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Résumé

De la pertinence du terme *approprié* : la « contrebande » des valeurs en milieu clinique

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Le terme *approprié** est devenu un élément clé du jargon employé en milieu clinique dans les échanges avec les patients et leurs familles et les discussions les concernant. Les auteures s'appliquent à décortiquer ce qualificatif en apparence anodin et ses implications pour la prestation des soins. Elles se questionnent d'abord sur le rôle du terme dans le discours clinique, d'un point de vue théorique et historique. Son origine serait de nature grammaticale et morale; il trouverait sa source à la fois dans la distinction qu'on a établie, au XIX^e^ siècle, entre le *normal* et le *pathologique* et dans la médicalisation du comportement qui s'est ensuivi au XX^e^ siècle. La réflexion proposée ici touche à la théorie rhétorique et à l'histoire des statistiques et de la psychologie, tout en prenant appui sur l'exemple des soins pédiatriques. Les auteures avancent que l'usage du terme *approprié* favorise une sorte de « contrebande » des valeurs dans les échanges en milieu clinique, susceptible de marginaliser les patients et de compromettre l'intégrité de la relation thérapeutique. Dévoilant les éléments discursifs (moraux) du terme, elles incitent les lecteurs et lectrices à réfléchir à leur façon de s'adresser aux patients et à leurs proches et de traiter des questions qui les concernent.

*Note de traduction : l'analyse proposée ici par les auteures concerne plus précisément l'emploi du terme anglais *appropriate*.

Mots clés : discours, normal, pathologique

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The Appropriateness of *Appropriate*: Smuggling Values into Clinical Practice

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The word *appropriate* has become an institutional given, part of the clinical jargon used in discussions with and about patients and families. The authors unpack *appropriate,* arguing that this seemingly innocuous word has implications for clinical practice. They begin with the theoretical and historical question What does *appropriate* "do" in clinical discourse? The answer is both grammatical and moral, rooted in the 19th-century distinction between *normal* and *pathological* and the 20th-century medicalization of behaviour. The examination references rhetorical theory and the history of statistics and psychology, and it uses pediatric health care as an example. The authors argue that the use of the word *appropriate* facilitates the smuggling of values into clinical encounters, which can marginalize patients and compromise therapeutic relationships. In uncovering the discursive (moral) elements of *appropriate,* they challenge readers to critically reflect on how they speak to and about patients and families.

Keywords: Discourse, language, family-centred care, moral reasoning, normal vs. pathological

Introduction

Every day, in every clinical setting, the word *appropriate* is heard. It has become a ubiquitous euphemism, a codified linguistic device with multiple meanings. One use of *appropriate* in clinical decision-making is for communicating whether the risk/cost/value trade-off of an intervention is sufficiently compelling to justify its initiation, continuation, or abandonment. Another use is for implying that an intervention is a "best fit" for the intended outcome. A common use of the word is as a comparator — for instance, to describe supportive care as an alternative to aggressive third-line chemotherapy. The word is also employed to describe strategies for reducing the use of health-care resources and to describe the shoring up of personal opinion under the guise of unbiased scientific certainty.

During the first author's ethnographic fieldwork on family experiences of life-threatening illness in a pediatric intensive care unit, *appropriate* (and its converse, *inappropriate*) became increasingly noticeable. Macdonald noted the frequent yet varied use of the word by clinical staff. Nurses, physicians, social workers, and physical therapists used it throughout their discussions with and about patients and family members.

Simultaneously, the second author, in reflecting on her long experience in acute and palliative care, observed that the word increasingly arose in conversations among clinicians and between clinicians and patients. It served as a device for conveying normative messages within seemingly neutral sentences. Murray observed a heavy reliance on the word during family meetings around the goals of care, during interprofessional team rounds, and during teaching moments with undergraduate and graduate physicians and nurses.

Anthropology encourages the scrutinizing of language, the questioning of what a linguistic device does. While *appropriate* appears to be a simple word, upon reflection it becomes clear that something is lurking behind its frequent use in the clinical setting, that it is employed in complex and multivalent ways that extend its simple adjectival function. What is truly appropriate is often a matter of debate among clinicians and between clinicians and patients and their families. Further, the use of *appropriate* as a normative descriptor is at issue for both the health-care system and consumers of health care.

One of nursing's key social roles is to foster health, to facilitate "human betterment" (Rogers, 1987). This requires that the therapeutic relationship be grounded in respect and trust, fundamental to which are clarity and transparency. Close inspection of implicit and explicit messages conveyed in and through language is thus an important exercise for the health professions, including nursing. This article is intended to contribute to that process. The authors, an anthropologist and an Advanced Practice Nurse, unpack the word *appropriate*. Though an ostensibly simple term, it harbours myriad meanings and values, from grammatical to moral. We theorize why *appropriate* is so prevalent in clinical language and what this says about clinical practice.

Clinical Uses of *Appropriate*: What Does It "Do"?

The word *appropriate* is rooted in Middle English and Latin, made up of *appropriare* (to take possession of), *ad* (to), and *proprius* (one's own).[1] In its adjectival form, the word describes that which is suitable for a particular person, condition, occasion, or place; that which is fitting, relevant, pertinent, or apt.[2] Following rhetorical theory (Segal, 1997), in clinical settings the word *appropriate* operates on two levels: grammatical and discursive.

[1] *Merriam-Webster Online:* http://www.m-w.com/.

[2] *Appropriate* can also be used as a transitive verb — that is, a verb construction that requires a direct object. To appropriate is to take or make use of something without authority or right; to confiscate or usurp. The noun would then be appropriation. While the two forms are tangentially related, only the adjectival form is discussed in this article.

Table 1 ***Clinical Uses of the Word* Appropriate**

	Condition		Person	
	Physical	**Behavioural**	**Patient**	**Family**
The child's growth was appropriate for his age.	X		X	
The mother's tears were appropriate given the news she had just received.		X		X
The child's neurological test showed that he was "completely appropriate neurowise."	X		X	
A father's series of questions was described as "inappropriate."		X		X
A child who was calm was said to be "unremarkable" and was being "appropriate" with her parents.		X	X	

Clinical Grammar: Appropriate *as a Descriptive Technology*[3]

Table 1 provides examples of the clinical use of *appropriate* by health professionals in a pediatric intensive care unit.[4] The two columns on the right indicate the target of the adjective *appropriate:* (a) condition (physical or behavioural), and (b) person (patient or family member). As the table shows, at the level of grammar *appropriate* describes or qualifies two categories of clinical concern in two populations.

Physical/patients. The word is employed clinically as a descriptor for the physical condition of the patient. In the sentence "The child's growth was appropriate for his age," *appropriate* refers to a growth rate that is considered normal or average. The child's growth rate falls within the

[3] In using the word *technology,* we are referencing Foucault's use of the term. Foucault (1970), for example, uses *technology* to refer to both tools and devices as well as structured behaviours and practices with which humans exercise power over nature as well as themselves.

[4] Taken from ethnographic fieldnotes recorded in the pediatric intensive care unit of a tertiary care teaching hospital in a large Canadian city. For more on this study, see Macdonald et al. (2005) and Macdonald, Liben, and Cohen (2006).

norm and thus does not require intervention. Had it been *inappropriate,* it could have resulted in clinical investigation and intervention.

Behavioural/patients and families. *Appropriate* also serves as a behavioural descriptor, for both the patient and family members. In the sentence "The mother's tears were appropriate given the news she had just received," *appropriate* refers to what is considered clinically acceptable behaviour for a parent. Had the mother's tears been *inappropriate,* her sadness might have warranted clinical intervention; for example, it could have ultimately been diagnosed as "pathological" or "complicated."

Thus, *appropriate* is a linguistic device for distinguishing that which is clinically "normal" or acceptable from that which is not. Appropriate physical or biological markers and social behaviours typically do not require intervention; inappropriate ones might. At the level of grammar, therefore, *appropriate* is a *descriptive technology* with three key functions: (1) it is a linguistic tool used by clinicians to distinguish the normal from the pathological; (2) it collapses two disparate categories, the physical and the behavioural; and (3) it describes the behaviours of family members in addition to those of patients.

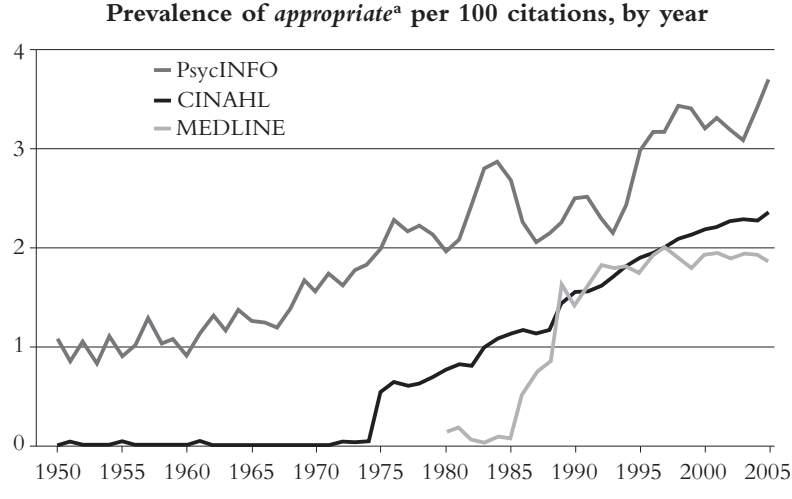
Clinical Discourse: **Appropriate** *as a Moral Technology*

Beyond grammar, *appropriate* can also be examined at the level of the clinical discourses in which it is embedded. Clinical discourse is a cultural product comprising many elements. As with Habermas's (1987) description of the validity claims that underlie speech (e.g., the intention to optimize inter-subjective understanding via truth, rightness, truthfulness, comprehensibility), clinical discourse contains several elements. While clinical language may, on the surface, appear neutral, objective, drawn from value-free science, close examination reveals that myriad meanings and values surround and accompany its use. Embedded in clinical discourses are grammatical, moral, social, and political practices and agendas. The increasing prevalence of binary oppositions in nursing theory and practice is a case in point (Thorne, Henderson, McPherson, & Pesut, 2004). We argue that, at the level of discourse, *appropriate* acts as more than a mere descriptive technology; it also acts discursively as a *moral technology* — it becomes a metaphor used not simply to flag but also to *pass moral judgement* with respect to the normal and the pathological. Clinical discourses are not static entities; they should be understood as constantly evolving as jargon, definitions, values, and topics are adopted or discarded. A review of various medical and allied health databases reveals an interesting perspective on the use of *appropriate* in health texts. As seen in Figure 1, the word is a relatively recent addition to the clinical vocabulary. In this example, the truncated form of *appropriate* was entered into three fields (keyword, title, and abstract) of three health databases

(MEDLINE, CINAHL, and PsycINFO) to produce a snapshot of its prevalence over time.[5]

If the published reports in Figure 1 are any indication, the term *appropriate* may have entered the clinical arena via psychology and then spread to medicine and nursing; regardless, the term remains common in the literature of these disciplines today. Why it entered the clinical arena when it did, why its use steadily increased in the last quarter of the 20th century, and what all of this means for current practice requires an examination of two elements: (1) rhetorical theory, and (2) the history and values behind the introduction of the word into health care.

Figure 1 ***The Prevalence of* Appropriate *in Health-Care Literature***



[a] Our database searches used a truncated form of *appropriate* (appropriat) to ensure the inclusion of all words beginning with this text string (e.g., appropriate, appropriately, appropriateness).

Metaphor and Rhetoric[6]

English is rife with metaphoric expressions (Lakoff & Johnson, 1980). While a metaphor may appear to be a benign figure of speech, close scrutiny reveals its polyvalent and value-laden nature. For example,

[5] A content analysis of the term is beyond the scope of this article.

[6] This discussion of metaphor and rhetoric is taken partly from Macdonald (2003), where a similar argument is made about health policy as a political technology.

a metaphor may be employed to disguise or excuse: Was the death a "medical failure" or did "nature take its course"? Rhetoric, a linguistic tool of persuasion, uses metaphor as a vehicle for expressing values (Segal, 1997). Comparison of the terms *fetus* and *preborn child* makes this point clear: the term *preborn child* may rhetorically convey values such as found in right-to-life movements (be they religious or humanitarian), whereas *fetus* may be used to convey values of scientific neutrality and objectivity. "When values are explicit they may be openly debated but rhetoric uses metaphor to smuggle values into discourse that proclaims itself rational, even-handed and value-free" (Kirmayer, 1988, p. 57). Contrasting the explicit values in the phrase "withdrawal of care," commonly heard in intensive care settings, to the more implicit values in the phrase "inappropriate approaches to care" demonstrates how subtle this smuggling can be.

Segal (1997) reminds us that the terms in which a debate is framed will constrain what can be discussed within that debate. For example, the "medicine as a business" metaphor commodifies health care, turns patients into "health-care consumers," and frames any crises as economic, their solutions to be found in financial or managerial reconfiguration and the economic bottom line. A rights-based metaphor projects a very different image of health care. In order to critically examine a discourse, one must scrutinize the terms, phrases, and metaphors commonly employed within it. Following Kirmayer (1988) and Segal, "waking up" and interrogating metaphors in the clinical setting allows us to unpack the "institutional givens" entrenched in the disciplinary jargon (Montgomery, 1996, in Segal).

If *appropriate* is a metaphor, what is it referencing and what values is it "smuggling" into the clinical arena? Taking our cues from both Table 1 and Figure 1, we will begin the "waking up" process by looking at the history of scientific values, focusing on the 19th-century distinction between the "normal" and the "pathological." Currently, *appropriate* appears to be serving as a politically correct proxy for *normal,* a word no longer in vogue. To make this point, we examine the rise of statistical science and the concomitant development of psychology as a science intent on defining the normal and the pathological via various measurement tools and the refining of its professional mandate. Further, we use pediatric medicine to illustrate the 20th-century medicalization of behaviours with the extending of the pediatrician's clinical gaze onto the family.

The Normal *and the* Pathological

The noted philosopher of science Ian Hacking (1990) draws on the seminal work of Canguilhem (1991) to show that the modern concept

of "normal" took over from where the Enlightenment concern for "human nature" left off. The word *normal* has two essential roots.

1. *Normal* entered European languages through its Latin form, *norma,* from geometry. In geometry, *norma* referred to a perpendicular T-square or right angle, a synonym for orthogonal. The root of the word *orthogonal* is *ortho-*, Greek for "straight," "right," or "correct." Thus, embedded in *orthogonal* are both the descriptive (right angle) and the evaluative (right or good). Hacking explains that *ortho-* continues to have this dual meaning in English: orthodontists straighten teeth, making them right; orthopedic surgeons make broken bones right; orthodox religions are straight, ostensibly the true or correct interpretations.

Thus, as Canguilhem (1991) argues, embedded in *normal* are both the factual/descriptive and the evaluative. For example, a norm is both what is usual or typical and what is morally right (e.g., ethical norms). According to Hacking (1990), "One can, then, use the word 'normal' to say how things are, but also to say how they ought to be. The magic of the word is that we can use it to do both at once" (p. 163).

2. Modern usage of the word *normal* also stems historically from a medical context. The ontology of disease in the late 1700s focused on pathological organs, disease being attributed to individual organs, not the entire body. Thus, "Pathology became the study of unhealthy organs rather than sick people" (Hacking, p. 164). Originally, the normal was viewed as secondary to the pathological: That which was not pathological was seen to be in a "normal state." In the positivist philosophy of Auguste Comte, "normal state" was transformed and placed at the centre and the pathological state was seen as deviating from the centre. The pathological state was considered not as radically different from normal but as a variation of it and defined in relation to it (Hacking, p. 166).

Through Comte's positivist philosophy, *normal* transcended the medical sphere to enter the social and political realm. During this transformation, *normal* took on an element of "ideal" as seen in the early *norma:* "The normal ceased to be the ordinary healthy state; it became the purified state to which we should strive, and to which our energies are tending. In short, progress and the normal state became inextricably linked" (Hacking, 1990, p. 168).

A fundamental tension was created within the word *normal:* On the one hand, it represented the average; on the other, it represented the perfection for which one strives. This tension was borne out in debates between sociology and statistical science, in which the normal was cast as

either the status quo, with any deviation seen as pathological, or simply average, with excellence at one extreme of a normal distribution. Thus, contends Hacking (1990), "The normal stands indifferently for what is typical, the unenthusiastic objective average, but it also stands for what has been, good health, and for what shall be, our chosen destiny. That is why the benign and sterile sounding word 'normal' has become one of the most powerful ideological tools of the twentieth century" (p. 169).

From Pathology to Psychology

A related phenomenon in the 19th century was the increasingly prominent role of quantification, particularly in shaping popular and scientific epistemologies. Both the desire and the ability to enumerate populations grew throughout the 1800s as European states developed institutions to collect and publish numbers (around issues such as taxation, crime, and public health). The potential of the resultant "avalanche of printed numbers" (Hacking, 1990, p. 2) for population management and control became evident as the century progressed, adding to the sophistication of statistical science.

Psychology was particularly enamoured of the potential of quantification and statistics. While early psychology relied on the individual attribution of psychological data, social issues such as urbanization, immigration, and industrialization were increasingly being conceptualized in terms of individuals as members of statistical aggregates (Danzinger, 1990). Thus developed a new framework in psychology based on statistical norms: "Individuals were now characterized not by anything actually observed to be going on in their minds or organisms but by their deviation from the statistical norm established for the population with which they had been aggregated" (Danziger, p. 77). This was not simply about counting heads, however; increasingly, individuals were seen as having quantifiable attributes as well. For example, social problems such as crime and deviance were increasingly attributed to the statistical distribution of individual psychological characteristics. With its growing relevance for society, psychology was to study this distribution in order to contribute to the management of these problems using administrative means (e.g., intelligence testing and personality assessment in public schools and the military). The historian of psychology Kurt Danziger writes:

> Quantitative data by themselves were of course just marks on paper, but they could be transformed into a significant source of social power for those who controlled their production and interpreted their meaning to the non-expert public. Quantitative psychological knowledge was a species of esoteric knowledge that was held to have profound social implications. The keepers of that knowledge were to constitute a new

> kind of priesthood, which was to replace the traditional philosopher or theologian. (1990, p. 147)

Enumerating people, their characteristics, and their behaviours using the standardization and measurement tools provided by statistics profoundly affected all areas of natural and social science, transforming the Enlightenment quest to understand "human nature" into the modern preoccupation with "normal people" (Hacking, 1990). There were far-reaching repercussions for people's understanding of themselves and their increasingly quantified worlds. For example, the noted Disability Studies theorist Lennard Davis contends that "[t]here is probably no area of contemporary life in which some idea of a norm, mean, or average has not been calculated" (1997, p. 3). Davis goes on to demonstrate the connection between this "construction of normalcy" and what he calls the "invention" of the "disabled body" in the 19th century, a body that became so defined in opposition to what came to be considered normal.

The Medicalization of Behaviour: The New Pediatrics

In our quest to "wake up" the "appropriate" metaphor, we have thus far explored two elements. First, we looked at the complex history of the concept of normal. The ideological values that accompany the word *normal,* with its ability to be both descriptive and evaluative, are smuggled into clinical discourse under the ostensible neutrality of scientific language. Next, we revealed the connection between the rise in statistics and the desire and ability to define and measure an evolving understanding of "normal people." In this final section we turn to a third element in the "waking up" process: the medicalization of behaviours — those of both the patient and the patient's family. We will use the example of 20th-century pediatric medicine.

The unprecedented decline in infant and child mortality, as well as the significant decrease in childhood morbidity, in the first half of the 20th century greatly reduced the clinical workload of North American pediatricians. Through vaccinations and public health campaigns, children became healthier and had less need of medical intervention. As the need for primary care pediatricians decreased, pediatricians recreated themselves and their discipline, abandoning their focus on infection and hygiene. Pawluch (1983, 1996) argues that pediatricians began to diversify by adopting a prevention approach, which was followed shortly thereafter by a promotions approach that increased their role in the lives of healthy children (e.g., monitoring growth or attending to minor illnesses).

Following this, the pediatric speciality revitalized itself, focusing on children's unmet needs, namely those related to behavioural problems and

other troublesome issues. Parents were encouraged to take their children to pediatricians in times of both illness and health, to book routine check-ups for such matters as growth measurement, school performance, and attention deficit disorder, bedwetting, and other behavioural problems.

The specialty of pediatrics thus broadened beyond illness and prevention and into advocacy for the "active promotion of child health in all its aspects" (Pawluch, 1983). This new understanding of health included the mental, emotional, and social development of the child and, increasingly, the adolescent as well. It was under this New Pediatrics that pediatricians extended their purview to the entire family (Halpern, 1988; Pawluch, 1983). For example, A. H. Washburn, in a 1951 speech to the Society for Pediatric Research in Atlantic City (published in the journal *Pediatrics* the same year), argued that pediatricians had a "moral obligation" to attend to children's emotional and social development, over and above their concern for physical health, and this included "child-rearing" practices (Washburn, 1951).

It was through this medicalization of childhood (Pawluch, 2003) that the clinical gaze widened, to include not only physical diseases but also the psychosocial evaluation of children and their families. This phenomenon is still evident today. For example, an article by Barlow and Stewart-Brown (2004) outlines the pediatrician's role in attending to "problem parenting."

Clinical Implications

In scrutinizing language in the clinical setting, it becomes clear that there are many hidden values behind one's choice of words and phrases. *Appropriate* is one such value-laden word. It is used by clinicians as a linguistic and moral technology to both distinguish between and judge the normal and the pathological. In clinical jargon, *appropriate* has replaced *normal,* a word deemed politically incorrect and thus no longer in vogue. In clinical encounters, *appropriate* serves as a means of defining what is suitable for a particular person, situation, or place — a determination that requires value judgement and that references the parameters of normal. *Appropriate,* like its predecessor, *normal,* has a dual role: It describes both what is and what ought to be.

Further, as we have shown, the word *appropriate* allows for the collapse of the categories of physical health and social behaviour into one realm that is open to both clinical and moral judgement. The word can be used to describe and judge two disparate phenomena — for example, a child's growth and a mother's tears. While physical growth and maternal sadness are two very different entities, their description and judgement are

underlaid by the same value: measurement against the norm. To determine whether the child's growth is normal, one references a clinical average — how tall the child "ought" to be; similarly, to determine whether the mother's sadness is normal, one references normal grief reactions — how the mother "ought" to react.

A recent publication (Eliott & Olver, 2003) illustrates the hidden elements of clinical discourse. In a study of the meanings, for patients, of do-not-resuscitate orders, a version of the word *appropriate* (appropriate, inappropriate, appropriateness) is used by the authors 11 times to describe and summarize the views of patients, yet it is not found in the quoted comments of patients. For example, where the authors write, "Many mentioned the medical circumstances in which it might be appropriate to forgo attempts to maintain life" (p. 102), the patients say things like "Where everything's sort of packing up,…really, why continue?" (p. 102) or "When all systems fail, do not try to bring back to life" (p. 102). Further along, patients are quoted as saying, "If a person's going to die, why string it out any longer than is necessary…why stretch it out, why try and preserve a life with agony and pain" and "[D]on't do anything extraordinary…to prolong life" (p. 102). From this, the authors conclude: "Such terminology connotes the extension of something beyond its appropriate length, implying some form of biological or natural limit for each human life… [P]atients here invoke a biological discourse to assert the appropriateness of limiting medical authority" (p. 102). Our intention is not to criticize this study, but the authors' comments do serve as a reminder of how we may unintentionally translate patients' words into our own clinical jargon, thereby transferring our values to their words.

As demonstrated by much social analysis (e.g., Foucault, 1980, 1994), power imbalances often characterize health-care relationships, especially those between clinicians and patients. The clinicians' gaze, in assessing the normal and the pathological, objectifies the patient; and reducing the patient to a body masks the inter-subjectivity of the clinical encounter, increasing the power imbalance. The use of *appropriate* in both a descriptive and a moral sense reinforces the clinician's role as arbiter of one's health and well-being, and increasingly incorporated into this assessment is the behaviour of both the patient and the family. Therefore, the values that underlie the use of *appropriate* serve to pathologize human conduct.

Several points of reflection summarize our concerns about the use of *appropriate* in health-care settings. Non-reflexive use of the word clouds the transparency of language and values hidden within an ostensibly value-free scientific discourse. As a rhetorical device, the word serves to smuggle in judgements under the guise of neutrality. In terms of communication, we challenge readers to consider what the use of this word actually facilitates. Does it create barriers? Does it create mixed messages

and lead to false expectations? We must be continually cognizant of the role of language in maintaining hierarchies. While *appropriate* may appear neutral and scientific, our examination reveals that it has underlying values and multiple meanings; it is an imprecise word whose intentions and implications are hidden and thus not open to debate or dialogue. This would seem to be the antithesis of the patient/family-centredness and shared decision-making currently espoused in best practice guidelines and policy statements.

Clearly, more work is needed in this area. Data for this examination of *appropriate* were a secondary gain from an ethnographic project on critical care and also came from observations made in clinical practice. More focused study would be required to elicit the context-specific moral values behind the word. For example, is the term used differently by nurses, physicians, and other health professionals? Similarly, when patients and family members use the term, are they parroting medical speak or invoking their own values? There is a tendency to reduce complex moral issues to dichotomies (e.g., good/bad, normal/abnormal, inappropriate/appropriate) (Gould, 2003; Thorne et al., 2004). Use of the word *appropriate* may signal intellectual laziness: It serves as a default or comfort word, its vagueness diffusing the need for explanation. Similarly, it may be used as a time-saver — for example, a busy clinician may write "inappropriate parents" or "inappropriate grief reaction" as a device for referring a patient to another practitioner or care intervention. Qualitative exploration of the meaning of *appropriate* from a variety of perspectives — that of the clinician, the patient, the family — is an important area for future work. Furthermore, examining definitions and goodness of fit between what health-care consumers and health-care delivery systems describe as appropriate may help to inform quality improvement initiatives.

Conclusion

We have theorized why the word *appropriate* has become common in clinical settings and what this implies for clinical practice. The word serves both as a grammatical device and as a moral technology. Distinguishing the normal from the pathological has been the modus operandi of health care for centuries. Originally reserved for physical pathologies, the word *normal* evolved to apply also to social behaviours. Taking over where *normal* left off, *appropriate* metaphorically references the historical shift that opened both psychology and medicine to the description as well as the judgement of the "health" and pathology of patients and families. Like its predecessor, *appropriate* collapses the categories of physical and psychosocial health and behaviour into one moral

realm that is open to both clinical and moral judgement. In using the word *appropriate,* one is describing both what is and what ought to be. The premises of *appropriate* facilitate an inadvertent smuggling of values, biases, and subjective judgements into clinical encounters that can disadvantage patients and compromise the therapeutic relationship.

Simply replacing one word with another is insufficient to change the attitudes and beliefs that underpin a metaphor. As Segal (1997) points out, "metaphors acquire power over time and in use, and they arise from the culture rather than being fed into it" (p. 228). It is essential that we bring an awareness to our language, to "wake up" the values so they can be discussed and debated by health professionals as well as the patients and families they serve. It is impossible to codify one explicit meaning of the word *appropriate.* Different people, different professions, different cultures, and different societies will continue to hold different views on what is appropriate. What we *can* do is reflect on what we mean and what messages we are conveying each time we use the word.

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