

# Your Father's a **Fighter**; Your Daughter's a **Vegetable**:

## A Critical Analysis of the Use of Metaphor in Clinical Practice

by TYLER TATE

Military metaphors are often thought to be harmful to patients, and some writers have proposed that empirical research could determine whether a metaphor is fit or ill for health care. But the “best” metaphor for a patient encounter can be known only from within the patient-clinician relationship. A conceptual framework can, however, give clinicians preliminary guidance for evaluating metaphors.

*No word can be judged as to whether it is good or bad, correct or incorrect, beautiful or ugly, or anything else that matters . . . in isolation.*

—I. A. Richards

Some metaphors are widely thought to be problematic for medical practice. George Annas argues that military and market metaphors are inappropriate for health care and recommends the ecology metaphor instead.<sup>1</sup> Marlaine Smith rejects the metaphor of “human being as machine” in favor of “human being as organism.”<sup>2</sup> Daniel Shalev also criticizes machine metaphors, but he endorses journey metaphors.<sup>3</sup> Susan Sontag, even more suspicious of medical tropes, famously denounces the use of all metaphors in medical discourse—especially metaphors used to illustrate the experience of having cancer.<sup>4</sup> Laurence J. Kirmayer seems to agree with Sontag and worries that rhetoric employs metaphor to influence biomedical discourse clandestinely, even though this discourse proclaims it-

self to be rational and value neutral.<sup>5</sup> Trope skepticism runs deep in health care.

Yet while many of biomedicine's metaphors have been maligned, no class of metaphors has been denounced as much as those of war. In bioethics, for instance, Jing-Bao Nie and colleagues have recently made a series of strong claims on this subject. In their 2016 article “Healing without Waging War: Beyond Military Metaphors in Medicine and HIV Cure Research,”<sup>6</sup> the authors argue that military metaphors are inherently harmful to patients and research subjects. They assert that “by silencing patients' voices through erasing their experiences and narratives of illness, the use of military metaphors can hinder . . . caring for people suffering from the increasing incidence of chronic health conditions.”<sup>7</sup> The authors allege that “military metaphors can inadvertently further stigmatize patients, and endorse the legitimacy of war and violence in social and political life.”<sup>8</sup> Nie and colleagues ask why it is “that healers, clinical doctors, and researchers committed to improving health continue to utilize violent metaphors when doing so runs the risk of devaluing human life?”<sup>9</sup> These critiques suggest that military metaphors are uniquely dangerous, disparaging, and harmful.

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This survey of opinions raises a number of questions. What exactly makes a metaphor a good metaphor, and what kind of evidence could support such a claim? How can war metaphors, considered so pejoratively by scholars, be so helpful and seemingly natural in many clinical encounters? Can a metaphor cause harm simply because of its topic? Should whole domains of language be banned from medical speech? And if so, by what criterion should they be appraised?

In a recent *Journal of the American Medical Association* perspective,<sup>10</sup> Brit Trogen attempts to answer some of these questions. She contends that there are good and bad metaphors and that medical language must strive to be more “evidence based” and scientifically grounded. Trogen notes that medical practitioners “strive to make conscious, empirical decisions on everything from drug dosing and treatment modalities to medical education and health policy.”<sup>11</sup> And so, she would add, why not language? As she sees it, the scientific logic needed in pharmacology extends to the process by which humans make meaning out of words. In medicine, she concludes, “[w]e should be just as rigorous with our words”<sup>12</sup> as we are with any other therapy, procedure, or policy. Trogen is not alone in this view; a number of social scientists have advocated for more sophisticated empirical research on the metaphors of health care. Their aims are, among other things, to bring the “use of metaphors into the domain of evidence-based practice”<sup>13</sup> and “assure that metaphorical language does not undermine public health or research efforts.”<sup>14</sup> These scholars appear to be advocating for the protocolization of metaphorical language in a way that mirrors the protocolization of treatment for asthma, meningitis, or lung cancer.

While the spirit of these efforts is laudable, multiple problems attend the idea that empirical research can either determine psychological valence or establish norms for medicine’s metaphors. The chief

problem with this thinking is that it rests on the false empiricist assumption that metaphorical language and literal language are fundamentally distinct—in other words, that these kinds of language play separate roles in communication and can be analyzed, systematized, and prescribed independently of each other.<sup>15</sup> Even if there were a sound rationale for making this conceptual distinction, in clinical practice, the distinction breaks down.

These two widespread beliefs—that military metaphors are harmful to patients and should be discouraged in medical practice and that the

metaphors of clinical practice can be judged by, and standardized in reference to, neutral criteria—rest on a shared but deeply flawed logic. In this article, I will examine these beliefs, expose their flawed logic, and then lay out a theoretical view of medical metaphors as grounded in use within clinician-patient relationships. Drawing from philosopher Max Black’s analysis of metaphorical qualities, which I discuss in terms of *indispensability* versus *replaceability* and *fixedness* versus *variability*, I will diagram a conceptual tool for clinicians to use when they consider whether a metaphor is appropriate for a specific patient encounter. This tool maps metaphors onto a qualitative grid and gives clinicians a method to understand how metaphors work in communication and to determine which metaphors might be felicitous within a particular context and relationship.

### The Purpose of Metaphors

A short history of metaphor is instructive. It can highlight several of the conceptual blunders committed by some writers on metaphor.

First, then, what exactly *is* a metaphor? The answer is not straightforward. The Greek root of *metaphor* is *metaphora*, literally meaning “transfer”: *meta* (“trans”) + *pherein* (“to carry”).<sup>16</sup> For Aristotle, one of the first to comment on the subject, metaphor is defined as “giving something a name that belongs to something else.”<sup>17</sup> Aristotle’s definition is a weak version of a “substitution” view of metaphor,<sup>18</sup> the idea that one word borrows from another and therefore “carries no new information, since the absent term (if one exists) can be brought back in.”<sup>19</sup> The strongest version of the substitution view—which holds that

metaphors are entirely superfluous (and even deceptive)—was a product of Enlightenment thinking.<sup>20</sup> For example, Thomas Hobbes expressed the strong substitution view in 1651 when he claimed, “The Light of humane minds is Perspicuous Words, but by exact definitions first snuffed, and purged from ambiguity; *Reason* is the *pace*; *Encrease of Science* the *way*; and the benefit of man-kind the end. And on the contrary, Metaphors, and senseless and ambiguous words, are like *ignes fatui*; and reasoning upon them, is wandering among innumerable absurdities; and their end, contention, and sedition, or contempt [*sic*].”<sup>21</sup> John Locke was equally suspicious of tropes and decried the “figurative application of words,” which does nothing but “insinuate wrong ideas, move the passions, and thereby mislead the judgement.”<sup>22</sup> This strong view eventually crested with the logical empiricists who discredited metaphor due to its lack of verification conditions (for example, you cannot prove or disprove that “man is a wolf” as you can prove or disprove that “the cat is on the mat”).<sup>23</sup>

In the later twentieth century, deflationary accounts of metaphor were

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increasingly criticized. In contrast to a substitution view, literary critic I. A. Richards, Black, and others argued that metaphor is essential to the growth of human knowledge. Black contended, for instance, that metaphors both create and disclose reality.<sup>24</sup> Metaphors create reality when they help forge novel cognitive linkages (i.e., new perspectives<sup>25</sup>) for understanding and engaging the world. Metaphors disclose reality when, like a good model (such as the computer as a model for the brain), good metaphors serve as cognitive devices for “showing” how things actually are.<sup>26</sup> According to this “constitutive”<sup>27</sup> view of metaphor, there is no objective vantage point for human beings, no disembodied perspective, for the “world is necessarily a world under a certain description.”<sup>28</sup> A powerful metaphor can redescribe the nature of the world and our place in it; in other words, metaphors can shape what is real to us and shape us in the process.<sup>29</sup>

More recently, questions around metaphor have ramified beyond philosophy and literary studies. Since the publication of *Metaphors We Live By* (1980), by George Lakoff and Mark Johnson, their conceptual metaphor theory<sup>30</sup> has dominated academic research on metaphor, especially in the social and biomedical sciences.<sup>31</sup> The theory postulates that human concepts are intrinsically metaphorical and embodied. According to the conceptual metaphor theory, metaphors are conceptual templates<sup>32</sup> that structure human cognition and emerge necessarily from physical facts about human existence: for instance, humans grow from small babies into larger adults, are spatially oriented with fronts and backs, and share the same basic anatomy, physiology, and lifecycle with other humans across history and geography. Hence, for the conceptual metaphor theory, abstract ideas such as argument is war, love is a journey, or time is money are physically and culturally determined ways that human beings understand and navigate reality, and linguistic

metaphors are viewed as emergent representations of deeper and more fundamental cognitive-physical relationships. Under this theory, linguistic metaphors are not arbitrary or accidental; they are expressions constrained by the physical structure and natural orientation of the material universe.

However, while the conceptual metaphor theory is taken for granted by many social scientists working in health care,<sup>33</sup> it is not problem-free. Janet Martin Soskice has characterized the theory as part of a questionable genus of ideas that promotes what she terms the “metaphor-as-myth” thesis, a thesis that posits that “man . . . deceives himself when he regards his own linguistic [read: metaphorical] constructs as embodying some trans-anthropological truth.”<sup>34</sup> According to the metaphor-as-myth thesis, metaphors merely reveal aspects of human thought; reality itself remains inaccessible, for “man, like the spider, spins out of himself the world which he inhabits.”<sup>35</sup>

Yet this “mythology” is unsatisfying; when a speaker claims that “Hitler was a monster” or “cancer is a battle,” they are not making statements completely unaccountable to a reality external to the speaker’s mind. Instead, the speaker is to some extent discussing objective facts about reality, about the way things are (even if these facts are invariably nested in a particular culture and historical moment). Another problem for the conceptual metaphor theory, then, is that it comes dangerously close to “confusing word derivation with word meaning.”<sup>36</sup> In other words, the theory can be taken to imply that speakers are always *used by* metaphors (in the sense that there is a primitive structure, disclosed in every metaphorical utterance, that subconsciously determines what they can or cannot think) instead of *using* metaphors to say what they mean.

Regardless of these debates, the important moral to extract from this discussion is that no single theory of metaphor should be accepted un-

critically as law. This is especially true for health care, as an examination of both the sundry metaphors of clinical practice and the diverse meanings metaphors can have for patients, clinicians, and family members will confirm.

### Metaphor, Metaphor Everywhere

Metaphor pervades medical language, and the use of metaphor by both patients and clinicians is effortless and unconscious. For example, metaphorical language is customary when discussing the body (“your heart is a *pump*”; “the liver *cleans* the blood of *impurities*”; “your brain is a *computer*”; “psychotherapy *reprograms* your thinking”; “antidepressants restore *balance* to the mind”; “your body is a *machine*—you have to *keep it oiled*, don’t let it *overheat*, give it good *fuel*”), disease (“seizures are a *short circuit* in the brain”; “cancer is a *battle*”; “Alzheimer’s disease is a *long goodbye*”; “asthma is a *roller coaster*”; “your cholesterol is *high*”; “the infection can *seed* other parts of your body—we are worried the bacteria will *swim* through the bloodstream and then *set up shop* in your brain”), making decisions (“making the decision to stop treatment feels like *turning a barge around*”; “chemo is a *full-time job*”; “tracheostomy is a *run-away train*”; “use your mom *antennae*, and if you sense anything wrong, come back and *see me*”; “whichever choice we make, it will be a *gamble*—we will have to *go all in*; we will have to really *double down*”), and end-of-life care (“brain *death*”; “she has reached the *end of the road*”; “the patient is *circling the drain*”; “is my daughter going to be a *vegetable*?”)<sup>37</sup>

Metaphor is ubiquitous in medicine. In fact, clinicians and patients seem incapable of speaking at all without recourse to metaphor. Certainly, there are disconcerting features of metaphorical language. Metaphors may objectify and dehumanize (as with “body as machine” and “body as battleground”). Metaphors may

confuse, deceive, and offend. Yet metaphors also open up valuable new perspectives for patients and clinicians and allow them and patients' families to talk about abstract ideas and negotiate emotionally freighted situations. Metaphor is an indispensable mode of discourse.

Furthermore, as many of these examples demonstrate, drawing a line between metaphorical and literal language is often difficult.<sup>38</sup> Metaphors are frequently indistinguishable from nonfigurative words (as with “high blood pressure,” “brain death,” and “turning a corner”), and it is language (whether metaphorical or not) and other signs—such as pictures, diagrams, symbols, models, sign language, gestures, and body language—that provides the content of patient-clinician communication. These various forms of communication cannot be disentangled without disabling communication and transforming patient-clinician interactions into something strange and alien. Moreover, once the ubiquity and depth of metaphor within medicine is recognized, it begins to seem odd to advocate that metaphors become “evidence based.” What could that even really mean? Pragmatically, to “rigorously” standardize medical metaphors would require a rigorous standardization not just of metaphors but of language and ultimately all communicative acts performed within the context of clinical care. The result would be, somewhat ironically, a thoroughly *dehumanized* (albeit limpid, rational, and evidence-based) system of medical communication in which clinicians communicate from preformulated scripts or machines read off new diagnoses and describe treatment protocols as objectively and rigorously as possible. This alternative seems highly undesirable.

### Wars and Rumors of Wars

The practical difficulties of separating metaphorical and literal language aside, what about the view that there is a relevant *philosophical*

distinction between these two categories? A first step toward evaluating this position is to examine medicine's military metaphors.

Trogen notes that there is “significant research suggesting that certain mental frameworks can contribute to worsened patient outcomes.”<sup>39</sup> As evidence, she points to the deleterious effects that the use of “militaristic” metaphors can have on cancer patients' quality of life.<sup>40</sup> To justify the common criticism that metaphors of violence and war are inappropriate for the field of medicine, most writers who endorse this view either cite empirical data taken to prove a connection between war language and a poor health outcome, or they

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expound a normative rationale. Both these efforts fail.

To see why, one must first attempt to discover what exactly is the intrinsic negative property contained in metaphors of war. Judging by the harshest critics, the property appears to be the distinct capacity to harm. But what does it mean to be harmed by a military metaphor? The options are diverse. Harm could be having your narrative commandeered by a story of war<sup>41</sup> or being viewed by your physician as the space for a battle against a disease, rather than as a person *with* a disease.<sup>42</sup> Harm could occur when a patient inappropriately believes that she still needs to fight when she is receiving only palliative care<sup>43</sup> or has a chronic illness that cannot be defeated.<sup>44</sup> Conversely, are patients harmed, as some empirical data is thought to suggest, if, by conceiving of their disease as an enemy, they tend to have higher levels of depression and anxiety<sup>45</sup> or report more pain and lower coping scores?<sup>46</sup> Or are patients harmed if, by envisioning

cancer as an enemy, they become less likely to imagine undertaking disease-preventative lifestyle choices?<sup>47</sup>

I will analyze the latter possibilities first. Two empirical studies often cited as support against the use of war metaphors in the medical encounter<sup>48</sup> find an association between cancer patients who used attack language (such as “punishment” and “enemy”) to describe the meaning of their illness experience and a higher prevalence of anxiety, depression, or poor coping.<sup>49</sup> The worry is that the milieu of war language produces these effects. However, at best, these data support a correlation rather than a causal connection. In other words, it is just as likely that patients who are most de-

pressed and anxious *feel* attacked and punished and consequently use this language and these felt categories of meaning to understand and articulate their cancer experience as it is that clinicians cause depression or anxiety by using attack language. These studies do not illuminate reasons that war metaphors are harmful or the nature of the harm, nor do they provide normative guidance for what metaphor a clinician should or should not use.

The third empirical study,<sup>50</sup> which was performed on volunteers who did not identify as cancer patients, found that after a person read descriptions of cancer that employed enemy metaphors, they were less likely to list prevention behaviors when asked what they would do to lessen their chances of developing cancer in the future. These findings are intriguing. But while they may be useful for programs or clinicians doing preventative screening (although they reveal little about real-world behaviors or why preventative choices are automatically superior to other kinds of

life choices<sup>51</sup>), they offer no insight into how war metaphors could be uniquely and essentially harmful.

The remaining critiques of military metaphor can be distilled into one dominant, theoretical claim whose logic seems to be this: war always kills and destroys human beings, and killing and destruction are equivalent to harm. Therefore, via a category substitution, war *language* also must be equivalent to harm (or must necessarily harm). Accordingly, war metaphors are essentially damaging. They paint the human body as a battleground (so the story goes), and they needlessly impose bloodshed, carnage, and the atrocities of war on an already sick and fearful patient. *There is something different about them.* By dragging the patient's narrative into the plot of war, they cause the patient to suffer, as the person's soul is dealt some sort of searing spiritual or existential injury.

But do war metaphors actually cause this kind of spiritual or existential harm? I am not convinced that they do. For one, the language of warfare is the ordinary language of many patients, and they seem none the worse for it. For numerous patients in the Veterans Affairs hospitals across the country, including many whom I cared for as a palliative care fellow at a VA hospital, bootcamp, invasions, airstrikes, generals, orders, and target practice are formative parts of both their lives and their natural language. The fact that *I* have not fought in battle or that *I* think that war is fundamentally vile is not reason to deny this language to *them*. For many people, the military is the noblest of callings and fills their life with value, dignity, and meaning. To deprive them of this language would be unjust and border on a hegemonic censoring of their voices and stories.

The seeming lack of concern for the many patients that find great strength, courage, and resolve from this kind of language is deeply troubling. In addition, even if most patients did prefer nonviolent metaphors, to encourage broad policies

for language use in medicine that, for example, teach medical and nursing students to generally avoid using military metaphors in their future practice would silence the voices of some patients and prescribe a subtle tyranny of the majority. Yet I doubt that they are the majority. For example, as Tod Chambers personally notes<sup>52</sup>—and as is the case with the vast majority of patients I treat—it can be extremely helpful to imagine fighting off an illness; after all, being sick or in pain often *feels* as if you are threatened and under attack.

Among the few studies that actually examine patients' own metaphors, war metaphors abound, and these metaphors are often viewed as positive and constructive. In one study, patients with cancer used violence metaphors more than any other class of metaphor when describing their illness experience in online writing, about 1.5 times per one thousand words.<sup>53</sup> The authors found that patients use both violence and journey metaphors and that both types can be used either to empower oneself or to reinforce negative feelings. Comparing violence metaphors with (the more in-vogue) journey metaphors, the authors forcefully conclude, "A blanket rejection of Violence metaphors and an uncritical promotion of Journey metaphors would deprive patients of the positive functions of the former and ignore the potential pitfalls of the latter. Instead, greater awareness of the function (empowering or disempowering) of patients' metaphor use can lead to more effective communication about the experience of cancer."<sup>54</sup>

Other published data corroborate this position. For example, in the largest survey of patients' metaphors performed to date—an analysis of a collection of patient, caregiver, and clinician interviews and online forums focused on end-of-life care<sup>55</sup>—patients employed a great number and large variety of violence metaphors to describe their illness experiences. The authors concluded that, based on their research, it is impos-

sible to assess any individual violence metaphor without understanding its context and function (of which there were numerous, some deemed positive and some negative) in the life of the patient. This versatility has been demonstrated in other qualitative analyses of violence metaphors.<sup>56</sup> Finally, in one of the first analyses of the metaphors of non-English-speaking patients, Dalia Magaña inspected the breast cancer narratives of fifty-one Latina and Spanish women<sup>57</sup> and found that violence metaphors were the most commonly used metaphors and that patients used these positively (for instance, to construe cancer as a "malevolent enemy" and themselves as "warriors"<sup>58</sup>). She concludes that "the functions of violence metaphors include expressing concerns and fears, offering wisdom about their [the metaphor users'] experiences, empowering people by creating a sense of optimism, and urging others not to give up."<sup>59</sup> For these women, violence metaphors served as a key source of resilience and hope.

Perhaps, in fact, patients' and clinicians' attraction to military metaphors is the result of something deeper, something woven into the very fabric of human thinking. This hypothesis is supported by insights from Lakoff and Johnson's conceptual metaphor theory. Under this theory, it is possible that human understanding and expression of illness is inextricably tied to—even necessarily generated from—a metaphorical, embodied template of war.<sup>60</sup> The thought pattern is this: *I am my body, my body is me, and I will not sit passively by when facing my own annihilation. I will fight, and if I'm lucky, I will be victorious in the end.* In my own experience, at least, that's how most patients respond to the existential threat of serious illness.

Where do these reflections leave us? They reveal why, contrary to what Trogen and others have suggested, empirical research cannot determine clinical practice norms for metaphor use. Empirical research cannot reveal what these norms ought to be because

it cannot “discover” which metaphors are good or bad or which fail to work in actual practice. Trogen claims that “[p]atients’ responses to clinical interventions, whether pharmacologic or linguistic, are necessarily variable, and understanding this variability will be important to investigate.”<sup>61</sup> Though more investigation may be informative, the underlying analogy between pharmacology and language is mistaken. Responses to pharmacologic interventions and responses to metaphors involve significantly different kinds of variability. If I give one hundred patients 300 milligrams of intravenous hydromorphone, a powerful opioid, the breathing of all will slow down or stop. However, if I tell one hundred newly diagnosed cancer patients, “You’ve got a real battle ahead,” I do not know a priori how they will understand and respond to this sentence, and no number of experiments can predict that for me with certainty. Human language, meaning, and understanding do not operate under the same rules as physics, chemistry, and physiology.<sup>62</sup> Contrary to what empiricists over the years have claimed, there is no law for how language works, no logical formula that “nails”<sup>63</sup> language to the observable and measurable “facts” of reality. How, then, does human meaning-making and understanding occur, particularly within a patient encounter?

### Our Lives in Language

Meaning-making and understanding can occur between patients and clinicians because both parties are imbedded in stories. By this I mean that the subjective human experience of being a body moving through space and time is rendered intelligible insofar as it is envisaged as a narrative, or story. Occurrences become meaningful events for a subject when they are knit together in a narrative arc, and it is only against the backdrop of a meaning-rich narrative that a subject’s constant interpretation of occurrences and projection of

themselves into the future hangs together as a life.<sup>64</sup> How should I live? What should I do? What does this pain mean for my life (well, what did it mean last time?)? This just *is* what it is like to exist as a human being.<sup>65</sup> But why is this important for metaphors and the medical encounter? Because, at the point of patient-clinician contact, two stories collide. And at that moment, it becomes critical for the patient and clinician to learn to understand each other. Metaphor plays a vital role in this process.

As Lakoff and Johnson have demonstrated, metaphor is an indispensable medium through which human

and talk about our lives may in some sense actually *be* our lives. Metaphors are the contact points of shared human reality. Metaphors are the tools that we humans have at our disposal to create a shared story in which words like “love,” “justice,” “illness,” “dying,” “god,” “hope,” and “forgiveness” mean anything at all.

Yet any individual metaphor is always part of a network of words and meanings. No word—metaphor or otherwise—can stand alone. No meaning is sacrosanct. Rather, words gain their sense publicly and in a community of speakers by being juxtaposed against a whole host of other

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beings both organize and express their experiences and understand the experiences of other people. But not any metaphor will do justice to a human experience. The right metaphor is the one that can accurately articulate a felt, lived experience. Charles Taylor identifies these kind of experience-organizing, rootlike metaphors as “template metaphors” for living.<sup>66</sup> These templates will be, at least partially, unique to each individual. It may be that, for one person, a journey metaphor captures the occasionally trudging, occasionally roller-coaster experience of illness; for another person, only a battle metaphor can accurately express the feeling of having to fight to survive against cancer, diabetes, or a bloodstream infection. Of course, these different templates will be “given,” in the sense that the narrative background against which we can understand anything is given (whether by our culture, laws, or doctors). However, this only heightens the importance of our template metaphors, especially if we are convinced that there is nothing under, or more foundational than, these templates. Put another way, the metaphors we use to conceptualize, understand,

words and meanings. In this network, words and meanings exist together as a story, and it is in the telling, hearing, and interrogating of the story that individuals learn to understand each other. It follows that the meaning and appropriateness of any word emerges only from within the linguistic practices of talking and listening. Meaning and appropriateness cannot be prescribed by committee or fiat.

Toril Moi extends this idea in her recent book *The Revolution of the Ordinary*. Moi, a literary theorist and philosopher, presents a Wittgensteinian vision of language that is grounded in use.<sup>67</sup> According to Moi, it is an error to presume that anything outside of the two people actually talking could determine what a word means or does, for only in use do words live. Within this “ordinary” vision of language, any prescriptions or grand theories are illegitimate, especially those claiming scientific authority. Moi quotes Wittgenstein scholar P. M. S. Hacker, who laments that we now “live in a culture dominated by science and technology. We are prone to think that all serious questions can be answered by the natural sciences.”<sup>68</sup>

Moi affirms Hacker's concern, noting that today "even humanists appear to have embarked on a quest to substitute measurement for judgement in every human practice."<sup>69</sup> Moi may as well be speaking to Trogen when Trogen appeals to a standard of "best" care, as if what is "best" for a patient exists prior to their own hopes, fears, emotional life, and story.

But the best metaphor cannot be identified before a patient is met, witnessed, and spoken to. Patients are not interchangeable, like carburetors, or even like their own hearts and kidneys. Communication is not simply a transfer of information, the moving of a computer file between two folders on a desktop, and it cannot be reduced to a formula. Rather, communication is the activity of communing or (etymologically speaking) sharing something, and communication is an active and cooperative process that requires reciprocity and work.<sup>70</sup> Crucially, though, this work can be done well only within the confines of a relationship, for the capacity to *relate* a story depends on there being a *relationship* in which that story can be received, praised, challenged, and responded to.<sup>71</sup> Only in relationship can the meanings of signs arc together and converge into genuine conversation. Whether that sign is a word, a sentence, an x-ray image, a new lab value, a metaphor, a shrug, a high five, or even a door slammed in the clinician's face, it is only in relationship and through the joint construction of a shared and meaningful story<sup>72</sup> that talking *with* (as opposed to talking *past*) can actually occur.

Once we see the priority of language use over and above dictionary definitions or prejudged determinations of meaning, the separation between metaphor and the rest of language collapses. The meaning of a metaphor in a patient encounter is how the metaphor is understood and used in that encounter. As Moi explains, "To understand a metaphor is not to translate it back to its 'literal' meaning, but to understand the work *this* image does *here*, in this specific

utterance."<sup>73</sup> Metaphor, like the rest of language and other signs, is simply a means through which humans can both understand the world and express to each other the embodied experience of being alive.

Finally, if the *right* metaphor for a patient encounter can be known only from within the discourse of the patient-clinician relationship rather than from outside it, the onus is placed on individual clinicians to actually listen to and understand their patients' stories. Since, ultimately, all language can both harm people and confuse, deceive, and conceal the truth, it becomes the responsibility of clinicians to practice and grow in the wisdom and discernment that is required to intuit the right words for the right times—rather than thinking that they can have easy recourse to a set list of words or phrases fashioned from a one-size-fits-all algorithm.

### Guidance for Choosing Metaphors

A relationally driven approach to metaphor use raises a practical concern: if the meaning of a metaphor is determined by use, then its meaning is ad hoc, and therefore, clinicians are permitted no guidance regarding what metaphors they generally should or should not employ. Consequently, a relationally driven approach appears both unfruitful for clinicians, who long for guidance, and incorrect, as some metaphors seem patently superior to others.

A framework for clinicians to use when conceptualizing metaphors may help circumvent this concern, and in what remains, I will attempt to outline such a framework. I envision this framework as a heuristic, or shortcut, that clinicians can turn to when considering the best metaphor for a situation. It is not intended to be authoritative, conclusive, or static.

Deploying a modified version of an analysis advanced by Black,<sup>74</sup> we can consider two aspects of every metaphor: *indispensability* and *fixedness*. A metaphor is indispensable if it

is critical for a speaker to convey a certain idea, meaning, or feeling; hence, an indispensable metaphor is difficult to paraphrase, and when a paraphrase is attempted, important meanings are lost. A metaphor is fixed if it holds its meaning across multiple hearers. The opposite of indispensable is replaceable, and the opposite of fixed is variable. So, any metaphor could, in theory, be mapped onto a grid, with the x axis indicating its degree of indispensability versus replaceability, and the y axis showing its degree of fixedness versus variability.

A metaphor's indispensability is connected to its uniqueness. Indispensability is a property of the tension between the metaphor itself and the idea or object it is being used to describe. This property manifests as a metaphor's ability to open up new horizons of understanding for speaker and hearer and to shed new light on a situation. Often, the indispensability of a metaphor will be recognized and felt only after the metaphor is spoken and considered. Indispensability is about work; what work does a metaphor do for us here, now?

Fixedness is determined to a greater extent by context and convention. Compared to indispensability, fixedness is more of a *hearer* issue; fixedness is therefore more amenable to empirical investigation, since local linguistic conventions and practices can be studied (as in Magaña's research).

Indispensability and fixedness are features of conversation in relationship, that is, when speaker and hearer are, at least partially, embedded in the same network of rules that determine which linguistic "moves" are intelligible and which are not. This framework is not intended to be used in situations where a clinician knows nothing about their patient, or their patient knows nothing about them.

Generally, the "safest" metaphors are highly fixed. An example of a highly fixed metaphor is "your heart is a pump." "Your heart is a pump" is fixed insofar as it is unlikely to be misunderstood, at least among

English-speaking patients acclimated to Western medicine.<sup>75</sup> This is a desirable trait for clinical communication. In addition, the “your heart is a pump” metaphor is moderately indispensable, as there are few other ways for clinicians to say what they mean.

At the other end of the spectrum lies a metaphor like “your daughter is a plant” (or “tree,” “fruit,” or “tomato”). Perhaps this phrase is silly, but one can at least imagine a clinician using it in a nervous attempt to tell a parent that their child is in a vegetative state (while resisting the urge to say “your daughter is a vegetable” due to that metaphor’s derogatory status) or, in a different situation, to remind a new parent that they must feed their newborn on a regular schedule. Here, the metaphor is both highly replaceable (there are better ways to say what the clinician means) and highly variable (the entailments of the metaphor are unpredictable). This metaphor would be a poor choice in nearly any clinical context.

Conversely, “whichever choice we make, it will be a gamble” is indispensable but variable. It is indispensable because it gives the clinician the distinct ability to describe the risk, optimism, uncertainty, and arbitrariness of many medical therapies (especially regarding intensive care and clinical trials). It is variable because of how it can be openly interpreted; people have highly unpredictable reactions to gambling generally, and patients may find hope or fear at the idea of “rolling the dice” with their own life. War metaphors can be similarly categorized, though they are more indispensable (insofar as they possess the *sui generis* power to accurately represent a predominant genre of the lived experience of illness) and less variable. For instance, when I say, “Your father is a fighter” (perhaps in reference to a man who has survived the Vietnam War and is now battling pneumonia in the intensive care unit), the metaphor is both more essential for good communication (indispensable) and less openly interpretable (more fixed)

than “whichever choice we make, it will be a gamble.”

The problematic metaphor “your daughter is a vegetable” is harder to categorize. The “vegetable” metaphor appears to be replaceable because it has, especially within American medicine, an easily paraphrased meaning: a patient is a vegetable if they have lost nonvegetative functions like language and cognition. But, of course, in the medical context, “vegetable” has another meaning. For some clinicians, to say that a patient is a vegetable is to mean that, because the patient lacks certain abilities, they

understanding. These features make them a good choice. Metaphors that are highly fixed but only slightly indispensable can be useful, especially when describing discrete objects or organs (as in “lungs are balloons” or “the brain is the body’s command center”). For similar but opposite reasons, replaceable and variable metaphors should be avoided. Metaphors that are indispensable but variable, like many war metaphors, are best employed within a developed and knowing clinician-patient relationship; within such a relationship, misunderstanding is less likely to occur,

### **The best metaphor cannot be identified before a patient is met, witnessed, and spoken to. Patients are not interchangeable, like carburetors, or even like their own hearts.**

do not deserve medical care or life-sustaining treatments. In this second, derogatory sense, the metaphor is actually quite indispensable (in my sense of the word) and even expedient.<sup>76</sup> Relatedly, its location on the fixed-variable spectrum is indeterminate due to the numerous offensive and disparaging interpretations and entailments that have grown up and are growing up around the metaphor.

Finally, a highly replaceable and highly fixed metaphor may be something like “asthma is a roller coaster” or “bacteria swim through the bloodstream,” as there are other suitable options (“asthma is a wild ride” or, more prosaically, “asthma is challenging” and “bacteria travel through the bloodstream”) and a lower likelihood that the metaphors will be questioned or misunderstood by the hearer.

So what combination of metaphorical aspects should be prioritized? As a rule of thumb, indispensable and fixed metaphors are both descriptively powerful and maintain a durable meaning across speakers and contexts. Due to their fixedness, they are also less reliant on the presence of a strong relationship for successful uptake and

and the power of the metaphor can be appreciated and even exploited.

This heuristic is meant to be a useful tool for clinicians. But, as with any tool, if it does not work for a particular job, it should be discarded, modified, or exchanged for something more apt. Moreover, because this heuristic is conditioned by the speaker’s intended meaning and the hearer’s interpretation, it necessarily depends on context. It cannot be applied to bare “text” or “textual data,” as if words disclose their meanings independent of the speakers and listeners, or writers and readers, who bring them to life. Only human beings can perform such a miraculous, life-giving act.

The conclusion that all language gains meaning through use and that, to grasp how another person understands a metaphor, sentence, or medical explanation, you actually have to spend time listening and talking to them may seem banal. Anyone who has spent time as a patient, caretaker, or clinician, however, knows that this is not the case. Sitting with the suffering of another person, engaging them in conversation and absorbing

some of their pain in the process, is not an easy activity. Furthermore, listening and talking to people well is no longer something our health care system prioritizes, with its top-down emphasis on efficiency, productivity, and cost saving. Efficiency, however, will not make medicine more humane or create a space for patient's stories to be witnessed and responded to. Only good and caring people can accomplish that daunting task, for, ultimately, it is good people who speak good words, not the other way around. Indeed, as medicine reimagines itself for the future, it is crucial for the field to refocus on the patient-clinician relationship, which forms the bedrock of good and ethical clinical care.

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### Notes

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12. *Ibid.*, 1412.
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15. A related way to describe this problem is that it commits a "conceptual error," as claimed by Benjamin Frush and John Brewer Eberly Jr. in a direct reply to Trogen (B. Frush and J. Eberly Jr., "Risks of Medical Metaphors," *Journal of the American Medical Association* 318, no. 5 [2017]: 482-83).
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34. Soskice, *Metaphor and Religious Language*, 80.
35. *Ibid.*
36. *Ibid.*, 81.
37. These metaphors were collected from both my own experience caring for patients as well as through email exchanges with residents and alumni of the University of Washington-Seattle Children's Hospital Pediatric Residency Program.
38. I. A. Richards seems to agree when he says that the "worst assumption" about metaphor one can make is "that metaphor is something special and exceptional in the use of language, a deviation from its normal mode of working" (*The Philosophy of Rhetoric*, 90).
39. B. Trogen, "Risks of Medical Metaphors—Reply," *Journal of the American Medical Association* 318 (2017): 482-83, at 482.
40. Trogen, "The Evidence-Based Metaphor," 1411.
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42. See A. Fuks, "The Military Metaphors of Modern Medicine," in *The Meaning*

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48. For examples of articles citing these studies as support, see Trogen, "The Evidence-Based Metaphor," 1411, and D. Khullar, "The Trouble with Medicine's Metaphors," *Atlantic*, August 7, 2014.

49. Degner et al., "A New Approach to Eliciting Meaning"; Barkwell, "Ascribed Meaning."

50. Hauser and Schwarz, "The War on Prevention."

51. Here I'm reminded of the honest lines of Maggie Smith's poem "Good Bones": "Life is short, though I keep this from my children. / Life is short, and I've shortened mine / in a thousand delicious, / ill-advised ways, / a thousand deliciously ill-advised ways / I'll keep from my children" (in M. Smith, *Good Bones* [North Adams, MA: Tupelo Press, 2017], 75).

52. T. Chambers, "Metaphors as Equipment for Living," *American Journal of Bioethics* 16, no. 10 (2016): 12-13.

53. D. Semino et al., "The Online Use of Violence and Journey Metaphors by Patients with Cancer, as Compared with Health Professionals: A Mixed Methods Study," *BMJ Supportive and Palliative Care* 7, no. 1 (2017): 60-66.

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55. Demmen et al., "A Computer-Assisted Study of the Use of Violence Metaphors."

56. See A. Byrne et al., "Patients' Experience of Cancer: Evidence of the Role of 'Fighting' in Collusive Clinical Communication," *Patient Education and Counseling* 48, no. 1 (2002): 15-21; C. Skott, "Expressive Metaphors in Cancer Narratives," *Cancer Nursing* 25, no. 3 (2002): 230-35; Gibbs and Franks, "Embodied Metaphor"; and Gustafsson, Hommerberg, and Sandgren, "Coping by Metaphors."

57. D. Magaña, "Praying to Win This Battle: Cancer Metaphors in Latina and Spanish Women's Narratives," *Health Communication* 35, no. 5 (2020): 649-57.

58. *Ibid.*, 655.

59. *Ibid.*

60. Bob Pearlman and I explore this idea in greater detail elsewhere: T. P. Tate and R. A. Pearlman, "Military Metaphors in Health Care: Who Are We Actually Trying to Help?," *American Journal of Bioethics* 16, no. 10 (2016): 15-17.

61. Trogen, "Risks of Medical Metaphors."

62. Nor can they be explained in any predictably rigorous or lawlike fashion by looking to the social sciences, as the social sciences do not follow "laws" either. See A. MacIntyre, *After Virtue: A Study in Moral Philosophy*, 3rd ed. (Notre Dame, IN: University of Notre Dame Press, 2012), 88-108; C. Taylor, *Human Agency and Language: Philosophical Papers I* (Cambridge: Cambridge University Press, 1999), 15-76; J. Blakely, *Alasdair MacIntyre, Charles Taylor, and the Demise of Naturalism* (Notre Dame, IN: University of Notre Dame Press, 2016); and A. W. Frank, "Can We Research Suffering?," *Qualitative Health Research* 11, no. 3 (2001): 353-62, at 355-59.

63. G. E. M. Anscombe, *An Introduction to Wittgenstein's Tractatus: Themes in the Philosophy of Wittgenstein* (South Bend, IN: St. Augustine's Press, 1971), 50.

64. MacIntyre, *After Virtue*, 204-25; A. MacIntyre, *Ethics in the Conflicts of Modernity* (Cambridge: Cambridge University Press, 2017), 26-27, 231-42.

65. J. Bruner, "The Narrative Construction of Reality," *Critical Inquiry* 18, no. 1 (1991): 1-21. This empirical claim about the narrative structure of the life of "a human being" may not apply to people with profound intellectual disability or cognitive impairment (such as dementia) and therefore does not actually refer to "the" human life but merely "a type" of human life, albeit the type that most, if not all, readers of this essay experience.

66. Taylor, *The Language Animal*, 146-64.

67. T. Moi, *Revolution of the Ordinary: Literary Studies after Wittgenstein, Austin, and Cavell* (Chicago: University of Chicago Press, 2017).

68. *Ibid.*, 2.

69. *Ibid.*, 2.

70. Janet Bavelas and colleagues showed that a person's ability to coherently tell a story depends in part on the degree of engagement and participation of the listener (J. Bavelas et al., "Listeners as Co-narrators," *Journal of Personality and Social Psychology*, 79 no. 6 [2000]: 941-52). For a discussion of the significance of Bavelas's work on the patient-clinician relationship, see D. Ofri, *What Patients Say, What Doctors Hear* (Boston: Beacon Press, 2017), 110-16.

71. R. Carson, "The Hyphenated Space: Liminality in the Doctor-Patient Relationship," in *Stories Matter: The Role of Narrative in Medical Ethics*, ed. R. Charon and M. Montello (New York: Routledge, 2002), 171-82, at 175.

72. H. Brody, "'My Story Is Broken, Can You Help Me Fix It?' Medical Ethics and the Joint Construction of Narrative," *Literature and Medicine* 13, no. 1 (1994): 79-92.

73. Moi, *Revolution of the Ordinary*, 247, note 27.

74. Black, "More about Metaphor," 25-27.

75. In my clinical experience, it can also be understood by non-English speakers, especially when a clinician is working with a good medical interpreter. In these situations, within the palliative care context, I find metaphors to be particularly useful when discussing complex and esoteric topics with patients and families, and I generally try to select metaphors that fall in this "safe" category. For a helpful and related discussion around the general usefulness of metaphor (focused on English-speaking patients but modifiable for patients that are not), see D. Hui, D. S. Zhukovsky, and E. Bruera, "Serious Illness Conversations: Paving the Road with Metaphors," *Oncologist* 23, no. 6 (2018): 730-33. Thanks to a *Hastings Center Report* reviewer for reminding me of this important topic and alerting me to this publication.

76. In this sense, the metaphor "vegetable" can work like a slur, in that it can invite or even underwrite a certain morally objectionable perspective (namely, that there is a tight relationship between neurologic function and moral value). When it does so, the perspective becomes a live and operative lens for clinicians to adopt or even hide behind (by saying something prejudicial without really "saying" it). For a germane discussion, see E. Camp, "Slurring Perspectives," *Analytic Philosophy* 54, no. 3 (2013): 330-49.