



SAPIENZA
UNIVERSITÀ DI ROMA



© Author(s)
E-ISSN 2531-7288
ISSN 0394/9001



MEDICINA NEI SECOLI

Journal of History of Medicine
and Medical Humanities

37/2 (2025) 53-70

Received: 21.10.2024

Accepted: 12.11.2024

DOI: 10.13133/2531-7288/3162

Corresponding Author:

cornetphilippe@hotmail.com

The doctor, the patient and his pain

Philippe Cornet, Sarraouinia Gakunzi

Departement of General Medicine, Sorbonne Université, Fr

ABSTRACT

Although pain is sometimes a warning sign, it is also very often the companion of the path of painful beings. We are beginning to understand the mechanisms of pain, but it is still difficult to treat. Pain imposes its tyranny on daily life, fostering isolation and narrowing the field of possibilities. Because it is an emotional experience, it can only be understood within a specific cultural context. In this sense, it is an anthropological fact, but it is also a political fact, since the relationship that doctors have had and still have with it is marked by stigmatisation, depending on the population studied. History tells us how children, women and certain populations, because of their geographical and cultural origins, have been the victims of ethically scandalous care practices. Therapeutic support for people suffering from chronic pain calls into question the ability of doctors to establish an authentic, respectful and understanding relationship, and their desire to encourage patients suffering from pain to tell their own stories, as part of a genuine hermeneutic of care.

Keywords: Anthropology of pain - Mediterranean syndrome - Racism in medicine - Object-body - Subject-body

*"Pain blends the body and the senses"*¹

D. Le Breton

*"Pain is the balance of all the languages of the past,
the deep root of all our words"*²

M. Foucault

Any human being experiences pain at some point in his or her life, and it is both lifesaving and threatening. Saving, because it acts as an external alarm, protecting us from aggression, and an internal alarm, pointing out a large number of pathological processes. Threatening, invasive and despairing when it shatters the fragile balance of well-being and imposes its tyranny on our daily lives.

We propose to approach the experience of pain from the patient's perspective, viewing it as an anthropological fact that challenges caregivers far beyond the clinical sign. In other words, it requires an interpretation of the symptom to understand the symbolic dimensions involved in the attempt to rearrange oneself during painful illness. It is in this cultural context that the painful symptom can be interpreted. At least, certain types of pain, like certain illnesses, come up against stigmatising representations and must be approached not only as an anthropological fact but also as a political fact in a historical perspective of racial discrimination.

The pain perspective approach not only raises the question of how to relieve it, which calls on knowledge in the field of therapeutics, but also why to suffer and how to live with your own pain? As a result, pain cannot be reduced solely to the activity of sensory neurons; it does not exist without a painful *human* subject, since it is above all a subjective experience that involves the whole of our being.

For the International Association for the Study of Pain (IASP), pain is an "unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"³. It is therefore in this double sensory and emotional dimension that we will address the question of the doctor, the patient and his pain. After a basic reminder of physiopathology and therapeutics, we will approach the 'racialized' construction of pain and the way in which medicine has, over time, constructed a hierarchy of beings according to their origins, based on scientist theories. This position is the source of an *underestimation* of others in their suffering and their demands. We will then look at the painful human being, who by his complaint, seeks relief from his physical as well as his moral pain, the hope of an encounter with care, the acceptance of a unique account of his illness and his suffering.

Physiological and therapeutic foundations

The aim is not to explain in detail the great complexity of the different circuits and mechanisms of pain, but to give a general but sufficiently precise view of its nature

and regulation to gain a solid understanding of its mechanisms, and then to position some of the major contributions of analgesia.

Pain

A distinction is made between acute and chronic pain. This distinction is based more on duration than intensity, as chronic pain often recurs with high intensity during episodes. While there is no difference in nature - both are nociceptive signals - there is a difference in representation: “While the acute pain can be considered as a symptom of an illness or injury, chronic pain must be considered as an illness in its own right”⁷⁴. Pain that initially was just a symptom becomes an illness for the carer⁵ in the context of a chronic pathology. It should be added that the pharmacopoeia used to treat acute pain, powerful but transitory, is markedly different from the one used to treat chronic pain. We identify three types of pain: *nociceptive* pain, *neuropathic* pain and *psychogenic* or *sine materia* pain. The distinction is of great value to the doctor in his diagnostic orientation and treatment proposals, but for the patient this classification is of little relevance, since what he feels first and foremost is pain.

- *Nociceptive pain*
- It involves an excess signal from the periphery to the spinal cord and then to the brain. These types of pain are sensitive to treatments that reduce (or interrupt) the transmission of nociceptive messages at a peripheral and/or central level: these are mainly analgesics.
- *Neuropathic pain*
- Modification of the transmission and/or control processes of the “painful” message following peripheral or central nerve damage. There are many possible causes: toxic, tumoral, metabolic, compressive, iatrogenic, viral, vitamin deficiency.
- *Psychogenic or sine materiae pain*
- *Sine materiae* pain corresponds to clinical entities that are well-defined from a semiological and diagnostic point of view (tension headaches, fibromyalgia, glossodynia, etc.). Psychogenic pain corresponds to proven psychopathological symptoms (hysterical conversion, depression, hypochondria). It is not a diagnosis of non-organicity.
- The sensation of pain

The nociceptive signal originates from specialized receptors located in the skin, on the surface of our deep organs, muscles, tendons, and even bones. These receptors sort information selectively so that only those relating to painful sensations are transmitted to the nerve fibers⁶. The signal thus generated is transduced, i.e. a chemical signal

is converted into an electrical signal (known as an action potential). The electrical signal is then conveyed by conduction to the brain by a system of neurons that relay the signal without altering it.

There is a short circuit known as the reflex arc, which provides a rapid response to the painful signal, by not involving the brain and remaining only at the local level of the spinal cord. This is a reflex system that comes into play when you burn or cut yourself.

Pain regulation

Pain regulation systems are complex, but the ‘gate control’ theory is particularly interesting as it explains why pain perception can vary widely, both for the same individual in different situations and between individuals in the same context. We will not go into the details of how it works, but this regulatory system reduces the pain signal when another sensory system is strongly activated simultaneously. Excitation of this second system inhibits the conduction of the pain signal. As an example, when a person bumps, she tends to rub hard the painful area to reduce the unpleasant sensation. In practice, she activates her “gate” system, so it reduces the signal transmitted to the brain and the painful sensation is lessened.

Pain in chronic illness

The chronicity of an illness is defined by the length of its evolution. It is considered that chronicity exists when the disease has been evolving for more than three months. Concerning the painful chronic pathologies, there are many of them, because in most cases the pain appears either immediately with the disease, or during its evolution, or is sometimes linked to disease complications. Diabetes, as an example, remains silent for a long time, but pain occurs at the time of its neuropathic complications. This is also the case with chronic renal failure, where bone pain appears late.

At the end of the physiological approach to pain, we realize that these arising, transmitting and regulating processes are well known, which makes it possible to understand how analgesic drugs work. Although doctors need to know the nature, causes and treatments of pain, it does not tell them anything about what the patient has experienced.

Pain treatment

Pain has always been at the heart of medical preoccupations, and there have been major steps in treatment, from Hippocrate, who used extracts of willow leaves (*salix alba*), to Bayer, who discovered it in 1899 and named it Aspirin. As to paracetamol, although it was discovered in 1878, it was not used as an analgesic until 1955. Many other molecules were added to the pain pharmacopoeia. This was the case with codeine, isolated from poppies in 1832. The use of poppy seeds, the source of opium, goes back to Neolithic times, and numerous of papyri bear witness to its use as a painkiller

in ancient Egypt. Morphine was isolated in 1805, and its medical use rapidly spread for its analgesic properties during the 19th century. Many other synthetic molecules appeared during the 20th century to complete the therapeutic arsenal. Endogenous opioids known as enkephalins, which are much less potent than exogenous alkaloids, may modulate nociceptive messages. Finally, let us not omit to mention acupuncture, which is widespread in Asia, and hypnosis, which is commonly used in anesthesiology. Today's physicians have a diverse and often complementary array of analgesics at their disposal. However, the possibility of attenuating or even eliminating pain, while partially resolving the sensory nature of the pain, has only a limited effect on the emotional experience of the sufferer.

Priorization of lives, priorization of pain

It all starts with a story...

The year 2024, we are in the emergency department of a major Parisian university hospital. A woman from Mali presents with abdominal pains. She is greeted by the resident on duty. She complains of pain, cries and seems to be suffering. The resident sees her, interviews her to understand her symptoms and looks for an emergency, a clinical examination reveals a painful abdomen as a whole, with a predominance of hypogastrium. He asked the patient: "Between 0 and 10, what would you estimate your pain to be? She replied "8, I'm in a lot of pain".

Given the intensity of this abdominal pain in a young woman, he decides to prescribe intravenous painkillers, as well as a blood test and an abdominal ultrasound.

The senior doctor supervising him looked at the file and asked the "interne"⁷: "Why are you prescribing all this? She doesn't have any abdominal defenses when you examine her, so there's probably nothing wrong with her". The intern, worried that he hasn't done the expected medical care, tried to justify himself: "She seems to be in a lot of pain, she has a pain assessment of 8 out of 10, it's a sudden onset pain... in my opinion, this clinical picture calls for an assessment". "But no, nonsense, she's maxed out at 4/10, you know, you have to be careful, you're just starting out, but I know them, another Mediterranean syndrome⁸! These patients are always piling it on! You give her Doliprane® (paracetamol) and Spasfon® (Phloroglucinol) and she's out! She'll go and see her GP if she doesn't feel better afterwards".

The "interne", bewildered but confident in his superior who has such a great experience compared to him, followed his instructions. Later, he searched the internet to find out "what is Mediterranean syndrome and how to recognize it", without finding any clear answers to his questions...

How can this situation be explained? Why does the doctor find it hard to believe and take into consideration this patient's pain? What is his history, and how to get rid of it?

Tell me where you're from and I'll tell you how you're suffering!

For several centuries in the West, biology and the medical sciences have been marked by a desire to classify nature and human beings⁹. As early as the 15th century, the concept of race based on blood and genealogy appeared in a legislative frame of ref-

erence: it was in Spain and Portugal that the ideology according to which social and moral characteristics are transmitted from generation to generation by blood entered the law and established different rights according to so-called biological criteria. This was the birth of the “*Limpieza de sangre*” statutes¹⁰, which justified the prohibition of access to certain corporations, towns and universities, followed by the mass expulsion of Jews from Spain.

In the 18th century, European scientists tried to develop an understanding of the world through the classification of living beings. Naturalism, developed by Georges-Louis Buffon and Carl Von Linné in particular, attempted to describe living beings, and humans in particular, by categorizing them. Carl von Linné has described four subspecies, with a hierarchy between them (*homo sapiens europaeus* > *americanus* > *asiaticus* > *afer*). At this time, descriptive anthropology was also being developed by Paul Broca, a doctor, anatomist and anthropologist who founded the Société d’Anthropologie¹¹ of Paris. His ambitions were to study the relationship between humans and the animal kingdom, to participate in the contemporary debate on the origins of man and to study human “races”. In the eyes of anthropologists, most of whom had medical training, physical characteristics were the most fixed and therefore the most reliable for scientific classification. Paul Broca developed anthropometric tools, in particular craniometry. This led to the development of phrenology, a theory formulated by Franz Joseph Gall, a German doctor, who assumed that the character, aptitudes and mental faculties of individuals depended on the shape of their skulls. Charles Darwin, Herbert Spencer, Francis Galton and other researchers of this time then pursued these theories and developed an understanding of the world divided into several species, hierarchized particularly by their ability to survive. These theories have had a major influence on the history of the transatlantic slave trade and colonization, and more recently on the genocides of the twentieth century, particularly the Shoah, as well as on medicine and its development. For centuries, this hierarchical classification of individuals served to justify experimentation on the bodies of those deemed inferior. Thinkers and researchers such as Denis Diderot, Louis Pasteur and Robert Koch justified experiments on death row inmates, prisoners and indigenous peoples on the grounds that they were inhuman. In 1690, Antoine Furetière wrote in his *Universal Dictionary*¹² that “remedies are experimented on people of little importance”. The experiments that contributed to the development of modern Western medicine were carried out on bodies considered to be non-human, incapable of emotions, feelings or even suffering. It was with these considerations in mind that doctors in the Nazi camps conducted experiments on deportees, with the aim to develop a better understanding of the physiology of the human body and also to develop new therapies. This was the case in the Sachsenhausen, Dachau, Natzweiler-Struthof, Buchenwald and Neuengamme. Researchers tested compounds and serums for the prevention and treatment of contagious diseases such as malaria, typhus, tuberculosis, typhoid fever, yellow fever and hepatitis. It is not

until 1946, after the Nuremberg trials and the end of the Shoah, that laws were established to protect human research subjects. One of the most high-profile experiments, revealed to the general public in 1972 but known long before to the scientific world, was the case of Tuskegee, Alabama. From 1920 onwards, an African-American population infected with syphilis was followed for 40 years without intervention, even at the time of the discovery of penicillin in 1946, in order to learn more about the natural course of the disease. This experiment was carried out without any prior information or consent from the people concerned. Blood samples and lumbar punctures were taken, again without explanation. It remains the most famous racist medical experiment in the history of the United States.

Closer to us, in 2001, genetic research led to the complete sequencing of the human genome. The idea of a biological race to characterize the different geographical subgroups of the human species was definitively deconstructed, since genetic diversity is much greater between individuals in the same population than between different groups. These conclusions can no longer be ignored by the whole scientific community. However, a 2016 study of future doctors in the United States found that 40% of them had false beliefs about biological differences based on skin color, including the following: Black people's nerve endings are less sensitive than white people's, Black people's skin contains more collagen (i.e. it is thicker) than white people's Black people have a better immune system than white people. These beliefs, influenced by history and the history of medicine, continue to be conveyed by medical training and prove that they are difficult to deconstruct in a collective imagination that gives pride of place to laymen's representations.

The 'Mediterranean syndrome': a construct of racist medicine

The concept of 'Mediterranean syndrome' is part of the racist prejudice that is passed on to students, in a more or less formal manner. This a pure construct with no scientific basis, but the term 'syndrome' gives it a certain legitimacy¹³.

Despite the knowledge acquired in genetics and the abandonment of the concept of biological race, errors persist in medical textbooks, using biological race as if it was a wealth determinant. Numerous American and European studies now demonstrate the consequences of these erroneous beliefs in medical practice^{14,15}. Thus, it has been shown that Hispanic and black women have been fewer to receive epidural analgesia during childbirth, and those who did receive, have had lower doses than the other patients¹⁶. Other studies carried out in Western hospitals have also shown that these populations received fewer analgesics in emergency departments in the event of fractured limbs or chest pain¹⁷.

When it comes to pain, doctors must accept that they believe the patient, that they cannot objectify the symptom or even sometimes understand it. It is only by accepting the validity of what the patient has to say that they can help relieve their pain. This

requires the therapist to listen attentively, to show kindness, to have an “unconditional positive regard”¹⁸ and to agree to limit the power involved in the healthcare relationship. It is not enough to have a “good intention”: social psychology has shown us, through the study of cognitive biases, that we can, despite us, reproduce stereotypes that have been transmitted to us by society and its history. Doctors, despite their desire to be neutral and benevolent, are no exception.

The relationship with the patient in pain is probably the one that confronts the physician with his own limitations, calling for humility. The physician must relinquish the desire to know and understand everything, accepting that only the patient can be the true expert of his own symptom.

From the body as object to the suffering being

In this third part, we will try to understand, based on some elements of Western medical teaching, what are the determinants that lead the doctor from the body as object - we have seen how the racialization of the symptom reduces the being to a body-thing - to taking an interest in the suffering being?

Illness affects an organism, but it also affects a body. If we are born with an organism, “corporeity is socially constructed”¹⁹. So, what does the doctor treat when he treats: an organism or a body? Can there be a body without a subject of the body? So, what does a doctor treat: a body or a subject?

If we are interested in the classification of diseases, those are enumerated according to the principle of the list, which, it must be said, does not protect us from vertigo²⁰ to the point of losing ourselves in the depths of the noise and untranquility of the organs; precisely those which are revealed by the symptom. The physician’s challenge stems from the need to interpret three layers: the organism, the body, and the subject along with his symptoms and pain. How can he move from nosology, the breviary of scientific knowledge, to caring for a suffering subject?

From organism to body

Until recently, the medical student’s first experience with a body was through dissection of a *corpse*. Dissection is - even if imaging plays an increasingly important role - an initiation into the mystery of an organism, but perhaps even more so, as Claire Marin writes, “it is less the body of the other that the student discovers in these dissection exercises than the unknown reactions of his own body to the abject. It is undoubtedly essentially from this perspective that dissection can still claim to have meaning”²¹. To do this, it is necessary to open, to cut, to see, the shapes and order of the organs, the muscular paths, the insertions of the tendons, the vascular connections and all the subtleties that link the different parts into a whole. Julien Offray de la Mettrie compared the human body to a clock, describing it as “a machine that

assembles its own springs”²². Almost a century earlier, René Descartes had preceded him in his metaphor: “I do not know any difference between the machines that craftsmen make and the various bodies that nature alone composes, except that the effects of machines depend only on the arrangement of certain pipes, or springs, or other instruments, which, having to be in some proportion to the hands of those who make them, are always so large that their figures and movements can be seen, whereas the pipes or springs that cause the effects of natural bodies are usually too small to be seen by our senses”²³; the escape from our senses is the foundation of its mystery.

This is how the teaching of anatomy is perpetuated in the lecture theatres of the faculty as much as in those of the morgues. This rite of passage shows the extent to which the initial objectification of the body influences the way future doctors think about suffering bodies. Moving from the cadaver to the body-object means apprehending two additional dimensions: the movement and warmth of a living organism, but without bringing the subject into being.

On the proper use of the body as object. A path of knowledge

Afterwards, clinical training takes place “at the patient’s bedside”, using a precise coding system: history-taking, inspection, physical examination, from which will emerge a diagnosis, if it has not already been made, and a therapeutic strategy. This is Mecano medicine. This way of acquiring knowledge has the advantage of creating a sort of anatomo-physiological microcosm which sets the learning framework and then the diagnostic approach when taking on responsibility. In the doctor’s mind, there is an effect from the whole to the part, and then from the part to the whole. Because these mechanisms of medical reasoning articulate the rudiments of a grammar of the sick body, by organ or function, it would be too hasty to consider this clinical approach obsolete. The main criticism that can be opposed to it, is to be confused later with the practice of care. Michel Foucault, quoting Jean-Nicolas Corvisart, provides a perfect illustration of the doctor’s initial position, free from any imaginary world or patient’s words, where only the organism has the right to express itself: “In the clinician’s theme, the purity of the gaze is linked to a certain silence that allows listening. The talkative discourses of systems must come to a halt: ‘All theory is silent or always fades away near by the patient’s bed’; and the words of the imagination, which anticipate what is perceived, must also be reduced [...] The gaze will be fulfilled in its own truth and will have access to the truth of things [...]”²⁴. This statement sums up the approach taken by French doctors in the nineteenth and early twentieth centuries, who believed that there was a pure clinic threatened by the dross of discourse, starting with the one of patients, and we wonder about the place left for the expression of pain in this silence imposed by doctors in the name of their art. Medicine presupposes a rational collection of signs based on the findings of the inspection and the irrational emer-

gence of symptoms from the patient. After the list, a veritable taxonomy of diseases was added to successive medical treatises. The major risk is “to live under the authority of the principles of *disjunction*, *reduction* and *abstraction*, which together constitute [...] ‘the paradigm of simplification’”²⁵, at the origin of a “blind intelligence”. This blindness stems from the impossibility of combining science and empiricism, or to be more precise, the reason of science and the culture of the humanities. This is the observation made by Michel Serres when he wrote about doctors, that “to reach the singular, learning medicine must also be based on culture, such as that contributed by the great writers and found in texts of universal scope, as these authors explore and describe individual experiences such as the doctor will encounter and which he will certainly miss if, limited to raw reason, he remains an uneducated scholar”²⁶.

From body-object to body-subject. A path towards otherness

It is a truism that medicine is not intended to treat body-objects, not any more than it is to treat illnesses, however “it sometimes considers the patient as an accessory to his illness rather than as its subject”²⁷. Thinking in terms of the body as a subject represents an initial shift in medical thinking towards the suffering being, by giving greater prominence to the complaint insofar that it contributes to understanding the symptom. This shift, although still tentative, is not self-evident. This anatomical and clinical curriculum has a profound impact on the legacy to be taken on by young doctors, and it spreads its shadow far beyond the end of their studies.

However, for more than a decade now, a discourse has been emerging within medical academia that takes the patient into account. The Université of patients, patient resources, the concepts of shared decision-making and patient preferences are all examples of this new desire for medical education to be concerned about the place of the patient in the healthcare relationship. However, we must not believe that there has been a definitive shift from the body as object to the body as subject, and then to the patient as subject. We are witnessing a kind of paradigmatic cohabitation, depending on the points of view chosen and the ideological orientations of opinion leaders. When the “*Livre noir de la gynécologie*” (Black Book of Gynaecology) was published²⁸, what did we not hear from certain heads of French gynaecology-obstetric departments who condemned the excessive use of women’s voices, so reducing a genuine suffering to hysterical complaints. This treatment of women’s pain is part of a very long history of medical treatment of the female body.

From the body as subject to the suffering being. The path of an encounter

Before setting off for a *meeting*²⁹, it’s worth taking a step back and asking the question: do illness and pain have a meaning?

Disease is one of the most common forms of entropy. As biological beings, human beings are constantly undergoing antagonistic destruction and recomposing. Allostasis,

the dynamic equilibrium between these opposing tensions, keeps us alive until... As time passes, entropy prevails, and biological disorganization leads to death. If we think of illness as an entropic stage, a deregulated allostasis, we can say that if it leads to death, it doesn't make sense. However, it is not only a form of reality of the body, an infected body, a demolished body, a diminished body, a body tragic in its pain, a body scattered by death itself. It is not in the depths of biology that illness and its pain take on their meaning, but in language. These are not just a state of being, these are also an experience and a discourse. Putting it into words is the central issue in the relationship between the sufferer and the doctor.

To understand what is at stake in clinical relationships, we need to refer to phenomenology and return to the "things themselves"³⁰, which make the interpretation the core of the analysis of a situation, but also a real need. To grasp the links, let's follow Paul Ricœur's presupposition that clinical practice and phenomenology intersect in the understanding of suffering: "The former instructs the latter by its competence, the latter instructs the former by the understanding of suffering that seems underlined to the therapeutic relationship itself"³¹. Medicine finds the very origin of its existence in its encounter with the suffering being: "medical training must lead students to understand that medicine finds its origin, its foundation and its specificity in the medical relationship, which must enable the doctor to meet his patient"³². The healthcare relationship involves a suffering person, with a request, a complaint, a cry, or even silence when words fail. Opposite (or beside) them is a being who is supposed to know and who, for Emmanuel Lévinas, receives this "first prayer addressed to the absent", who is "the one who hears these complaints"³³, which he considers to be as "the anthropological category of the medical, primordial, irreducible, ethical"³⁴. The care relationship is an encounter based on values: hearing the suffering of the other, not ignoring his loneliness, caring for his humanity while respecting his dignity and singularity, offering him *philia* (φιλία) by sharing³⁵; care presupposes this love of the sick men. The relationship is asymmetrical, since one person asks and the other is supposed to respond, but it is equal in its humanity sameness. For the philosopher Martin Buber, relationships is at the root of everything. When he evokes the "principle-words" *I-Thou* and *I-It*, he allows to grasp the authenticity of a being's posture in its encounter with the other - for the doctor, the one of a carer and a sick person - he states that "the principle-word *I-Thou* can only be pronounced by the whole being. The word *I-It* can never be pronounced by the whole being"³⁶. What does this mean? Otherness only arises when the doctor subjectifies the suffering person and thereby allows the *Thou* to exist, to express itself. Whenever this is not the case, by objectification of the person (body as object), by a false self, by a paternalist whose gentle kindness infantilizes the patient, it is the *It* that is summoned. The *It* is the *He/She* of the indefinite and of the distance. For Martin Buber, saying or being *I* is the same thing. By clarifying the contours of the world of things and its limits, he makes it possible to separate the things of the *I-It*

from the beings of the *I-Thou*: “I experience a thing. I represent something. I want something. I feel something. Human life is not made up of all these things and others like them. All these things and others like them form the basis of the empire of *That*. But the empire of the *Thou* has another foundation”³⁷. Martin Buber’s invitation to allow the emergence of the *Thou* from the *I* that we are, appears to be the foundation of the *encounter*, and emphasizes that there is no *I* without otherness³⁸. From this, it is possible to hope for a therapeutic alliance and a path of concerted action when it is a question of making a long-term commitment to each other, patient and doctor. In the relationship between the sufferer and the doctor, there can only be an *encounter* if, and only if, a mutual trust is established, an authentic interaction takes place without deception, and a mutual recognition seals the deal “of a commitment obligation”³⁹. Medicine is a commitment, an ethic, a morality in action that is constantly adjusted to the unpredictability of illness.

We cannot ignore the illness which is the reason for a person to see a doctor. Often the symptom, even if it is pain, does not find any translation into a sign⁴⁰, which is fortunate, in the doctor’s nosology. However, it generated concern, to the point of driving the person to the doctor’s surgery. Chronic illnesses, most of which are painful, offer the most fertile model for analyzing healthcare relationships. They require time and duration, due to the slow evolution of chronic illnesses: a gradual deterioration in health, the appearance of complications and increasing pain. Through the distress they cause, they produce a narrative, a self-narrative, a narrative of care.

From suffering to self-narration

Illness is an “intimate catastrophe”⁴¹ that is accompanied by a shift in identity that calls for a reworking, a new balance to ensure that we are coherent with the world, and a recompositing of our image, as “how can we even have the possibility of explaining when we first make of anything an *image*, our image!”⁴². Going from being well to being ill, from well-being to pain, is a social upheaval. An authentic crack in our existence, for Claire Marin illness is “a real test of our nakedness, to be taken in an existential sense. It leads us to question deeply what constitutes us, sustains us and defines us”⁴³. But it is not only an existential questioning, a realistic confrontation with having to die, it profiles, as said by Paul Ricœur, a “reduction in the power to act”⁴⁴, a reduction in the field of what is possible. To be ill is to face suspicion and reproach: suspicion of weakness of will, suspicion of indulgence about one’s pain.

It is perhaps by putting a narrative in order that the sufferer is able to best transcribe his or her experience to those who are able to hear it. It’s not a question of sharing; it’s impossible to share the experience, it’s untransmissible, all we have is a narrative. Everything is at stake in the collection of this fragile account of raw existence: “The paths of before are abandoned. You burn your previous life. You must build a new one.

Even as everything within us unravels and deteriorates. Secret demolition is at work. It's the demolition of the body that captures the whole being, an existence disrupted and devastated by this underground disorganization"⁴⁵. This is how, consultation after consultation, the patient weaves a narrative, often reworked, clarified, modelled and fantasized. In this process of becoming, a narrative framework is created that can restore a new architecture to life. The doctor listens alongside the patient, since he or she is powerless to "suffer-without-reservation"⁴⁶. The seats are not interchangeable. He listens in order to welcome, he listens in order to grasp the suffering of the other, he listens in order to act with and for this other who comes to ask for help. In his book *Soi-même comme un autre*, Paul Ricœur discerns some levels of efficiency: speech, doing, narration and moral imputation⁴⁷. He focuses on the suffering that affects the power to say, to do, to tell (oneself), and to value oneself. The four proposed axes constitute a relevant clinical proposal for making room for the composition of the self-narrative.

Hermeneutics under construction

The narration of ourself proceeds from a tangle with the lives of others. Absent third parties haunt medical consultations with their symbolic presence. The doctor thus welcomes a procession of others whom he or she will never meet outside the patient's narrative. This creates a combination of life stories, which has the virtue of keeping the patient within the social fabric of meaning.

Illness challenges the doctor and the patient in two different ways: the first is concerned with the how, while the second wonders about the why. These distinct quests give rise to a misunderstanding about the explanation. While information plays a key role in the announcement of the disease, in its painful manifestations and in its follow-up, it does not appear to be the primary necessity. It is the questioning of meaning that takes center stage in the relationship: "Why me? What have I done?" The evil-victim, the evil-guilty, the evil-expiatory, the evil-unjust, the evil that seeks to find its source from which a truth will spring; if everything has a cause, not everything has an answer. Of course, all occurrences are acceptable, since the point is not to rationalize but to symbolize. It doesn't matter if the story is irrational in scientific terms, it is, in the face of disarray, a first attempt at a new recomposing of the world through the readjustment of representations. Fritz Zorn, in *Mars*, after learning that he had cancer, had this to say about it: "On the one hand, it is a disease of the body, from which it is very likely that I shall soon die [...]; on the other hand, it is a disease of the soul, of which I can say only one thing: it is fortunate that it has finally declared itself. By this I mean that, with what I have received from my family during my unhappy existence, the smartest thing I ever did was to catch cancer"⁴⁸.

Whether the illness is absurd because of entropy or whether it makes sense, that is not the issue. It is the call, the request to be helped, to be relieved, of the person who is ill

and in pain that the doctor must listen to. Sharing one's imagination is not an obstacle to rigorous care, quite the contrary. Telling the story of oneself and of the care, and making sense of it, are invaluable assets in ensuring that the two parties involved in the care process get on well together. This posture presupposes an ethic of care coming from the doctor that definitively rejects the racialization of beings, the hierarchization of complaints, of lives and of suffering.

Outlook

At the end of this journey, from the physiology of pain, the historical perspective of beings confronted with pain, from the body as object to the suffering being, and the attempt at a hermeneutic of illness and care, it becomes clear how much the doctor finds himself on a ridge. On the one hand, the choice of a clinical approach based on data; on the other, *philia* in action, a listening and the right words. Both constitute the act of caring, with respect for the other and his uniqueness. There is no need to choose between reason and emotion, there is no need to alter judgement by leaving all the room to otherness, kindness and hospitality. It is no longer a battle against illness, but a therapeutic alliance with the person who is ill, to determine together his needs, expectations and preferences, and listening to his doubts, fears and hopes. Caring for someone else begins by giving him the freedom to tell his own story, to reconstruct his own meaning, which is a source of self-coherence. Medicine provides the means; the doctor provides the ability to listen and the conviction of his commitment to support the patient in the relevance and generosity of his care.

Bibliography, notes and references

General bibliography

- Badreldin N, Grobman WA, Yee LM, Racial Disparities in Postpartum Pain Management. *Obstet Gynecol.* 2019;134(6):1147-53.
- Bijur P, Bérard A, Esses D, Calderon Y, Gallagher EJ, Race, ethnicity, and management of pain from long-bone fractures: a prospective study of two academic urban emergency departments. *Acad Emerg Med.* 2008;15(7):589-97. doi: 10.1111/j.1553-2712.2008.00149.x. PMID: 18691208.
- Buber M, *Je et Tu.* Paris: Aubier - Philosophie; 2012.
- Déchalotte M, *Le livre noir de la gynécologie.* Paris: First - Documents. 2017.
- Descartes R, *Principles of Philosophy.* IV, art. 203. Paris: Vrin, Les philosophiques; 2000.
- Eco U, *Vertigine della lista.* Milano: Bompiani, Giunti ed.; 2009.
- EFIC. European Federation of IASP Chapter. Baker M, Collett B, Fischer A, Dr Volker H, et al. Pain proposal. Improving the current and future management of chronic pain. A European Consensus report 2010.
- Students false beliefs. <https://www.pnas.org/doi/10.1073/pnas.1516047113>.
- Foucault M, *Naissance de la clinique.* Paris: PUF, Quadrige; 2017. In english: The birth of

- clinic. An archaeology of medical perception. Routledge: Tavistock Publications; 1976.
- Furetière A, Dictionnaire universel. Available on: <https://gallica.bnf.fr/ark:/12148/bpt6k50614b> view 20/02/25.
- Glance LG, Wissler R, Glantz C, Osler TM, Mukamel DB, Dick AW, Racial Differences in the Use of Epidural Analgesia for Labor. *Anesthesiology*. 2007;106(1):19-25.
- Goffman E, Les rites d'interaction. Paris: Editions de Minuit, Le sens commun; 2015. In English: Interaction Ritual: Essays on Face-to-Face Behavior. New York: Pantheon Books; 1982.
- Hurssel H, Recherches Logiques. Recherches pour la phénoménologie de la connaissance. Paris: PUF, Epiméthée; T1, vol 1. 2011. pp. 6-10.
- La Mettrie (de) OJ, L'homme machine. Paris: Folio Essais; No. 344. 1999.
- Le Breton D, Douleur. From pain to suffering. Dictionnaire du corps. Coll. Quadrige, PUF; 2010.
- Le Breton D, Sociologie du corps. Paris: PUF, Que sais-je; 2012.
- Le Breton D, Tenir. Douleur chronique et réinvention de soi. Paris: Métailié, Traversées; 2017.
- Le Breton, D, Visages. Paris: Métailié, Anthropologie; 2022.
- Lefève C, Devenir médecin. Paris: PUF, Questions de soin; 2012.
- Levinas E, L'Ethique et transcendance. Entretiens avec le philosophe Emmanuel Levinas. 1996. In: Emmanuel Hirsch, Médecine et éthique, le devoir d'humanité. Paris: Cerf; 1990. p. 46; Quoted by Benaroyo L, Les classiques du soin. La vocation médicale de l'homme. Paris: PUF, Questions de soin; 2020. p.106.
- Levinas E, La souffrance inutile. In: Cahiers de la nuit surveillée. Paris: Lagrasse, Ed. Verdier; 1984. p. 331; quoted by Benaroyo L, Les classiques du soin. La vocation médicale de l'homme. PUF, Questions de soin; 2020.
- Marin C, Hors de moi. Paris: Edition Attilia; 2020.
- Marin C, L'homme sans fièvre. Paris: Armand Colin, Le temps des idées; 2013.
- Marin C, La maladie, catastrophe intime. Paris: PUF, Questions de soin; 2014.
- Nietzsche F, Le gai savoir. Paris: NRF, idées; aphor. 112. 1950.
- Raja SN & al, The revised International Association for Study of Pain: Concepts, Challenges, and compromises. *Pain* 1976-1982;161(9). DOI: 10.1097, PMID: 32694387
- Reach G, For a human medicine. A philosophical study of an encounter. Paris: Hermann, Le bel aujourd'hui; 2022.
- Reach G, A theory of care. Souci et amour face à la maladie. Paris: Les Belles Lettres, Médecine et sciences humaines; 2010.
- Ricœur P, La douleur n'est pas la souffrance. In: Souffrance et douleur. Autour de Paul Ricœur. Dir. Claire Marin, Nathalie Zaccari-Rzeyners, Paris: PUF, Questions de soin; 2015.
- Ricœur P, Soi-même comme un autre. Paris: Seuil; 1990.
- Rogers CR, The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology* 1957;21:95-107.
- Serres M, L'éducation médicale vue par un philosophe. *Pédagogie médicale* 2006;7(3):135-141.
- Zorn F, Mars. Paris: Gallimard; 1977. In English: Zorn F, Mars. Éd. Macmillan; 1982.

1. Le Breton D, Douleur. From pain to suffering. Dictionnaire du corps. PUF Coll., Quadrige, 2010. p. 323.
2. France Culture programme by Michel Foucault, 1963.
3. Raja SN & al., The revised International Association For Study of Pain. Concepts, Challenges, and compromises. *Pain*, 1976-1982;161(9).

4. EFIC. European Federation of IASP Chapter. Baker M, Collett B, Fischer A, Dr Volker H, et al. Pain proposal. Improving the current and future management of chronic pain. A European Consensus report, 2010.
5. The symptom is the patient's complaint, the way he or she feels, and the sign is the interpretation the doctor makes of it in order to give it meaning in the diagnostic process.
6. This is only partly true, as other environmental information is processed: temperature, stretch, pressure or chemical changes.
7. In France the "intern" is a doctor junior of medicine in doctoral level.
8. In France, the "Mediterranean syndrome" refers to the racist prejudice which consists of health care providers considering that people of North African or African origin, or other foreigners, exaggerate their symptoms and pain.
9. Chamayou G, *Les corps vils. Expérimenter sur les êtres humains aux XVIIIe et XIXe siècles*. La Découverte, coll. Les empêcheurs de penser en rond; 2008. 422p
10. Limpieza de sangre = blood purification.
11. Anthropology is presented as the science whose objective is the study of the human group considered as a whole, in its details and in its relations with the rest of nature.
12. Furetière A, *Dictionnaire universel*. <https://gallica.bnf.fr/ark:/12148/bpt6k50614b>.
13. Dergham M, Rodolphe C, The "Mediterranean syndrome": stigmatization by categorizing disease patterns. *Médecine* 2020;16(10).
14. Hoffman KM, Trawalter S, Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences of the USA* 2016;113(16):4296-4301.
15. Lee P, Le Saux M, Racial and ethnic disparities in the management of acute pain in US emergency departments: meta-analysis and systematic review. *The American Journal of Emergency Medicine* 2019;37(9):1770-1777.
16. Glance LG, Wissler R, Glantz C, Osler TM, Mukamel DB, Dick AW, Racial Differences in the Use of Epidural Analgesia for Labor. *Anesthesiology* 2007;106(1):19-25.
17. Bijur P, Bérard A, Esses D, Calderon Y, Gallagher EJ, Race, ethnicity, and management of pain from long-bone fractures: a prospective study of two academic urban emergency departments. *Acad Emerg Med*. 2008;15(7):589-97. doi: 10.1111/j.1553-2712.2008.00149.x. PMID: 18691208.
18. Rogers CR, The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology* 1957;21:95-107.
19. Le Breton D, *Sociologie du corps*. Paris: PUF, Que sais-je; 2012. p.18.
20. Eco U, *Vertigine della lista*. Milano: Bompiani; 2009.
21. Marin C, *L'homme sans fièvre*. Paris: Armand Colin, Le temps des idées; 2013. p.144.
22. La Mettrie (de) OJ, *L'homme machine*. Paris: Gallimard; folio, 1999. p.152.
23. Descartes R, *Principles of Philosophy*. IV, art. 203. Paris: Vrin, Les philosophiques; 2000.
24. Foucault M, *Naissance de la clinique*. Paris: PUF, Quadrige; 2017. p.153-154.
25. Morin E, *Introduction to complex thinking*. Points; 2014. p.18.
26. Serres M, *L'éducation médicale vue par un philosophe*. Pédagogie médicale 2006; 7(3):135-141.
27. Le Breton D, Tenir. *Douleur chronique et réinvention de soi*. Paris: Métailié, Traversées; 2017. p. 22.
28. Déchalotte M, *Le livre noir de la gynécologie*. Paris: First, Documents; 2017.
29. Reach G, *For a human medicine. Étude philosophique d'une rencontre*. Paris: Hermann, *Le bel aujourd'hui*; 2022.

30. Hurssel H, *Recherches Logiques. Recherches pour la phénoménologie de la connaissance*. Paris: PUF, Epiméthée; T1; Vol 1, 2011. p. 6-10.
31. Ricœur P, La douleur n'est pas la souffrance. In: Ricœur P, *Souffrance et douleur*. Marin C, Zaccai-Rzeyners N (Dir.), Paris: PUF, Questions de soin; 2015. p.13-14.
32. Lefève C, *Devenir médecin*. Paris: PUF, Questions de soin; 2012. p.16.
33. Levinas E, *L'Ethique et transcendance. Entretiens avec le philosophe Emmanuel Levinas*. In: Hirsch E, *Médecine et éthique, le devoir d'humanité*. Paris: Cerf; 1990. p. 46; Quoted by Benaroyo L, *Les classiques du soin. La vocation médicale de l'homme*. Paris: PUF, Questions de soin; 2020. p.106.
34. Levinas E, La souffrance inutile. In: *Cahiers de la nuit surveillée*. Lagrasse: Ed. Verdier; 1984. p. 331; quoted by Benaroyo L, *Les classiques du soin. La vocation médicale de l'homme*. Paris: PUF, Questions de soin; 2020. p.105.
35. Reach G, *A theory of care. Souci et amour face à la maladie*. Paris: Les Belles Lettres, Médecine et sciences humaines; 2010. p.117-19.
36. Buber M, *Je et Tu*, Aubier. Philosophie 2012;36.
37. Ibid. p. 36-37.
38. This approach to otherness can be found in the philosophy of E. Levinas when he addresses the question of the face, or in Paul Ricœur's work "moi comme un autre". But also in the work of the anthropologist David Le Breton in his book "Des visages. Une anthropologie" Métaillé, 2022.
39. Goffman E, *Les rites d'interaction*. Paris: Ed. de Minuit, Le sens commun; 2015. p.102.
40. If the symptom is on the patient's side, the sign is on the doctor's side, who interprets it to seek a causal relationship.
41. Marin C, *La maladie, catastrophe intime*. Paris: PUF, Questions de soin; 2014.
42. Nietzsche F, *Le gai savoir*. NRF, idées 1950:112;159.
43. Marin C, Ref. 41. p. 50
44. Ricœur P, Ref. 31. p.19
45. Marin C. Ref. 21. p.15
46. Ricœur P, *Soi-même comme un autre*. Paris: Seuil; 1990. p. 32
47. Ibid.
48. Zorn F, *Mars*. Paris: Gallimard; 1977. p. 320.

