CLINICAL ETHICS

What should we say?

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Abstract ethics mostly focuses on what we do. One form of action is a speech act. What we say can have profound effects. We can and should choose our words and how we speak wisely. When someone close to us suffers an injury or serious illness, a duty of beneficence requires that we support that person through beneficial words or actions. Though our intentions are most often benign, by what we say we often make the unfortunate person feel worse. Beginning with two personal accounts, this article explains what can go wrong in the compassionate speech of wellwishers, and uncovers some of the reasons why people say things that are hurtful or harmful. Despite a large body of clinical evidence, there is no perfect strategy for comforting a friend or relative who is ill, and sometimes even the best thing to say can still be perceived as insensitive and hurtful. In some cases, we may have good reason to knowingly say a hurtful or insensitive thing. Saying these 'wrong' things can sometimes be the best way to help a person in the long term. To complicate matters, there can be moral reasons for overriding what is good for the patient. What kind of admonishments should we make to a badly behaved patient? What is the value of authenticity in our communication with the people we love? These questions demand an ethical defence of those speech acts which are painful to hear but which need to be said, and of those which go wrong despite the best efforts of the wellwisher. We offer an ethical account, identifying permissible and impermissible justifications for the things we say to a person with a serious injury or illness.

What should we say:

To the man who has lost an arm in a farming accident?

''You're very lucky, you could have died.''

To the man who has lost a leg in a motorcycle accident?

''You are very lucky you didn't lose the other one. You will be able to walk with a prosthesis.''

To the man who broke his neck on a family skiing holiday?

''Well, you were skiing… Serves you right for enjoying yourself so much.''

To the woman who has lost her sight in an industrial accident.

''It has happened now. You need to accept it. You need to learn to live with it. Move on.''

To the man who did not look before crossing the road and is now a quadriplegic.

''It was your fault.''

PERSONAL PERSPECTIVE—JULIAN SAVULESCU

Nearly two years ago I suffered a badly broken leg. Now I have a numb foot, metal holding my leg together, large gaping holes in my calf from fasciotomies and skin grafts and an artery graft. I may develop arthritis. I cannot do the things I used to most enjoy. I view it as a terrible loss.

Yet all these things were said to me at one time or another.

The commonest, especially while I was in hospital, were:

''You are so lucky you didn't lose the foot.''

''You are so lucky—at least you will be able to walk again.''

When one person found out it happened on a family skiing holiday, she said:

''Oh…well, you shouldn't have been enjoying yourself so much.''

Another said:

''It was your own fault.''

People frequently tried to help by pointing out how lucky I was in other ways:

''You have two beautiful healthy daughters. You should remember that.''

What was especially irritating was the ease with which other healthy able people were able to accept my misfortune:

''It is a part of your life now—you have to accept it.''

''You should be happy doing what you can do. There are lots of things you can still do.''

A WIDER PERSPECTIVE—JULIAN SAVULESCU AND JOHN ROGERS

This experience was not unique. John Rogers, a clinical geneticist and practising psychoanalyst, endured similar comments during a series of events that were much more punishing. He suffered (separately) a life threatening lymphoma treated with a bone marrow transplant, a life threatening streptococcal infection requiring intensive care admission and hyperbaric oxygen therapy, and the death of his child following withdrawal of medical treatment following severe meningitis, which had left her severely and permanently brain damaged.

During his lymphoma, his haematologist said just prior to his bone marrow aspiration: ''This will not hurt''.

His mother said, when she heard he was diagnosed with lymphoma: ''How can he do this to me''.

His friend said, when he was pale and bald from chemotherapy and painfully thin: ''You look well''.

During his streptococcal illness, contracted in Vanuatu, his cousin said: ''If you will go to those places…''

Distressed when his daughter was suffering from a disease that was going to cause brain damage, the matron said: ''Having a retarded child is a wonderful experience''.

After she died, a rabbi said: ''At least you have two children''.

When some important part of our life was lost, we felt there was nothing good or lucky about it. We increasingly hated all these comments people made to us.

No doubt people felt inclined to tell us these things because they viewed a broken leg as a relatively trivial thing. Lymphoma, a life threatening streptococcal infection and the death of a daughter can hardly be regarded in the same

light. Yet the comments we received were surprisingly insensitive to the seriousness of the misfortune.

What should we say when disease or injury befalls someone?

''It's a terrible thing. There is nothing good about it.''

''You were very unlucky.''

''You have done a great job to get where you are in coping with this.''

''Few people could have done what you have with this kind of injury.''

''You have had the best medical treatment.''

Perhaps best of all is:

''What can I do?''

As is most often the case, actions speak louder than words. When JS broke his leg, one friend offered the use of his automatic car. One colleague, who was famous for his apparent lack of empathy, brought books and a chess set. He played chess for hours in the hospital.

''WHAT SHOULD WE SAY?''—THE ETHICAL DIMENSION

Two of us (Julian and John) shared similar reactions to what was said to us following our medical misfortune, but, as counsellors can attest, a person's emotional reactions to some medical misfortune can differ radically. ''What should we say?'' is in part an empirical question, best answered by clinical psychologists and doctors, based on the best clinical evidence. Through evidence, we can find the strategies that are most likely to produce good outcomes for the unfortunate person.

Yet there is more to answering this question than finding a formula for the best outcome. When we say something to a person who is suffering, we perform a speech act that can have significant impact on their wellbeing. It is morally important why we say what we say, particularly in cases where we say something that upsets the person who is sick or injured. In the extreme, people can kill themselves because of a speech act against them.

Bad reactions can happen to even the best counsellors and the most experienced, empathic doctors—partly because different coping strategies work differently for different people,[1] but also because there may be more to saying the right thing than just making the person feel good. Here, we will try to dissect the moral value of the different reasons for what we say to someone suffering a medical misfortune.

WHY DO PEOPLE SAY WHAT THEY SAY?

Psychological explanatory reasons for what we say

Not all of the things we say to a sick or injured person are motivated by the pursuit of some particular outcome. Sometimes we act from strong psychological tendencies, which are not sensitive to our goals.

Empathic distress

We do not cry alone. When we are around a person who is suffering, we suffer too. It is hard to be around people who have a negative mood. Evidence and personal experience shows that it makes us feel bad to be around depressed people.[2] It has been observed that even nurses can become hostile to depressed patients.[3]

Sometimes, we unthinkingly try to avoid or reduce our empathic response in these situations, either by escaping the situation, or through speech that attempts to force the sufferer to be happy.

This could come in the form of a joke. Or it could come in the form of a speech act that makes it impossible for the sufferer to respond with something that might make the healthy person feel some of their pain. A sick person will struggle to express the extent of their suffering when we say, as was said to John:

> You are looking well.

When we are moved to make a sick person feel better so that we may feel better, it is unfair. We can reasonably assume that our empathic distress is less severe, and less important, than the emotional suffering of the sick or injured person. Our empathic distress will also pass when we leave the person's hospital room or home. We should try to resist our impulse to reduce our empathic suffering.

Not all of these attempts to improve the mood of the patient are selfish. As we will see below, there are normative reasons for this kind of behaviour. But we must first consider several other ways in which we selfishly act from an unthinking emotional or psychological response to another's suffering.

Kafka and the alienation of the victim of suffering

The story of *The Metamorphosis* begins with the protagonist, Gregor, waking up after turning into a giant insect. Initially horrified, his family grow to accept his condition. Initially, they care for him. But their care for him exacts a financial burden on their boarding house business, as well as a heavy emotional burden. Gregor's appearance revolts his family. For his part, Gregor finds it impossible in his physical state to interact in a human way. His bug like behaviours dehumanise him further in the eyes of his family. Gregor's loss of language makes him unable to express the attachment to his family, which he still cherishes. Gradually he gives up his hold on his human roles and identity entirely, though he never ceases to care for his family, and feels remorse over the trouble he has put them to. After he frightens his mother and sister, his father wounds him with an apple. Gregor begins a slow decline toward death, increasing the feelings of guilt and grief that his family must contend with. His sister finally cracks.

> ''We must try to get rid of it'', the sister now said decisively to the father, for the mother, in her coughing fit, wasn't listening to anything, ''it is killing you both. I see it coming. When people have to work as hard as we all do, they cannot also tolerate this endless torment at home. I just can't go on any more.''[4]

Becoming certain that her real brother would have voluntarily left the family, his sister locks him in his bedroom until he dies. The maid discovers his corpse:

> She pulled open the door of the bedroom and yelled in a loud voice into the darkness, ''Come and look. It's kicked the bucket. It's lying there, totally snuffed!''
> ... ''Dead?'' said Mrs Samsa and looked questioningly at the cleaning woman, although she could check everything on her own and even understand without a check. ''I should say so'', said the cleaning woman and, by way of proof, poked Gregor's body with the broom a considerable distance more to the side. Mrs Samsa made a movement as if she wished to restrain the broom, but didn't do it. ''Well'', said Mr Samsa, ''now we can give thanks to God''. He crossed himself, and the three women followed his example (Kafka,[4] p 55).

Kafka himself was afflicted with tuberculosis. Gregor's experience, and his family's experience, is one example of how people think about the sick person. The transformation

of a person into the role of the ''sick person'' is a dehumanising transition, or at least it severs the ties that the family feels toward the patient (but not vice versa). Though this makes the final parting a relief for the family, it also turns the caring process into an unmitigated burden.

Existential distress

When a person close to us is sick it can shake our beliefs about the world. We realise that the worst can happen to us, that there is danger, and that there is injustice. These realisations are upsetting and we often seek to find ways to reassure ourselves.

We need to cling to optimism. When we drive cars, play sports, or eat meat, we cannot constantly worry about the real risks. We need to pretend that there are no risks at all. Evidence shows that we all need to be unrealistically optimistic to cope with life.[5 6] This is why a friend or family member's misfortune can be so disturbing. When we are upset in this way we can blurt out the worst things.

> You must have been driving too fast.
> You must have been working too hard.

When a friend gets sick or is injured, we also form new counterfactual rationalisations for their misfortune. One of these is the belief that life is a ''zero sum game''—that we cannot benefit without another person suffering, and that we benefit from our friend's medical misfortune. This belief can be a source of guilt, but it can give us an explanation for someone's random misfortune, and it is also an explanation that allows us to conclude that our friend's suffering cannot also befall us.

By attaching a cause to a misfortune, it seems avoidable. We do not want our friend's suffering to be pure bad luck; if it were, it could also happen to us. This could be why Julian heard:

> Oh…well, you shouldn't have been enjoying yourself so much.

Children believe in ''immanent justice'', meaning that the world punishes us for our bad deeds.[7] In some ways, this is a belief that never leaves us.[8] But there is no possible benefit in telling a person that they deserve their suffering when they do not, or that their misfortune had a cause when it did not. When our help is needed, we should resist our most childish and untrue beliefs about the world.

The sick role

In the 1950s, Talcott Parsons defined the ''sick role'' as a medically sanctioned form of deviant behaviour, which the sick are guided into enacting.[9] He argued that the way that sick people are exempted from their duties, and given heightened attention from others, was similar to the way children are treated. This model of the doctor/patient relationship is changing as patients become consumers rather than recipients of medical care, yet it remains relevant to the way that sick people are treated by family and friends. Some of the things people said to Julian and John can be understood in the light of a parent/child relationship.

Whether or not Parsons's particular claims about the sick role are correct, it is clear that there are normatively appropriate behaviours for a sick person, and we may object when a sick person behaves in a normatively inappropriate way. We might—for example, find it difficult if a sick parent insists on maintaining their position of authority over their children.

Yet sometimes the responses that are normatively appropriate may be harmful. Judith Rabkin interviewed a man who said this about sympathetic responses:

> I thought I wanted it and had always without much thought considered it to be one of the natural virtues, but once I became seriously ill and the recipient of an enormous amount of sympathy, I began to detect something pacifying, something that seemed to promote in me a kind of passivity.[10]

What ethical weight should we place on our normative views on how the sick should act? When we try to get someone to conform to norms of sick person behaviour, is it an irrational or a rational behaviour? Is it an ethical or unethical behaviour? These questions depend on what the reason for the norm is.

Taking responsibility for our words

Whatever psychological forces are at work when we are confronted with a sick or injured friend, we have the option to say nothing. When we speak from knee jerk reactions, such as those that have been described above, we act selfishly and recklessly, even if the sick person appreciates what we say. We are responsible for our speech, even when it comes from the heart or off the cuff. These psychological reasons, therefore, will never be a good ethical defence for what we say.

Normative reasons for what we say

As we have seen, in some cases, there are no normative reasons for these speech acts. Some negative remarks occur almost accidentally, as a person vomits out a feeling or because the person is narcissistic or totally lacking in empathy.

But sometimes there are normative reasons to say some particular thing to an unfortunate person. The most basic case is where we have an honest belief that what we say will help the person. But there are a number of reasons for saying things that serve other purposes instead.

Some speech acts serve the interests of the speaker. In some cases, the motivation is positively malicious—to take the chance to get even or exact revenge. And in some cases, the motivation is to reform the behaviour of the sufferer.

Some of these reasons are quite defensible, whereas others, such as malicious intent, are clearly unethical.

Serving the speaker's interests

Sometimes a person deliberately pursues their own personal interests when approaching a sick or injured person. Often a person does not want to be asked to help, in either an emotional or practical sense. Perhaps they are busy, perhaps they are not close to the person. Sometimes we pursue our own interests by distancing ourselves from the suffering person—by avoiding their phone calls and failing to visit them, or by being rude. A more common method to avoid obligation is to try to distance or distract the person from their suffering, reducing their need for assistance, and reducing the social pressure to help.

> You're ok, right?

The sick and injured often want people to offer to help: but there are ways to offer help which are impossible to accept. Saying ''what can I do?'' or ''how can I help?'' sometimes obliges the sick or injured person to explicitly absolve you of your duties. It may thus be a form of manipulation. If we

wish genuinely to offer practical help, we must offer it in ways that make it possible to accept.

> I'm going shopping near your house tomorrow; would you like a lift to the hospital?
> I insist on paying for your treatment.

Are self interested speech acts in these situations ethically defensible? Whether we view these cases as valid self defence, or selfishness, depends on how much the speech act helps the speaker, and harms the listener.

If the patient is less seriously ill or injured, then our social obligations to them are lessened. They are also weakened if we are the least capable of providing help. But there is no good defence for eschewing our social obligations just because we find them burdensome.

Most of us want to be visited when we are in hospital. Michael Stocker claimed that we should visit the sick person out of friendship, not out of duty[11]: but an injured person may not care what the overriding reasons are for people visiting him. He might not be perturbed if someone visited him out of duty. No doubt many do. When people visit it does the patient some good, regardless of why they are there.

Trying to help by improving a person's mood

Sometimes when we attempt to cheer up a sick or injured person, it is not for purely selfish or automatic reasons. First, negative mood is in itself a type of suffering, and we may feel that things are automatically better for a person if their mood is improved. But there are times when we intuitively feel that a pessimistic outlook is bad for the sufferer's wellbeing in other, long term ways.

There are many ways that we try to improve the mood of a sick or injured person. We tell jokes, talk about good news, and smile. When none of that works, we are sometimes moved to offer admonitions:

> Look on the bright side.
> Cheer up.

Part of this can be motivated by a justified belief that an optimistic attitude is better for the person who has suffered a harm. There is—for example—some evidence that looking on the bright side promotes better recovery and mental coping.[12 13] HIV patients fared the worst when they gave in to pessimism.[14]

Although it has not been proved that positive emotions such as humour directly affect one's health,[15] emotions can also affect health in indirect ways, especially when we are disposed toward feeling them a lot of the time. Carver and Scheier argued that optimistic people would be more likely to pursue their goals, since they saw them as attainable,[16] and at least one study found that optimism, as distinct from denial, would encourage greater attention to one's medical state and thus lead to more reactive medical care.[17] Schulz *et al* found that pessimism was correlated with an earlier death among recurrent cancer patients[18]; other studies have found that optimism is associated with a quicker return to normal life in coronary bypass patients.[19] These studies are focused on ''dispositional optimism''—that is, they support the idea that your attitude can influence your recovery. Furthermore, there is some evidence that ''finding benefit'' in an aversive experience results in less depression and distress.[20 21]

Few, if any, of us bear this kind of empirical research in mind when we approach a sick or injured friend, but the evidence lends support to what may be a strong intuitive belief that optimism is good for a person in the long term.

Such attempts to improve a person's mood or disposition can therefore be medically and emotionally beneficent in their intent. But not everyone will react positively or predictably to a given attempt to influence their mood and thus the attempt will frequently fail to be beneficial. It seems—for example—that males respond worse than females either to advice on how to cope with troubles, or to being told ''not to worry''.[22] It is unclear whether we can predictably help someone to attain a more positive mood or disposition just by finding an appropriate thing to say.

There are many other ways in which we attempt to improve a sick or injured person's attitude. Sometimes we ask a sick or injured person to compare themselves to a less fortunate person

> It could have been much worse.
> A friend of mine also fell when skiing, and is now paralysed.

These aphorisms may also be motivated by justified intuitions about what is good for the patient. When people are very ill, one popular coping mechanism is to compare oneself with (often fictitious) less fortunate people. It is also thought that this is a successful coping mechanism.[23] But when we try to make a friend or relative engage in this coping mechanism it can be offensive. Our attempts to help them to cope can backfire.

Trying to directly improve a person's mood does not always help. Very often, it does more harm than good. The evidence shows that it is not unreasonable of our friends and family to assume that we will be helped by having our mood improved, but it seems that telling a person to ''cheer up'' just does not work.

When a person says these things with an honest belief that they can improve a person's mood and help them to recover, the person intends to help. But perhaps it is reasonable to expect empathic friends to know that sick or injured people cannot be ordered into a good mood. Good intentions give bad results when we give no thought to what we are doing.

Moral disapprobation

Some speech acts may be designed to snap a sufferer out of an attitude that is perceived to be immoral. Perhaps they are complaining a great deal about a minor misfortune, which displays disrespect for those who are worse off. Perhaps their self centred attitude comes at the expense of someone nearby who is worse off.

Pity and self pity are viewed as being intrinsically wrong moral attitudes. D H Lawrence wrote:

> A small bird will drop frozen from a bough without ever having felt sorry for itself.[24]

''Look on the bright side'' might in some cases be a way of telling a person to abandon their self pity. Many people believe the sick are morally required to suffer gracefully, and perhaps this has its basis in the medical harms of self pity,[25] or in the effects of ungraceful suffering on empathic listeners. Self indulgent complaining from a person who has suffered a minor misfortune might indeed cause more suffering in onlookers than the medical misfortune causes in the sufferer.

Anger and desert

Sometimes doctors and relatives apply moral blame to a person, not for their attitude but for the illness or injury itself.[26 27] This happens most often when risky behaviour was involved in the misfortune, as in the case of Julian's leg and

John's streptococcal infection, but it also happens in cases where there was no risk.[28]

To blame a person for a random misfortune, for which they are not responsible, is unjust. We are not responsible for diseases or injuries that we did not cause: but we are responsible for the suffering that we knowingly bring upon ourselves. Should we speak differently to smokers with emphysema or skydivers who break their bones?

We deserve compensation when someone harms us. One view, put forward by Cohen among others, is that we deserve compensation for any misfortune which we did not knowingly bring on ourselves, even if those misfortunes are not caused by anyone.[29–31] Cohen's arguments are borne out in our everyday sense of justice; we do compensate people who suffer a misfortune for which they are not responsible. We can compensate our loved ones for their loss in a number of ways. We speak to them more kindly, we humour their negative mood, we offer to help even with tasks that they can still perform by themselves. These acts constitute the special treatment that we give to the sick and the injured. But when a person has knowingly brought suffering upon themselves, they do not deserve this kind of compensation.

When someone we love engages in a behaviour we consider reckless or self destructive, we are bound to try to dissuade them from this behaviour. We do this out of love, but when the risky behaviour results in a harm to our loved ones, we are also harmed. It is a harm to which they have consented, and we have not. For these reasons we may be justifiably angry with our loved ones, when they put off going to the doctor until it is too late to be treated, or when they hurt themselves while engaged in some highly risky sport.

Speaking in an inappropriate way

It may be that a sick or injured person behaves in a way that leads us to admonish them. But these admonishments are of no benefit to anyone unless they have a chance of reforming that person's behaviour. The 17th century Japanese philosopher Tsunetomo gave this advice about giving advice:

> To give a person one's opinion and correct his faults is an important thing. It is compassionate and comes first in matters of service. But the way of doing this is extremely difficult. To discover the good and bad points of a person is an easy thing, and to give an opinion concerning them is easy, too. For the most part, people think that they are being kind by saying the things that others find distasteful or difficult to say. But if it is not received well, they think that there is nothing more to be done. This is completely worthless. It is the same as bringing shame to a person by slandering him. It is nothing more than getting it off one's chest.[32]

Perhaps we may wish to tell an acquaintance or a distant relative to stop complaining, or to look on the bright side. When we do not know a person, this advice is inappropriate. When it has no chance of being received well, advice such as this cannot be defended.

The way we express these sentiments can also control their appropriateness. One of Julian's close friends said—for example:

> What are you worried about?

When said in one way, it could be interpreted as a constructive exploration of the victim's fears. When said in another way, it is seen as a command to stop worrying about nothing.

Counsellors tell us that most people want an empathic listener.[33] That is all that many people want from their friends and family. If we decide to do more than listen, we must try to speak in an appropriate way.

Yet sometimes an overtly empathic response can be inappropriate. It can feel impossible to be an empathic listener when the patient is a person with whom we have never had an empathic or compassionate conversation. It could be an employer, a distant relative, or a sporting team mate. It can feel as though emotionally sensitive speech will be inappropriate because it violates the implicit terms of the relationship.

When someone needs help, the character of the relationship should be of secondary importance. This is part of the reason why we expect sick people to adopt the ''sick role'', abandoning their usual roles and becoming more passive: it gives others the opportunity to care for people who are normally independent, or who have authority over them. Sometimes we must speak to people in ways which would be inappropriate if they were healthy.

CONCLUSION

Empirical evidence from psychologists, counsellors, and doctors can tell us which speech act has the best statistical chance of helping a person. Better empirical evidence will give us better odds of success. But people vary so much and their circumstances vary so much, that we will often get it wrong, no matter how much we listen, no matter how empathic we are.

A spinal nurse once told one of us that they try to get paralysed patients to tell friends and family what to say to them—to help others to help them feel better.

But medical ethics is not only about medical outcomes, even for consequentialists. Nor is helping people simply about making them feel immediately good. There are important moral and personal outcomes, which also should be considered. When we approach a friend or relative who has suffered some misfortune, these non-medical returns are all the more important.

How will we measure whether a speech act has had an overall good outcome, on a moral or personal dimension? Sometimes the most helpful things we say will be the most hurtful, or the most upsetting. This is often the case when we rebuke someone who is acting in an antisocial or self destructive manner.

Since the outcomes will be unmeasurable in most cases, we need to make sure when speaking to a sick or injured person that our reasons for what we say are ethical. It is selfish to make speech acts that come from a psychological predisposition.

But we also lose something when we discard all of our human reactions to a person's illness, and say what we know is the ''best'' thing. What we say in our close personal relationships often needs to be authentic, yet our authentic feelings can sometimes find expression in speech that seems insensitive or cruel to the person who is suffering.

When a person is harmed, we can choose what we think about that person and his or her misfortune. We can also choose what we say. Our central claim is that a person who has suffered a misfortune has been harmed. That person deserves something. The sick or injured person suffers a deep sense of alienation or risk of abandonment, as described in *The Metamorphosis*. In the harsh times of human history, the injured or sick would have been abandoned, to protect the survival of the group. Abandonment is, of course, no longer necessary, but we frequently visit further harm on the victim.

Our obligation to make the sick feel better is not boundless, nor is our ability to say the right thing. If we can eliminate our knee jerk emotional or psychological responses and act

for normative reasons, then these harms may have an ethical defence. This is all the more important when the unfortunate person is someone we love.

We should choose carefully what we say.

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