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THE 'MEDICINE IS WAR' METAPHOR

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As the Berlin Wall fell and the Iron Curtain was raised, we entered the post-Cold War era. Adapting to this new situation will require reconceptualizing how we interpret political events and make political decisions. Experiencing life in terms of war is more than mere rhetorical flourish. Metaphors may influence which ethical issues we raise, how we interpret problems, which alternatives we notice, how we rank those alternatives, and how motivated we are to carry out a solution (1) (2).

The war metaphor affects more than foreign policy. It pervades our thinking about many areas of life. U.S. Presidents declare wars on poverty and on drugs, or offer us "the moral equivalent of war." In business, countless products are advertised as fighting some enemy -- from dirt to dandruff. We hear of football linemen engaging in "trench warfare," and of basketball rebounders fighting "the battle of the boards." We are frequently reminded of "the battle of the sexes." And G. Lakoff and M. Johnson note that my own profession is hardly pacific. Academic philosophers talk about attacking their opponent's premises and about finding a claim to be indefensible -- as part of the "rational argument is war" metaphor (3, pp. 61-65, 77-81, 87-96).

The war metaphor has a powerful effect on medicine. The 'medicine is war' metaphor influences not only our language, but also our attitudes, moral beliefs, and actions relating to the physician-patient relationship and to medicine generally. I will examine the pervasiveness of the 'medicine is war' metaphor (section I), identify three issues affected by it (section II), critique the metaphor and explore another model for understanding medicine, based on caring (section III), and propose what might be done to limit the use of the war metaphor in medicine (section IV). Throughout, I will identify the relevance of this metaphor for hospital ethics committees (HEC). Once we see how the war metaphor shapes one area of life -- medical practice -- it will be easier to see its influence on the rest of life, including politics and personal relationships.

I. THE METAPHOR

Words of war are commonly used to describe medicine, as S. Sontag notes (4, pp. 14, 57, 64-65). We speak of microbes as *enemies* that *invade* the body, to be resisted by the body's *defense* mechanisms. People succumb to heart *attacks*. Cancer *strikes* us down. High blood pressure is the silent *killer*. Once we have *declared war* on these diseases, we unleash our *arsenal of weapons*. Treatment may consist of *bombarding* the *foreign* cells with X-rays, giving a *shot* of painkiller, or using the *'magic bullets'* of antibiotics. The *first line of defense* is backed up by a second. Nurses and emergency room personnel serve on the *front-line*. The psychological state of patients matters: they should *fight* for their lives, not *surrender* to the disease. Thus is the 'medicine is war' metaphor played out in the language used by laypeople and health care professionals.

The metaphor's influence reaches beyond language. It is entrenched in our beliefs and behavior. As patients we often experience medicine and war as similar. First, both realms involve pain, blood, injury and death. Second, we feel illness as an enemy threatening our everyday life. Third, we see a win-lose situation: either we triumph or the enemy does. An exception is winning a moral victory through courage and dignity, even if overpowered by superior enemy forces. Hence, those soldiers and patients who are dying may be seen as heroes. Fourth, we feel morally responsible to repel the enemy. Patients are expected to make large personal sacrifices to regain their health, as citizens are to sacrifice for the war effort. A sense of moral duty is invoked to protect important cultural ideals: freedom and national honor (in war), and maximal bodily function and postponement of death (in medicine). And we are drafted to fight.

Other similarities between war and medicine go beyond the patient's responses. First, experts are often needed to repel the enemy. These experts -- soldiers and health care professionals -- gather information, make and execute plans. Second, both types of experts need to coordinate people and machines, to make quick life-or-death decisions. Hence it is assumed that someone issues commands. A well-defined hierarchy of power and authority is built on the need to make and to carry out decisions swiftly. Within the ranks, power relations are reflected in titles, uniforms (with badges indicating rank), status, and income. Third, physicians in some contexts (e.g., performing surgery) and soldiers are expected to quell compassionate feelings in the line of duty. Fourth, both groups make large personal

sacrifices for the good of others, and so are heroes deserving respect and gratitude. Fifth, given a moral duty to repel the enemy and given the sacrifice experts have made, we may sometimes start a war that costs more than we are prepared to pay. In warfare and medicine, the "cure" can be worse than the "disease." The risk of nuclear war may be worse than the risk of political domination; and the side effects and complications of medical treatment are sometimes worse than the disease process.

II. APPLICATIONS OF THE METAPHOR

The 'medicine is war' metaphor influences how health care professionals and laypeople view three important issues: (a) Should medical decisionmaking be controlled by physicians or by patients? (b) Why are not more medical resources shifted to preventive medicine? (c) Why does acquiring a medical education involve such a severe personal trial? Examining the 'medicine is war' metaphor will not lead to easy solutions. But it may help us to see hidden assumptions about medicine and medical ethics, and ultimately to make better medical decisions.

(a) *Control and patient autonomy.* When illness disrupts ordinary life, we try to wrest back control by declaring war on that illness. If we need a medical expert to help us fight, the issue of control may become complicated; physician and patient may vie for control of the war effort. Patients often see indignity or pain as worse than death. And, while many physicians may personally agree, mortalities are still commonly viewed as a quantifiable index of failure for physicians and generals alike.

Once locked into a struggle with an enemy, whosoever is not with us is against us. Those not fighting with us against the original foe become enemies, too. Physicians sometimes see patients who refuse treatment as traitors in the war against illness and death. Conversely, patients may see their physicians as enemies when those physicians take command away from them.

The original political metaphor ('medicine is war') is joined by a second: autonomy. Autonomous nations -- and individuals -- are ruled by none other. The way the issue of patient autonomy is framed -- Who has final authority to make medical decisions? -- presupposes a winner and a loser. Much of medical ethics now concerns who shall win various power struggles, and bioethicists should question whether they are asking the best questions. Perhaps bioethics should focus more on how power struggles can be prevented and on how groups can best share responsibility for decisions.

The war metaphor -- conjoined with the rise of the consumer

movement, which encourages 'fighting back' -- contributes to a climate in which medical malpractice suits are initiated. When patients see their war against disease being lost, they may look for someone to blame. They may see as traitors not only those few physicians who commit negligent errors, but also physicians who fail to cure *through no fault of their own.* Conversely, physicians may feel betrayed when patients 'attack' with lawsuits, and may protect themselves through 'defensive medicine'. HECs should be aware that occasionally a battle may exist between the patient/family and members of the health care team -- and one or both sides may feel it. If an ethics committee is called in on such a case, it is likely to be perceived by patients and their families as siding with the involved hospital staff. To mitigate the appearance -- and occasionally the reality -- of bias, a HEC would be wise to include as members former patients or their family members.

(b) *Preventive medicine.* Countless lives have been saved through vaccines, improved sanitation, people changing their lifestyles because of research on diet and smoking, etc. Yet high-technology developments, such as the artificial heart, receive funding out of proportion to potential lives saved, as compared to preventive methods (5) (6). Even in private practice, prevention is often shortchanged because patient education is time-consuming and difficult, and because patients may prefer taking a pill to changing their way of life.

Preventive health care should receive more resources, even if some cuts in crisis medicine would result. Resistance to shifting resources to prevention is partly explained by two factors: vested interests, and the tendency to weigh lives of people already in need more heavily than lives of those likely to be in need later. A third factor involves our metaphor: a major shift to prevention would alter who the enemy is. Changing who is perceived as the enemy has important implications. First, in crisis medicine, patients are viewed mainly as innocent victims of disease. But, in preventive medicine, patients refusing to change how they live are their own enemies; and society is an accomplice if it tolerates polluted, unhealthful living and working conditions. Second, preventing disease would expand the physician's role to include more patient and public education, more political involvement in health issues. Third, a major shift to preventive medicine would cause much of the uniqueness of medicine -- as a war on disease -- to be lost. Nurses, teachers, and public health workers educate; and all citizens can promote preventive medicine through politics. Yet, if undertaken broadly, more emphasis on preventive medicine would promote better health overall. So we should either (i) define medicine's unique role in improving health as something other than a war on disease, or (ii) stress those obligations (such as political involvement) which moral agents have regardless of

professional role, instead of emphasizing differences among health care specialties.

Virtually all HECs encounter crisis situations. Such committees quickly caught on after the 1976 New Jersey Supreme Court ruling in the Karen Quinlan case, which encouraged their use as an alternative to going to court to determine when life support systems may be removed. Some HECs still work primarily on a case-by-case basis. Others address prevention by developing a few guidelines (e.g., for DNR orders and infant care).

Currently, however, few HECs act systematically to prevent morally problematic situations from arising. For example, in discussing a case, when sources of recurrent problems (e.g., misunderstandings that arise because no bilingual nurses or social workers are available) are identified, they are usually dropped. Why is no action taken to prevent similar problems in the future? Perhaps because HECs are composed mostly of hospital staff, and bonds of friendship as well as a nebulous fear of reprisal make it safer for colleagues not to rock their institution's boat. A second example concerns the allocation of scarce medical resources. These justice issues are usually set aside, even though they are raised in particular cases all the time (e.g., "But if the hospital continues to treat such patients in the ICU, eventually there will not be enough money to pay for it, or enough ICU beds for those who may benefit most"). In the decade of the nineties, hospitals -- and their HECs -- may be forced to deal with allocation.

(c) *Medical education.* The manner in which technical knowledge and clinical judgment are taught to physicians is itself significant. The way of life of physicians-in-training prepares them for a life of fighting the enemy of disease, even as novice soldiers are prepared -- in boot camp or West Point -- for fighting a war. In both cases, status differentiation by rank is clearly maintained, and technical proficiency is stressed. There is little time for sleep, let alone time for reflection upon personal values and goals and for critical evaluation of one's profession. Moreover, to question the profession's methods and goals may be considered disloyal since it might obstruct the overall mission of defeating the enemy. The training period does more than prepare one for the future, however. It is a moral test. To pass, obedience and extreme self-sacrifice are required; one gives up one's youth. Paul Ramsey wisely counsels that we need to see 'the patient as person' (7). Yet we also need to see the physician as person -- and not just as a soldier, not just as a means to an end. When a battle with an enemy is not presupposed, it is much easier to see both patient and physician (as well as nurse, social worker, etc.) as persons. HECs at teaching hospitals would do well to consider medical education from a moral point of view, though the impetus for such an examination is unlikely

to come from physicians themselves.

III. GOING BEYOND 'MEDICINE IS WAR'

It might be thought that the 'medicine is war' metaphor is natural -- that some basic similarities between medicine and war would be noticed in any culture having both institutions. Even were this claim true, which I doubt, the following three features of war are inappropriately applied to medicine.

First, quick decisions are often needed on the battlefield to surprise an enemy. When medicine is seen as war, all medical decisions may be presumed *urgent*, though not all are. Many patients rebound from the shock of facing disfigurement or death in time to make a reasoned decision. Even though some do not, the answer is not simply to have the physician act paternalistically -- that is, to seek the best outcome for patients even when those patients feel differently about what the best outcome is. Adopting a strategy of "preventive ethics," as I like to call it, means that there will be fewer situations in which the merits of autonomy and paternalism need be weighed. Prevention may take the form of public education, which prepares people before illness or accident strikes to make difficult bioethical decisions. Prevention may also be practiced by health care professionals. HECs could actively encourage attending physicians (and possibly other health care professionals) to initiate discussion of the "Durable Power of Attorney for Health Care" (a legally binding document which, in my view, improves upon the idea of a "Living Will") with patients before a situation turns desperate. With foresight, many urgent situations can be avoided.

Second, in war it is often fairly simple to identify the enemy. (Terrorism and guerrilla warfare have been perplexing exceptions.) In medicine, however, there is considerable disagreement about who the most fearsome enemy is: death, pain, or the obliviousness of unrelenting senility, coma or PVS. It is easier to reflect on and to discuss disagreements about prioritizing these burdens in a climate less urgent than war.

Third and most important, deception and manipulation are more easily justified during war than during peace. When perceiving medicine as war, other moral considerations are likely to be brushed aside to win the war, as Sontag notes (4, p. 65) (8, pp. 94-5). War makes life -- including making moral decisions -- simpler. But simpler is not always morally better.

False beliefs such as these stem from the 'medicine is war' metaphor, and may lead to bad moral decisions. We have three alternatives: (a) to use the metaphor, but modify it (Mike W. Martin

suggested two modifications of the 'medicine is war' metaphor: viewing physician and patient as soldiers of equal rank, or seeing the patient as a commanding officer advised by physicians and other experts.); (b) to conceptualize medicine in a new way (W.F. May suggests that we conceive of the physician-patient relationship as a 'covenant'.) (9); or (c) to adopt a middle course by taking an existing way of thinking about medicine and expanding its scope and importance. In line with (c), I propose a middle course: medicine should be seen primarily as *caring for people's health* rather than as fighting a war against disease.

To clarify the difference between war and caring, consider patient autonomy. When physicians see medicine as war, choosing the most efficient means of vanquishing the disease is what matters. Respecting the patient's autonomy may be deemed a distraction -- time-consuming at best, hazardous to the patient's health at worst. Moreover, some physicians believe that they face this dilemma: "Should I be paternalistic, deciding what is best for the patient, then motivating the patient to accept it; or should I leave the patient -- who probably feels confused and uncertain -- alone to act autonomously?" That is, physicians may see but two choices: controlling their patients through orders or manipulation, or emotionally abandoning them. When fighting a war, it is assumed that someone will command. The question is who: physician or patient?

On the caring model, the relationship between care-giver and care-receiver matters in addition to the results. Physicians need not choose between controlling patients and abandoning them. A third alternative is offering support without orders or manipulation. Caring involves not just feeling, but skill: the ability to encourage others to draw on their own resources and coping strategies, and the ability to respond to different sorts of people in various situations without needing to be in control. [S. Hauerwas discusses how caring involves skills, not just feelings (10); R.J. Wicks gives a practical guide to supporting others without controlling or rescuing (11); M. Mayeroff discusses many subtle aspects of caring (12).] Counselors, social workers, and nurses are formally taught these skills; physicians should be, too. Admittedly, in shifting from fighting to caring, physicians would be giving up a large measure of control -- because *the issue of control would be less important.* Many physicians and patients alike would have difficulty giving up -- not this or that fight -- but the activity of fighting itself.

Two objections may be raised to how the caring model handles patient autonomy. The first objection claims that taking caring as primary in medicine leads ineluctably to paternalism. My reply is that caring does *not* entail paternalism. Caring for patients means caring all *all* of their interests: about their life and health (based on

beneficence) and about their sense of self and capacity for independent choice (based on autonomy). So the paternalism-autonomy debate would continue, after all. Yet adopting a caring model leads to three changes in that debate. First, although patient wishes might sometimes be overridden, in reaching a conclusion the physician would weigh patients' predictable feelings of frustration and violation. Second, we would no longer ask "Who wins? In this situation, who has the moral right to make the decision -- the patient (autonomy) or the physician (paternalism)?" That is because respecting patient preferences would be viewed as an integral part of caring for patients' health, rather than as an obstacle to medicine's "real" job of fighting disease. Third, when we stop asking "Who wins this time?" we focus not on one isolated decision, but on the long-term physician-patient relationship. For example, after overriding patient wishes, the physician would explain to patients why their wishes were overridden; and they could jointly make plans for contingencies, discussing what they might do if they disagreed on fundamental issues in the future (e.g., another physician might be consulted). Thus, physicians can act to respect patients' autonomy overall even when patients' specific desires are overridden.

The second objection is the opposite of the first. It claims that the caring model emphasizes autonomy too much. The assumption is that physician paternalism often outweighs patient autonomy, and that the war model better serves patients' long-term interests.

The second objection has several replies. First, I hold that respecting someone's autonomy matters in itself, not simply as a way of maximizing that person's other interests. Second, even were maximizing patients' interests (other than autonomy) held to be medicine's highest value, a physician and patient may differ in their willingness to take risks, or they may value outcomes differently. Third, caring about patients' autonomy -- as well as their physical health -- may well *not* lead to worse medical results than will fighting a war on disease. Evidence is mounting of the effect of beliefs and attitudes on physical well-being; hence attending to patients' values and choices may play a part in curing and preventing disease. Also, concern for patient autonomy may lead some physicians to consider a wider range of alternative treatments. Improved medical care may result from examining new alternatives sooner (e.g., ways of reducing stress without drugs), and to rejecting earlier, or being hesitant to use, standard procedures that may not be worth the risks (e.g., past use of DES to prevent miscarriages).

If medicine were primarily viewed as caring for patients' health instead of as fighting to a war against disease, the applications discussed in section II appear in a new light.

First, we have already discussed the issue of patient autonomy.

Whether a war will be won or lost dwarfs all else; but, in caring for someone, the human relationship matters, not just the end. When decisions must be made, instead of a chain of command which someone must head, the care model encourages a team effort among medical personnel, the patient, and the family, making power struggles less likely. HECs could study how genuine team decisions are made (rather than decisions wherein the physician asks for team input, but the team -- if not the physician -- knows that this request is a formality, and that the physician's decision is predictable and will be binding), decide when team decisions are desirable in different parts of the hospital (e.g., in the I.C.U.), and educate and encourage health care professionals to adopt a thorough-going team approach in those circumstances.

Second, preventive medicine and hospice treatment -- which focus on the patient's well-being rather than on vanquishing the disease -- are given higher priority on the care model. Prevention receives more attention because caring for others includes encouraging people to become more autonomous and to care for themselves. And, when cure is impossible, hospice treatment is viewed not as failing in the war against disease, but as another phase of caring for the patient.

Third, while the war metaphor is often used to justify the extreme trails of medical training, the exhaustion felt during medical school and residency tends to anesthetize, rather then to sensitize, one to the daily suffering of one's patients. Caring for others takes time and energy -- to notice, to listen, to empathize, and to respond. Ironically, caring for others may also require that one care for oneself (12, pp. 41-49). While a call to arms is a call to extreme self-sacrifice, caring for others rarely requires that one's own most basic needs be sacrificed for years on end.

Despite the care model's advantages over the war metaphor, two features count against some physicians accepting it. First, 'caring for peoples' health does not identify but one's specialty; nor does caring fit the ideal of professional reserve. While professionals' responsibilities to clients have limits, caring is not limited to routine or habitual responses. Caring enriches even brief encounters, and spills over role-defined boundaries. The caring model unites rather than separates.

Second, caring is usually considered an intuitive, feminine virtue. Rarely is caring deemed heroic, though the caring acts of hospice staff and others often should be. Also, emotions are commonly thought to block effective action. But, while emotions can impede action, care-givers can learn to channel their sympathy to benefit patients; and emotion can motivate action. When it is not understood that caring involves action in addition to feeling, caring is considered intuitive. And, since what is intuitive is thought not to be learned, caring could not be taught as part of professional education. However, caring -- like

uncaring -- is learned. One can develop the imagination needed for empathy, and learn the skills to help others without making the decision for them.

IV. CONCLUSION

While I have argued that the 'medicine is war' metaphor should be replaced, as does Sontag (4, pp. 3-4, 86) (8, pp. 14, 94-95), there are several reasons why I believe that physicians should *not* be attacked for using the 'medicine is war' metaphor. First, the authority and status its use confers on physicians may sometimes help in dealing with patients. The authority of "doctor's orders" sometimes gives confused, sick patients hope, encouraging them to do what will make them well, and enabling them to be more autonomous in the long run. Second, while physicians benefit from society's perception of medicine as war (e.g., through honoring them as warriors), they are also harmed by it (e.g., through extraordinary personal sacrifices). Third, physicians not wanting to perceive medicine as war often find themselves caught in the war mentality anyway; for this attitude is expressed by many patients and permeates the formal and informal rules of medical institutions. Fourth, physicians experiencing medicine as war reflect a general truth: firmly entrenched metaphors are regarded by most of us as indisputable. Why? They are invisible. We do not stop to question what we do not see. And the war metaphor is indeed deeply entrenched. It influences our thinking and behavior in numerous aspects of life, whenever we are asked to sacrifice in order to meet a new challenge. But fifth, and most importantly, those who accept the 'medicine is war' metaphor should not be attacked as enemies because *declaring war on a war mentality is self-defeating.* Giving up the war metaphor entails giving up seeing people as enemies.

If we refrain from finding new enemies, what should we do about the common perception of medicine as war? I see two tasks. Laypeople and health care professionals should become aware of how the war metaphor influences beliefs and behavior in medicine. And we should assess whether it would be better to continue experiencing medicine as war or to change.

If the 'medicine is war' metaphor is less good than some other model (e.g., 'caring for people's health'), I propose three things. First, the language and attitudes appropriate to war should be markedly toned down by all involved with medicine, including patients and bioethicists. Doing so would allow preventive medicine and hospice treatment to receive a higher priority, and would make the (conscious and rational) patient an integral part of medical decisionmaking -- neither an after-thought nor an obstacle to good medicine.

Second, avoiding the 'medicine is war' metaphor may have exceptions, yet each one should be viewed as a last resort. The experience of illness does sometimes parallel the hardship and struggle of the soldier -- as when an emphysema patient struggles to breathe and "fights" for life. The war metaphor may also be appropriate when its omission has dire consequences. Convincing others of the merits of one's cause is difficult when the alternative is funding a war. For example, consider persuading members of Congress that more money is needed for health care generally, or that hospice care should receive some of the money slated for the "war against cancer." It is tempting to argue for "the fight against disease" in the former case, and for "the war against pain and despair" in the latter.

Third, even where the 'medicine is war' metaphor is justified, it should be subsumed under another model: medicine is caring for people's health. At those rare times when caring for someone requires fighting, the fighting should be seen as intrinsically undesirable -- rather than as glorious and heroic -- and valuable only as a short-lived means to an end. Caring should be *primary* in medicine, with fighting and fighting back being temporary and derivative.

Yet the 'medicine is war' metaphor will be hard to phase out until we kick the habit of seeing life as war. While it is difficult to lose a battle, a defeated soldier is a soldier still. Much harder is to give up battling as a justification, a source of self-esteem, a way of life. This warlike, hero/enemy attitude pervades our life -- from love and marriage to sports and business. Especially dangerous is experiencing politics, including domestic elections and arms limitation negotiations, as war. These 'cold wars' keep us hooked on the thrill of victory and the excitement of risking defeat. They are not genuine peace, which would require a radical change in how we see ourselves and relate to others. To eliminate all inappropriate occurrences of the 'life is war' metaphor, we must start somewhere, and wherever possible. As we enter the post-Cold War era, we need to find ways to meet challenges other than by fighting metaphoric wars. Avoiding metaphoric wars may be essential to avoiding literal ones.

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