

▣ The Military Metaphors of Modern Medicine

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Medical discourse is replete with the language of war and such phrases as "the war on cancer," "magic bullets," "silver bullets," "the therapeutic armamentarium," "agents of disease," "the body's defences," and "doctor's orders" are deeply engrained in our medical rhetoric. The mindset engendered by this discourse of war renders the patient as a battlefield upon which the doctor-combatant defeats the arch-enemy, disease. The reified disease becomes the object of the physician's attention, displacing the patient as the interlocutor in the doctor-patient relationship. This shift of attention is exacerbated by contemporary imaging methodologies, and patients, who in Foucault's clinic became open to the medical gaze, are rendered totally transparent, perhaps virtual. Diagnostics becomes centred on the putative agent and therapeutics revolves around extirpation and conquest. Arguably, the most important effect of this framing of medicine is the eradication of the patient's voice from the narrative of illness. The dialogic construction of the narrative of illness is supplanted by the physician's case record of his search for the physical seat of disease and the healing effected through the development of meaning falls victim to a militarized discourse. The military metaphors that pervade medicine undermine the ability of physicians and society to deal with the burgeoning burden of chronic illness.

Metaphors, medical language, war, military discourse, narratives, doctor-patient relationship

1. Introduction

Modern medicine has achieved stellar successes in dealing with acute infectious diseases and modern surgery has developed remarkable tools for repairing and replacing many organs and parts of the body. Despite these accomplishments, the public arena is filled with discussions about the "crisis in medicine"¹. Indeed, health care is a major topic of political debate and a recurring feature of public policy forums in Canada, the United States and the United Kingdom². Physicians complain about third party interference in medical decision-making and young graduates, concerned with the quality of their own lives, choose non-traditional modes of practice in clinics with fixed hours and interchangeable doctors. Patients are concerned with flexible and easy access to their physicians, continuity of care, and, most of all, seek a physician who will listen to their needs and concerns. Perversely, the length of the typical medical interaction has shortened substantially and the patient community has increasingly turned its attention to "alternative" healers – at a time when medicine can actually provide greater benefits than ever before^{3,4}.

These social, economic and political forces have resulted in enormous strains in the doctor-patient relationship, the arena for diagnostic and therapeutic interventions, and have cannibalized the medical interview, and perhaps the clinical relationship, without which medicine devolves to a mechanical and technical pursuit within a chaotic system of care delivery.

How can one understand this paradox? What might explain the dissonance between the daily evidences of success, for example, hip replacements, cataract surgery, cardiac angioplasties and renal dialysis, on the one hand, and the common complaints by patients that doctors fail to listen to their concerns⁵? Why is contemporary practice stroboscopic in character, with physicians interrupting their patients' narratives within seconds of the beginning of their stories of illness⁶? This paper intends to make the case that the language and metaphors of contemporary medical discourse express and reflect the stresses in the doctor-patient relationship and, more importantly, that this discourse is, at least in part, responsible for shaping the behaviours that characterize the practice of medicine today.

The language of medicine, both lay and professional, is thoroughly infused with the language of war. Kathleen Sebelius, the newly sworn-in Secretary of Health and Human Services in the United States announced in her first press conference, "We're determined to fight this outbreak", referring of course to the swine flu, "and do everything we can to protect the health of every American⁷". The World Health Organization raises the alert levels for epidemics as the Pentagon does for a terrorist attack⁸. We speak of the 'magic bullets,' and 'silver bullets' of 'the therapeutic armamentarium' targeted to destroy the 'agents of disease'⁹. Presidents and prime ministers announce 'global combats against malaria' and 'wars on cancer', the latter propounded by President Nixon in 1970¹⁰. We are told to eat well to strengthen 'the body's defenses,' in preparation for 'the battle against infections,' and to avert 'heart attacks' and sidestep 'killer T cells'. Little wonder that oncologists fight 'fire with fire' as tumours are 'locally invasive', 'aggressive', 'silent' and 'widespread' or 'under control', precisely consonant with an imperialist, militarized view of malignancy¹¹. Of course, the 'battle' cannot be won without following 'doctors orders'. The war metaphor is so familiar and commonplace in our medical rhetoric that we easily lose sight of its militaristic origins and significance.

Though some have attributed this metaphoric stance to the advent of the germ theory of illness of the late 19th century, such language can be found as early as in the works of Thomas Sydenham in England in the mid 17th century¹². Sydenham noted a physician to be one who is well equipped, thus, "In eradicating a chronic disease therefore, whoever is possessed of a

medicine, powerful enough to destroy the species of it, justly deserves the appellation of a physician.¹³” He described his system of therapeutics as follows, “Meanwhile I attack the enemy within by means of cathartics and refrigerants, and by means of a diet of the kind described,¹⁴” and the difficulties of clinical work by noting, “A murderous array of disease has to be fought against, and the battle is not a battle for the sluggard.¹⁵” Finally, this physician, known as the Hippocrates of England, depicted the work of the practitioner with this phrase, “I steadily investigate the disease, I comprehend its character, and I proceed straight ahead, and in full confidence, towards its annihilation.¹⁶”

Published almost three hundred years later, the following three book titles illustrate the continuing persistence and pervasiveness of the military in medical discourse, both in the formal medical literature and the public press: Robert N. Proctor, *Cancer Wars: How Politics Shapes What We Know and Don't Know About Cancer*¹⁷; Karen Stabiner, *To Dance with the Devil: The New War on Breast Cancer*¹⁸; and Roberta Altman, *Waking Up, Fighting Back: The Politics of Breast Cancer*¹⁹.

2. Reification of Disease

This military metaphoric language reflects and parallels a centuries-long cultural process of the reification of disease, starting with Sydenham, who saw diseases as distinct entities and species and undertook their classification much as Linnaeus had organized the flora and fauna in biology. Sydenham's intent was to achieve a classification by criteria that could then lead to clear therapeutic choices in purging, bleeding and the like in releasing the “morbific matter²⁰” and restoring the balances of the humours. Nonetheless, the ontologization of illnesses as independently recognizable disease entities represents the first stage of the shift of attention of the physician from the patient to the disease entity. This redirected medical gaze was later focussed by the early pathologists on the morphologic evidence of disease within the body, and, with the introduction of the microscope, on increasingly smaller portions of the patient. The pioneers of the Parisian school of clinical medicine laid the foundations of the modern clinical method by developing methods for ascertaining the presence of disease by external clinical examination, and made the embodied disease visible to the medical gaze, as described by Foucault²¹. I would argue that the biochemical and molecular understanding of disease characteristic of the 20th century has pushed this trend along its vector of reification and reduction to the point that a genetic disease may be thought to reside in a misshapen molecule due to an error in DNA orthography. The patient's body has become superfluous to the molecular physician; now not simply open to the medical gaze, but rather

completely transparent to it. Magnetic resonance imaging aims to visualize pure disease, untainted by the patient or his body, and tissues are merely ghosts on the computer screens of the MRI output. The psyche, totally invisible and ephemeral from the stance of radiologists and molecular pathologists, has been left behind on the analyst's couch.

The earliest examples of this reification of the patient's illness into the physician's disease, to use a distinction proposed by Arthur Kleinman, use the word "conquer" to indicate a battle between "nature" and the disease in which the protagonist is the ameliorative power of nature that leads to the resolution of the illness with little or no physician intervention²². However, should this natural process not have proven sufficient to the task, the protagonist becomes the combatant physician battling the enemy, the disease. There are no instances of the patient taking up the fight, as it were. Contemporary uses of the metaphor treat the enemy as the disease but one can again distinguish two subtypes, one in which the patient is the fighter, and another in which the doctor is cast as the disease slayer. The latter is the more common of the two, though the website of the Canadian Cancer Society envisages a partnership with its French slogan: "le cancer: une lutte à finir"²³ and that of its American counterpart in the US asks us to "Join the Fight Against Cancer."²⁴ The British analog, Cancer Research UK, issues its own invitation with the pronouncement, "Together we will beat cancer"²⁵.

Far more common in the modern discourse of medicine is the physician taking up therapeutic arms against the enemy, disease, towards its eradication. Though attractive at first glance, for who could gainsay the eradication of smallpox as an epidemic illness, the consequences of this metaphoric stance are broad and perverse. First and foremost, the reified disease has not only become the focus of the physician's attention, it has become the interlocutor in the relationship, supplanting the patient. That individual in turn, has been relegated to the passive status of battlefield, in keeping with the state entailed by the term, patient. Thus, the interface between physician and patient, the central arena for the development of trust, meaning and healing, disappears as the medical gaze shifts to the disease, and, as noted previously, is increasingly removed almost in stepwise fashion, from the sickroom of the 18th century, to the pathologist's bench of the 19th century, the imaging room of the 20th, and the DNA sequencer's computer screen of the 21st.

3. Diagnoses

The shifts of locale for the diagnostic act are the result of increasing technological sophistication from the stethoscope to the MRI machine and the human genome project. This development reinforces what Charles

Rosenberg has called the “tyranny of diagnosis²⁶”, once again putting the doctor’s desire for diagnostic clarity ahead of the patient’s need for relief of suffering. In fact, while the surgical hero is the one who removes a tumour or repairs a coronary artery, the physician’s hero is the Sherlockian or Oslerian diagnostician. The relief of uncertainty that attends an accurate diagnosis can be helpful for the patient, it can hardly substitute for the development of personalized meaning relevant to the particular patient and his unique variant of the illness in question. The quest for diagnosis pins a label on the enemy and provides a target for the therapeutic attack; it is also a taxonomic act that erases the messy individuality of the particular patient. Thus, while illnesses are unique, diseases are abstracted archetypes relevant to the physician and, perhaps as important, to the modern hospital administrator and insurance provider who rely on diagnostic categories for their spreadsheets and payment schemes. Within the prevailing metaphoric framework, therapeutics becomes a final act of conquest, whether by purging, by drugs or by the fleam. All revolves around elimination and extirpation with little contribution from the passive patient. In this reified construction, preventive medicine is assigned to develop a security cordon to thwart an attack by an enemy invader, reflected in the recent discourse around the flu pandemic. In the case of non-infectious diseases, preventive medicine has been transformed into a search for disease at its preclinical stages, and thus, readily susceptible to conquest. Again, this strategy is reminiscent of the early warning systems of anti-missile defences.

Most exemplars of the military metaphors cast the physician in heroic terms, in many instances, as the individual responsible for identifying the reified disease resident in the patient’s body, naming it and arranging for the means of extirpation or elimination. Modern medicine’s chemotherapy, whether antimicrobial or antitumour, is the analogue of Sydenham’s “medicine, powerful enough to destroy the species of it [disease]²⁷”. The self-evident successes in treating bacterial infections have served to entrench this construct and reinforced the positioning of disease as the physician’s natural enemy, leaving the patient as a bystander and spectator to the fray. In order to understand why this displacement is so important, one must examine its impact.

4. **The Patient’s Voice**

As disease became ontologized, the patient’s voice began to disappear from the chronicle of illness. Mary Fissell has described that in the mid 18th century, a physician’s notes quote the patient’s own words²⁸. By the end of century however, the narrative is in the words of the doctor and the patient’s voice is gone from the casebook. At the outset of the century, the narrative was constructed by the patient as a historical and idiosyncratic

explanation of causality and meaning rooted in her own individual history and experience. The physician often recorded and accepted these models, basing his diagnosis and treatment upon them. The physician was also keen to serve the patient well as a continuing source of his livelihood. With the shift to the hospital and the clinic, the agent with greater autonomy is increasingly the physician rather than the patient. Moreover, with the growing impact of scientific technologies, reified diseases become known to the clinician (and pathologist) through a series of abstractions increasingly removed from the patient. These were first seen as physical signs, moving to x-ray and MRI images and arriving at molecules in this century. The casebook now reveals only medical jargon and the physician's words, however sparse—the doctor has abducted the narrative and transformed it into a genre not recognizable by patients. As Fissell describes, in England in the 1770's, 70 percent of all diagnoses were in English, and 19 percent in Latin. A mere three decades later, “79 percent of all diagnoses were in Latin; only 1 percent were still in English²⁹”. An instruction to a medical student of that era quoted by Fissell aptly captures the transition: “give early Relief to your Patient and it will be a means of gaining his confidence and esteem, then attack the Disease more radically.³⁰”

The loss of the first person story is emblematic of the transformation of the patient from author and owner of the narrative, whose very uniqueness served as a means of explicating the mysteries of illness, to a passive, generic, and often solitary observer of care. The patient's story, especially when validated by the attendant physician, aided in the reduction of uncertainty and served in the construction of meaning without which the experience of illness is fraught with fear and anxiety. All reflexive descriptions of illness, including those by physicians of their own experiences, describe the loss of control and the disorientation that accompany the inability to participate in the affairs of daily living and the uncertainty that attends the sudden, unexpected onset of illness. In those instances where we also expect the patient to be a “fighter” who must “resist” being ill, the state of sickness can be complicated by a feeling of having failed to achieve the suitable level of the “desire to win”³¹. Thus, we compound the injury of disease with the social insult of failure.

5. **From the Battlefield to Eden**

The ability of the physician to help patients while working within the current reified model depends in part on the nature of the illness for which the patient seeks help. That is, the construct of eradication may not be counterproductive where the illness is one in which a clear and rapid diagnosis can be made and is generally susceptible to cure. But, anything

short of “complete victory” will not suffice. In disease, as in war, partial victories are more like unsatisfactory stalemates rather than welcomed successes-in any event, they are most appreciated by those who leave the field early, when winning is a declared fiction rather than reality. No matter what one calls it, the battlefield remains occupied and the patient’s suffering remains unknown to all but the patient. Yet, few illnesses fit this clear-cut mold any longer. Many patients are afflicted by maladies that have no name, yet whose suffering is real. Further, the major disease burden in this new century is chronic illnesses that can be greatly improved but hardly cured. Amongst others in this group are cardiac disease, chronic inflammatory conditions of the joints, connective tissues, lungs and bowels, diabetes mellitus, mental illness and increasingly, malignancy. Add to these the incurable ailments of aging, and we are dealing with a vast battery of illnesses for which medicine offers few cures but, by contrast, very powerful means of ameliorative care. Hence, modern illnesses do not lend themselves to rapid cures and cannot be extirpated. Hypertension cannot be cut out, nor can diabetes mellitus be destroyed. Thus, military metaphors undermine the ability of physicians and society to deal thoughtfully and effectively with the growing prevalence of chronic illnesses. In fact, there are hints of new metaphors of renewal, springtime and blooms that accompany discussions of regenerative medicine and stem cell therapies. We may yet witness a shift from warlike eradications to edenic fountains of youth.

6. **The Paradox**

The contemporary paradox is thus not simply a result of nostalgia for the good old days of kindly physicians. It reflects the outstanding capacity of a highly technical medicine to work wonders for those diseases that capture the attention of physicians while its practitioners fail to recognize and acknowledge the sufferers that sit patiently while the doctor addresses the ubiquitous computer screen. Given that declarations of war are limited in their capacity to support a conversation, the arena of the sickroom and clinic are bereft of a language that can be shared by patients and their physicians. The healing capacity of the listener needs a phenomenological fusion of horizons with the speaker, or at a minimum, shared goals and the acknowledgement thereof. Given the powerful guiding force of a metaphor that redirects the physician’s attention and intent, it is not surprising that patients continue to search for an interlocutor who has long since left the clinical arena³².

The capacity to listen attentively and actively is a skill necessary to the proper practice of medicine and an integral part of the clinical method. In this context, the clinician’s capacities and habits, call them art or science, are crucial to curing, caring and healing. These are not the add-ons of a medical finishing school that provide a veneer of communication skills to make

patients “feel good”. The personhood of the physician is intrinsic and foundational to his capacity to relieve suffering. Lifelong learning is effectively the continual becoming and development of those clinical skills and not simply the accumulation of new knowledge. These needed skills are closer to the evolution of wisdom, or more properly perhaps, Aristotelian *phronesis*³³. It is through the deepening of the physician-patient relationship that the skills become rooted in the morality of medicine. It is through the recognition of the patient as a significant other, an alterity that has a natural right to respect and one whose personhood is at once at stake and the focal point of the obligations and duties of the doctor, that we finally discover the moral grounding of the profession.

Lastly, it is not simply for patients that medicine must create new metaphors. What is also at stake is the very persona of the physician whose own identity cannot be rooted in warfare and assaults. When physicians forget how to listen to their patients, they also become deaf to their own souls.

Notes

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