of Tasmania 2021). The emphasis is on self-administration whenever possible, hence the term “voluntary assisted dying” (VAD). The pathways are long and bureaucratic, consisting of several steps to ensure that nobody is coerced or wrongly diagnosed. To accommodate the opposition in each jurisdiction there are subtle but important distinctions between the various state acts of parliament. Okninski (2023) has done a helpful comparison of these laws and their eligibility criteria in the legal *Recent Developments* column. McDougall, Pratt, and Sellars (2023) have undertaken a qualitative study of clinician experiences of the introduction of assisted dying legislation in the state of Victoria, Australia. They found that the main issues centred around the ethical “diversity” of staff members and how to ensure that there was respectful organizational culture whilst ensuring that citizens can access assisted dying according to their legal rights. There was also concern about whether the procedures involved would accommodate diverse clinical situations.

It is a mark of the progress in organ transplantation that Sawinski et al. (2023) survey the issue of post-transplant reproduction as an issue worthy of

systematic guidelines as there are still significant knowledge gaps about risks.

It is salutary for those of us who live in welfare systems that give state-funded carers financial support to know that many countries do not. Fan and Yung (2023) argue that Hong Kong should do so and that to provide carer payments would not undermine Confucian notion of filial piety or act as a perverse incentive and would not have a negative economic impact.

The fallout from the COVID-19 pandemic will no doubt continue for some while, and four papers in this issue deal with it. Free speech in the J.S. Mill tradition would normally suggest that even speaking what others believe to be a falsehood should normally be permissible. Saunders (2023) argues that this right might not extend to spreading of false information about vaccination during a pandemic, presumably because the potential harm is considerable. It could also be said that there might also be a case for maintaining free speech and that the buyer should beware. Censorship, even in a time of community danger, is itself a potentially more serious harm. Listeners must surely be responsible for their own discernment. It is to be hoped that when the dangers and fears of death and COVID-19 subside, that all jurisdictions can have an honest appraisal of the harms of excessive closure of borders, schools, and even prohibitions of outdoor activities (for which there was no evidence), with the benefit of hindsight, and at least to question the degree of infringement of personal liberty that so many seemed to take for granted during the pandemic. Kraaijeveld (2023) points out that the effectiveness of vaccines to prevent transmission of the COVID-19 virus has not been established. This is serious in terms of human rights concerns as it can then be argued that being vaccinated is primarily for personal protection and that the notion of there being some kind of civic duty to vaccinate to protect others was and is false. Ortiz-Millán (2023) considers health passports/passes for movement across borders to prove that someone has been vaccinated, has recovered from the disease, or has negative results on a diagnostic test and comes out in favour of them despite concerns about discrimination and privacy.

Otterman (2023) notes that psychedelic drugs are now being widely tested for serious mental health conditions. Despite the no doubt obvious fears about exposing very vulnerable young people to such drugs, it is argued that those suffering from anorexia nervosa should have

access to psychedelic-assisted psychotherapy research as present therapy options have serious limitations.

Claesen et al. (2023) question the impact of prenatal genetic testing and future child rights to what is termed an “open” future. Expanded non-invasive prenatal testing (NIPT) is increasingly available. The authors contend that it is theoretically flawed to apply the open future concept to NIPT because the main value is to allow parents to reflect on what they want/need to know about their future child’s genetic prospects.

Objections to selling organs for transplantation, most notably kidneys, may refer to the infringement of dignity that could result from this monetarization of one of their organs. Reese and Pies (2023) conclude that there is a moral argument for preventing organ sales on the basis of donor dignity.

Anonymous donor conception has been under ethical and legal scrutiny for some while now, apparently leading to a dearth of sperm donors now in jurisdictions where the right to know their identity for resultant offspring has been recognized. Amanda Roth (2023) reviews Daniel Groll’s book *Conceiving People* and finds it readable and engaging, especially the author’s personal experience narrative, although it would have been good to see more linkage of the personal and the philosophical. Key issues include the right to know one’s genetic heritage and what constitutes a “worthwhile” interest for children, and what duties parents have to promote these interests. This work points out that genetics is just one dimension of our identity construction and maybe socially over-valued in the sense that over emphasis on genetics can give rise to what is termed “bionormativity”: whereby genetically connected conventional families are seen as superior to, for instance, same gender parents with donor conceived children. The review concludes that the author makes a very good case against anonymous donor conception in a very readable book, but it also critiques the arguments and their flaws whilst still recommending it.

We have received two letters from Chinese academics Bingyuan Chen, Laitan Fang, and Ronghui Liu (2023a, 2023b) about the pandemic and its consequences. China has received much attention during the global pandemic. Firstly, because of the pandemic origins, with much speculation about the biological causal chain, secondly, because of concerns about the sharing of data, and lastly, because of the severity of lockdowns that persisted until recently when they abruptly ended. We publish these letters largely unedited to show their concerns about the

fragility of social solidarity and the tensions between what they term the “impossible triangle” of health protection, social consensus, and economic development. China, they say, waged a “people’s war” against the effects of the virus, with a flavour of Marxist struggle and the need to subjugate individual freedom for broader community public health reasons (which of course all countries chose to do to a greater or lesser degree). They gently urge us to avoid criticizing other jurisdictions about their pandemic measures and show that concerns about individual freedom and social kindness/solidarity have been aired in China just as they have in western democracies. It is noteworthy that public protests influenced the lifting of restrictions in China and that the veneer of social cohesion and political weaponization of lockdown fears in countries like Australia (with ridiculous rivalries between the states) show that these tensions are alive everywhere. One can only hope that rigorous enquiry around the world will give a true picture of what worked and what was unnecessary (and often unduly oppressive!) everywhere, not just in China.

For many years the French newspaper *Le Monde* ran a column called “Sur le Vif,” written in colloquial French about contemporary issues from the perspective of the “man or woman in the street.” This expression is also used in the title of the French edition of a collection of the writings of the celebrated war correspondent Martha Gelhorn (2019). A modern equivalent might be the so-called pub test of political issues, an appeal to some sort of normative common-sense evaluation from an everyday life point of view. In Gelhorn’s case it is more about being there, dispatches from the front line. Our Associate Editor David Shaw (2023) follows on from his previous articles about pub philosophy (Shaw 2019) with a new piece about how some dog owners refuse to take responsibility for their animal’s behaviour: a meditation on epistemic indefensibility and ethical denial. If readers enjoy this, maybe we should start a regular “street ethics” column. There can surely be no harm in speaking plainly to and maybe with the “man (nowadays person) on the Clapham omnibus” that so informed the English common law tradition.

Bioethics as a discipline in its argumentation dimension (and to a lesser degree in the empirical domain) is conducted via concepts painted by words in a language, in the case of the *JB* Anglo-American formal academic house style. Just as with politics, where difference about societal government is addressed (hopefully

in democracies at least) in a peaceful way with words rather than guns, so in bioethics, that deals with difference in moral conduct, we should not be surprised if language is weaponized for tactical ends. Meanwhile back on the Clapham bus, “sur le vif” so to speak, meaning needs to be clear and inspire right actions, from right intention, regardless of the word war that has gone on in the academy or the courts. We all have responsibility to ensure that our academy “in-house” words can be understood and engaged with outside the club or at the pub, on the bus, or at the dog park.

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