The Ordinary Language of Pain and Medical Education

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Abstract

There is a deficit within medical education in terms of understanding pain a s part of the wider move towards shared decision making (SDM), and particularly in the area of general practice. The aim of this paper is to consider, from a Wittgensteinian perspective, how pain is a managed discourse within these consultations. Talk about pain is part of what Wittgenstein refers in his *Philosophical Investigations* as embedded within language games. In medical consultations there are ways of talking about pain, either directly or indirectly, which are part-and-parcel of an interactional event and which impact on the degree to which SDM is engaged in. The paper contrasts a discourse analytic perspective with a Wittgensteinian one with reference to an example of talk about pain within a medical consultation. This example serves as a means of highlighting the benefits of the latter approach for medical education.

Keywords: pain, language, medical education, Wittgenstein

Introduction

Healthcare professionals require an understanding of pain in order to be able to treat or manage it effectively. However, despite there being a clear need for this to be a significant aspect of medical education, pain education at medical schools is limited in its inclusion in the curriculum. Pain topics are typically subsumed within diagnostics for specific conditions rather than as an area. Foe example, pain management education in the United Kingdom accounts for less than 1% of university teaching time for healthcare professionals (Vadivelu et al., 2012). A UK survey of 11 major universities showed that the average content of pain teaching for undergraduates was 12 hours (Briggs et al., 2011). The APPEAL study on pain education curricula within undergraduate medical studies during 2012–2013 (surveying 15 European countries) showed that 55% of the medical schools taught pain within compulsory non-specific pain modules and 31% of medical schools taught pain in dedicated pain modules (Briggs et al., 2015).

Corrigan et al (2011) found that most medical students had a negative perception of their encounters with pain patients, with chronic pain being the difficult condition to deal with The failure to teach undergraduate medical students a broader biopsychosocial approach to chronic pain management skills points to the mismatch between what is learned in the preclinical setting and what is actually encountered in the clinical setting (Egnew and Wilson, 2010). Giordano and Boswell (2016: 206) have noted, ‘So, while mechanisms of pain and analgesia are taught during basic neuroscience courses, there is no direct link to how the complexities of these systems are relevant to the illness of chronic pain and challenges of chronic pain management’.

However, more recently there have been attempts to listen more to patients as part of a biopsychosocial approach to medical consultations and notably in the area of general practice. While this is now part of continuing professional education, it is still not widely adopted as part of undergraduate medical education (Durand et al., 2018). The traditional model of

medical decision-making, in which general practitioners (GPs) make almost unilateral decisions about their patients' treatment, has increasingly come to be seen as outdated. Support for shared decision-making (SDM) has been expressed through government policy, medical education and other organisations. There is evidence that patients themselves want a more inclusive approach and that doctor–patient collaboration correlates positively with a number of health outcomes, although offering patients opportunities to be co-decision makers has been questioned (Towle et al., 2006).

One area, of particular interest, is the way that GPs and patients discuss pain within the medical consultation; what this means as a symptom, and what treatment decision follows. For patients and doctors alike much of this communication hinges on the use descriptions of pain. This raises the question of how such communication between patient and doctor occurs through the use of ordinary language rather than a specialist medical vocabulary. In addressing this issue, the next section considers work in the area of discourse analysis.

Discoursing pain

This discourse analysis perspective is founded upon an examination of various discursive devices that are used in terms of performative actions and the participants' orientations. The focus of performativity leads us to consider the language use in terms of the agency of the language user within the speech act (Austin, 1975). The aim of this kind of study is to examine how discourse is put together by speakers to perform requests, invitations, blamings, refusals, and so on. These actions are taken as being the key to what is going on in the interaction as participants (e.g. doctors and patients) engage in dialogue and interpret and respond to what each other is saying and *doing*. It is the latter point that is of importance in terms of viewing language as a means of engaging in action, rather than a form of representation.

However, in setting up the study of language use this way, there is a tendency to leave the door ajar for a mentalist view in terms of *designing* and *interpreting* these actions. In other words, it is suggested that participants treat each other as taking into account a mental world of thoughts and feelings as a background and reason for their action. As Edwards and Potter (2005: 241) put it:

> There is some substance to the idea of referring to private mental states, though not as the analysts favoured theory of language and mind. […] The status of reference to internal mental states is not something to be refuted, even though it is conceptually refutable, but rather, studied as a practice within a public form of life. People may sometimes talk as if, or on the proposed and oriented-to basis their words are expressing inner thoughts and feelings.

Note that the argument being made here is that in doing discourse analysis, there is an eschewal of a *theoretical* siding with mentalism. In place of this is a commitment to study the ways in which it is implicated in how people themselves *orientate* towards it in their interactions as part-and-parcel of the actions they are engaged in.

The problem with this stance is that there is an elision between agents and actions. Somehow these discursive constructions are produced, in terms of the actions that people are engaged in whether this is, for example asking for something, or refusing something. People are considered as being orientated towards what is going on *behind* the words as they design and interpret what is said. The upshot of this is that, in seeking to steer clear of adopting a

theoretical siding with mentalism, this kind of work instead examines the discursive devices used to bring off certain actions but at a distance from the assumed pragmatic orientations towards this by participants.

Thus, in the context of a medical consultation, the analytic focus is that of explicating the sorts of discursive moves that are made by doctors and patients in their turns at talk as they seek to treat each other as engaged in certain kinds of actions with accompanying certain kinds of motives. A doctor's questioning of a patient's pain sensations may, for example, be examined as an attempt to diagnose its severity through the sequential nature of the question-and-answer turns. The patient's answers, on the other hand, are examined in terms their engagement with the action, the extent to which they cooperate, through the responses they provide or questions that they may ask in turn. However, the main problem here is the focus on how each other *interprets* what is said and the imputation that this is a participant's concern. This introduces an element of mentalism into the participants' orientations, something that has to be assumed by the analyst, despite not contributing particularly to the intelligibility of the discourse. In order to avoid reading how doctors and patients attend to potential psychological business in talk it is necessary to turn to Wittgenstein's ordinary language philosophy as a way into understanding the medical consultation as a 'language game'.

Wittgenstein's ordinary language philosophy and pain

Wittgenstein's (1953) private language argument is most often associated with his discussion of the use of the terms 'pain' and pain behaviour. The latter is taken to be such things as crying out, grasping an afflicted area, writhing etc. If such behaviour is taken as being a referent of the word 'pain', then this construal would be to make pain into something external, something beyond the word. However, Wittgenstein was not denying that people do feel pain or that the word 'pain' has nothing to do with a particular kind of sensation.

What his argument was about is the way in people use the word 'pain', often in terms of first-person usage, not as a direct referent or sensation, but instead as a socially acquired and sanctioned equivalent for pain behaviour. In this understanding pain does not refer to pain behaviour neither the sensation. Pain behaviour is a criterion by which third-person identification of that sensation is enabled. In other words, others are able to tell from the display of pain behaviour that someone is in pain, or that a person is feigning being in pain.

By tackling conceptual nature of pain in this way Wittgenstein demonstrates the ways in the inner (sensation) of pain and the outer (display) of pain behaviour are bound to each other and inseparable. He also goes further in attacking the misconception of the privacy of the 'inner' as something that is a mental phenomenon, based on knowing what words mean through their association with one's own sensations. Thus, the argument that a given person knows the meaning of pain through accessing their own inner private mental theatre is something that Wittgenstein considers as a misconception. Instead he argues that the meaning of the word 'pain' is fundamentally associated with its usage within what he refers to as language-games, that is the normative and, therefore, culturally learnable ways of using that word. Words are not simply 'read off' a given situation but rather are applied in a criterial manner. Thus, learning the language of pain, or other sensations, is not simply a case of learning what the word means and then learning to apply them in a given situation. People do not learn how to apply it and then learn where to apply it. What they learn is the public use of language, its grammar and how it can be used in situ, rather than some mentalist notion of an inner process in which pain sensation is translated into the language of pain. Indeed, in many

instances, pain sensations are replaced by talking about pain, but of course, it is also the case that people may opt not to talk about pain sensations at all.

The best way to understand the foregoing arguments is to apply them to extracts from GP-patient interactions (Roberston et al., 2011) These extracts correspond to what can be considered as a relatively common instance of a consultation about a sore throat and are taken from a wider corpus of recorded general practice consultations. They are used here to illustrate the potential of Wittgenstein's ordinary language philosophy approach.

Extract 1

1. Dr: Okay how can we help you?
2. Pt: Well my throat ha ha (right) it started er I think last week
3. and I just sort and er I mean I smoke and I'd been having a few
4. late nights and I just thought well it was down to that (yeah) but
5. especially (right) this wee' well yesterday and today it was
6. really painful actually on Saturday round here and its spreading
7. Dr: Right and
8. Pt: Down there (down there)
9. and I don't know if its related but a colleague of mine
10. I've been working with she's was off for a couple of days
11. (right) with the same sort of thing (okay) but because I go out
12. working with people I just need to make sure it's not (yeah) too contagious
13. Dr: Quite, okay (erm)

Within the opening sequence of turns the patient formulates a warrant for seeing the doctor. This is accomplished through putting forward and then dismissing his/her initial assumption (e.g. late nights and smoking) as erroneous on the basis that the throat condition has become "really painful" and is "now spreading" (L1-6). This accounting also provides the patient's expectations from the visit, "because I go out working with people I just need to make sure it not too contagious" (L11-12). This formulation works to introduce a moral orientation into the interaction and disposes an inference that the claims are prompted by not exposing others to any potential virus. If the doctor can confirm the condition as contagious, this would provide the patient with the legitimacy required should he/she decide to address the implicit issue of sickness absence from work. As such shared-decision-making would coalesce around this issue.

However, the problem with such an analysis is that it requires the analyst to impute to the patient at this stage a private (unstated) motive or state of mind behind what is said. Yet, there is nothing in the words spoken that requires the introduction of such a mentalist conception. Note that the patient qualifies the descriptions of "really painful" with that of "spreading". This literal extension of the description can be seen as an evidential basis for seeking medical attention and in aiding with a diagnosis, and therefore functions as part of the language-game of the consultation.

In examining Extract 2 below from the same consultation, it is possible again to take a discourse analytic position. In doing so, it is evident that the GP engages in questioning the patient in a typical diagnostic fashion, which directs the patient and consequently controls the nature of the interaction. After examining the patient, the doctor 'suggests' that the 'likelihood' is that patient has a 'viral illness' (L35-36). The words "suggest". and "likelihood" constructs the diagnosis as tentative and implies there is still some doubt. This

sort of vagueness acts as a means of protecting the claim from being undermined in terms of potentially questioning the legitimacy of taking time off work due to the pain.

Extract 2

19. Dr: Have you been taking anything to help?
20. Pt: Em I take medication anyway which is down there (right)
21. that's for something (yeah) completely different. I bought
22. some cough linctus from Boots (right) (coughs)
23. Dr: Nothing to help the pain? Paracetamol, Aspirin gargles
24. Pt: (no, no)
25. Dr: There might be something we could (.) you know (.) add in
26. lets have a look and see what there is to see (.) open wide and say
27. Aaah (Pt: aah) a bit louder (Pt: aah) stick out your tongue a bit (.)
28. Yep (.) that's fine and 'Aaah' (Pt: Aaah) (1.) yep.
29. Pt: Sorry I can't:
30. Dr: That's fine (.) let's just check your glands (.) and it just
31. started over the week:end d:id it
32. Pt: We:ll no (.) its (.) er (.) sort of Wednesday (.) it just happened
33. its keeping me up most of the night with a tickly cough (right) but
34. the pain its in the neck side
35. Dr: yeah okay I think what I would suggest is that the
36. (Pt: coughing) likelihood is that it's a (Pt: coughing) viral illness

However, if instead we focus upon this interaction from an ordinary language philosophy perspective, then the doctor's initial focus on something to "help the pain" is a clear reference to what the patient has raised as "really painful" and the suggestion of medications to alleviate this is, in effect, doing medical talk. Far from potentially being construed as focused on one unstated (but in the 'back of the mind') issue, the GP is talking the language game of a medical consultation. By both talking with the patient about pain and observing their pain behaviour the GP can be seen as engaging in typical diagnostic work while verbalising and sharing his or her decision-making as they go along.

Conclusion: implications for medical education

The Wittgensteinian position outlined above does not deny that there is an inner life to people, but rather it eschews the traditional Cartesian inner/outer dichotomy as the basis for understanding the intelligibility of the words we use. Instead, the focus becomes one of examining the grammatical nature of how words are used within language games, in this case medical consultations. Wittgenstein argued that we need to "make a radical break with the idea that language always functions in one way, always serves the same purpose: to convey thoughts - which may be about houses, pains, good and evil, or anything else you please" Wittgenstein, 1953 § 304). In a medical consultation, although a person may engage in the display of pain behaviour, for the most part, pain has to be expressed through pain descriptions. What is interesting here is that it is not just the patient who has to engage in the ordinary language use of pain, but also the doctor. Thus the doctor as a speaker of ordinary language participates in the interaction on the same level, so to speak, as the patient, in terms of eliciting descriptions of pain but must also make use of these ordinary language descriptions and interrupting the interaction with the application of medical knowledge. The upshot of this is that in an institutional setting where medical knowledge is systematically being applied, the immediacy of ordinary language usage is both operating whilst at the same

time being interrupted through the insertion of steps (questions, directives) that literally speak of medical discourse. Language use in this setting is therefore framed within a paradoxical framework: ordinary language descriptions and medical interjections.

In such a setting understanding the language of pain is rooted in discriminating how it is used, not simply according to the patient's own descriptions of pain sensations, but how it is used according to the 'rules' of medical diagnosis in an evidential manner. This is something that medical students should perhaps be exposed to in a more all-encompassing examination of pain within their curricula. Turning students' attention to the role of doctor-patient talk as a shared experience is a key step in bring about a deeper understanding of SDM. As Veen, Skelton and Croix (2020) argue in another, but distinct application of Wittgenstein's later philosophy in medical education, students' self-awareness is an important aspect of becoming a doctor and is not something that is readily amenable to measurable assessment. Understanding the ordinary language of pain and its role in medical consultations is arguably a very important part of medical education. While it is possible to imagine scenarios where students watch video recordings of such encounters (or themselves in mock consultations), and attend to pain descriptions, it is nonetheless important to note that much of what they 'know' about such matters may well trade upon their own implicit understanding of the life world. Learning about medicine in terms of the nature of human diseases, pharmacology, physiology, pathology etc. is all within the ambit of the biomedical emphasis in medical education. However, learning how to talk to patients, to a common language and understanding is another matter, and perhaps this needs to be brought more to the fore, and in particular when sharing understanding of the ordinary language of pain.

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