Medicine, Health Care and Philosophy **6:** 255–262, 2003.

Scientific Contribution

Pain and communication

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Abstract. It is frequently said that pain is incommunicable and even that it "destroys language". This paper offers a phenomenological account of pain and then explores and critiques this view. It suggests not only that pain is communicable to an adequate degree for clinical purposes, but also that it is itself a form of communication through which the person in pain appeals to the empathy and ethical goodness of the clinician. To explain this latter idea and its ethical implications, reference is made to the writings of Emmanuel Levinas.

Key words: communication, empathy, ethics, Levinas, pain

> In pain, sorrow, and suffering, we once again find, in a state of purity, the finality that constitutes the tragedy of solitude.[1]

We take it for granted that clinicians have a duty to relieve pain. We do not consider it questionable to take an aspirin when we have a headache and, in the case of others, we accept that we should seek to relieve pain when we are asked by the sufferer to do so. And yet, when it comes to others, we sometimes do adopt differing attitudes. It is not uncommon for patients in various clinical settings to receive inadequate palliation for pain. For example, according to a recent newspaper report, internal hospital research has shown that for cancer sufferers in palliative care at the Peter MacCallum Cancer Institute in Australia, seventeen per cent of prescribed doses of morphine and thirty five per cent of doses of paracetamol were not administered.[2] Very frequently, pain-relieving drugs tend to be administered in time-regulated and parsimonious amounts irrespective of the expressed wishes of patients, or even of doctors. Patients who complain or seek more frequent relief are sometimes deemed soft, self-seeking, or trouble-making. Pain relief is considered a scientific and objective discipline administered by experts on the basis of objective regimens rather than that of patient needs. Perhaps one of the causes for this approach is that pain is thought of as not directly communicable. As a result, clinicians must use an objectifying diagnostic form of judgement in relation to it and the treatments that they prescribe are based only upon such judgement rather than upon the communication of pain on the part of the patient.

In this paper, I raise the question of the extent to which pain is communicable and of the form in which it might be communicable. I then suggest that there are ethical implications arising from the analysis which I offer.

Pain defined

Pain is defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."[3] What this definition highlights is firstly the unpleasantness of pain. It goes without saying that, standardly, pain is something we would rather be without. Our bodies react with withdrawal reflexes and with flinches and cries when we are subjected to it. "That hurts!" is a cry for help or an appeal for the cessation of the hurtful event. The second most obvious point that this definition highlights is that pain is an experience. It makes no sense to say that a person is in pain but that he does not feel it. A person may suffer an injury or a malady of a kind that typically causes pain but, unless they feel it, they are not in pain. Thirdly, this definition points to the body. Pain is an experience that is felt in the body and, indeed, usually in specific organs or regions of the body. Even though there are cases such as those of phantom limbs or of psychogenesis, where pain is felt in the absence of any bodily lesion, pain is always felt *as if* it were located in a specifiable portion of the body.

This point is important in that it allows us to distinguish pain from other forms of suffering. The grief that one might feel at the loss of a loved one or at some other kind of disappointment, the fear that one might feel at the thought that one might be suffering from a disease, or the depression that one might feel at the

thought that one's illness has rendered one's projects meaningless, are sometimes described as pain, but they do not fall under the official definition. They are emotions and forms of suffering, but they do not have that essential reference to the body which the definition of pain points to. Nor do they have that phenomenological quality of physical hurt which is definitive of pain. This is not to deny that such forms of emotional or spiritual distress may be accompanied by, or cause, visceral forms of discomfort, but such a bodily state should be thought of as pain separately from the grief, fear, or depression that may be causing it. The emotion mentioned in the definition is the feeling of aversion and distress which colours the sensory experience. It is an inseparable quality of the experience rather than an element which is added to it.

There is a vast range of kinds of pain which differ as to type, intensity, frequency, recurringness, location, and other phenomenological qualities. Some pains are so mild that we hardly suffer because of them in the sense that we feel but little distress and undergo but little disruption to our lives. Other pains are so intense as to cause deep suffering. The most appalling pains of all are those intense and chronic pains that seem to admit of no relief and of which, sometimes, the aetiology cannot be clearly identified. Whether a person suffers because of their pain is a function of a range of factors and not just of the nature of the pain itself. One person may be more susceptible than another to reacting badly to pain and some societies will be more permissive than others in allowing victims of pain to adopt a suffering stance towards it.

Our definition also speaks of pain as a sensory experience. "Sensory" here does not mean that one sees one's pain or hears it. One does not even feel it in the way that one feels the surface of an object that one is touching. Pain is not an object of the senses. Rather, calling pain "sensory" means that the pain is actually felt and experienced in the body rather than in thought. Pain is not an idea. It is not spiritual. It is an immediate and insistent, physical experience of hurt. It is a felt condition of one's body or a part of it.

Normally most parts of one's body are, as it were, absent from one's attention.[4] Internal organs like the heart, lungs, or liver do their life-preserving work without calling attention to themselves in any way. Even where we are able to be aware of them indirectly, as in the case of our own heart and lungs, our attention is normally upon the things in the world with which we are actively engaged. Similarly, those parts of our body which we regularly use and can apprehend, such as our legs and hands, are absent from our attention as we use them. Our agency flows through them, as it were, and focuses upon the things in the world with which we are dealing. Let any part of our body be in pain, however, and our attention is likely to be drawn to it. Rather than an anonymous aspect of our agency in the world, that part of our body will now be an object of our concern. While we may be able, like an active person with a toothache, to get past this concern and focus on the tasks at hand, pain brings a part of our body into explicit awareness. We are aware that this part of our body now exists in a new way. It is no longer hidden on our side of the divide between self and world, but becomes part of our world as a problem for us to deal with. Just as the senses give us objects in the world for us to apprehend, so pain makes parts of our body into objects as the locus of hurt. It is in this sense that pain is sensory.

And pain is, lastly, an emotional experience because of our negative reaction to it. It hurts and we want to be rid of it. There may be circumstances when we do not want to be rid of it whether because we have adopted a policy of extreme asceticism or because we are masochistic, but it is still essential for what we want to achieve in such cases that the experience be unpleasant. Again, we might have a pain which is not so distressing and which we are too busy to worry about. But even then there is some unpleasantness and some small degree of negativity in our attitude towards it. Cases of intense and meaningless pain such as are often encountered in clinical situations will elicit powerful negative emotions and distress. Even if we had a theory about pain which allowed us to accept it intellectually, as when we call to mind the evolutionary advantage of being able to feel pain, or understand pain to be a warning of something gone wrong in the body,[5] or when we consider pain to be an acceptable part of God's plan for humanity,[6] we still feel it in its immediacy as unpleasant. To overcome this feeling and to accept it or even feel blessed because of it requires that one objectifies the pain to some degree. It requires that one ask what the merits of pain as such, or of a pain such as mine, might be. It requires that I place a little distance between myself and my pain so as to frame it in an intellectual construct. But to the degree that the pain is mine in an immediate and felt way, it cannot but be unpleasant and unwelcome. My body recoils from it. Its very nature is to be an attack upon, or a disturbance of, my bodily equanimity. Pain is a hurtful mode of subjectivity; a way of being which is distorted, tortured, and distressed. In itself and as an experience, pain cannot but be of negative value. Notice that I am not arguing that pain is a value-neutral physical condition and that it is the suffering which it may cause that is unpleasant. This would be to separate pain from suffering in a dualistic manner. Pain is a form of suffering. It is inherently unpleasant.

The privacy of pain

Like other forms of suffering, pain leads its bearers to powerlessness, alienation, loss of control, and anomie, and the withdrawal of the self into itself. Relief and comfort will therefore comprise, not only alleviation of the pain, but also the empowerment of the patient, their enlivenment, their re-engagement with the world, and the re-establishing of communication and rapport with others. Clinicians will seek to achieve all of these goals. But this paper focuses just on the last of these because there are some understandings of pain that seem to suggest that this is hardly possible.

As a mode of subjectivity pain is intensely private. As a mode of subjectivity my pain is radically my own. There exists no objectification of it that would allow another to share my pain. It is this feature of pain which sets up a difficulty for a clinician's approach to it. Clinicians respond to what, in a clinical situation, calls out for a response. If pain were as intensely private as I have just suggested, therefore, how can it be an operative and salient feature of a clinical situation for a clinician to respond to? The idea that pain is intensely private and non-communicable would seem to suggest that nothing can be done to overcome the isolation that severe pain forces upon its sufferers and that there is nothing communicable for a responsible clinician to respond to with caring. So let us look more closely at the notion that pain is private.

An observation frequently made about pain is that it is incommunicable. These sentences from Virginia Woolf are often quoted: "English which can express the thoughts of Hamlet and the tragedy of Lear has no words for the shiver or the headache ... 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."[7] It is suggested that the words that we do use to describe pain: words like throbbing, piercing, persistent, stabbing, and so forth, are clumsy at best. They are metaphors and do not carry literal meaning. One may have a stabbing pain without actually being stabbed. It is also said that such descriptions are not as helpful towards the clear delineation of symptoms and the making of diagnoses than are the visible or otherwise detectible lesions found in the body. After she notes that pain is frequently described with metaphors, the claim that pain is essentially incommunicable is expressed by Irena Madjar in this way: "Thus, because bodily pain resists objectification in language, it is marked by a strong element of *unshareability*. In other words, pain silences and actively destroys language."[8]

This seems to me to overstate the case. Firstly, there is nothing unusual about experiences having to be described in metaphors. Try describing the beauty of a sunset without using them. That one needs metaphors here does not imply that the experience is radically private, incommunicable, or unshareable. Secondly, all experience is inherently unshareable in some sense. It is in the nature of experience, being subjective, that it is the experience only of the experiencer. As such it is not shareable. It cannot be another's experience. You cannot make another feel a pain by talking about it. But this is both obvious and uninteresting. I am not prevented by this unshareability from communicating the experience to another in a variety of ways. Reading the paper over breakfast is an unshareable experience in this sense but I can certainly communicate aspects of it to you by commenting on the stories I have read, by getting you to read them, or by saying that I found it very interesting to be reading them. Similarly, the experience that I have when I enjoy a beautiful sunset is unshareable, but I can communicate much of it to another through language even if to do so effectively I might have to become rather poetic or metaphorical.

Is it any different with pain? As a subjective experience it is as unshareable as any subjective experience. But Majdar's own table of pain descriptors (burning, stinging, searing, etc) shows that communication about it is possible. Virginia Woolf may be right in suggesting that our repertoire of words is relatively poor for communicating pain, but this just shows why we need a range of metaphors. Indeed, we often use them quite successfully. It is noteworthy that attempts have been made to systematise the descriptors of pain into a more coherent symptomology. The McGill Pain Questionnaire developed by Melzack and Torgerson[9] explored the connotations, relationships, contrasts, and similarities between the metaphors used in describing pain and their relation to actual maladies. It drew up numerical scales and tables. The result is a more systematic and reliable set of interpretations of such pain descriptors which allows clinicians a more assured access into the conditions that patients are suffering. This is not to deny that pain words are highly relative to the context and emotional state of the sufferer. Despite the refined diagnostic tool that the McGill Pain Questionnaire provides, there can be no simple lexicon of words for describing pain. The metaphors that patients use must be heard in their contexts and with their contrasts, and clinicians must here, as in other cases, be sensitive to the particularities of the case before them.

But what does it mean to say that pain can destroy language? Elaine Scarry has argued this point with reference to such extreme situations as torture and war.[10] One might refer also to cases of extreme, chronic, and unbearable pain which clinicians attempt to alleviate in the clinical setting. In such cases, sufferers often find themselves unable to speak. Not

only might their distress physically prevent them from speaking but, were they able to speak, nothing that they would say would be adequate to the severity of what they were experiencing. The moans and cries to which such victims are reduced by extreme pain are not cases of language. In a strict sense this is true. But it does not follow that such aural gestures are not communicative. Even a flinch is communicative. It is difficult to imagine a more eloquent expression of pain and a more effective communication of its cruelty than a cry of distress. That language is unable to convey this verbally does not mean that it cannot be conveyed at all.

It is interesting to note that many sufferers of chronic pain cease to evince, not only expressive bodily gestures such as cries, but even direct bodily expressions such as dilated eyes or increased heart rate. The objective signs of pain seem to be repressed.[11] The only evidence for pain in such patients is what they say and the ethical difficulties that they present is that of whether the clinician should give credence to what they say in the absence of any such objective signs. Perhaps it is this problem that gives rise to the documented aberrations in clinical practice where clinicians are apt to regard their patients as faking the severity of their pain and thus to give too little pain relief.

There are a number of philosophical reasons for the difficulties that attend the communication of pain. The first of these is that pain is not "intentional". What this technical philosophical term means is that it is not *about* anything and does not refer to anything aside from itself. Other subjective states of persons are not like this. When I am angry, I am angry about something. When I feel fear there is an object or an imagined object that I am afraid of. While there may be some mood-like states which seem not to have an object in this way, they are nevertheless manifest by the way that objects in the world or in thought present themselves to me. If I am depressed without being depressed about anything in particular, my world and my thoughts take on a colourless hue and events lack excitement or interest. In this way even an objectless state like depression manifests itself in the way that the world appears to me when I am in that state. But pain does not refer to the world in this way. Not only does it make no sense to speak of a pain as being about anything, but also pain need not colour the world in any way. If anything it distracts from the world. I do not see objects in the world in a pained way and my pain does not refer me through it to objects or other things. What my pain does is draw attention to itself. It comes to preoccupy me in direct proportion to its severity. It is not a way of apprehending the world, but a mute and brutal presence that pushes all other subjective states, and the world itself, to the periphery of my attention. The consequence of this for our problem is that pain becomes hard to describe. I can describe my anger by saying what it was that annoyed me. I can describe my fear by saying what I was afraid of. But I cannot describe my pain in this way. I can refer to that part of my body in which the pain is located, of course, but this is not identifying an intentional object of pain so much as its locus. The ways in which I can describe my pain in language (as opposed to expressing it in gestures) is certainly limited by this feature.

Another technical argument, and one offered by Scarry,[12] is that pain defeats language because the primary function of language is to refer to objects. When I say "hat" in an appropriate context, I can be taken to be referring to a hat, whether a particular hat present in that context, or the more general idea of a hat. What makes communication possible in such a context is the presence in the world of hats, such that my words can refer to one or more of such hats. It is then suggested that pain is not an object in the world in this way and so is not an object that words can refer to. Now, if this argument were sound, then it would not be possible to speak about any of our inner, subjective states. What am I referring to when I say that I am happy or that Mary is happy? Without going into the technicalities of linguistic philosophy it might be enough to say that even in the absence of worldly objects to refer to, language requires objective criteria for the ascription of such terms. I can call Mary happy on the basis of seeing how she behaves. If she were crying at the time, my description can be deemed to be wrong. Similarly, I can call myself happy when I notice myself behaving in certain ways as well as experiencing certain feelings. It is the burden of Wittgenstein's so-called "private language argument" that I cannot attribute inner states to myself solely on the basis of my own experience of those states. My own experience does not tell me what such terms mean in the public domain. I must be able to apply the public criteria for ascribing a subjective state to myself in just the way that I have learnt to ascribe them to others. I cannot have learnt what the word "happy" means just by noting my own internal states. How do I know that the state I am experiencing is the state that our language designates as "happiness"? By seeing that my expressions of that state are similar to the expressions that others evince when they are standardly described as happy.

And so it is with pain. Certainly the experience is irreducibly subjective. My pain is radically my own. But how do I learn to call it pain? I do so by noting that the way in which the term "pain" is used in the public domain is in order to describe a person who is grimacing, holding his mouth and making a dental

appointment, or a person who has suffered an injury to his leg and is hobbling to a surgery for treatment. When such persons say they are in pain, they are not only expressing their inner state, they are also, in effect, teaching me what the word "pain" means. I will then be able to use the term to describe my own inner states when I suffer such or similar injuries, engage in similar behaviours, and experience hurtful sensations. And having learnt it, I can use the term to describe similar inner states of mine which arise in differing contexts. In this way language can refer to pain, even though pain is not an object in the world. This is not to deny, however, that things are more difficult when we come to describe the qualities of pain. There are few external or objective criteria for describing a pain as "throbbing" or "piercing". The meaningfulness of these terms arises from their being metaphors. We know what it is for an item to throb or to be pierced. These words do have an external reference in their non-metaphorical usages. And we can go on to imagine what it might feel like for our bodies to throb or to be pierced. What a victim of pain is saying is that a pain feels like that. Provided we can imagine what throbbing or piercing might feel like in our own bodies, we can understand what they are saying to us.

But this whole argument is premised on the thought that the primary function of language is to refer to objects, whether these objects be things in the world or inner subjective states of people. But a further function of language is to express our selves in an intersubjective world. More simply put, it is simply to chat.[13] We spend a lot of our time in idle conversation. If we were to reflect on the amount of time we spend talking in a typical day, we might find a surprisingly high proportion is non-pragmatic or apparently purposeless communication. The real purpose of such exchanges is not to convey information about the world so as to complete some task or other, but to establish and maintain intersubjectivity. It is an expression of sociability and of our need for community. Perhaps the thought that pain destroys language means that it destroys such sociability.

One effect of pain that is relevant here is that pain isolates. Pain presses its victims back from the world into a preoccupation with the state of their bodies, and in so doing it isolates persons from the world and from others. Despite what I have been saying about the communicability of pain, it remains true that it moves the boundary between subjectivity and the world inwards. Healthy and pain-free persons are able to transcend themselves into the world and project their subjectivity in such a way as to invest the world with meaning. Moreover, such persons are able to relate to others by reaching out to them in an encounter in which they lose themselves to a degree in the reality of the other and of the relationship. But persons in pain withdraw into themselves. For them, in proportion to the severity of their pain, their world reduces to their own isolated reality. The world ceases to engage such persons. They are not able to forget themselves and be fully in the world. They are not able to throw themselves into relationships with those around them and partake of the common subjectivity characteristic of social existence. Their pain crowds out all other interests and commitments. Their attention is focused upon themselves. They are obsessed with the states of their own bodies. It is not just that their experience is their own or that it is unshareable. All subjective states are like that. It is not that they do not have the words to express or describe their pain as others have argued. It is that they are not able to escape the prison of self-involvement which their pain has created around them. There is no reality for them but their own suffering. There is no subjectivity present to them but the nagging and searing insistence of their own tortured and isolated subjectivity.

For the clinician to open up a communicative channel to such a self-absorbed subjectivity requires a form of rapport which is different from that established by everyday language. The objective and intersubjective world which language establishes and refers to is no longer available to the patient in severe pain. Thus a new form of intersubjectivity needs to be established: namely, one grounded in empathy.

Empathy

Empathy as a form of intersubjectivity is already known to us from everyday experience. Imagine yourself engaged in conversation with another person. It may be about a practical matter or project upon which you are both engaged, or it may just be idle chat through which social relationships are maintained and enriched. There is communication here and it is mediated by language. But now suppose that, in the course of the conversation, your eyes meet those of the other and you suddenly become aware of a new depth of rapport between you. Sometimes such a moment can be embarrassing. At other times it may have a sexual component. When it is not appropriate to the socially structured nature of the relationship it can cause problems. But at other times, it can be a moment of unique joy and encounter with the other.

Emmanuel Levinas has theorised such moments by suggesting that in them we come into contact with the mystery of another's subjectivity. Whereas our apprehension of things in the world and our talk about them is always mediated by concepts through which we understand them, and whereas those concepts are part

of our own linguistic and conceptual repertoire through which we make sense of, and appropriate, the world, the mystery and infinity of the other cannot be grasped in this way. The other person is always "Other" in the radical sense that he or she cannot be appropriated by me in my understanding or perception. I cannot understand another person in the way that I can understand a motor car, for example. In the case of a motor car, even without too much mechanical knowledge, I can completely grasp what it is, what it is for, and how it stand in relation to me. I can put it into the category in which it belongs. I cannot do this with another person. Even a person whom I know well (indeed, especially a person whom I know well) will always be beyond my intellectual, emotional, or conceptual grasp. The Other is infinite and ungraspable.

It follows from this, for Levinas, that the way in which I approach another person, my comportment and attitude towards them, is ethical in nature from the very first. It always places an ethical demand upon me. If I do classify them and put them into a predefined category, and if I do relate to them just and only as structured by that classification, then I act unethically. If I relate to an employee just as a functional item in my enterprise, or if I relate to my patient just as a problem to be solved, then my comportment is unethical. Kant had already said as much when he said that we should not use people as means to our own ends, but Levinas deepens the point by showing that it is not just a matter of what we do, but also a matter of how we perceive the other. More positively, the ethically proper comportment that I ought to adopt toward the Other is that of letting their mystery be. I must not appropriate or classify. I must leave space. I must be open to encounter. I must be prepared to be surprised. I must be generous in my comportment, accepting in my attitude, and caring in my approach.

The point that I wish to draw from this is that, despite my arguments showing that pain is more communicable than many have claimed, there is still something important being expressed in the claim that pain is radically private and unshareable. Like so many other identity-constituting features of subjectivity, pain is a mystery to the one who observes it from the outside. It is part of the infinite and ungraspable nature of the "Other". For a clinician, as for anyone, observing another person is a case of trying to do the impossible. It is a case of trying to grasp and understand Otherness or infinity. Just as I cannot fully understand the love that you feel, the beauty that you experience, or the fear that you undergo, so I cannot grasp your pain. The theoretical reason for this is that, to me, your pain is not a phenomenon. It is not a percept. It is a modality of your subjectivity. It is a condition of your mystery, of your otherness, of your infinity. While you can convey much of it to me by the things you say, the metaphors you use, or the bodily or verbal gestures that you evince, it remains *your* pain. At the deepest levels of encounter, I cannot grasp it or classify it. Even if I compartmentalise it as part of a diagnosis or treatment regimen, I cannot take possession of it or make it mine. I must respect it as yours. The irony of the argument is that pain is indeed mysterious. Just as the subjectivity of the other is mysterious, so that modality of their subjectivity which we call pain is mysterious.

Pain as an ethical challenge

But more, I must accept pain as an ethical challenge. The ethical challenge of encountering the other as the Other is that of letting the other be and of establishing intersubjective rapport. More specifically, in the case of pain, the ethical challenge is to reopen the patient's world so as to break open the isolation into which their pain has forced them. In the clinical context, empathy or compassion is the form that this challenge takes. Communication of and about pain must therefore be possible. But this is not just communication of factual and pragmatic information. It is not just answers to questions like "Where does it hurt?" or "What does it feel like?" It is the establishment of intersubjectivity, an encounter between two selves. The pain of the other, which tends to their self-enclosure, must be made into an opening through which the care of the clinician flows through to the patient. The clinician must bring to this encounter a mode of apprehension which does not objectify the other or their pain.

Levinas' analysis of the other relates to the nature of both parties in an intersubjective encounter. Not only does it imply that the clinician, in encountering the person in pain, must not objectify or classify that person, it also implies that the person of the other, the person in pain in the clinical case, is a different kind of entity from that which can be appropriated in a knowing and assimilating gaze. The first significance of the point that the other is a mystery or an infinity is that it cannot be grasped epistemologically so that our response must be non-grasping and therefore ethical. But the point is not only that the other may not be appropriated or used as a means. It is also that the other *appeals* to me in an ethical manner. The other calls out to me for help. Many things in the world appeal to me, of course. If I see a fancy sports car it may strike me as a thing of beauty and of power. It may strike me as desirable. Or it may strike me as something objectionable in a world of poverty and exploitation. But in each of these cases it is my mode of apprehension of the object that dictates how it will

appeal to me. In each case, and especially in the case where I desire the object, the way the object appeals to me will be a function of the way I appropriate it into my world. In the case where it strikes me as desirable, it will be because I am one who desires to possess the object.

But another person is not to be assimilated or possessed in that way. The otherness of the other dictates not only that I should not appropriate it or that I cannot, it also constitutes a primordial, ethical appeal to me. As I look into the eyes of another I feel a call upon my being. As Levinas puts it, "In expression the being that imposes itself does not limit but promotes my freedom, by arousing my goodness".[14] It is as if the other reaches out to me in the expression of their pain. Their depth and mystery, their infinity, is a space that draws me into it. Their needs and desires, whether or not they are articulated to me, become like a magnet to my being. I am drawn into their Otherness. The encounter between us is structured not only by my ethical refusal to appropriate the other into my world, but also by the lure of the mystery of the other which draws me out of myself into the infinity of the other so as to elicit my ethical response. The other is a call to me to become engaged with that other.

Of course, it is perfectly appropriate that the forms and structures of everyday life place an overlay of reserve over this intersubjective magnetism. We cannot, in our routine situations, answer this call to personal rapport fully. The business of everyday life could not go on if we succumbed to the lure of the other in every context. This is why it is considered bad etiquette to gaze too deeply into the faces of others and why we resent what we call intrusions into our personal space. Nevertheless, the potential for deep rapport is always there and various degrees of friendship and communication that the structures of social and private life permit to us should be such as to allow such deep rapport with significant others.

In professional settings such as health care there is a special need to negotiate the right degree of rapport with patients. On the one hand, a patient is a client with whom the clinician's relationship is mediated by the forms of the professional setting. As is well known, there are risks here of objectification and routinisation. One the other hand, the patient is a human being with all the depth, mystery, and infinity that Levinas has described. More to the point, the patient is suffering. Specifically in this paper, the patient is envisaged as being in pain. This condition adds urgency and immediacy to the ethical call that the other places upon the clinician. Not only is the other an infinity that calls out to me for my response, but the other's pain and need is an intensification and focusing of this appeal. The other calls out to me from their need. And I hear the other from out of my general ethical stance of letting the other be and my more specific and professional ethical comportment of caring and professional attention.

It will be the eyes of the other that most eloquently send out this appeal. But, in the clinical setting, it will also be their bodily state. The cries and groans, the flinches, the writhings, and the bodily contortions that express pain will all be gestures of appeal. They are all modes of supplication. They are not just symptoms of malady. They are not just indicators of where and how palliative interventions should take place. They are also personally expressive gestures that open up the interpersonal space into which the clinician enters as rescuer. Moreover, the patients' reports of their own pain, whether formalised into a symptomatology or not, will be more than useful diagnostic information. They will be appeals for help that arise from the deepest need of the other and appeal to the deepest ethical levels of the clinician. However it is expressed and whether or not it causes suffering in milder cases, pain is a direct appeal from the depths of the otherness of the patient to the depths of the humanity of the clinician.

Contrary to the often repeated contention that pain is silent, private, incommunicable, and destructive of language, therefore, I would contend that pain is an eloquent amplification of the intersubjective rapport which human beings naturally establish between themselves. Pain not only causes its sufferers to become self-preoccupied but it also leads them to seek help from others. Pain amplifies and intensifies the interpersonal appeal that exists between people who engage in genuine encounter. It amplifies it because the need of the other is greater and more immediate and because the comportment of the clinician is one of caring and benevolent attention. It intensifies it because, along with the lure of mystery and infinity which each person presents to another in encounter, pain highlights the vulnerability and finitude of each one of us. It is from this finitude that we reach out to each other and it is because of this finitude that we embrace one another in rapport.

Notes

1. Emmanuel Levinas, "Time and the Other," in: Seán Hand (ed.), *The Levinas Reader* (Oxford: Basil Blackwell, 1989), p. 39.
2. Victoria Button, "Cancer Patients Not Given Drugs," *The Age* (November 23, 1999), p. 8.
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