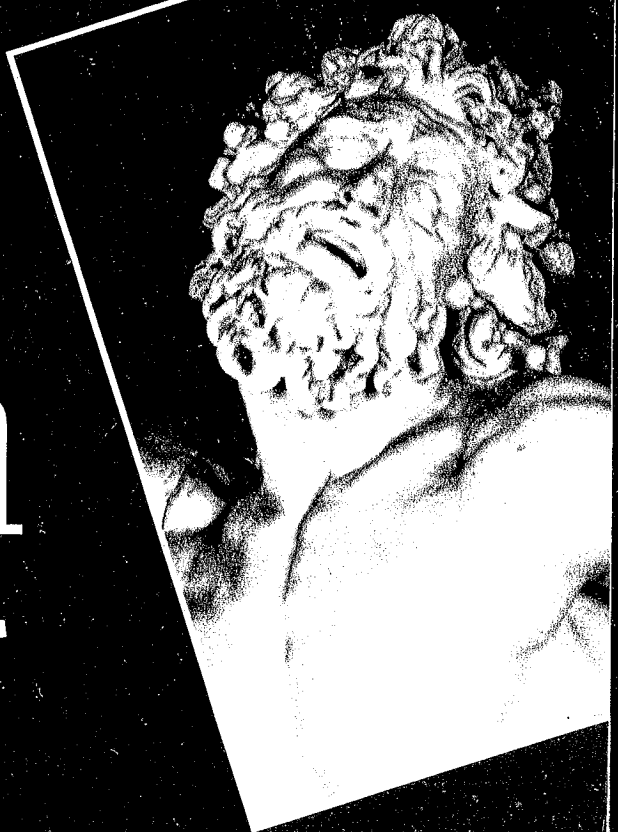
The Culture of Pain



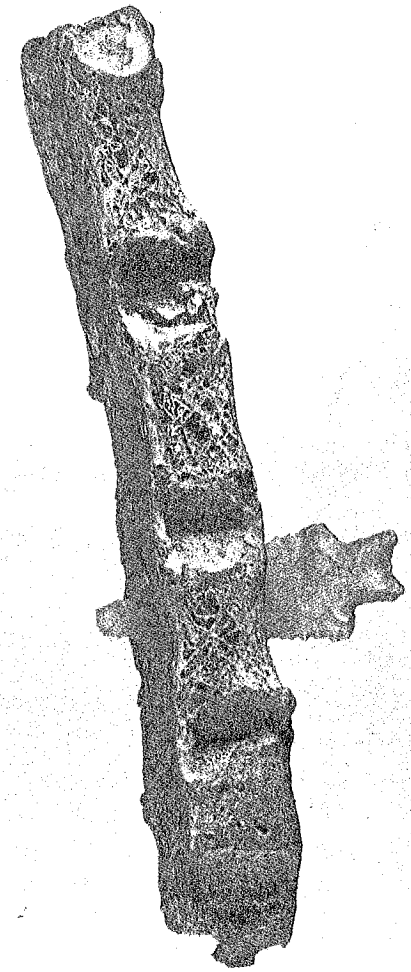
DAVID B. MORRIS

3
AN INVISIBLE EPIDEMIC

Pain—has an Element of Blank—
It cannot recollect
When it begun—or if there were
A time when it was not.
EMILY DICKINSON[1]

THE WHITENED BONES dug up from prehistoric sites reveal abscessed teeth and unhealed fractures that provide unmistakable evidence of suffering among our ancestors. One fragment from a human skeleton still contains an ancient stone arrowhead embedded in the sternum (fig. 9). A shot striking the sternum so directly in the front may not be fatal, since it would penetrate no vital organs, but it would make the victim easy prey, and it is certain that this New World casualty did not survive to extract the arrow.[2] We could not speak the language of such ancient ancestors or perhaps even recognize it as human speech. Yet we probably believe that we can understand the pain they felt when an arrow suddenly tore through the skin and bone, as if the entire chest were on fire. Still further back in time, however, our remotest ancestors perhaps lived in a world where consciousness operated in ways we cannot imagine, like madness. Perhaps they understood no more (and no less) about their own individual pain than a lion or tiger understands.

The awareness that I trust will emerge from the evidence gathered in this book is that the pain we feel today differs from the pain our ancestors felt. It is not even the same pain that Freud's cultivated and well-heeled European patients experienced less than a century ago. Too much has changed. Today we experience pain within a cultural field as unique and original as the skylines of our major cities. We take for granted a way of understanding pain that would have seemed very odd not merely to Plato



COLLECTION MUSÉE DE L'HOMME, PARIS

FIGURE 9. Ancient fragment of human sternum with flint arrowhead still embedded.

and Aristotle or to Shakespeare and Cervantes or to Jeremy Bentham and Cardinal Newman but also to our own grandparents and great-grandparents. The social forces responsible for this momentous change are so powerful that wholly escaping them is almost as difficult as evading the earth's gravitational field.

Differences, then, are our subject: differences between ancient and modern pain, between visible and invisible pain, between acute and chronic pain. The reason for exploring such differences is quite simple.

They help to explain how we got where we are now—how the present constitutes an enormous break with the past—and what the future may bring. For a modern patient struggling with torments no less debilitating (and often far more mysterious) than an arrow shot directly into the chest, the differences we will examine all converge on the curious new social and medical institution known as the pain clinic. It is a door that anyone who wishes to understand pain today must open.

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The white coat I was assigned after long, formal negotiations with three or four layers of administrative bureaucracy gave me an immediate stab of self-doubt. But as I walked from the Department of Anesthesiology to the distant location of the pain clinic, I felt growing within me the dangerous exhilaration that no doubt inspires the world's greatest impostors. My years as a professor had never conferred such a mantle of power. A handful of the more obsequious, confused, or respectful students invariably addressed me as doctor—technically correct in view of my doctoral degree—but among my colleagues in the humanities only the terminally insecure encouraged such Germanic formality. My main problem, as I struggled to imitate a confident stride through the long, indistinguishable corridors of the hospital, was trying not to appear lost.

I will not deny that I enjoyed the sense of power that came with my white coat. The desire never seized me to dash off a prescription or to suture up a wound, but I made a point of not switching back to civilian dress for my return across the river to the main campus. (Consider the genius required to place the medical school and English department on opposite sides of a river.) Inside the hospital I blended into the surroundings like an average, slightly overage resident. I smiled a reassuring professional smile to patients who seemed particularly anxious. My white coat, of course, told a monstrous lie, but only about me. Patients expect a doctor to radiate competence, and I did not want to disappoint them by looking nervous or wandering aimlessly through the halls.

A cold panic, however, stopped me in mid-sentence as I finally asked directions at a nurses' station. Our bookshelves at home as I was growing up contained several slim collections of humor among my father's ponderous medical textbooks and journals. One anecdote described an especially unpleasant three-star general who was a patient at a military hospital. In revenge, the long-suffering staff left him lying face down for

twenty minutes with a daffodil instead of a thermometer sticking out of his rectum. Medical humor, I had noticed, tends to be a little rough and anal. As I walked away clutching a diagram of the quickest path to the pain clinic, I secretly glanced back to see whether the nurses were slumped against the filing cabinets in laughter.

On the neat, red-inked nametag of my cherished white coat I had just read, horrified, the name "Dr. O. Bastard."

Several weeks later—when I trusted the pain clinic staff well enough to ask about my shameful nametag—I received assurance that Dr. Oliver Bastard had been a visiting resident, from overseas, who on returning home simply left his coat in the departmental closet. (Sure, I thought, a story I can't verify: perfect.) Eventually I came to believe this explanation, but it was too late. I could not help secretly thinking of my nametag as an allegorical statement. It asserted something beyond my illegitimate claims to a white coat. It reminded me that doctors and patients belong to fundamentally different worlds and that the experience of pain in our culture always looks very different depending on which world you belong to. Yet whenever I entered the freshly painted doors of the pain clinic, the distance between these two worlds began to shrink a little. Here doctors and patients seemed to be working out a new understanding.

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A new understanding seems absolutely necessary if we hope to deal with the unprecedented crisis in chronic pain. Indeed, the most distinctive, insidious feature of this contemporary epidemic, as it has been rightly called, is that we cannot recognize it as an epidemic. Disasters such as AIDS or drug addiction leave a visible wreckage behind. They also openly change our behavior and our culture: they alter our sex lives, infiltrate our homes and schools, dominate our films, books, and newscasts. Chronic pain, by contrast, generally escapes notice, even though one in ten Americans suffers from its often crippling assault. Thus, as a way of bringing the problem of chronic pain into sharper focus, it will be useful before we enter the clinic to shift our gaze in space and time. The world we have recently left behind was a place where no one would call pain invisible.

The medicalization of pain is indeed so characteristic of our own time that historians seeking a date to mark the advent of modernism might do

far worse than select 1899, when salicylic acid was first commercially developed into acetylsalicylic acid, popularly known as aspirin. It is hard to imagine either medicine or the modern world without aspirin. Aspirin achieved such instant fame in the early twentieth century that it even figured prominently in World War I.[3] The (German) Bayer Chemical Company held manufacturing secrets and world patent rights. Britain therefore offered a large cash prize for anyone able to "reformulate" aspirin and to discover a workable manufacturing process. At the German surrender, the British Custodian of Enemy Property sequestered the Bayer trade name "aspirin," which thereafter became simply the generic term for acetylsalicylic acid. It was a rich prize. Today the annual world output of aspirin runs well over thirty thousand tons: a figure of course that represents merely a fraction of the total consumption of legal and illegal substances for relieving pain.[4]

Probably no other drug—not even such modern favorites as Valium or cocaine—has established itself so firmly in our culture as aspirin. Yet aspirin is far more than our most common over-the-counter analgesic. It is an emblem of our immense faith in chemical assaults on pain. Americans spend more than four billion dollars annually for various painkilling medications.[5] This mountain of pills, if it could be measured, might stand as a monument to our belief in a medical solution to the problem of pain, like the weird statue (still standing in the Boston Public Garden) that commemorates the first surgical use of ether. Dedicated in the mid-nineteenth century, this four-sided pillar topped by a stone healer ministering to his stone patient bears on its pedestal the brief, unfulfilled prophecy from Revelation: "And there shall be no more pain."

Our nineteenth-century predecessors had good reason for erecting a statue to commemorate the surgical use of ether. The year 1846 effectively divided human history into periods so different that we really cannot recapture what life was like before that date. Before 1846 surgical procedures—from pulling teeth to amputations—took place without any form of effective modern anesthesia (figs. 10 and 11). Early dentists set up makeshift wooden platforms in the center of town and pulled teeth with hideous elongated pincers the size of fireplace tongs. In England before 1743 surgeons still belonged to the guild of barbers. The best educated and most highly skilled surgeons operated in the patient's home. On the appointed day, one can easily imagine the mounting sense of dread as the

carriage stops in the street, as the surgeon knocks at the door, as he slowly climbs the stairs with perhaps three or four burly assistants to hold you down.

The novelist Fanny Burney—perhaps best remembered for her friendship with Samuel Johnson—has left us a detailed account of the mastectomy she underwent in Paris on September 30, 1811. No woman would forget such a date, just as Samuel Pepys each year celebrated the anniversary of his successful operation for removal of an agonizing kidney stone the size of a tennis ball. Her only preparation was a wine cordial, possibly containing laudanum. When the surgeon and his assistants arrive—"7 Men in black"—she is at first startled and upset. ("Why so many? & without leave?") Fear grips her with such force that she cannot utter a syllable in protest. She regains a measure of dignity and composure in the presence of these overbearing black-robed figures by somehow getting to the bed under her own power and refusing to let them hold her down. Over her face they drape a transparent cambric handkerchief through which she watches the chief surgeon trace on her breast the path his knife will take.

With a passion for exactness, Burney records every detail of this brutal operation. She describes the knife plunged into her breast, "cutting through veins—arteries—flesh—nerves." She describes the air rushing into the wound like a mass of "sharp & forked poniards"—the surgeon "cutting against the grain" as he repeatedly scrapes at her breast bone. Who would not be impressed by her enormous courage? It was not, however, a courage of silence and denial. Modern readers will find it hard to forget the scream that she says lasted uninterruptedly during the entire time of the incision. "I almost marvel that it rings not in my Ears still!" she wrote afterward: "so excruciating was the agony."[6]

This preanesthetic world of pain is now enormously difficult, if not impossible, to reenter. Like Burney, thousands of less eloquent patients somehow endured their surgery without more than a stiff drink in preparation. Yet it is not just modern patients who find this ordeal almost unthinkable. Courage was required on both sides of the knife. For example, one admiring modern physician—who had studied with the earlier nineteenth-century surgeons steeled to the demands of cutting into the bodies of fully conscious patients—described his predecessors as if recalling a race of vanished demigods: "They were indeed giants in the surgical profession in those pre-anesthetic days, men of iron nerve and in-

domitable will, who could bring themselves to inflict such untold anguish upon their fellow-men, even in the hope of ultimate relief."[7] It is a tribute offered as if from a different universe.

The tribute was offered in 1914 by John M. T. Finney, professor of clinical surgery at Johns Hopkins, in an address delivered at the Massachusetts General Hospital. There, sixty-eight years earlier on October 16, 1846, a group of skeptical doctors and medical students witnessed the first public demonstration of the surgical uses of ether. To their astonishment, a Boston dentist named William Morton with an ether-soaked sponge and a hastily contrived inhaling apparatus (delivered only a few hours earlier) succeeded in putting the patient into a deep sleep. Then the distinguished senior surgeon John Collins Warren—as surprised as anyone—effortlessly removed a large tumor from the patient's jaw in what was otherwise fated to be an operation of unimaginable pain.

Warren knew that few spectators in the room were prepared to believe the almost miraculous event they had just witnessed. The scene required such a complete reversal of previous modes of thought that even eyewitnesses suspected it was a carnival trick. New England in the mid-nineteenth century sheltered a host of itinerant snake-oil salesmen, mesmerists, and assorted amateur chemists all professing to rid the world of pain. Even as late as 1890, to the accompaniment of a loud brass band, an American Indian named Sequah drew large crowds in London with his offer to extract teeth free and painlessly.[8] Warren knew how to rise to an occasion. He faced his audience with the full authority of a Victorian sage. "Gentlemen," he announced to the disbelieving students and colleagues assembled in the operating theater, "this is no humbug."[9]

The events of October 16, 1846 changed more than the art of surgery. (No longer was the best surgeon necessarily the fastest.) They also forever transformed our cultural assumptions about pain. The anniversary came to be known as Ether Day, and each October 16, for well over half a century, the Massachusetts General Hospital celebrated the event with ceremonies and distinguished lecturers. The renowned Oliver Wendell Holmes delivered one of the first celebratory addresses. It was the equally famous nineteenth-century American neurologist and popular novelist S. Weir Mitchell, however, who best captured the sense of irreversible change. In 1896—speaking at the Massachusetts General Hospital on the fiftieth anniversary of Ether Day—he recited a long poem he had composed for the occasion, including these dramatic couplets:

Whatever triumphs still shall hold the mind,
Whatever gift shall yet enrich mankind,
Ah! here no hour shall strike through all the years,
No hour as sweet as when hope, doubt, and fears,
'Mid deepening stillness, watched one eager brain,
With Godlike will, decree the Death of Pain.[10]

After 1846 it was not just medicine but human life that would never be quite the same again.

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Pain, of course, did not die. We still inhabit a planet filled with more pain—from war, poverty, disease, injury, and neglect—than an entire mountain range of pills could erase. In fact, we now face an unprecedented dilemma. Although we possess not only ether and its subsequent generations of chemical painkillers but also innumerable over-the-counter remedies, the epidemic of chronic pain seems to be gaining ground. The pills in a sense just make things worse. Treatment at pain centers and pain clinics often begins with a period of detoxification in which patients gradually withdraw from the host of ineffectual and even harmful medications that they consume, fruitlessly, in hopes of relief.

Weir Mitchell would probably be surprised at the most recent evidence that he was somewhat premature in announcing the death of pain. One report—from the distinguished Institute of Medicine—describes the situation in sober but forceful prose. "Chronic pain, especially musculoskeletal pain," the authors write, "is a common health problem afflicting a substantial proportion of the adult population and interfering with every aspect of their lives."[11] The new pain clinics and pain centers that have sprung up in most major hospitals since 1960 are packed with patients whose lives have been disrupted. Pain is so far from dead that it has become a booming business.

Chronic pain, indeed, though far less visible than cancer or AIDS, certainly belongs among the characteristic maladies of our time. It seems clear that specific historical periods possess not only their characteristic crimes (treason for the Elizabethans, robbery for the Georgians, drug-dealing and stock manipulation in the postmodern era) but also their defining or representative illnesses.[12] Thus leprosy and plague haunted the medieval world with their aura of demonic terror much as madness obsessed the Renaissance. Gout (considered the disease of luxury and high

living) aptly reflected the more secular, hedonistic spirit of the eighteenth century, while the Romantic era spun a vast mythology of spiritualizing illness around tuberculosis. Recently, as Susan Sontag has argued, cancer and now AIDS have accrued around them the mystery, fear, and morbid fascination that make them far more than mere diseases.[13] Chronic pain, mysterious, dull, and nonfatal, might be called the defining illness of our low-profile, private, safe-sexed, self-absorbed era.

Its relative invisibility gives chronic pain a feature that makes it both insidious and almost unique. What AIDS, cancer, tuberculosis, leprosy, madness, and other representative illnesses share is a graphic power to seize the imagination. They not only threaten personal and public health but also, equally important, fill the world with disturbing new images of our vulnerability to disaster. Chronic pain, by contrast, proves especially treacherous because it works almost totally in secret. Its presence is completely undramatic, like white collar crime or a terrorist in a business suit. It does not inspire telethons and rock concerts. There is simply nothing photogenic about an aching back that will not let you sleep, sit, travel, or make love and never stops hurting.

Chronic pain keeps its low profile by doggedly failing to convey the macabre glamor of deformity, contagion, and imminent death. Former U.S. Surgeon General C. Everett Koop contrasted the current publicity surrounding AIDS with our relative unconcern about the vastly more common affliction of migraine. "You almost have to die of something in order to get the attention that the disease process deserves in the American health system," he said. "That's why AIDS, which is 100 percent fatal, attracted so much attention. People could understand that. Migraine is 100 percent nonfatal."[14] Koop is correct, I think, that the problem is not simply lack of publicity about pain but lack of understanding. The damage is all around us. The typical patient at Seattle's Multidisciplinary Pain Center has low back pain, has had 2.6 operations, and has been off work for 3.6 years.[15] Still, we find it hard to grasp or comprehend a condition that attacks millions of people without leaving outward signs of damage.

Chronic pain is invisible in large part, then, because it is commonplace and nonfatal. Almost every serious illness seems more important. Only within the past several decades have specialists appeared ("algologists": from the Greek *algos* or pain) who devote themselves full-time to the study and treatment of chronic pain. A doctor who has no special training in chronic pain often finds such patients deeply frustrating. Understand-

ably, many physicians prefer the postpenicillin model of swift and total cure. Patients with chronic pain, however, too often just do not seem to get well. They may undergo multiple surgeries—between ten and twenty are not uncommon. They often take vast, exotic, and harmful combinations of prescription drugs, mixed with home remedies and drugstore staples, as if concocting a desperate smorgasbord of analgesia. Medical staffs sometimes refer to such people as "thick-folder" patients. They shuttle from specialist to specialist, in a revolving door of referrals, seen so often by so many different doctors that finally no one really sees them.

Like shadowy Homeric spirits of the dead, chronic pain patients tend to move in an in-between realm: they clearly are not well, but their malady will not let us see them as absolutely sick. An affliction that operates in-between and in secret, of course, generates endless paradoxes. How can we combat an epidemic so clandestine that no one (except its victims) really notices it? We hardly know how to mobilize public opinon when denied access to the lurid rhetoric of crisis. A dilemma so quiet, we are tempted to assume, cannot be a serious problem. It is easy to entertain this thought until one day chronic pain hits you with its invisible fist, like a knife in the back that the doctors cannot find. Suddenly nothing looks the same. It is as if the world has abruptly and completely changed, turned sinister, even evil, but no one knows except you.

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What surprised me most when I began my research at the pain clinic of a large university hospital was the apparently normal faces of the patients. I had steeled myself to expect agonized expressions and frightful cries. The clinic, I anticipated, would probably look and sound something like an antiseptic Nazi torture chamber. It amazed me that patients arriving for appointments talked with the receptionist in calm, hushed voices. They thumbed through out-of-date magazines or sat quietly on the hard, vinyl chairs with the resignation of people who know exactly how hospitals suspend the everyday flow of time. The waiting room—more like a wide, blind tunnel—had the air of a place in which your name is never called.

The patients looked far more cheerful than their surroundings. The pain clinic consisted of three small rooms: the so-called waiting room, a treatment room, and a minuscule staff room. That was it—a sure sign in medical circles of a young program with shaky funding. The treatment

room held in the center a standard examining table with its swatch of stiff white paper running down the middle like a blank scroll. Against the walls stood various low cabinets and tables containing surgical gowns, sterilized instruments sheathed in plastic, and standardized legal consent forms. I was impressed at how carefully the Director explained to patients each new procedure, describing in great detail the risks, possible benefits, and inevitable uncertainties. Pain seemed capable of dissolving otherwise rock-hard resistances. I never saw anyone refuse to sign the consent form. Patients did not flinch at hypodermic needles so long and thick that (even from across the room) they resembled hollow barbecue skewers.

The stories that the patients shared with me when I explained my research belied their normal faces. One young woman (I'll call her Laura) rolled up her loose jeans, exposing along the length of the calf a fiery mass of twisted scar tissue. Modern farming depends upon machines more dangerous than many weapons. An augur, for example, is a vast enclosed funnel used for processing grain. At the center, where the sides slope downward toward a narrow opening, a rounded screwlike blade turns slowly to move the grain. Occasionally the augur needs cleaning, and then a farmhand climbs inside to sweep down the sides. If at that moment someone by mistake turned on the machine, the effect would be like falling into a giant, vertical meat grinder.

Luckily they turned off the augur before it had mangled more than half of Laura's lower leg. A helicopter flew her several hundred miles to the university hospital, where a team of surgeons worked for hours to repair the shattered bones and to rebuild the shredded muscles. Almost miraculously, they managed to avoid an amputation. With a cane and heavy metal brace she now walked to her appointments at the pain clinic, stiffly, awkwardly. But no one who saw her during those first terrible hours following the accident believed that she would ever walk again.

It is not a pleasant trait, but we sometimes feel suspicious of people who say they are in pain but who do not groan or writhe or pound the floor. Pain patients know what it means to face daily suspicion. Laura's leg, however, contained a pain no one could doubt. Its sources lay deep within the flesh, beneath thick layers of scar tissue, but doctors were unable to locate its exact source. Where the damage was so extensive, pain might issue from a hundred different hiding places, like the smoke from a smoldering ruin. Very likely, explained the Director, there were multiple

sources, layer upon layer of pain. Unmask one pain and the next simply took its place. Even if the process of medical unmasking might finally discover the last pain hidden beneath overlapping and intervening strata, doctors might be unable to repair the damage or to relieve the suffering.

For Laura, what proved finally worse than the awful moment when the augur mangled her leg was a constant, irreparable pain that lingered long after the process of healing should have run its course. The leg in its healing had sealed in a tormenting and never-ending ache that gave her no freedom. She was in effect a prisoner shackled to her pain. She told me in a cold, emotionless tone that she wished the surgeons had simply cut off her leg at the knee. An artificial leg was something she could learn to live with: she could still cook, dance, work, take care of the kids. Chronic pain, however, had made the rest of her life a permanent daily torment. Bitterly, she warned me never to accept treatment at a university hospital, because the surgeons use you for practice or research. They don't care what pain does to you later on, she added.

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Laura's experience—which includes her lingering bitterness—offers a particularly clear picture of the difference between chronic and acute pain.[16] Almost everything in the modern medical treatment of pain can be said to follow from this fundamental distinction. Thus, although a fully adequate definition of pain continues to elude us, we nonetheless need to distinguish carefully between two essentially different *kinds* or classes of pain. What Laura felt when the augur tore into her leg belongs, like the minor daily injuries or short-term illnesses that befall us, to the class of pain that doctors call acute. Acute pain descends in a sudden storm. The misery that lingers months and years later belongs to the class of pain that doctors call chronic. On this simple but absolutely basic distinction rests an entire revolution in medical understanding.

Chronic pain is the medical term for a pain that, perversely, refuses to disappear or that reappears over extended periods, in episodes. Sometimes, as in the pain from inoperable tumors or in degenerative diseases such as rheumatoid arthritis, the cause is clear but cure impossible. Sometimes the pain persists long after healing is complete or, as with migraine headaches, it may recur at frequent intervals. Sometimes there is no identifiable organic cause. Despite the variations, one feature remains con-

stant: unlike acute pain, chronic pain simply will not go away and stay away.

Chronic pain in addition possesses no biological purpose. Acute pain, by contrast, serves a recognizable function in protecting us from further harm. It warns us to remove a hand from a hot stove, it accompanies the process of healing, and it leads to growth and accomplishment. Acute pain is what weight-lifters celebrate when they say "no pain, no gain." Doctors sometimes speak of chronic pain as bringing with it a "secondary gain," by which they usually refer to some dimly perceived psychological benefit that the patient receives from the pain, such as increased attention or even the unconscious gratification of a guilty need for punishment. But secondary gain comes only at the cost of an unending conscious misery that the patient desperately wants to shed. Chronic pain solves nothing. It is sheer hell.

The refusal to disappear, which characterizes chronic pain, creates a condition that often baffles and defeats medical judgment. Doctors know pretty well how to deal with acute pain. They understand many of its basic mechanisms, and the local pharmacy stocks dozens of tested remedies. In chronic pain, by contrast, the usual remedies simply do not work, or they do not work for long. (Some operations once commonly used for chronic pain actually left 15 percent of the patients with *worse* pain.) Over the months or years of persistent pain, the patient's behavior changes. One typical change in behavior is a reliance on large numbers of prescribed or unprescribed drugs. (Laura was up to fifteen aspirins a day, but there are patients who use many more.) Although much remains unknown about this frustrating malady, on one point we can be absolutely clear. Chronic pain may *begin* as acute pain, but is not merely acute pain that persists. Over time the pain seems to change its nature. Chronic pain and acute pain are as different as cancer and the common cold.[17]

Like most classifications, of course, the contrast between acute pain and chronic pain contains ambiguous, twilight areas. Inevitably, specialists propose technical adjustments designed to wipe out twilight, with the result that new categories suddenly spring to life: subacute, ongoing acute, chronic benign neoplastic, and so on. Our categories for thinking about pain still remain less flexible than pain itself. It is merely an arbitrary convention that sets six months as the period when ongoing acute pain gets reclassified as chronic. Why not seven months or five and a half? Such questions, however, miss the crucial point. We enter into a very different

state of being when our pain passes, at whatever arbitrary point, from acute to chronic.

Acute pain keeps us within a daylight world that remains fundamentally familiar. We know what to expect, and the gradual lessening of our pain assures us that our expectations are valid. Chronic pain destroys our normal assumptions about the world. It never releases us from its grip and continually frustrates our hopes for gradual improvement. Ultimately it introduces us to an unsettling counterworld where, as Emily Dickinson described it, time has stopped. (The time before pain is almost inconceivable, or else recedes in memory like a faded dream.) It is a place where, gradually, almost without noticing, you find yourself at last all alone. Chronic pain penetrates so completely that it leaves no escape. It lives within us like an unimaginably dull nightmare.

Nightmare is not simply a figure of speech when applied to chronic pain. Lawrence LeShan, from the Institute of Applied Biology, described the universe perceived by the patient in chronic pain as structurally identical with the universe of the nightmare. Nightmares, according to LeShan, possess three unvarying features: (1) terrible things are being done and worse are threatened; (2) we are helplessly under the control of outside forces; and (3) we cannot predict when the ordeal will end. LeShan concludes: "The person in pain is in the same formal situation: terrible things are being done to him and he does not know if worse will happen; he has no control and is helpless to take effective action; no time-limit is given."[18] Only one feature should be added to LeShan's description. Chronic pain is a nightmare from which we may never truly awaken—or a waking state in which the nightmare never ends. One pain patient expressed the uninterrupted dislocation he felt as follows: "It's always three o'clock in the morning."[19]

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We can better grasp the dilemma facing people with chronic pain—especially their sense of dislocation—if we consider the ways in which our culture teaches us to confront pain with silence and denial. Americans today probably belong to the first generation on earth that looks at a pain-free life as something like a constitutional right. Pain is a scandal. Leonardo da Vinci in his notebooks wrote that "the chief evil is bodily pain."[20] Leonardo and his age, however, also knew something about how to live in a world where evil cannot be routinely exorcised with a bottle of pills.

We are not well equipped for what happens when our pills fail. Suppose the pain simply will not go away. Suppose it follows us and takes up residence in our bones so that nothing we buy or swallow or rub on our skin will make it vanish. What then?

Silence is among the most frequent responses to chronic pain. We tend to think, with good reason, that pain almost instantly finds a voice. All newborn infants cry, and their cries (as all parents know) come in distinctively different tones. Yet this apparently natural response to pain—although not itself learned—is swiftly *un*learned and *re*learned. We very soon replace our earliest natural responses to pain with carefully calibrated understandings about how much crying is permitted, about when and where you can cry, about who can cry and for what reasons. The truth is that we learn almost everything we know about pain, including the need to deny it and to smother it in silence.

Ronald Melzack, one of the major figures in modern pain research, early in his career designed an experiment in which he raised dogs from birth in the laboratory equivalent of padded cells. They were isolated from other dogs and completely sheltered from painful stimuli. When full grown, these dogs proved deficient in the ability to perceive and respond to pain. Melzack reports that one dog, observed in a room with low-lying water pipes, knocked its head on the pipes more than thirty times in an hour without showing any evidence of pain behavior.[21] Such experiments strongly suggest that an understanding of pain is something we learn in the course of our normal growth. ("People were taught to bear necessary pain in my day," says a sixty-year-old man in an 1899 play by Shaw.)[22] As soon as we are born, we are educated day and night in the school of pain. But it is mostly acute pain that we learn about. No one teaches us what to do with a pain that never stops.

Nevertheless we learn. Patients with chronic pain soon discover that their complaints (potentially endless, like their pain) often exhaust, frustrate, and finally alienate family and friends and physicians. Many patients thus learn to retreat into a defensive isolation. They keep to themselves. They experience firsthand the failure of words in the face of suffering. Virginia Woolf wrote: "The merest schoolgirl, when she falls in love, has Shakespeare or Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry."[23] The normal failure of language under the assault of acute

pain, which Woolf describes, is a common but not devastating experience. A pain that lasts for months or years, however, begins to wear out everyone's patience and goodwill; it constitutes a radical assault on language and on human communication. There is simply nothing that can be said.

It is not entirely clear why language should run dry or crumble under the influence of pain. Love is no less mysterious, yet it fills thousands of songs, poems, and novels with its apparently inexhaustible speech. Even the inventive McGill-Melzack Pain Questionnaire reduces the patient's experience of pain to a mere seventy-eight words. Love, of course, draws people together, creating an intimacy that bypasses and transcends normal communication. The understanding between lovers is deep, instant, and unspoken. Chronic pain, in contrast, most often seems to build up walls of separation. It breaks down understanding. It places people in utterly different worlds of feeling. It surrounds them with silence. In many ways, the person in chronic pain might as well be standing on the moon.

"Pain," wrote Aristotle, "upsets and destroys the nature of the person who feels it."[24] Notice how even a minor irritant—a passing headache, say, or stiffness in the neck—tends to change your mood. Pain makes most of us irritable and cranky. The composed face with which we greet the world begins to look slightly pinched or haggard. A stronger pain can succeed in driving out every erotic impulse. ("Not tonight, dear.") It can turn a normally imperturbable man suddenly mean and hostile, as if replacing him with his savage twin. A scream, which we might think of as speech unraveled, seems to be the natural language of intense acute pain. Yet all these instances are somehow familiar. Even a scream manages to communicate something, if only the presence of a nameless terror. The shift from acute to chronic pain, however, initiates a difference of kind, not degree. Prolonged chronic pain threatens to unravel the self.

There is much to be said for the view that silence is the natural language of chronic pain. Everyone responds to acute pain with more or less distinctive but related cries: in English, *ow*! in French, *aie*! in German, *ach*! in Yiddish, *oy*! These hollow monosyllables, however, are eminently social. Like a scream, they communicate instantly and quite often constitute an implicit request for help. Chronic pain opens on an unsocial, wordless terrain where all communication threatens to come to a halt. Cries for help prove mostly useless. Indeed, at its most intense or most protracted, chronic pain may push us toward an area of human life we

know almost nothing about. Its inarticulate silences serve as the expression of an otherness so alien that we have no words and no language with which to comprehend it.

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Chronic pain is usually an unrelieved disaster to the person who suffers it, but the challenge it poses to traditional medicine seems to be moving us into a new era of understanding and treatment. Any future history of pain will need to meditate on the particular moment in which Western culture now uncomfortably finds itself fixed. Medicine—like the culture surrounding and interpenetrating it—is entering a period of profound transformation. The invention of the multidisciplinary pain clinic beginning about 1960 promises in fact to overturn centuries of medical thinking about pain.[25] This quiet medical revolution is far from complete. Too many doctors still know little about it. What is happening goes far beyond the development of miscellaneous new treatments. The pain clinic stands as an innovative, revolutionary way of thinking about our oldest and most implacable foe.

This new medical understanding of pain can be best summarized by contrast. From the time of the ancient Hippocratic writings, pain has held the clear and secure status of a symptom. In effect, Western medicine has understood pain as a more or less readable inscription that the skilled physician might interpret for its revelations about processes hidden deep within the flesh. Pain on this view is a message composed, sent, and delivered by illness. The medical revolution now under way does not seek to overthrow the ancient—and surely sound—wisdom that interprets pain as a symptom. Rather, alongside this familiar view it introduces a basic change in perspective from which we see that pain is sometimes completely illegible. This more or less unreadable pain no longer resembles a message that passes, by means of a common code or language, in-between the physician and the illness. Now the message *is* the illness.

The pain clinic serves as a convenient symbol of this new paradigm in medical thought. "We treat pain as a diagnosis, not a symptom," explains anesthesiologist Michael Kilbride, founder of the new Pain Management Center at the Muskegon (MI) General Hospital.[26] This view of pain as diagnosis rather than symptom—an approach typical of the pain clinic movement—requires an enormous shift in perspective. It is not just a new

thought but the basis for an entirely new way of thinking. Chronic pain, in this rethinking, no longer always points beyond itself to a hidden disease or illness that constitutes the real object of medical attention. Now pain itself has emerged as the malady under treatment. We might think of the transformation of pain from symptom to diagnosis—from the sign of illness to the illness itself—as representing a kind of Copernican revolution within medicine. No longer a satellite circling around disease, pain has begun to move toward the center. Increasingly, illness now circles around pain.

A shift so fundamental will take years to accomplish, of course, and will encounter steady resistance, both open and covert. Some doctors remain skeptical, even suspicious, about the activities of pain clinics. It surprised me to find specialists sometimes deeply hostile as (off the record) they discussed how their colleagues in other disciplines treated pain. One oncologist I interviewed flatly refused to send his patients to the anesthesiologists running the local pain clinic, claiming that anesthesiologists know next to nothing about cancer pain. Many clinics never entirely break free from the institutional politics of medicine. If the Department of Psychiatry runs the pain clinic, for example, orthopedists may want nothing to do with it. Treatment can differ greatly depending on whether the director is, say, a neurologist or a behavioral psychologist. Some clinics emphasize managing pain; some aim for rehabilitation; some promise cure. The best, in my view, have staffs drawn from multiple disciplines and departments. Despite political wrangling and philosophical conflict, however, the trend is clear. There are now close to one thousand private and public pain treatment centers in the United States alone.[27] In 1960 there were no more than a handful.

The shift from symptom to diagnosis finds a parallel in another momentous change. Many of the best pain clinics, reflecting new directions in research, accept the bold thinking that redefines pain not as a sensation but a perception. This shift represents an absolute repudiation of the dominant thinking about pain that has characterized nineteenth- and twentieth-century medicine—a mode of thought that the general public has accepted on faith, to our lasting confusion. Sensations, like heat and cold, require little more than a rudimentary, functioning nervous system. A salamander or a june bug can experience sensation. Perceptions, by contrast, require minds and emotions as well as nerves. When we understand

pain as a perception, we are implicitly challenging the deeply entrenched mechanistic tradition in medicine that treats us as divided into separate and uncommunicating blocks called body and mind.[28]

The new clinics that regard chronic pain as a perception rather than a sensation (and not all clinics accept this view) necessarily acknowledge the importance of understanding body and mind as inseparably linked. Further, because people experience pain only within specific cultures or subcultures, the link between bodies and minds extends also to the surrounding field of social life. Families, lovers, ethnic groups, advertising campaigns, wars, scientific discoveries—all directly or (most often) indirectly influence our perception of pain. A medicine willing to take account of cultural and psychosocial influences on the perception of pain needs to consider resources not generally explored or even acknowledged by medical schools. Eventually, modern doctors and writers may find—to their mutual surprise—they no longer gaze at humankind from opposite sides of an abyss.

The benefits that flow from viewing the mind as absolutely intrinsic to the experience of chronic pain do not require us to abandon decades of progress in medical research. We are not turning back the clock to a time before aspirin and ether, but rather moving forward in an advance that also finds a purpose for what Plato and Aristotle and Cervantes have to teach us about pain. Change comes slowly, however, when ideas entrenched in medical education and in the general culture—ideas such as the absolutely rigid division between mental pain and physical pain—must be challenged. It is likely that many doctors will not change their thinking about pain until patients begin to demand it. Luckily, however, modern medicine is a consumer-driven enterprise. Doctors will decide that change is a good thing when patients demand a change. If in the manner of the best new pain clinics we insist on understanding and treating our pain as a perception rather than a sensation, we will find, I think, that the medical profession suddenly believes we are right.

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A revolution in medical thinking about pain—like a political revolution—falls far short of creating an instant utopia. We need to recognize that, despite the avalanche of new research and publications, despite promising work at the new clinics and centers, the mysteries of pain remain veiled. The person in pain belongs to a world that no one else can

entirely share or comprehend. Perhaps there is something finally incomprehensible in pain that supplies, as Emily Dickinson saw so clearly, its peculiar quality of blankness. "It was the whiteness of the whale that above all things appalled me," writes Melville's narrator, Ishmael, in *Moby Dick*. This mysterious, unresponsive absence of color—"a dumb blankness," as Ishmael calls it—seems to him somehow infinitely terrible. "There yet lurks an elusive something in the innermost idea of this hue," he writes, "which strikes more of panic to the soul than that redness which affrights in blood."[29] Pain partakes of this eerie and sometimes appalling power to drain off everything that gives the world vividness, color, coherence, and value. The blankness of pain may be its most terrifying attribute. It casts us back upon a featureless landscape.

The meanings that over the centuries we have carved out of pain—the features we have imposed upon its oppressive blankness—constitute an achievement of the human spirit. A hard look at pain, however, will force us to acknowledge that these personal and cultural achievements are not uniformly fine. The uses and meanings of pain, from Nazi death camps and the torture of the Inquisition to the latest death squad or political tyranny, also reflect our worst abilities to rationalize and to accept the unspeakable. The same progressive Enlightenment culture that built Monticello, with slave labor, also decreed that slaves were subhuman creatures who did not truly feel affliction. In the achievements it has called forth, pain ranks with the soaring cathedrals and hideous dungeons of medieval Europe as a testament to the contrary powers of the human spirit.

It is the final thrust of my argument to contend that the history of pain has brought us to a moment of profoundest change. The human spirit must again choose directions. It is not just we who have changed as the invisible tide of chronic pain rises around us. Pain too has changed. Isolated from the various cultural and personal systems of explanation that formerly gave it meaning, pain today still presents itself most often as entirely and solely a medical problem. The medical problem most often presents itself as a matter of hidden tissue damage that constitutes an occasion for drugs, surgeries, and referrals. We have entered a time, in short, that confronts us with a radically new threat. It is a time when, outside and inside the specialized language of medicine, pain threatens to become entirely meaningless.

Certainly the cultural resources available in previous ages now gener-

ally lie forgotten or ineffectual, largely because they cannot compete with our faith in medical cures. Chronic pain, as one of its most troubling features, eventually robs us of our ordinary belief in medical solutions. When denial too fails to work (and it fails with absolute regularity), we are left more or less without resources. Such inexplicable pain is not simply too complex or too severe to be contained within language. As one medical treatment after another fails, chronic pain becomes an experience about which there is increasingly nothing to say, nothing to hope, nothing to do. It is pure blank suffering.

This new chronic affliction—the creation of our own scientific, demystifying era—may rapidly and closely approach the inhuman: a pain to which we can assign no meaning at all. Yet there is also reason to resist despair. The pain clinic movement offers a sign of significant change. Groups inside and outside medicine have initiated programs to educate physicians in the rights of patients and in new methods of pain relief. Ancient, concealed wrongs that fill the world with pain, such as wife-beating and child abuse, are beginning to emerge into the light of discussion and reform. We still have a long way to go. Nevertheless, as glib or heartless as it may seem, it is altogether possible that in the struggle against the blankness and meaninglessness of modern pain we may find occasion to recover an indispensable but disdained and neglected resource whose therapeutic value we have vastly misunderstood: laughter.