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# Metaphors for ‘good’ and ‘bad’ deaths

## A health professional view

Zsófia Demjén,<sup>1</sup> Elena Semino<sup>2</sup> and Veronika Koller<sup>2</sup>

<sup>1</sup>The Open University / <sup>2</sup>Lancaster University

This paper discusses the metaphors used by sixteen palliative healthcare professionals from around the United Kingdom in semi-structured interviews to describe what they see as ‘good’ and ‘bad’ deaths. The interviews, conducted for the large-scale “Metaphor in End-of-Life Care” project, are set against the background of contemporary practices and discourses around end-of-life care, dying and quality of death. To date, the use of metaphor in descriptions of different types of deaths has not received much attention. Applying the Metaphor Identification Procedure (Pragglejaz Group, 2007) we find that the difference between good and bad deaths is partly expressed via different frequencies of contrasting metaphors, such as ‘peacefulness’ and ‘openness’ as opposed to ‘struggle’ and ‘pushing away’ professional help. We show how metaphors are used to: evaluate deaths and the dying; justify those evaluations; present a remarkably consistent view of different types of deaths; and promote a particular ‘framing’ of a good death, which is closely linked with the dominant sociocultural and professional contexts of our interviewees. We discuss the implications of these consistent evaluations and framings in broader end-of-life care contexts, and reflect on the significance of our findings for the role of metaphor in communication about sensitive experiences.

**Keywords:** end-of-life care; hospices; medical communication; metaphor; death and dying; good death

### 1. Introduction

This paper focuses on metaphors used to describe ‘good’ and ‘bad’ deaths in semi-structured interviews with sixteen UK-based healthcare professionals in hospice or palliative care. We discuss the contrasting metaphors in terms of their relative frequency, evaluative function and the remarkably consistent framing they provide of a sensitive and highly subjective experience such as death.

The interviews that constitute our data were conducted as part of the “Metaphor in End-of-Life Care” (MELC) project at Lancaster University (see <http://ucrel.lancs.ac.uk/melc/>). The project investigated how healthcare professionals, patients and unpaid family carers use metaphor to talk about their experiences, attitudes and expectations of end-of-life care, and what this might suggest about their needs, challenges, and emotions, as well as potential causes of anxiety and/or misunderstanding. The project took place in the context of contemporary practices and discourses around end-of-life care, dying and ‘quality’ of death in the United Kingdom.

Metaphor involves talking and, potentially, thinking about one thing in terms of another, where the two ‘things’ are different but a similarity can be perceived between them (Semino, 2008). The ‘thing’ or experience being talked about — the topic or target domain — is often abstract, complex, subjective, intangible, or sensitive, while the other experience — the vehicle or source domain — is often more concrete, physical, tangible and intersubjectively accessible (Dancygier & Sweetser, 2014; Lakoff & Johnson, 1980). Metaphor is recognised in the human, social and cognitive sciences as a powerful phenomenon, which can reflect conventional and implicit ways of thinking, and help to overcome, but also contribute to, communicative problems. Terminal illness and the process of dying are highly individual, subjective experiences, often associated with physical discomfort or pain, feelings of anxiety, fear, isolation, and, potentially, shame. As such, these experiences belong to the kind of complex, subjective, and poorly delineated experiences that tend to be conventionally verbalised and conceptualised through metaphor (Kövecses, 2000).

While death and dying are still taboo topics in the UK, there is increasing recognition in the public sphere that talking explicitly about death and dying is necessary for as ‘good’ a death as possible. Modern hospice care, increasingly important as the UK faces an ageing population (Kelly, 2014), aims to facilitate a positive experience of the end of life through such explicit conversations and a holistic approach to the needs of patients with life-limiting or terminal illnesses. The first “End-of-Life Care Strategy” for England and Wales was published in 2008 by the UK’s Department of Health; 2012 saw the launch of the “Liverpool Care Pathway for the Dying Patient” (LCP) (since discontinued); and in 2013, the European Association for Palliative Care (EAPC) launched “The Prague Charter”, urging governments to “recognize palliative care as a human right”.

Despite such recognition, what counts as ‘good’ or ‘bad’ when it comes to dying remains highly individual, subjective and somewhat elusive, as attested by our interviewees. While recognising this, the healthcare professionals we interviewed were generally able to provide examples of what they considered good (as in

Example 1) or bad deaths (Example 2). In addition, they used a notably consistent set of metaphors to evaluate deaths as good or bad.

Example 1

the patient comfortable, the family erm at peace with the journey as it's going and where things have got to erm and that you know they can go through a natural normal grief. That to me would be a good death. (Interviewee 9<sup>1</sup>)

Example 2

they want to keep fighting fighting fighting and therefore they want all the stops pulled out to keep them going. So those are the sorts of deaths that are that are difficult (Interviewee 14)

In the rest of this paper we briefly outline some of the literature on metaphor and death, and metaphor and evaluation. We then introduce our data and methods and discuss the types of metaphors for death that our interviewees used. Finally, we reflect on the patterns and functions of these metaphors within the sociocultural context of end-of-life care in the UK.

### 1.1 Metaphor, evaluation, and death

Traditionally, studies of metaphor and death have been based on decontextualized or literary examples and have focused on conventional conceptual metaphors, such as DEATH IS SLEEP, DEATH IS DARK, DEATH IS A REAPER, DEATH IS A JOURNEY, DEATH IS DEPARTURE, DEATH IS THE END OF THE JOURNEY, DEATH IS AN ADVERSARY or DEATH IS REST (e.g., Lakoff, 2008; Lakoff & Turner, 1989; Ritchie, 2013). These conceptual metaphors tend to capture death as a concept or event, rather than a process with a period leading up to it. They also they tend to involve a very general evaluation of death as negative by default, based on the assumption that being alive is preferable to being dead. In contrast, in our data, death is not evaluated relative to life, but by comparing different ways of dying to each other. Previous studies in healthcare and hospice contexts tend to discuss metaphor implicitly in relation to quality of death (e.g., Steinhauer et al., 2000; Vig, Davenport, & Pearlman, 2002; Zimmermann, 2012) and often advocate a conscious and sensitive use of metaphor, especially on the part of professionals interacting with patients (e.g., Canter, 1988; Czechmeister, 1994; Reisfield & Wilson, 2004). To the

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1. The interviews were numbered based on the alphabetical ordering of the interview subjects' first names. For ease of readability, we lay out our extracts from the interviews as continuous text and use orthographic marks to provide minimal information about intonation contours: a full stop indicates falling or final intonation; a comma indicates continuing intonation, whether within or across clause boundaries; three full stops indicate a significant pause.

best of our knowledge, however, no studies have focused explicitly on what metaphors are used to describe a good versus a bad death, especially from a linguistic perspective.

The evaluative function of metaphors, on the other hand, is widely acknowledged, and often linked to ideological perspectives (e.g., Goatly, 2007; Lakoff, 1996; Lakoff & Johnson, 1980; Maalej, 2007). Summarising the literature, Deignan (2010) discusses four ways in which metaphors can evaluate: by entailments, by triggering ‘scenarios’ or ‘mini-narratives’ (cf. Musolff, 2006), by source domains that align the speaker with a particular group, and by exploiting the connotations of literal meanings. The fact that metaphor evaluates indirectly in these ways can be particularly useful in interactive situations involving vulnerable individuals and/or sensitive topics, as in our data.

The evaluative potential of metaphor is linked with its ability to frame topics in particular ways, highlighting some aspects and backgrounding others (Lakoff & Johnson, 1980; Ritchie, 2013). Different framings — “the process of using words and phrases to establish a particular way of thinking about a topic or a social interaction” (Ritchie, 2013, p. 106) — have potential consequences for how patients experience their situation and for how they are treated by healthcare professionals (cf. Thibodeau & Boroditsky, 2011). For example, if a good death is framed in terms of ‘openness’ with regard to what is happening, a healthcare professional will want to guide dying patients and their families towards explicit discussions that may not be welcome in all cases (cf. Scarre, 2012). As Walters (2004) puts it most poignantly:

The rhetoric of palliative care sets great store by the autonomy of the individual patient and the fulfilling of the latter’s wishes about how and where (if not when!) she chooses to die. In reality, however, this freedom can sometimes be compromised by the pressure of control towards what professionals consider to be a ‘good death’ (p. 406).

The concept of a good death in the UK surfaced at the beginning of the hospice movement and remains key in contemporary discourses on death and dying (Costello, 2006; Cottrell & Duggleby, 2016; Van Brussel & Carpentier, 2012). In the UK, the components of a good death from a health professional perspective can be summarized as: knowing when death is expected; having control of what happens, including symptom control, location of death, presence or absence of others; having dignity and privacy; having access to information, expertise, spiritual or emotional support, and appropriate hospice care; being able to issue advance directives; and having time to say goodbye (Smith, 2000).

A considerable amount of research supports these principles, and it is also generally acknowledged that certain aspects remain subject to unresolved ethical

debate. For example, there is evidence that people from various cultural backgrounds mention pain and symptom management as an important component of a good death (Seymour, Bellamy, Gott, Ahmedzai, & Clark, 2002; Steinhauser et al., 2000). At the same time, Seymour et al. (2002) note that it is difficult to know what constitutes the 'best interest' of dying people and that it may not be possible to preserve autonomy beyond the point at which dying people are able to make their wishes explicit. A number of studies have also emphasized the cultural and historical relativity of the notion of the good death (e.g., Van Brussel & Carpentier, 2012; Walter, 2003). Drawing on Walter (1994, 2003), Carpentier and Van Brussel (2012, p. 100) argue that the construction of a good death in late-modern Western societies relies on the notions of "control, autonomy, dignity, awareness, and heroism". This, they suggest, reflects a social context that is individualistic, increasingly secular, values independence, self-mastery, self-care, and believes in the power of medicine. This 'medical-revivalist' discourse of death, only emerged in the second half of the 20<sup>th</sup> century as a result of a combination of an already persistent medicalization of death with a perceived need to rehabilitate death from its earlier taboo status (Carpentier & Van Brussel, 2012; Seale, 2004; Van Brussel & Carpentier, 2012; Walter, 2003; Walters, 2004). However, even today, what counts as a good death is not the same around the world, or even within the 'Western' world. Cipolletta and Oprandi (2014) for example, point out that patient autonomy is considered important in countries like the Netherlands, Switzerland, and Australia, but less so in Italy and Sweden.

Despite such acknowledgements of the sociocultural variability of what counts as a good or bad death, the medical-revivalist discourse seems to dominate. Seale (2004) describes how media portrayals of death in the UK are highly consistent with the medical-revivalist approach "giving little space to the 'resistant' readings of the minority" who might prefer "reliance on others for decision making and a preference for avoiding information because 'ignorance is bliss'" (p.967). Even within a nation, especially a multicultural one like the UK, the dominance of one view could lead to the marginalisation of alternative views or minority groups (cf. Walter, 2003).

We now return to our interviews with sixteen UK-based healthcare professionals in hospice or palliative care. After a more detailed description of our data and methods, we focus on the metaphors they used to describe good and bad deaths and discuss the unified professional view that emerges.

## 2. Data and method

The semi-structured interviews with healthcare professionals were conducted in late 2012 at institutions spread across the UK and lasted between 40 minutes and an hour. All interviewees held leadership positions at their respective places of work; they were managers or team leaders, for example. The interviews were conducted by one of two of the authors, with both interviewers working from the same interview guide and avoiding topic-related metaphors as much as possible in their questions. The questions about good and bad deaths came towards the end of each interview and were expressed as: ‘How would you describe a good death? How would you describe a bad or difficult death? Can you provide any examples from your experience?’ The notion of the good death in particular is one that health professionals in end-of-life care regularly encounter and discuss in their professional practice (Low & Payne, 1996; Smith, 2000). As such, their responses are likely to have been informed by such professional discourses as well as publicly mediated talk about death and dying. For this paper, we focus on the stretches of text that interviewees produced in response to our good/bad death questions.

We identified metaphorical expressions in good and bad death descriptions through manual analysis using the established MIP procedure (Pragglejaz Group, 2007). According to this procedure, an expression is regarded as metaphorically used when (a) its ‘contextual meaning’ contrasts with a ‘basic meaning’ that is more physical and concrete (although not necessarily more frequent), and (b) where the contextual meaning can be understood via a comparison with the basic meaning (e.g., the use of *fighting* to describe an attitude to end of life in example 2 above). We used the corpus-based Macmillan Dictionary Online (<http://www.macmillandictionary.com/>) as a point of reference for the establishment of basic meanings. For the purposes of our analysis, we also classified as metaphorical a number of expressions where the relevant contextual meaning is also included in the dictionary. An example of such highly conventional metaphorical expressions is the use of the adjective *free* to suggest absence of pain (e.g. *pain free*). The relevant contextual meaning corresponds to one of the meanings listed in the dictionary (“not affected by something bad”), but (a) contrasts with a more concrete ‘basic’ meaning (“not held, or tied, or fixed to somewhere”), and (b) can be understood by comparison with the basic meaning (although we do not claim that this will necessarily happen in each particularly case of the production or reception of the expression). As will become clear below, this maximal approach to potential metaphoricity was particularly effective in capturing contrasts between descriptions of good vs. bad deaths in our data (e.g. Peace metaphors vs Violence metaphors, and Openness metaphors vs. Hiding metaphors).

The word was taken as one lexical unit for the purposes of metaphor analysis, with the exception of phrasal verbs (as identified by their labelling in the Macmillan dictionary) and proper nouns. For the purposes of quantification, therefore, the use of the adjective *open* in the noun phrase *open discussions* counts as one instance of metaphor in the data. We crossed part-of-speech boundaries in establishing basic meanings only where words belonging to different parts of speech shared the same base forms (e.g., *spider* as a noun and *spider* as a verb, as opposed to *base* and *basic*). We also included similes and other figurative comparisons in accordance with Steen et al. (2010)'s definition of 'direct metaphor' within the MIPVU development of the Pragglejaz Group's identification procedure. We excluded from the analysis common words and expressions that arguably lack sufficient semantic content to be able to establish a distinction between basic and contextual meanings, such as the deliteralised verbs *make*, *have*, *get* and *do* and the prepositions *for*, *of*, *with* and *about*.

The analysis involved all three authors using the collaborative online annotation tool eMargin (<https://emargin.bcu.ac.uk> 2011–2014). Metaphorical expressions<sup>2</sup> were highlighted and additionally assigned semantic tags or labels corresponding to their literal meanings (e.g. Violence, Journey, Machine and Sports/Games) in a data-driven fashion. These tags can be broadly related to the 'source domains' of Lakoff and Johnson's Conceptual Metaphor Theory. We kept the tags as close to the actual vehicle terms as possible, while still abstracting enough to arrive at meaningful categories (cf. Cameron, Maslen, & Low, 2010). Expressions that shared semantic tags and were used to describe a good or a bad death resulted in the 'vehicle groupings' (Cameron et al., 2010) that we discuss below.

### 3. Findings and discussion

Most interviewees emphasized that what constitutes a good death is entirely a matter of perspective and that it is therefore essential to give patients options, and to try to fulfill their wishes. Our interviewees recognized that most people wish to die at home, but emphasized the ways in which hospice care can actually provide patients and their families with a better overall experience. In fact, the good deaths

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2. Unless otherwise indicated, in the rest of this paper the term 'metaphorical expression' or 'metaphor' in relation to language use includes similes and other figurative comparisons, as well as the metaphorically used words captured by MIP (cf. Steen et al. (2010)'s distinction between 'direct' and 'indirect' metaphors in language). For the purposes of quantification, in similes each open class word or preposition relating to the 'source' or 'vehicle' domain was counted as one instance of metaphor in the data (but with the exclusions mentioned above).



that our interviewees described were often a result of successful intervention on their part, while bad deaths were often described as a result of interventions that were less successful due to external circumstances or to the attitudes of patients themselves and their relatives. We discussed this pattern and its relationship to professional identity in Semino et al. (2014).

Despite acknowledging the subjective and personal nature of evaluating a death as good or bad, most interviewees were able to give concrete examples of both in response to our questions. In all responses, metaphors were used to evaluate the different ways of dying, but there were differences between good and bad death descriptions in terms of both frequencies and kinds of metaphor use. To begin with, metaphors for end-of-life and dying were more frequent in descriptions of bad deaths, as shown in Table 1.

**Table 1.** Metaphor frequencies in good and bad death responses

	Total no. of words	No. of relevant metaphorical expressions	Relevant metaphorical expressions per 1000 words
A good death	5,305	167	31.5
A bad death	5,341	223	41.8

Based on a log-likelihood calculation, this difference between good and bad death responses is significant at  $LL = 7.69$ ,  $p < 0.01$ . As we show below, the metaphors describing bad deaths also tended to be more complex and elaborated in the sense that they often involved dense clusters of different source domains. This seems to be consistent with Cameron's (in press) hypothesis that metaphor favours the negative. However, the relative frequency and creativity of metaphorical expressions can also be indicative of the intensity of emotion that speakers feel towards the topic. Gibbs, Leggitt, and Turner (2002) note that metaphors are more frequently used to describe intense emotional topics, while Ortony and Fainsilber (1987) found that a higher percentage of novel or creative metaphors are used when intense emotions are involved. The higher frequency of metaphors in bad death narratives could therefore indicate that bad deaths are more emotional, sensitive or difficult to talk about, even for professionals. In Semino et al. (2014) we noted that this may partly be related to the fact that the very existence of bad deaths is a potential challenge to the interviewees' professional identities, and to the fact that their accounts of bad deaths often involved rhetorically sensitive criticisms of the patients themselves.

Aside from these overall differences in frequency and creativity, the metaphors that described good and bad deaths were highly consistent across interviewees, although different for good as opposed to bad deaths.

### 3.1 A good death

The extracts below show how, according to our interviewees, a good death involves having *reached a stage of acceptance*, being *at peace* and *pain free*, with *controlled or managed* symptoms. Achieving this state is sometimes described as resulting from *open* conversations with family members, and 'preparing' for the *end*.

#### Example 3<sup>3</sup>

for me I suppose it's a good death ... it's about peacefulness you know and having peace being peaceful being comfortable you know being at peace with yourself but also with the your surroundings erm being as comfortable and pain free, I think pain free is to the a the crucial element to it (Interviewee 3)

#### Example 4

she was able to accept that it was the end so I think that's what you would call a good death. Where both the patient and the family have reached the stage of saying this is now where where it needs to end. (Interviewee 14)

#### Example 5

so there's an acceptance that they're dying erm and I think part of it being able to let probably to let go and also maybe having that permission from their family that they can let go as well. (Interviewee 2)

#### Example 6

patient can be sort of prepared and sort of you erm they're just quite accepting and pain management works well and symptoms are managed (Interviewee 1)  
a symptom controlled erm death (Interviewee 7)

#### Example 7

So it's having those kind of open discussions with them to try and erm give them the options (Interviewee 8)

The metaphorical expressions we identified in these extracts, and in good death descriptions more generally, were subsumed under the following vehicle groupings:

- Movement and Location (e.g., *reached the stage of*)
- Acceptance/exchange (e.g., *accept*, *acceptance*)
- Peace (e.g., *peace*, *peaceful*)
- Freedom (e.g., *pain free*)
- Control (e.g., *symptom controlled*)
- Openness (e.g., *open discussion*)

These expressions are highly conventional in English generally, but are used in a specific way by our interviewees as members of a particular professional discourse

3. In these examples, metaphor vehicles related to the topic of end-of-life care are underlined.

community (Deignan, Littlemore, & Semino, 2013). Most interviewees agreed that a good death is characterized both by a positively evaluated attitude or atmosphere that is described as ‘peaceful’ and by the absence of negative physical sensations, such as pain. The latter are implicitly presented as potential restraints by means of the adjective *free*. Sometimes, when absolute freedom from such symptoms is not guaranteed, the objective becomes to have them ‘under control’ or well-managed. Similar views were found by Low and Payne (1996) among nurses and social workers, who associated a good death with being able to control the patient’s symptoms and help them prepare for and accept death. Interestingly, in our data there is a complex interaction between these various metaphors of a good death.

For instance, ‘peace’ at the end of life is not only contingent on the absence of negative symptoms, but also on the patients’ and families’ attitudes, specifically *acceptance*. As a result, both Peace and Acceptance/Exchange metaphors (which include expressions such as *give*, *provide*, and *receive*) can be seen as counterparts to the Battle or Violence scenario that, as we show below, is regarded as leading to a bad death. However, as the Movement metaphor *reached* in Example 4 shows, the attitude of acceptance is not a given but needs to be obtained or arrived at through a mental journey on the part of patients and families. This resonates with what Seale (1998, p. 92) described as the socially valued “inner-directed heroics of the self”, or the effortful emotional progress from denying, to fighting, and finally accepting death. The notion of the dying person’s mental journey towards acceptance reflects the influential model, most famously propagated by Kübler-Ross (1969), of five stages in attitudes towards death and dying: denial and isolation, anger, bargaining, depression and finally acceptance. At the same time, however, Scarre (2012, p. 1084), echoing Walters (2004), argues that asking people to accept their own death may be unrealistic and unwarranted.

The mental journey towards *acceptance* is helped by ‘preparation’ (which, for the purposes of this analysis, we subsumed under the broad Control group) through explicit conversations in which the patient and his or her family acknowledge to themselves and to one another that the patient is dying (Example 7). These are referred to by Openness metaphors and the verb *address*. The metaphorical use of *open*, with its associations of open doors and arms, helps to convey a positive evaluation of these explicit conversations, which are assumed to be necessary for controlling — i.e. articulating wishes and making decisions regarding — one’s death.

In addition to this mental journey, another type of journey is referred to in these examples via Movement and Location metaphors: life itself. Death is described as the *end* of LIFE AS A JOURNEY, where the living need to *let go* of the dying and vice versa. To some extent, these Movement and Location metaphors provide useful vocabulary for talking about death euphemistically, as in the case

of *end* and *let go*. In addition however, they also help to integrate the deaths that our interviewees consider to be good into the conventional LIFE IS A JOURNEY conceptualization. In this way, the frequent use of these metaphors in descriptions of a good death, in contrast with their absence in descriptions of a bad death (see below) implicitly normalizes these so-called good deaths. They are presented as very much in line with the LIFE IS A JOURNEY conceptualization of everyday experience. Of course, death is the natural end to life, but these metaphors suggest that perhaps only a good death, as described by the professionals, is such a natural end. This evaluation may or may not be shared by patients and carers, and it may affect how professionals approach their work (cf. Zimmermann, 2012).

In fact, professional practice, training and identity seem to play an important role in constructing other aspects of a good death as well. The various Control metaphors in Example 6 (*prepared, controlled*) for instance, denote a kind of control by proxy. The control is exercised by the medical professionals, but is in accordance with patients' wishes. Van Brussel and Carpentier (2012, p. 485) call this the "articulation of the subject position" of the dying person as in control of their death but "without detaching it completely from the medical field". From a professional identity perspective it is understandable why our interviewees consider control to be such a crucial aspect of a good death (and why its counterpart 'uncontrolled' is often implicated in bad deaths): this control is the active manifestation of their role; it is what they can actually do (cf. Costello, 2006; Low & Payne, 1996). Acceptance and openness are also presented as absolutely essential to a good death by our interviewees. Similar patterns have been noted and critiqued by Van Brussel and Carpentier (2012) and Zimmermann (2012). Zimmerman for example questions the motivation behind the requirement of acceptance and suggests that arriving at that attitude not only facilitates the dying process "but also renders care easier" (2012, p. 217). Others have also questioned such an uncritical promotion of the acceptance of death, especially when combined with criticism of the 'battling attitude' (e.g., Bennett, 2013). Regarding the Openness metaphors, it could be argued that, from a different perspective, explicit conversations about death might be perceived by some patients and their families as unnecessarily distressing and harrowing experiences, and, where hospice staff are involved, as unwelcome or unnecessary intrusions.

### 3.2 A bad death

In contrast with the good deaths of the previous section, bad deaths are described as involving a lack of 'acceptance' of death on the part of patients and family members, and a 'pushing away' of professional help or *support*. Patients who experience a bad death are described as seeing death as an opponent against which to 'struggle'

or ‘fight’ (also in Example 2 in the introduction) in order to ‘keep going.’ External circumstances and various life choices are also described as contributing to a bad death. Patients’ problems, ‘conflicts’ or ‘tensions’ within families are sometimes *amplified* or *highlighted*, while at other times they remain *in the background* or in a *place* inside the patient that hospice staff are not allowed to *reach* or which cannot be *addressed* or ‘sorted out.’ In this way, ‘control’ is again an important aspect of the descriptions of bad deaths, with the absence of ‘control’ leading to the negative outcome. The extracts below are typical of interviewees’ accounts of bad deaths.

#### Example 8

where there is some tension or discord and it almost gets amplified (Interviewee 1) there can be a lot of anger and concern, which has been highlighted because someone is dying. So I think ... dying you know where we can’t get the symptoms completely under control erm dying perhaps where they didn’t really want to die but circumstances they’ve landed up there erm and somebody who really still hasn’t reconciled themselves and they want to keep fighting fighting fighting and therefore they want all the stops pulled out to keep them going. So those are the sorts of deaths that are that are difficult. (Interviewee 14)

#### Example 9

so they are the deaths that I think that are psychologically difficult where somebody where somebody not only doesn’t want to address it, cos people can die OK not having addressed it and be OK. But it’s where they’ve not addressed it but actually there’s a lot of fear in the background or a lot of battling in the background. And so you’d get this kind of horrible overlay of pretending it’s not going on, but actually they’re really scared and you can’t quite reach into the scared place to support them, because they won’t let you, but you know it’s there. So I find those deaths really ... difficult, where the conversations that needed to happen haven’t happened where the support’s been pushed away (Interviewee 7)  
the person isn’t settled [...] there’s just something going on internally that they can’t quite settle with (Interviewee 9)

#### Example 10

they haven’t accepted yet that [...] they’re going to die (Interviewee 2)

#### Example 11

As a nurse that’s part of your make up, your training. You go in, you get people sorted and she wouldn’t let me sort her ... as I felt she needed to be sorted (Interviewee 16)

#### Example 12

a bad death, entirely the opposite, the things are out of control, the family are angry, the erm patient is distressed thrashing around erm it just doesn’t feel under control. (Interviewee 6)

These examples show that descriptions of bad deaths do not just contain a larger relative number of metaphorical expressions, but also involve a greater variety of semantic domains and greater complexity in terms of how they are combined. The extracts above include:

- Hearing and Vision metaphors (e.g., *amplified, highlighted*)
- (Negated) Control metaphors (e.g., *can't get [...] under control, out of control*)
- Violence metaphors (e.g., *fighting, battling*)
- (Negated) Acceptance/exchange metaphors (e.g., *haven't accepted*)
- Hiding/Invisibility metaphors (e.g., *in the background*).

These main groups co-occur with:

- Movement and Location metaphors (e.g., *landed up there, keep going, place*)
- Building/construction metaphors (e.g., *make-up, support*)
- Container metaphors (e.g., *reach into the scared place, internally*).

As the examples show, several of these different types of metaphors often occur in close proximity to describe the circumstances that lead to a death being bad. All of these metaphors help to express the interviewees' challenges, practices, frustrations and evaluations, not just of the death, but also of the individuals involved.

The Violence metaphors in these examples (e.g., *fighting, battle*, but also *isn't settled*) represent a counterpart to the metaphors of 'peace' and 'acceptance' that we identified in descriptions of good deaths. There are two types of 'battles' that can lead to a bad death: those that refer to a way of living one's life generally and those that refer to attitudes towards death. The use of Violence metaphors to describe these attitudes and ways of life allows the healthcare professionals to offer a negative evaluation of vulnerable individuals indirectly by exploiting connotations of the literal meanings of the vehicles. In fact, Scarre (2012) argues that normally there is insufficient recognition of the fact that personality traits and characteristics also contribute to the quality of death, so the indirect recognition displayed by our interviewees that people die the way they live may be evidence of increasing professional insight.

A further counterpart to patterns we demonstrated in good death descriptions are the metaphors describing things being *in the background* and difficult to *reach* (also *overlay*) (Example 9). These contrast with the openness valued in good deaths. Hospice staff see it as part of their role to enable patients to discuss their most intimate feelings and fears, and to discuss explicitly the fact that they are dying with them and/or with their families. The cases where this does not happen are negatively evaluated, and these metaphors help to express that. Openness as good combined with Hiding/Invisibility as bad presents another comprehensive and coherent professional framing.

The absence of control in two different senses is also an important factor potentially leading to bad deaths and again represents a counterpart to the existence of control in good deaths. It is seen as detrimental to the situation if the patient feels that they have no control over their own destiny (e.g., *landed up there*), as opposed to having their wishes fulfilled (cf. Smith 2000). In Example 8, the patient's agency or ability to control is effectively reduced to unfulfilled mental processes of volition (repetition of *want*). Similarly, it is also important for the professionals to have proxy control over the situation (as in Example 6), fulfilling patients' wishes when they are unable to realize them themselves. The absence of this leads to a bad death (Example 11 and Example 12) (cf. Costello, 2006).

There is a similar kind of complex interaction between the vehicle groups here as we described for good deaths. Metaphorical violence (both as an attitude towards death and towards other people) prevents *acceptance* and the interviewees from doing their job, which in turn prevent a good death. The kinds of antagonistic attitudes described are often a result of things *in the background*, or not being *addressed*, i.e. the absence of *open* conversations. This inter-relationship is the converse of the good death scenario and is therefore also consistent with the dominant discourse of a good death (Cottrell & Duggleby, 2016; Seale, 2004; Van Brussel & Carpentier, 2012; Walter, 2003). It is worth noting the absence of conventional LIFE IS A JOURNEY metaphors, or other movement metaphors that would easily integrate into it. Although there are Journey metaphors, they are negated or presented as reflecting unrealistic and potentially inappropriate expectations. In example 8, the use of *keep going* and *all stops pulled out* contrasts with the acceptance that the journey must end and the attitude of 'letting go' from the good death examples. As we pointed out above, linguistic manifestations of LIFE IS A JOURNEY help to integrate or normalize the types of death that our interviewees considered to be good. Their absence in bad death descriptions suggests that such deaths are not only bad, but also less 'natural' than the kinds of deaths that are described as good.

The fact that several of our interviewees produced such complex but coherent combinations of metaphors suggests that these ways of thinking about what makes a death bad are well established and relatively stable conceptualizations. In the concluding section below, we reflect on the significance of these consistent framings for the vulnerable individuals involved.

#### 4. Concluding remarks

In this paper we discussed the metaphors used by sixteen UK-based hospice professionals to describe good and bad deaths. We found that a good death involved

being *at peace*, *free* of negative symptoms, and 'accepting' death as the *end* of one's 'journey', having had *open* conversations with healthcare professionals and family members. Some of these metaphors helped to normalize the deaths that our interviewees considered to be good by integrating them into the LIFE IS A JOURNEY conceptual metaphor. By contrast, a bad death involved opposing conceptualizations: a lack of 'acceptance' of death and a 'pushing away' of professional help; problems *in the background* or in a *place* inside the patient that hospice staff are not allowed to *reach*; as opposed to 'peace' there was a 'struggle', *battle* or 'fight' against death in an effort to keep going. Our comprehensive approach to metaphor identification was particularly appropriate for capturing the different conceptualisations suggested by these lexical contrasts.

Our study confirmed the importance of metaphor in talking about sensitive and relatively inaccessible experiences such as death, and examined a different metaphorical construction of death from what has been discussed so far in the literature on metaphor. More specifically, we found that bad death descriptions contained more frequent and more complex metaphors than good death descriptions. This may reflect the intensity of emotion that bad deaths evoke in our interviewees, and the rhetorical challenge involved in explaining how they occur. The very existence of bad deaths is a potential challenge to the interviewees' professional identities, and accounts of bad deaths often involve criticisms of the patients themselves. Metaphors are mostly used in our data to express evaluation, and, in some cases, to criticize indirectly patients' attitudes and life-styles in a context where explicit criticism would not be appropriate. In fact, the metaphors in our data do not only evaluate different ways of dying; they also support the interviewees' general arguments for the role of hospices and hospice staff in facilitating good deaths and avoiding bad deaths. This is not surprising: Steinhauser et al. (2000) found that social and professional roles shaped the views of their participants on a good death more than age or gender.

We commented throughout on the consistent framings of good and bad deaths via the metaphors used in our interviews. Not only did the metaphors for good deaths have their opposite counterparts in bad death descriptions, suggesting coherent scenarios, but there was also notable uniformity amongst the interviewees themselves. This may partly be due to the fact that the interviewees had potentially similar educational and training backgrounds, despite working at different institutions, and responded to the questions about good and bad deaths from a professional point of view. Their answers may well have shown more variation if they had interpreted them from more personal perspectives.

Nevertheless, what seems to emerge is that, despite an explicit verbal recognition that, when it comes to dying, what counts as good or bad is highly individual and subjective, there is in fact a stable and unified professional view of what counts



as and leads to each of these kinds of death. While we have to leave generalisations about how people conceptualise other difficult situations to future research, the stability, consistency and coherence of metaphors in our study could be signalling a certain hegemony of dying (cf. Van Brussel & Carpentier, 2012) which may potentially preclude alternative perspectives. An open awareness of impending death, for example, has only recently been re-accepted as part of a good death (Van Brussel & Carpentier, 2012) and this social construction may not (yet) be shared by everyone. In fact, Payne, Langley-Evans, and Hiller (1996), conducting interviews with patients and staff in a palliative care unit, found that staff's descriptions showed greater uniformity, while patients' views on what constitutes a good death were more heterogeneous (see also Vig et al., 2002).

The discrepancy between a unified, consistent professional view of what a good death is and the more heterogeneous lay view could potentially be a source of conflict/tension in end-of-life care. A number of scholars have noted that a dominant professional view will influence the kind of guidance and advice health professionals give patients and their families (e.g., Costello, 2006; Walters, 2004; Zimmermann, 2012). Perhaps more importantly, it could prevent those with alternative views from voicing their wishes and receiving the end-of-life care that *they* believe will lead to a good death. As we have shown, metaphors are an important part of how these different views are expressed and reinforced.

Analyses of the metaphors used by members of different stakeholder groups in end-of-life-care can identify areas of convergence and divergence, and contribute to a greater awareness and acceptance of non-dominant views and to the achievement of more sensitive and effective communication among healthcare professionals, patients and their families.

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### *Corresponding author's address*

Dr Zsófia Demjén  
 Department of Applied Linguistics and English Language  
 The Open University  
 Milton Keynes  
 MK7 6AA  
 UK

zsafia.demjen@open.ac.uk

### *Biographical note*

**Zsófia Demjén** is Lecturer in English Language and Applied Linguistics at The Open University. Her research focuses on the intersections of language, mind and health(care). She is author of *Sylvia Plath and the Language of Affective States: Written Discourse and the Experience of Depression* (2015, Bloomsbury) and co-editor of the *Routledge Handbook of Metaphor and Language* (forthcoming). Her most recent projects investigated metaphor in end of life care and language in the experience of schizophrenia.

**Elena Semino** is Professor of Linguistics and Verbal Art in the Department of Linguistics and English Language at Lancaster University. She works in the areas of stylistics, metaphor theory and analysis, health communication and corpus linguistics. She is author of *Metaphor in Discourse* (2008, CUP), co-author of *Figurative Language, Genre and Register* (2013, CUP; with Alice Deignan and Jeannette Littlemore) and co-editor of the forthcoming *Routledge Handbook of Metaphor and Language*.

**Veronika Koller** is Reader in the Department of Linguistics and English Language at Lancaster University (UK). Her research interests are in discourse analysis and metaphor, which she applies to health communication, corporate discourse, and language and sexuality. Her publications include *Metaphor and Gender in Business Media Discourse* (Palgrave 2004), *Handbook of Communication in the Public Sphere* (co-edited with Ruth Wodak, de Gruyter 2008) as well as numerous book chapters and journal articles. Her most recent work addresses issues of metaphor, cancer and the end of life.