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Commentary on Brian Martin's "Tactics Against Scheming Diseases"

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[1] *Disclosure*: Brian Martin and I are occasional collaborators, primarily on studies of censorship that apply backfire dynamics, which is the approach that Martin takes in "Tactics Against Scheming Diseases" (2020). Martin has also published a generous retrospective of my early work on censorship. In addition, I am an admirer of his activism on behalf of intellectual freedom and in defense of whistleblowers as well as of his own intellectual courage in taking on unpopular causes.

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Brian Martin's backfire model provides a recipe for activists to respond to actions that violate established norms and are publicly perceived as unjust or extreme. It involves situations where disclosure of an offending act causes a public outcry, which fuels criticism, anger, revulsion and outrage, for example, government sanctioned torture. When the perpetrator of the action is a powerful entity—government, corporation, person, etc.— crisis management efforts are frequently mobilized to avoid public accountability. These efforts include:

> (1) Covering up the action;
> (2) Devaluing the target;
> (3) Reinterpreting the events by lying, minimizing consequences, blaming others, and reframing;
> (4) Using official channels to give an appearance of justice;
> (5) Intimidating or rewarding targets and witnesses. Public relations and lobbying consultancies are frequently commissioned to orchestrate such efforts.

Although targets of injustice and their supporters face more powerful and well-funded adversaries, they are not without options or resources. Sometimes the tactics of the powerful misfire on their own: public relations and public diplomacy textbooks are full of forensic case studies of such failures. However, targets of injustice can also work proactively to trigger such misfires by turning the tables on the perpetrators. They can counter attempts to reduce public outrage by:

> (1) Exposing the action;
> (2) Validating the target;
> (3) Interpreting the events as unfair;
> (4) Avoiding or discrediting official channels and mobilizing support;
> (5) Resisting intimidation and/or the lure of rewards/bribes. If the activists are successful, the adversary's efforts to contain and defuse public outrage will backfire.

In addition to censorship, Martin and his collaborators have successfully used the backfire model to analyze a wide range of perceived injustices, including treatment of refugees, labor disputes, massacres, genocide and sexual harassment. "Tactics Against Scheming Diseases" marks a distinctive departure from the injustices these situations involve. It uses a thought experiment: an approach that has a long, if somewhat controversial, history in science and philosophy. Martin cites examples from physics, history, literature, and science fiction, arguing that "imagining a hypothetical situation, even an impossible one, can be a way of gaining insights" (3).

Prefacing his thought experiment with reality-based qualifiers, Martin contends that "in countering disease, it can be useful to imagine how a disease agent and its allies scheme to reduce outrage over damaging impacts" (3). He points out that "it is not necessary that

disease agents actually plan their efforts, or to believe that they do. Whether or not they do," Martin maintains, "it can be useful to imagine that this occurs and thereby gain insights that can be useful for opposing disease" (3). The point is to encourage doctors and patients to respond to disease with the kind of outrage and struggle that is similar to the way activists respond to social injustices. This, he argues, will help them to think strategically "taking into account the likely tactics adopted by opponents and their allies" (16).

Martin applies this framework to three cases: AIDS, smoking and human evil, with, as he anticipates, the controversial nature of the the latter concept posing the largest challenge to the exercise. In each case he describes how scheming disease agents and their allies can be thought of as frustrating or countering health care initiatives; and he identifies counter tactics that can induce backfire against scheming diseases. These counter-tactics include: exposing the disease and its impacts, validating disease sufferers, interpreting the disease as something to be opposed, avoiding or discrediting official channels and instead mobilizing support, and resisting intimidation. In explaining how counter-tactics could elicit backfire, Martin does not limit himself to the three case studies, but ranges more generally across the spectrum of diseases.

"Tactics Against Scheming Diseases" was published in May 2020 presumably it was written before or in the earliest days of the current global pandemic. It is, however, virtually impossible to read it in 2021 without filtering it through the omnipresent lens of SARS COVID-19. Disease now dominates much of public and private discourse, creating a natural laboratory for analyzing the way various constituencies conceptualize, frame and respond to it.

My commentary focuses on three interrelated factors that Martin's thought experiment is likely to encounter in seeking acceptance. First, the metaphors used to describe disease. Second, cultural differences in responses to disease. Third, power relations in health care institutions.

Metaphor

In this section, I draw on my own longstanding interest in metaphor analysis. Martin's two opening paragraphs directly address metaphor. He cites the 'battle' metaphor that is most commonly used to frame disease: disease is an 'enemy' to be 'conquered,' 'war' must be declared against cancer or other afflictions, 'strategies' and 'weapons' need to be 'mobilized' to 'fight' them, etc. Contending that the battle trope "creates misleading priorities for responding to disease," Martin proposes an alternative, 'struggle' (Martin 2020, 1). He acknowledges that 'struggle' has remained an underdeveloped alternative because "most disease agents are seen as lacking agency and therefore lacking any capacity for strategic initiative" (10). Later in the analysis, he adds 'outrage' as a component of 'struggle'.

Metaphors are essential constituents of language, cognition and communication (Lakoff and Johnson 1980, 1999). The "language of science is largely metaphorical," although many practicing scientists are unaware of it or deny it (Taylor and Dewsbury, 2018). Metaphors

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make conceptual leaps from the known to the unknown possible. They are essential to constructing hypotheses and theories and securing paradigms. Once embraced and established, however, generative metaphors can be difficult to dislodge. They can inhibit as well as empower insight.

Battle imagery is deeply embedded in the language of disease in Western cultures: it goes back back to at least sixteenth century England, where it was used by a prominent physician, Thomas Sydenham, who became known as the English Hippocrates. (Khullar, 2014). It has been the dominant, one could even say, generative metaphor in public discourse about the COVID-19 pandemic, especially in media coverage where it fits neatly within the established 'conflict' framing of news. It also intersects with adversarial divisions in domestic politics in some countries, U.S., Britain, Brazil, Philippines, as well as with nationalism and international conflict and competition. Political leaders, who exercise powerful influence over media agenda-setting, have also drawn heavily on battle metaphors in response to the global pandemic. Queen Elizabeth and Italian Prime Minister Giuseppe both invoked the Second World War. Former U.S. President Donald Trump referred to himself as a "war-time president." U.N. Secretary-General declared "We are at war with a virus..." and legions of other government and corporate leaders added to this chorus (Musu 2021).

Martin is not, however, an isolated critic of the militarization of medical language. For almost a half-century, this critique has had currency within cultural and feminist criticism, and in recent years it has gained traction within the medical community (Semino et al, 2018). In her deconstructions of the battle metaphor's pervasive presence in discourses on cancer and AIDS, the late Susan Sontag maintained that it "overmobilizes, oversdescribes, and powerfully contributes to the excommunicating and stigmatizing the ill" (Sontag 2001, 182). That is, it often has the unintended effect of silencing and blaming victims of disease for not fighting hard enough, or not being courageous or vigilant enough, etc.

The magic of metaphors is their fluidity: they make poetry possible. But that also makes generalizing about their influence in ordinary language nearly impossible, especially when dealing with linguistically diverse populations. Nevertheless some research within medical contexts has attempted to do so. The results are predictably mixed. Some patients report that thinking of themselves as 'fighters' helps. Others, including some former military personnel, strongly reject that framing. Historically it has been a gendered, masculinist, metaphor (Reisfield and Wilson 2004). Research has shown that patients who viewed their diseases as an 'enemy' were more prone to depression and anxiety and had higher pain scores (Khullar, 2014). The battle frame dichotomizes outcomes into victory or defeat, life or death. This can lead some patients to adopt a fatalistic outlook which leads them to neglect preventative care and avoid treatment (Hauser and Schwartz 2009).

Efforts have been made to launch more positive metaphors: some suggest that patients should be encouraged to think of their encounters with serious disease as a 'journey'(Nie, et al 2016). Others worry about deceiving patients: while some synonyms for journey may be neutral, for many it has positive connotations. Positive thinking can backfire too as it did for social critic Barbara Ehrenreich during her personal 'journey' through breast cancer

treatment (Ehrenreich 2009). Ehrenreich, who has a doctorate in cellular immunology, found that the 'upbeat' attitude that prevailed within the literature and in breast cancer care-giving communities in the U.S. bordered on the delusional. She maintained that it was supported by an extensive fundraising and marketing infrastructure as well as strong communal norms that mandated cheerfulness in the face of adversity. Conversely, Ehrenreich like Martin, regarded 'outrage' as an appropriate response to disease.

Culture

War and medicine are not the only arbiters of human life and death. Death, we have been told, is the force that gives meaning to human life (Frankl 2006, original 1946; Becker (1973). And long before modern science and medicine began 'battling' disease, religion organized human rites-of-passage through life and death. Even in our secular age, religious traditions still provide controlling metaphors for many as a cursory review of the obituary pages of daily newspapers attests. And those metaphors support remarkably heterodox narratives across different cultures. There are also great variations in approaches to disease among different ethnic traditions within the same faith traditions. Add to this individual variations in life experiences, trauma, and medical histories. As a result, the variables that can influence patients' responses to messaging about disease and mortality are complex and multi-faceted; even a patient's closest kin can err dramatically in suggesting supportive metaphoric frames.

In one of the wisest and most nuanced discussions of medical metaphors that I have found, "The trouble with medicine's metaphors," physician Dhruv Khullar begins and ends his critical analysis of that trouble with an account of a conversation with one of his former patients, a young mother who had just given birth to her second child. A month earlier she had received a diagnosis of leukemia and her lab results left little hope (Khullar, 2014). Khullar found himself using the battle metaphor in attempting to comfort her —the metaphor that his article critically interrogates. He recognizes the inevitability and utility of metaphors in physician-patient speech where they make complex diagnostics accessible.

Citing a study (Casarett, 2010) that shows that physicians use metaphors in almost two-thirds of their discussions with patients who are seriously ill, Khullar reports that physicians who use more metaphors are considered better communicators. Yet, he also recognizes the potency of metaphors. Contending that none are inherently good or bad, he maintains that "the utility of each depends on the patient's culture, values, experiences, and preferences" (Khullar, 2014, p. 12). Therefore, he concludes that it is not for physicians or health care institutions to choose. It should ultimately be the patient's decision —ideally a decision made with the support of a caring community.

Institutions

Access to specialized knowledge creates a significant power differential between physician and patient in conversations about disease. Khullar's wisdom lies in his recognition of the boundaries of that power-knowledge and his refusal to reach beyond them. However, physicians, as members of a community of knowledge have their own subculture,

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hierarchies, professional codes, values, experiences, and preferences (Semino et al, 2018). They collectively depend on metaphors to organize and expand their knowledge and actions; and history attests to the strong preference of the medical profession for battle metaphors. Khullar acknowledges this, and claims that "it's almost instinctive to think of disease, especially cancer, in the context of a battle" (Khullar 2014, 11). To wit, he quotes researchers Gary Reisfield and George Wilson who write, "there exists a seemingly perfect metaphoric correspondence: there is an enemy (the cancer), a commander (the physician), a combatant (the patient), allies (the health care team), and formidable weaponry, including chemical, biological, and nuclear weapons" (quoted by Khullar 2014, 11).

Nevertheless, even patients who consciously choose the 'combatant' metaphor to characterize their roles in fighting their *'dis-ease'* are, at best, reluctant recruits or draftees who would surely desert the battle if they had the opportunity. Unlike the physician and the health care team, they had no agency in choosing their role within the military model. Even the cancer and weaponry seem more animate than the patient in this scenario. While the battle metaphor may work for organizing the efforts of the care-giving team, in most cases it seems to do a disservice to patients (Semino et al, 2018).

This brings us full circle back to Martin's thought experiment where we will discover that he has a most unlikely ally in the animation he imputes to scheming diseases —an ally who delivers a discourse on metaphors in science in a most unlikely venue, on television in a CNN special entitled [of course] "Covid War: Pandemic Doctors Speak Out" (March 26, 2021). Ironically, from the perspective of step #4 of the the backfire model, this ally is an official source: Dr. Anthony Fauci, Director of the U.S. National Institute of Allergy and Infectious Diseases, and leading medical spokesperson for America's response to the pandemic.

Describing the Institute's research and responses in the struggle against disease, Fauci says, "You kind of live in a metaphor. Using metaphors is very common when describing diseases, especially viruses. They have a mind. They're smart, they're evil or they're benign." He continues, describing COVID-19, "A virus that has adapted itself, almost insidiously, adapted itself perfectly to a human. Not only am I going to infect you [it says], but I'm going to make sure that many of you don't have symptoms, the people who are young and don't have symptoms, I'm going to use them to spread as much as I can." Fauci concludes by repeating "extraordinary virus," "viruses particularly have a mind," "It's such a bad evil virus" (Fauci, March 26, 2021).

In a later interview with Indian Express, Fauci also imputes agency to the virus, "If left to its own devices, it will explode" (Fauci, May 1, 2021). Serendipitously his framing of the COVID-19 virus seems to closely parallel, even mirror, Martin's portrayal of 'scheming diseases'. Fauci' s characterization of COVID-19's *agency*, its scheming, does —as Martin hypothesizes— generate more diffuse images, and presumably responses, than the hierarchal battle metaphor. It should, however, be noted that when describing planning for and mobilizing organizational resources to deal with the virus in India, Fauci reverts to the familiar war metaphor (Fauci, May 1, 2021).

Conclusion

Metaphors matter. And it appears that the 'struggle' metaphor advocated by Martin, already has some traction in practice among those like Ehrenreich and Fauci, who are deliberate in their choice of generative metaphors. Of course 'struggle' and 'outrage' can also have currency in battles too. And etymologists report that one of the earliest uses of the term 'backfire' referred to the "accidental backfiring of firearms" (*Online Etymology Dictionary,* 2021). Like viruses and diseases, language too has a mind of its own as a culture's collective unconscious.

My commentary has focused more on metaphors, which are themselves thought experiments, than on how the 'struggle' metaphor can be used to trigger backfire. I've also argued that power dynamics matter in determining what metaphors prevail in institutional settings, suggesting that one metaphor generally does not equitably fit all roles within complex systems or work for each of the diverse humans who play those roles. Anthropomorphizing diseases—thinking of them as strategizing and scheming—may, as Martin suggests, be useful in expanding the variables considered and the tactics used in efforts to counter the spread of disease. Exposing the actions of a virus like COVID-19, which uses symptomless humans as a medium to silently spread its 'evil', can, for example, motivate health conscious people to follow public health guidelines, and thereby 'frustrate' the virus' efforts. Similarly when the virus' powerful allies describe it as a 'hoax', scheming diseases undermine those public health efforts.

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