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Moral Horizons of Pain*

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Abstract

The performance installation *Moral Horizons of Pain (MHP)* responds to calls to centre touch, presence, and poetics in the praxis of medical care. In their account of the project, researcher-creators Pratim Sengupta, Ariel Ducey, Martina Ann Kelly, Santanu Dutta, and Erin Knox describe *MHP*'s critical framing in relation to negative-form counter-monuments and Third Form theatre. They describe how the project allowed the spectator-participants to recognize the moral horizons too often silenced in technocentric approaches to pain and suggest how such projects can contribute to broader social justice initiatives in the medical humanities.

Introduction

In response to calls for centring touch, presence, and poetics in the praxis of medical care for pain (Kelly, "Tear-Stained Sepia" 552; Kelly et al. 1893), we created *Moral Horizons of Pain (MHP)*. This participatory theatrical experience explores the ineffable moral undertones of sensing and caring for pain in Western medicine, making visible moral and historical dimensions of human experience that are often hidden in technoscientific, disciplined spaces (Ducey et al.; Critical Data Sense). In health care, the body is often reified as an object and a site of work (Ducey 20), thus making invisible experience as gendered, cultured, racialized, and emotional (Dutta et al., "Sensing" 1597). These experiences, in themselves, are often tacit and unarticulated, perhaps unconscious for provider and patient, but nevertheless influence care (Kelly, "Learning" E1420). In this article, we explain how *MHP* makes visible the fundamentally moral and historical character of medical care of pain through embodying and enlivening

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the notions of negative form counter-monuments (Young, "Counter-Monument" 267) and Third Form theatre (Sircar and Chaudhuri 288).

James Young defines counter-monuments, such as those marking the Holocaust, as "memory against itself" ("Counter-Monument" 267). Artists have used counter-monuments to make historical violence perceptible through designing spaces and structures—rather than symbolic artifacts like statues—in ways that put the onus of remembering and reflecting on observers by making explicit the negative form, that is, what was missing historically from the collective, hegemonic conscience. For example, Emily Jacir's installation *Where We Come From* asked more than thirty Palestinians living both abroad and within the Occupied Territories, "If I could do anything for you, anywhere in Palestine, what would it be?" (qtd. in Léger 317). The exiled and occupied status of their existence made it impossible for them to do activities such as placing flowers on a mother's grave, playing soccer, and the like. Jacir's photographs of these activities being carried out by proxy, alongside letters from those in exile, can be seen as counter-memories that illustrate "the near impossible status of being Palestinian in the context of violent occupation, land seizures, displacement and exile" (Léger 317) by the Israeli government. The negative forms reveal not only what is rendered impossible through the exiled status of the Palestinians but also (and perhaps more important) the collective moral-historical silence on the part of the audience and the broader society, silence that enabled continued violence on and the exiled existence of Palestinian peoples. In a similar vein, James Young describes the physical impression of an inverted fountain (*Aschrottbrunnen*) in the town square of Kassel, Germany. The installation, created in 1980 by the artist Horst Hoheisel, marks a missing original fountain, which was donated by a Jewish resident, then violently destroyed by Nazis in 1939 (Young, "Counter-Monument" 267). In Hoheisel's counter-monument, the physical form of the abyss is a counter-memory of the collective moral-historical silence of the German population that enabled the Nazis to carry out the destruction of the fountain and the Holocaust in the first place.

In our work, we position negative-form counter-monuments as contrapuntal models of moral and historical dimensions of experience that are typically rendered invisible in technoscientific disciplines. Building on Edward Said's argument for contrapuntality (32), Thomas Philip and Pratim Sengupta note that a contrapuntal reading of technoscience can render visible marginalized and silenced stories and counter-stories of peoples whose forcibly extracted labour sustains both imperialism and disciplinary hegemonies in technoscience (330). Our empirical research on physicians' and caregivers' experiences of supporting disciplined and technologized forms of medical care of pain bears evidence of this claim. For example, Santanu Dutta, Ariel Ducey, and Pratim Sengupta show that for Indigenous patients, current approaches to medical care of pain are deeply intertwined with intergenerational trauma resulting from histories of medical violence on Indigenous peoples, through which disciplinary practices and knowledges in medicine have been developed (Dutta et al., "Sensing" 1597). Furthermore, sociologists of medicine have also argued that disciplinary practices in technologized forms of medicine are in turn shaped by institutional

expectations of efficiency, leading to silencing or making invisible the moral and affective dimensions of patients' experiences (Ducey et al. 2).

To engage the audience in interactions with counter-memories in medicine, we adopted an approach based on Third Form theatre. A form of participatory theatre, Third Form theatre places the audience on the same plane as the actors and "seeks to bring the audience within the ambit of touch" (Sircar and Chaudhuri 297). Similar to Badal Sircar's plays *And Indrajit* and *Bhoma*, in which the audience is in search of a missing protagonist, we designed our installation to make explicit how feelings of pain, including its moral and historical dimensions, are often absent in medicine. Recasting medical practice as participatory theatre allows for the denaturalization of hegemonic realities in institutionalized medicine. Sircar positions denaturalization as a key objective of Third Form theatre (Sircar and Chaudhuri 288). We use Third Form theatre to render visible the experience of disorientation (Ahmed 544) of medical care of pain, through embodied ways of sensing and feeling that are the moral conditions for the countenance of erasure and silence. The design scaffolds that MHP provides for this collective critical enactment are the hegemonic, everyday words (questions, concepts, scripts), sounds, materials, and devices that make up the labour and interactions involved in the treatment of pain.

MHP as theatrical installation

The theatrical installation took place at Arts Place, a community-based arts centre in Canmore, Alberta, in August and October 2021. The August presentation was a trial run that invited audience-participants to provide feedback, which was then incorporated in the design of the October installation. The final October installation was configured as five areas that audience-participants experienced sequentially: waiting area, clinic, research space, the "Moral Horizons" area, and debrief space. The overall duration of each participant's engagement with the installation typically ranged from an hour to an hour and a half. Participants spent about fifteen minutes in the waiting area, between twenty and thirty minutes in each of the three spaces inside the theatre, and then another five to ten minutes in the debrief space.

The waiting area was located in the lobby leading to the theatre, inside which the clinic, the research space, and "Moral Horizons" were located. While waiting to be admitted to the theatre, usually in groups of two or three, audience members watched a two-minute film about the intent and creation of the installation, which was played on a loop, and were asked to fill out a 'pain questionnaire' based on existing standard clinical instruments for measuring pain and its experience. Audience members were informed they could either participate as themselves and draw on their own experiences as they went through the installation or participate in fictional ways that they determined. Our team members rotated through roles in the installation, integrating performance and facilitation, and we were available to listen and reflect with audience members in the final debrief space, located in a cordoned-off section of the lobby.

Figure 1: The theatre floor space is separated into three spaces—the clinic (right) and the "Moral Horizons" area (left) are visible here.
Photo by Santanu Dutta

Although we are a research team, and here refer to our roles in the installation as researcher-actors, the installation did not involve data collection: we instead used our collective experience as researchers to create an experimental, participatory, and transdisciplinary space at the intersection of scholarship, performance, and public engagement.

The theatre was divided by black curtains into three sections: the clinic, the research area, and "Moral Horizons." Audience-participants entered the clinic first, which was situated closest to the entrance to the theatre. Audience-participants were greeted by a 'clinician' dressed in dark blue scrubs, were informed that they were not the subjects of research (no data about them or their pain questionnaire responses would be recorded or retained), and were given the choice of whether to observe the first two spaces or to participate. Another researcher-actor, also dressed in scrubs, performed the role of 'clerk,' seated at a table with several computer monitors, a phone, inboxes and outboxes, sticky notes, and so on. Those who opted to participate as 'patients' were then told to give their questionnaires to the clerk, who attached a label with a generic "Patient ID number" to each questionnaire, verified it was complete and gave it a stamp (or two), and handed the patient a blank form to give to the clinician

Figure 2: Audience members wait in the lobby space, filling out a questionnaire and watching the introductory film.
Photo by Santanu Dutta

for recording a variety of biometric measurements (temperature, pulse, oxygen level, blood pressure, head circumference, hearing and vision assessments, as well as light touch sensation) (see image "A 'patient' undergoes an examination with a 'clinician.'"). The patients were asked to sit in a series of three chairs, next to each of which were machines or small tables of equipment used by the clinician to take the measurements before recording them.

The clinic was dis/orienting. A sound designer created a background track that played throughout the performance and gave the entire space a hollow, distal quality: footsteps on tiled floors, curtains being pulled open and closed, muted but continual conversations, the beeping of monitors, with all sounds reverberating off hard surfaces. Spotlights illuminated each measurement area. The cuff of the blood pressure machine hummed as it inflated, and never-explained numbers flashed in red on its screen; the clinician bent in close to patients' faces to measure their pupillary distance; equipment was regularly wiped down with strongsmelling sanitary wipes; medical signage was posted at various points ("sit here," "you will be called into the clinic shortly").

Figure 3: The 'clerk' (a researcher-actor) at the clinic space processes an incoming 'patient' while other participants wait.
Photo by Santanu Dutta

Behind the clerk's desk was a projected image of the whiteboard of a real-life clinic, covered by printouts of treatment pathways and algorithms. Audience-participants went through the usually familiar physical experiences of being measured or observing others being measured, but theatrical lighting transformed typically private moments of physician-patient interactions into spectacle; technical and medical objects were stripped of their sense of disciplinary belonging; and the skills and roles of the clinician and clerk were often suspect, or, at best, complex and obscured. The spotlights revealed the intimacy of labour that goes into taking measurements and the ease with which the conditions and possibility of such human connection are displaced in medicine. Interactions with the researcher-actors in the clinic also gendered, raced, and aged them (the researcher-actors) in different ways, and some audience-participants seemed troubled when the performers' embodied presences did not match their expectations. This space, therefore, was dis/orienting for both the researcher-actors and the audience-participants.

Audience-participants were then directed by signs around the circumference of the theatre from the clinic to the research area. As they exited the clinic to the research area, the clerk attached a new label to each patient's mea-

Figure 4: A 'patient' undergoes an examination with a 'clinician.'
Photo by Santanu Dutta

surement form, with a summative classification that supposedly indicated how their measurements aligned with the medical literature on pain categorization. Their bodies and feelings, reduced to numeric measures, were thus intellectualized as they became variants of medical categories (a 'pain catastrophizer' or 'low self-efficacy'), bereft of their lived identities. The research area included a large table, cluttered with abstracts, markers, highlighters, and various stationery. Adjacent was a large whiteboard for collecting notes, phrases, or ideas that arose during the conversation. In the background, a slide show with visualizations of scales of measurement used in pain research was projected on a curtain wall. Audience-participants were invited to join a 'research meeting' with two researcher-actors discussing the selection of research abstracts from a major clinical journal on pain. The researcher-actors facilitated this discussion but also inevitably performed what it means to be a researcher, inviting audience-participants to join in a scholarly, critical analysis of medical discourses of pain. Participants could leave or join the conversation at any time, regardless of whether they were previously known to each other. A researcher-actor jotted down on the whiteboard key points raised by the audience-participants during the discussion.

The research area was then the site of unfolding the labour and materials that

Figure 5: The clinic space (left), separated by black curtains from the adjacent research space (right).
Photo by Santanu Dutta

undergird the intellectualization of pain experience. As audience-participants engaged in interpreting and discussing the different categorizations of pain in the medical literature, they also shared their stories of pain. Their stories of feeling pain often stood in contrast to the symbolic measurement and categorization of pain, and these interactions between audience-participants and researcher-actors also made public the inner workings of a research industry that extracts value out of people's experiences and bodies through reducing their experience to discrete variables with purported clinical relevance.

In the "Moral Horizons" space, audience-participants were ushered into comfortable and intimate cinema-style seating to watch three short projected videos, totalling about ten minutes, playing consecutively in a loop. In the first video, a montage of photographs and diagrams from medical textbooks, journal articles, and classificatory and diagnostic clinical charts appeared and faded alternately on either side of a projected black frame to the rhythm of a manually pulsating blood pressure gauge. The images—with extreme close-ups decontextualized from the human condition and bereft of colour—spoke to how the pain-inflicted and 'imperfect' bodies and body parts of countless patients from history become reified visual epistemic objects embedded in medical literature. The theme of

disidentification of humans in pain in service of clinical photography was taken up in the second video—an audio recording of Martina Ann Kelly's reflective article "Tear-Stained Sepia." The final presentation, an animated film titled *Moral Horizons of Pain* (Dutta et al.), revealed the hidden ethical and moral undertones that are often left unspoken in clinical pain encounters. The central vignette of the film came from a story told to us (researchers) by a Métis physician, about one of her Indigenous patients whose pain went untreated for years as a result of the implicit imperial and colonial histories hidden in disciplinary structures. The physician's story included the patient's account of a seemingly mundane instance of the misrecognition of pain by a prior physician, a misrecognition rooted in the history of Indigenous erasure and intergenerational trauma. The voice of the physician who told us this story, as captured in the film, also offered hope in the form of a reorientation of how moral and historical dimensions of care can be interwoven with disciplined and technologized forms of care.

Figure 6: Stills from the animated film, illustrating the physician's story of the patient's account of a seemingly mundane instance of the misrecognition of pain by a prior physician, rooted in histories of Indigenous erasure and intergenerational trauma.
Photo by Santanu Dutta

Dutta and colleagues' film thus served as an essential counter-memory for the *discipline* of medicine. The animations revealed how remembered and lived histories of violence toward and trauma of Indigenous people are re-enlivened through Indigenous peoples' interactions with professional medicine. The use of cinematic animation allowed essential perspectival shifts to reveal the absent present of this history. For example, animated images of undulating grasslands, temporally juxtaposed with stories of a Métis physician and an Indigenous pa-

tient's experiences, affectively suggest the loss and pain of Indigenous peoples that are at once enacted by the discipline of medicine but also deeply connected with the broader political history of imperial and colonial oppression of Indigenous peoples. Similarly, stories of practitioners' experiences that reveal how touch and care are inseparable were juxtaposed with animated close-ups of the intimate micro-interactional moments of clinical work—of hands, and eyes, and bodies in proximity. These close-ups offered an affective amplification of the underlying moral dimension of medical care.

Finally, upon exiting the Moral Horizons space, audience-participants were invited to the debrief space, where they could sit on comfortable couches and sofas with researcher-actors and each other. We drew the empty outline of a human body on a wall in this space and invited participants to annotate it using sticky notes. In the conversations that ensued, participants interpreted and reflected on their experiences in *MHP*. We learned that many of the audience-participants were clinicians and/or people living with chronic pain, many of whom learned about *MHP* through the Pain Society of Alberta, a group of health care professionals committed to the study, treatment, and management of pain. Many audience-participants shared their lived experiences of pain, in particular, how their felt experiences are misconstrued socially and medically, and their annotations also reflected this dissonance.

Conclusion: How *MHP* interweaves Third Form theatre and negative-form counter-monuments

MHP illustrates how interweaving elements of a Third Form theatre with negative form counter-monuments can enliven implicit moral undertones in medicine. In resonance with Sircar's Third Form theatre, MHP draws on stories and feelings of pain (from our research and from audience-participants). *MHP* also goes beyond Sircar's positioning of the audience by inviting them to be central participants in enacting the conditions of erasure and silence in medicine. In a deeper sense, by making the audience 'feel' (rather than 'know'), *MHP* carries forward Sircar's axiological reorientation of knowing as feeling: if *MHP* has a 'message' (Sircar and Chaudhuri 292), it is that bodies and feelings are absent, despite their measurements and categorizations, in caring for pain in medicine. For example, in the clinic, the sensation of being touched by cold metal objects is a primary feeling for audience-participants. Through this touch, their senses of selves are left behind, as their bodies and identities are reduced to measurements. Their bodies and identities are now made invisible through the discipline of medical diagnosis. Similarly, in the research area, audience-participants' encounters with the medical categorization of pain reveal the dissonance between their stories and feelings of pain. In both spaces, participants' bodies and their felt realities of pain are indeed the negative form, and their here-and-now experiences serve as counter-monuments of pain. From Sircar's perspective of Third Form theatre, they are indeed on the same plane as the researcher-actors, en-

gaged in various forms of direct interactions (both verbal and embodied) with them in these two spaces.

These interactions reveal a fundamental absence of bodies, stories, and feelings in the disciplined language of medicine, which is at once moral and historical. The inner sanctums of medical research and practice are defined by the practice of transforming and decomposing the vast, historically and culturally grounded continuity of our bodies into discrete, tangible objects (including symbols and symbol systems) that can only be valued intellectually (Ducey 20). This also undergirds "device-centered discourse of control" (Sengupta et al. 24) in technoscience and is how our bodies, stories, and feelings are made invisible through 'discipline' (Sanyal and Sengupta 2). The experience of being an audience-participant in *MHP* makes this form of being disciplined a felt reality. A distinctly contrapuntal abyss is modelled in the "Moral Horizons" space through cinematic animations that reveal how the politics of empire and the historical violence of medicine for Indigenous peoples continue to silently shape their here-and-now experiences of medicine. Bearing witness to this pain offers a space for solidarity with voices relegated to the margins of society, and this is the pain that we must live with, even when the physiological we feel may be 'cured' in professional medicine.

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