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Title: Birth of the Pain Clinic: An Essay on the Phenomenology and Politics of Chronic Pain

Abstract: This monograph explores the social regulation of the body in pain and how, through the emerging nodal point of an ordoliberal governmentality, the struggles to define and control the individual-self create the possibility of an identity politics founded on the body in pain. Foucault's concept of governmentality provides insight into the Bio-politics of modern social institutions. The panopticon overseeing this internalization – the creation of a 'conduct of conduct' – generates a self-regulating consenting individual. Supplanting the notion of the singular self, the independent free and self-determining individual so essential to the American notion of the self-reliant (e.g., R.W. Emerson) self-made man. Foucault understood the subject as constructed through the bio-politics of institutionally conditioned expectations that eventually implant in that subject's consciousness and sense of right conduct. Moving on then to discuss a specific medicalized form of governmentality, we can see how 'docile bodies', compliant self-regulating individuals, emerge through interactions with the medical-industrial complex. This will, in the end, allow us to understand the role of the pain clinic in the emerging struggle to create a social identity for the person with chronic pain. There are underlying metaphysical, phenomenological, and epistemological issues that need to be addressed before we can begin to understand the issue properly. Pain, as Wittgenstein says, is a private language. No one can see pain or measure pain with any degree of determinacy, nor can one directly communicate pain mental events. That said, looking at the nature of pre-linguistic audio and visual cues, and other ways of knowing, we can try to get some insight into how pain can indeed be communicated such that there can be some sense of individual identity for those with chronic pain. And, of course, an identity politics can only be developed if there is a possibility of identity formation to begin with. At the end we will see how the modern pain clinic, as an emerging nodal point of control in the industrial/medical complex, struggles to find a way to define the object of ordoliberal governmentality and thus create compliant subjects. At the same time, we will lay out the conditions of possibility for social identity formation and the chance for an identity politics that serves the interests of those living with severe chronic pain.

Introduction

Engaging the American medical-industrial-governmental complex that structures and orders our personal health care requires that we enter through a very specific nodal point of control. We may start in an emergency room, a cancer ward, a dialysis clinic, but each of these nodal points in this ordoliberal governmentality present carefully developed techniques of practice and highly articulated behavioral expectations. However, for someone with severe chronic pain, pain that is unrelenting and permanent, the point of entry, the modern pain clinic, is anything but intelligible. As an emerging nodal point of control in a medicalized governmentality, the pain clinic is a place with limited techniques of practice and few clearly articulated expectations. The nascent status of this nodal point, combined with the phenomenological peculiarities of pain-mental events, makes navigating this structure a tremendous challenge and a politics of pain and the possibility of resistance problematic. *

This essay will explore the phenomenological and political implications of the rise of the modern pain clinic as a nodal point of control in an ordoliberal medicalized governmentality. The political implications arise from the phenomenological assumption that pain mental events are fundamentally incommunicable. One cannot form an identity and organize resistance where the shared property defies, or as we will hear claimed, actively destroys language; a 'politics of pain' becomes logically impossible. Further, the phenomenology and politics of pain must be seen as operating within an ordoliberal structure we can call the medical-industrial-governmental complex. Understanding how power works within such structures, I would argue, requires an understanding of Foucault's notion of 'bio-power' and identity formation within institutional structures, a process Foucault calls 'governmentality'. After unpacking the concept of a medicalized ordoliberal governmentality, I will argue that the widely accepted phenomenological assumption around the fundamental incommunicability of pain mental events is patently false, allowing space to create the conditions of possibility for a chronic pain identity and an identity politics conducive to developing a clearing of inclusion for those with permanent severe chronic pain.

As an initial caveat, I am, of course, not a physician or medical professional of any kind. My experience with pain clinics comes principally from over 4 decades as a customer. As an undergraduate, I was riding my motorcycle to the library when my headlight went out and a pickup truck struck me directly, crushing my left leg and breaking my back. One truth suddenly became clear — the 'disabled' is the only 'minority' group that anyone can join at any moment. Fortunately, I had a backpack full of philosophy books and managed to slide on F. M. Cornford's translation of Plato's Republic for about 30 yards down the street in what must have been the most practical use of philosophy to date (Plato 1941). And, while Plato saved my life, the concomitant crush injury meant a lifetime of surgery and constant pain fluctuating between unpleasant and unspeakable. For the purposes of this essay, this experience will suffice.

Governmentality and Bio-Power

Situating the modern pain clinic within an ordoliberal governmentality means first that we need to be clear about the term 'ordoliberal' and how I am using it. Backing up a bit, the traditional liberal political theory that provides a foundation for western thinking about The Social per se focuses on the natural rights of the free individual, equal to others, where narrowly defined governmental power exists solely to protect these naturally free individuals from harm and to safeguard their property. Traditional liberal political theory rests on a notion of consent from these naturally free individuals in terms of a 'social contract' of sorts, where said individuals in a society implicitly agree to relinquish some of their natural freedoms in exchange for a defense of life and treasure. This gives rise to the libertarian notion of a 'minimal state' where competition in an open market provides for the common good. Ordoliberalism expands on the liberal paradigm by placing the state in a more central role for the economy. Ordoliberalism, as we know it, is a school of economic thought that originated in post-war Germany, emphasizing the need for government regulation to ensure free market efficiency. The state here is seen as necessary for preserving market competition through anti-trust laws, regulating the banking sector and basic environmental and public health, as well as certain strategic investments in different economic sectors. Within specific industries, then, ordoliberal structures arise. Rather than taking the time to describe just what an ordoliberal structure would look like, let me define it ostensively. The obvious one that comes to mind is what President Eisenhower called the 'industrial-military complex'. For our purposes, we will be speaking about the medical-industrial-governmental complex. The web of loosely connected organizations, hospitals, medical insurance companies, pharmaceutical companies, medical device manufacturers, clinics, injury attorneys, and the list goes on, constitutes an interconnected industry deeply interwoven with government practices. This massive mixture of governmental industrial relations directs so much of our lives and effects power by manufacturing consent in a very particular way.

When we consider diffuse, sprawling ordoliberal social structures, we are immediately struck by a wonder on how they actually work. Power cannot come from one person or a group of decision makers in such a vast and loosely woven set of institutions. How do people come to do what is required of them in order for a structure of this magnitude to be effective? This is where we need to turn to the work of Michelle Foucault and his concept of 'bio-power'. Foucault's sense of biopolitics explains how society and social institutions operate through the creation of a self-regulating consenting individual. Supplanting the liberal notion of the singular self—the independent free and self-determining individual—Foucault understands the 'subject' through a 'bio-politics' of institutionally conditioned expectations that eventually implants in that subject's consciousness a sense of right conduct. By internalizing the 'master's gaze,' the individual navigating modern institutions at school, at work, in hospital, or in prison learns to act and self-correct in a manner conducive to the institution's operational needs. A 'conduct of conduct' arises from this bio-politics that replaces the master's panopticon with a self-policing that assures organizational efficacy. In sum, Foucault sees the individual subject as a product of continuously evolving institutions that create the boundaries and

possibilities for identifying who we are and what we can become. Power works through what Foucault calls a 'governmentality', that is, the process of creating 'docile bodies' that move through the system in a self-regulating manner, compliant with the needs of the institution.

Chronic Pain as Disability

Looking then at the role of the modern pain clinic as a nodal point of governmental social control means that we must understand chronic pain as a 'disability', something that impedes participation in the larger competitive market. Speaking to the issue of how people with severe chronic pain navigate this social complex requires that we step back and address the concept 'disabled' simpliciter as a socially constructed identity existing in the political/economic sphere. Too often, pain, even chronic pain, is seen as simply an effect of some other somatic incapacity. But in reality, long term chronic pain can be in and of itself every bit as disabling as any missing limb or severe psychosis. With that said, I support an epistemological reading of 'disability' as an identity suggesting that there is nothing inherent in the person, no specific property, that makes them 'disabled'. One may have an inherent incapacity or somatic life challenge. But that only translates into a disability when overlaid with some economically necessary social affordance. I am referring here to the 'social model' of disability laid out in the UK that makes the intuitive distinction between impairment and disability. The former may be inconvenient, but the latter is detrimental to economic participation and hence a 'disability'. One of the leading scholars in disability theory, Shelly Tremain, says that "Impairment may be seen in the lack of a limb, but disability involves a disadvantage, something imposed on top of the impairment caused by social organization" (Tremain, 2005, p. 9). Economic organizations create social affordances that favor some physical bodies over others in relation to what makes them fit for the necessary labor. The fabricated group, or 'human-kind', called 'disabled', is created and persists over time in order to make sensible a category required by extant forms of expertise and institutional imperatives. A similar epistemic reading of disability is offered by Tobin Siebers, one of the most influential disability theorists of our time. Siebers says,

Identity is neither a liability nor a disability. Nor is it an ontological property or a state of being. Identity is, properly defined, an epistemological construction that contains a broad array of theories about navigating social environments. (Siebers, 2008, p. 42)

Understanding identity formation, and *a fortiori* disability identity formation, epistemologically is less controversial than one might expect, though not everyone sees it this way. Merleau-Ponty, the architect of existential phenomenology and pioneer of modern somatic philosophy, still gives an ontological reading. He says,

The environment affords human beings to behave in a certain way whereas other ways are less supposable. For instance, chairs afford sitting on them just because human beings' knees, kneecaps, and thighs enable movements like bending the legs and sitting down. This relation between agent and environment can also be

interpreted from the perspective of chairs: they are built: in a certain way in order to afford and match certain embodied capabilities. (Merleau-Ponty, 1962, p. 144)

Merleau-Ponty seems then to suggest that having two legs with knees that bend is 'normal' expected—the way things naturally are placed in 'embodied capabilities' as an ontological property. Implicit in this reading is a sense of the normal and its relation to an idealized human body. Interpreting the individual from the perspective of the chair assumes that chairs somehow exist in a 'normal' state contained in 'the given'. From the chair's view, any significant deviation from that norm makes for an abnormal 'impairment' resulting in a 'disability'. Fortunately, chairs do not have 'views'. Chairs, tables, and other social affordances are designed for economic and political reasons. That chair, so easily used by those who have knees that bend 'normally' as Merleau-Ponty suggests, may be a small table for someone, like me, who has knees that do not bend well; or equally a chair may be an effective table for an 'able bodied' person who happens to be smaller in stature. I traveled often with a colleague who was quite tall, with very long legs, and would be, on any account, considered 'able-bodied'. Yet, when we travelled, an economy seat on an aircraft was terribly cramped and unpleasant for him. However, even with my disability, I fit quite comfortably into the next seat, given my general dimensions; though, standing side by side, anyone would identify me as the one with a disability. Which one of us, then, is 'disabled' when confined for a long period of time to the extraordinarily restricted 'affordance' of flying in coach? Perhaps Merleau-Ponty only flew business class.

The Phenomenology of Pain

Understanding disability as an epistemological category leads us towards understanding the phenomenology of pain and the perspective that pain is a private language, something that is known with absolute certainty to one experiencing pain but completely incommunicable to the other. In one of the most important works on the phenomenon of pain, *The Body in Pain*, Ellen Scarry suggests that:

So, for the person in pain, so incontestably and unnegotiably present is that 'having pain' may come to be thought of as the most vibrant example of what it is to 'have certainty,' while for the other person it is so elusive that 'hearing about pain' may exist as the primary model of what it is 'to have doubt.' Thus pain comes unshareably into our midst as at once that which cannot be denied and that which cannot be confirmed. Physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned. (Scarry, 1985, p.13)

For Scarry, the experience of pain is something completely beyond doubt and communicating that pain to another is simply not possible. Pain, for Scarry inevitably destroys language, making our words useless. This inevitably leads us to Wittgenstein's private language argument. In aphorism 246 of the *Philosophical Investigations*, he asks:

In what sense are my sensations only I can know whether I am really in pain; another person can only surmise it. — In one way this is wrong and is nonsense. If we are using the word 'to know' as it is normally used (and how else are we to use

it?), then other people very often know when I am in pain.—Yes, but all the same not with the certainty with which I know it can't be said of me at all (except perhaps as a joke) that I know I am in pain. What is it supposed to mean—except perhaps that I am in pain? other people cannot: be said to learn of my sensations only from my behaviour—for I cannot be said to learn of them. I have them. The truth is; it makes sense to say about other people that they doubt whether I am in pain; but not to say it about myself. (Wittgenstein, 1958)

Wittgenstein thus supports much of what has been said about the nature of pain and inter-subjective communication. Like Scarry, he also makes the strong claim that one cannot doubt that one is in pain. Wittgenstein goes so far as to say that even the word 'know' when speaking of pain is redundant. Further, pain can be seen as a language so completely phenomenologically isolated that it becomes a private language, utterly inaccessible to others.

The greatest minds to discuss the issue of pain seem to share the notion that pain is something that cannot be doubted and cannot be communicated. But if pain as a mental-event cannot be somehow communicated to another, then any sense of shared identity and a politics of pain become impossible. How then do chronic pain patients organize and advocate for their interests if they cannot create a shared identity? Can chronic pain be the locus of an identity? Tobin Siebers says no:

Pain is a subjective phenomenon, perhaps the most subjective of phenomena. It is therefore tempting to see it as a site for describing individuality. This temptation is troublesome for two reasons. First, individuality, whatever its meaning, is a social object, which means that it must be communicable as a concept. Individuality derived from the incommunicability of pain easily enforces a myth of hyperindividuality, a sense that each individual is locked in solitary confinement where suffering is an object of narcissistic contemplation. People with disabilities are already too politically isolated for this myth to be attractive. (Siebers, 2008, p. 60)

For those of us who live with chronic pain, this is just an astonishing statement. Given Siebers's strong stand on the moral imperative to see disability not as an individual defect, but as a matter of social injustice, it is rather painful to hear him suggest that the incommunicability of pain makes us narcissists.

I can only respond to the claims here that pain is incontestably private and fundamentally incommunicable by expressing what I know from so many decades of personal experience. In terms of doubt, the difference in some thinking here might come from the fact that Siebers, Scarry, Wittgenstein, and others might be thinking of pain in terms of an immediate event. One stubs a toe and cannot really doubt that the pain is real. But this is not how chronic pain works. Anyone enjoying a lifetime of serious constant chronic pain will say that there are times when we are not sure if we are in as much pain as we think we are in. We cannot compare today's pain to yesterday, as the pain mental events are so common, so ordinary and a constant companion, that we cannot separate them out in any meaningful way. Such comparisons and recollections are further confounded by anxiety, fear, depression or other mental-events closely tied to pain experience. No one doubts their own experience more than someone with chronic pain.

In terms of the incommunicability of pain, several lines of reasoning suggest otherwise. First, I take issue with Scarry's dismissal of pre-linguistic audio and visual cues as a "reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned." Audio cues like a moan, a crying-out, the clear sounds of a person in pain, or the wince, the grabbing a twisted limb after falling – there is not one of us who would not look at this and KNOW that the person is in pain. Suggesting that we are somehow reduced to a primitive state simply because we are entertaining a pre-linguistic speech act is rather meaningless. Witnessing a broken bone when someone falls and we hear a loud crack, we do not actually need to see the broken bone itself or see an x-ray to know that this person is injured and in pain. The sound of the bone breaking and the extreme utterances coming from the injured tell us all we need to know. In fact, those of us with chronic pain spend a tremendous amount of energy every day masking these natural visual and audio cues. People can see we are in pain and often react in terribly unpleasant ways; we mask to avoid discrimination and condescension, most often with the best of intentions. I can see my pain reflected in their face if I do not mask and know that my pain, despite my best efforts, has been well communicated. Furthermore, we do not see any mental-events of any kind, be it a sense of depression, anxiety, fear, whatever. Why the experience of pain as a unique phenomenological event should be any less communicable than talking about how an event provoked a state of depression or fear seems arbitrary. One cannot see depression or anxiety or other mental-events that lead to a diagnosis. We know and treat these phenomena, in part, based on self-reported statements from the patient. We do not seem to have the same doubts about a patient who speaks about depression as we do understanding those with pain. Pain patients can use relatable analogies, 'it feels like burning needles', and the like in order to effectively communicate. It is not easy to just flatly disagree with great minds like Wittgenstein or Scarry. But the notion that pain is a private language that cannot be communicated, particularly to the extent where Siebers makes us out to be narcissists, is from the experience of anyone with severe permanent chronic pain just patently false.

Conclusions

Thoughts on Pain Politics and the Clinic

I have argued that the modern pain clinic exists as an emerging nodal point of control within this larger medicalized governmentality. Over the last few decades, I watched pain clinics grow from a one-off anesthesiologist working in the hospital basement to large centers that offer a wide range of treatment. Each patient comes to the clinic from a different systemic place, neurological, cardiac, oncological, etc. And yet, each struggles to develop a shared identity, since what they share is neither visible nor easily communicated. They are all chronic pain patients—the object of study and treatment often completely distinct from their systemic etiology. Walking into an orthopedic office, one immediately confronts shared characteristics and techniques of practice. Crutches, braces, and surgical scars create a commonality, a shared identity created by clinical practices. This is not the case at the pain clinic.

The modern pain clinic has much to offer in some ways, little in others. But the confusion for the patient is extraordinary. We live in times where the organization of pharmacists is suing the pharmaceutical companies. Doctors are going to jail for treating pain with medications for which there really is no substitute. Medical professionals take the blame for an epidemic of narcotics fueled by illicit drugs and gangs. Insurance companies profiteering, lack of clear government guidelines, lawsuits against manufacturers causing shortages, and the relatively primitive state of the field create a tremendous amount of uncertainty and confusion for patient and practitioner. Chronic pain individuals are often baffled as to how they should 'conduct their conduct' in order to simply manage day-to-day living. Gradually, an orderly system of profit maximization and control will emerge, the confusion will abate, and a clear 'conduct of conduct' will emerge. The networks of colluding and colliding institutions are barely beginning to integrate to the point where the individual with chronic pain can identify, let alone internalize, conduct conducive to the operations of the pain management industry. This is an emerging governmentality, and until the dust settles, attempting a Foucauldian genealogy is premature and the chronic pain identity produced by this nascent governmentality must be understood as existing in a primitive and unstable state.

The governmentality of managing pain is, however, beginning to provoke some resistance, or at least a small form of direct organization putatively advocating for those with chronic pain. Outside of the medical societies for pain management and those with vested economic or professional interest, non-profit support organizations for chronic pain patients are beginning to form. The US Pain Foundation, a non-profit support organization, developed 'the Invisible Project', which disseminates thought provoking photographs of those with chronic pain. The images connect the viewer to the component of pain mental-events we all share to 'create pain, awareness, empower survivors and generate change'. This approach in many ways validates my point that pain can be communicated effectively through pre-linguistic visual cues. And the American Chronic Pain Association has a similar mission, providing useful information in order to help the individual with chronic pain become 'a well-informed consumer' (or 'docile body'). Of course, these organizations fighting to create a politics of pain are just beginning to have any impact. But to the point, if a rudimentary chronic pain identity politics effectively exists, then a basic chronic pain identity must exist, as nothing can be phenomenologically impossible if it is socially actual.

As a concluding thought, pain and disability occupy a peculiar place in the American mind. Up through the 19th century, pain was considered an essential element of treatment, where pain was seen as an important symptom or as playing an important part in the healing process. That said, the issue goes deeper. Central to the American self-understanding and its relation to pain and disability is a sense that disability represents a challenge to the deeply held liberal notion of the self-contained, able-bodied and naturally autonomous individual. Rosemary Garland Thomson (1997) expresses this elegantly by turning to Ralph Waldo Emerson's quintessential nineteenth century American Transcendentalist's work *Self-Reliance*:

And now we are men . . . not minors and invalids in a protected corner, not cowards fleeing before a revolution, but guides, redeemers, and benefactors advancing on chaos in the dark. (Thomson, 1997, p. 134)

The vision of 'real men' as strong, able-bodied, and capable of being the self-reliant American who conquers the western frontier to achieve a manifest destiny; a dream that casts the disabled as living in a protected corner, impotent and of no more assistance to the economic task of building America than a child or a coward. Thomson continues, Thus translated, physical difference yields a cultural icon signifying violated wholeness, unbounded incompleteness . . . susceptibility to external forces. The body's threat of betrayal thus compartmentalized the mythical American self as unfolded, unobstructed and unrestrained, according to its own manifest destiny". (Thomson, 1997, p. 26)

The 'disabled' self becomes a threat to our idiosyncratic nationalistic ambitions and our sense of who we are as Americans. Engaging this 'unpatriotic' stigma daily, those of us with chronic pain must be mindful of the extant governmentality of the pain management clinic as it grows within its historicity. Finding robust modes of communication such that we can build solidarity and perhaps create a path for resistance and social hope is the challenge we must meet. *This essay attempts to provide a summary of a much longer argument made in a previously published monograph (Gold, 2017)

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