Cambridge Quarterly of Healthcare Ethics (2025), 34: 3, 513–515
doi:10.1017/S096318012400077X

CAMBRIDGE UNIVERSITY PRESS

DEPARTMENTS AND COLUMNS: PERSPECTIVES

Against the Phrase "Aggressive Care"

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Abstract

Language is the primary technology clinical ethicists use as they offer guidance about norms. Like any other piece of technology, to use the technology well requires attention, intention, skill, and knowledge. Word choice becomes a matter of professional practice. The Brief Report offers clinical ethicists several reasons for rejecting the phrase "aggressive care." Instead, ethicists should consider replacing "aggressive care" with the adjacent concept of a "recovery-focused path." The virtues of this neologism include: the opportunity to set aside the emotion of "aggression," the phrase's accuracy when capturing the intention of the patient or their representative, and an unappreciated rhetorical force—and transparent logic—that arises when the patient's recovery is unlikely.

Keywords: Clinical ethics; Healthcare communication; Patient-centered care; Effective communication; Professionalism

The history of medicine shows humans looking for, and occasionally finding, proper ways of responding to the unfortunate, implacable facts of sickness and death. Medicine accomplishes this response with co-created technologies. The word "technology" may call to mind petri dishes, computers, and artificial organs, but language will forever be medicine's principal technology. And it is language that we, clinical ethicists, use when doing clinical ethics. In fact, language demarcates the limits of our technology. We ask questions, listen, analyze ethical considerations, make recommendations, teach, and write—all activities that require an expert's command of language. We, as ethicists, commit ourselves to continued reflection on our words and arguments, in hopes of refining the concepts we use. We also hope that we might uncover what ought to be done when we understand and communicate normative concepts properly.

But a lack of attention to word choice may dampen this hope. Ethicists in the United States use contradictory phrases, such as "withdraw of care." We use terms with unsavory histories and implications, such as "debrief." We rely on insular and idiosyncratic definitions of common terms, for example, when we say "emergent" to name an emergency (rather than referring to a phenomenon that emerges). We say "family meeting," thereby focusing on meeting the family rather than focusing on the patient. Imagine an ethicist saying, "I am going to set up a debrief to discuss a recent emergent withdrawal of care." A reasonable response to this would be, "What the hell are you talking about?" I would like to start a conversation about perhaps the most ubiquitous notion needing reformation, that of "aggressive care."

The phrase "aggressive care" usually represents some constellation of life-sustaining or life-saving technologies with which the clinical care team disagrees. The phrase is heavy with disapproval. I would wager it unlikely that an anesthesiologist placing a child on ventilator support for a recommended, beneficial surgery would call this usage "aggressive." Ditto with an infectious disease specialist prescribing a course of life-saving antibiotics for tuberculosis. This tells us that it is not the technology, *in essence*, that we refer to when we say "aggressive care."

One of the shortcomings of the moniker "aggressive" is that it suggests an emotion, anger, and its concomitant action, aggression. Who is feeling this emotion and taking this action? Perhaps neither the

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https://doi.org/10.1017/S096318012400077X Published online by Cambridge University Press

healthcare professions, nor the patient, nor their loved ones. Perhaps more than anger, "aggressive care" suggests a way *of using* medical technology. It suggests an uncritical, headstrong, and harmful use of technology. By using this term, the ethicist hopes to stack the deck toward its opposite path—accompanied by its own oblique term of art—"comfort care."

By "comfort care" ethicists, and healthcare professionals in general, mean withholding or withdrawing life-sustaining technologies while also promoting the patient's comfort, often as they die. Here, as we saw with "aggressive care," intention and purpose do the conceptual heavy lifting when withholding or withdrawing a technology earns the label "comfort care." That same anesthesiologist who placed the child on the ventilator before surgery would not consider it "comfort care" to withdraw the ventilator when the child is ready to breathe on her own post-operation.

Let us imagine an ethicist justified in concluding that the continued use of life-sustaining technology wrongs a patient by violating their right to be treated with dignity. (While the notion of "dignity" is no longer à la mode, healthcare professionals are not aware of this new fashion, so ethicists ought to be ready to respond to it.) Aiming to avoid a protracted, uncontrolled death that amplifies this violation of the patient's dignity, the ethicist joins the chorus of healthcare professionals arguing against "aggressive care" and for "comfort care." Will describing the path of continuing life-sustaining technologies as "aggressive" help them make their case? Perhaps, but my anecdotal experience would deem it unlikely. No matter what language we might use to describe the process "comfort care" represents, and no matter what chaotic the imagery we marshal to accompany a description of the "aggressive" path, it strains credulity to believe that the labels *themselves* would result in a patient or their representative rejecting "aggressive care." In fact, the word "aggressive" may be counterproductive. Aggression has, so far, offered the patient continued biological life. As Susan Sontag rightly points out, medicine is steeped in war metaphors and terminology. We might describe a patient with pneumonia as beginning her battle, and fighting for her life, as the antibiotics attack the infection that invaded her body. Soldiering forward with "aggressive care" seems a natural extension of the patient's war against their ailments. If the ethicist hopes that the label "aggressive" might dissuade the patient's representative from this form of medical care, they may be mistaken given the productivity and benefits of medicine's "aggressive" use of technology.

A revision is due. Ethicists in the United States can more accurately—and, perhaps, more effectively—represent this binary choice. I suggest that ethicists distinguish a "comfort-focused path" from a "recovery-focused path." Recasting "comfort care" as a "comfort-focused path" promotes attention to *purpose* of the interventions: using technology to focus efforts on the moribund patient's comfort. This phrase sets aside the notion of "care" as some diffuse combination of added or subtracted medical technologies. It suggests a new focus of the team's efforts. Also, "path" evokes a sense of movement through time, with purpose, toward a goal.

Opposite the comfort-focused path, we find the "recovery-focused path." Reframing "aggressive care" as a "recovery-focused path" uses straightforward language to describe the purpose of continued life-sustaining technology, i.e., recovery. Now, the ethicist and the healthcare team might disagree with a representative that a recovery-focused path is feasible. That is fine. However, disagreement does not authorize obfuscating or confusing language. Disagreement calls for less ambiguous language. Accuracy is a primary virtue of the phrase "recovery-focused path." The possibility of recovery focuses the team's efforts while setting the patient's recovery in the foreground.

But ethicists may want to preserve the visceral pull of "aggressive care." Could "recovery-focused path" lose rhetorical force when rhetoric is most needed? I would suggest that the notion of a "recovery-focused path" (and a detailed description of what interventions constitute this path) may have more rhetorical force than "aggressive care." Compare two simplified scenarios. First, imagine an ICU intensivist, ethicist, and palliative care professional agreeing that performing cardiopulmonary resuscitation (CPR), initiating dialysis, and continuing respiratory support would not benefit an incapacitated, unstable, and dying patient. They meet with the patient's representative and say, "Now is the time to decide whether to keep providing aggressive care or to transition to comfort care. We believe that aggressive care is inappropriate…comfort care is best. Continuing aggressive care would not be beneficial because we are harming the patient." The representative may be confused. "Aggressive care" has gotten the patient this far. And the representative may wonder whence came the language

https://doi.org/10.1017/S096318012400077X Published online by Cambridge University Press

of harm for a patient lying sedated and paralyzed without any manifest distress (for the time being, at least).

Now imagine a clinically identical scenario. Instead, during the meeting the team says, "Now is the time to decide whether the patient should remain on the recovery-focused path. We believe this path is inappropriate because recovery is not possible. Continuing the recovery-focused path is appropriate only when recovery to the kind of life [the patient] would find acceptable is likely, but, unfortunately, [the patient] will not recover. Instead, we recommend switching to a comfort-focused path. For [this patient], the comfort-focused path means…" Notice that this latter monologue relies on clear language and sound logic. To wit, (1) if this patient's recovery is likely, then a recovery-focused path is appropriate; (2) this patient's recovery is not likely; (3) therefore, the recovery-focused path is not appropriate.

Of course, a patient or their representative may disagree with either point 1 or point 2. But the logical clarity and rhetorical weight that accompany my suggested neologisms lift these phrases above the staid options of "aggressive care" and "comfort care."

Language—not scalpels, intravenous pharmaceuticals, or psychotherapies—marks the ethicist's primary technology. Sometimes focused on argument, sometimes heavy with emotion, and sometimes conspicuously absent, words are the primary tools in the ethicist's toolkit. My suggestions will need refinement according to context or rejection according to taste. Although a grandiose idea, it is true that when we ethicists work to improve the language of clinical medicine, we participate in a millennia-long process of searching for better ways of caring for the sick. As we participate in medicine's project, it is incumbent upon us, as ethicists, to continuously hone our tools lest these tools become blunted. A dull knife is more dangerous than a sharp knife.

Acknowledgments. Thanks to Dr. Alison Suen for reviewing an early draft of this article.

Competing interest. The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

https://doi.org/10.1017/S096318012400077X Published online by Cambridge University Press

Cite this article: Bibler TM (2025). Against the Phrase "Aggressive Care". *Cambridge Quarterly of Healthcare Ethics* 34: 513–515, doi:10.1017/S096318012400077X