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ONTOLOGICAL COLLATERAL: The Entanglement of "Cancer Pain" and "Chronic Non-Cancer Pain" in Thailand

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We don't have chronic pain in Thailand. It is a Western invention. But we might have it soon.

— Dr. Paiboon, director of a community hospital in Northern Thailand

"It was the best day of my life," said Suchart, describing the day he was diagnosed with terminal cancer. It was the summer of 2015, and we were sitting on a roadside bench facing his one-room concrete house outside of Chiang Mai, the urban center of Northern Thailand where I was conducting ethnographic fieldwork on pain. Suchart was in his sixties, wearing an old T-shirt and torn dress slacks meant for working the longan fruit orchard stretching out from his house. But despite his outfit, Suchart had been unable to work his orchard for a long time.

Four years earlier, he had begun feeling a gnawing pain in his upper abdomen. He went to his local hospital, a few miles from home. There, he received an ultrasound and was told that his pancreas was inflamed, and that the pain would resolve on its own. Instead, it worsened. Every day, he lay incapacitated in his bed, unable to work, enjoy meals, or receive friends who came to visit from his social club. At times, the pain erupted in flares that he explained "I thought might kill me." When such episodes came, his son took him to the hospital for "medicine

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injections" (*chīt yā*), intravenous morphine. Once they had controlled his pain, doctors would send Suchart home with paracetamol (acetaminophen).

Before the mid-2000s, no opioids had been allowed out of hospitals in Thailand, but a new movement had emerged, arguing that those with cancer pain required special, aggressive out-of-hospital pain management. Since Suchart did not have cancer, he did not qualify for this new exception. Besides, his doctors explained to him that his pain resulted from "acute episodes" of pancreatitis, which required in-hospital treatment. Thailand's low-cost universal healthcare system made periodic hospital care accessible and affordable enough to become a routine part of Suchart's life.

Each time he returned home from the hospital and the morphine wore off, Suchart found himself debilitated again. "The pain ruined my life," he explained. "I couldn't do anything." And it continued to flare, on and off for more than a year.

Eventually, he was sent to the regional university hospital to have his gallbladder removed and a stent placed endoscopically into his pancreatic duct to prevent further episodes of pancreatitis. But the pain did not subside after the surgery, and Suchart returned to his cycle of pain, this time for six months of what he described as "life worse than death."

Finally, another round of scans showed a cancerous mass in the head of his pancreas. Doctors told him that it was inoperable (wrapped around important blood vessels) and not amenable to radiation (too deep in the abdomen) or chemotherapy (no effective regimen for his type of tumor). Instead, they referred him to Chiang Mai University Pain Clinic, one of a few specialty pain clinics in Thailand, staffed by three physicians who had trained abroad in pain management. They prescribed him a fentanyl patch and oral morphine to take home to treat his cancer pain for the expectedly short remainder of his life.

It was one year after that when Suchart and I sat on the bench outside his house and he declared the day of his fatal cancer diagnosis as the best day of his life. "After that, I started doing everything again. Now, I take care of my granddaughter; I enjoy the company of my friends; I'm thinking of trying to work the orchard, though my son yells at me not to. Maybe the tumor will take me, but I don't care, because I have my life."

Later, I had a chance to interview several of Suchart's physicians about his case. One reflected:

> We only give take-home opioids for cancer, but Suchart's case makes me wonder: should we have been giving him morphine at home before, too?

> What about patients with chronic pancreatitis from another cause? I don't know. That is a question we were able to avoid before this new policy [allowing take-home opioids for cancer patients].

Another physician at the table added:

> I worry that this new field of "palliative care" [English], of treating "cancer pain," [English] will force Thailand to accept the West's category of "chronic pain" [English], too. But "chronic pain" isn't really a thing, it's an invention of the West. We don't want to be like the U.S.—everyone using morphine to escape the discomforts of life. That is a dangerous path.

He then began discussing the deterioration of Thai society, its young generation obsessed with instant gratification, iPhones, and video games, looking for solutions outside themselves for the ordinary discomforts of life. Because of this, Thais might begin to "experience more pain, and 'chronic pain' could become a real thing."

In their narrative, Suchart's physicians slipped between disease categories, bodily process, and experiences of those processes. The areas often demarcated in Western philosophy—epistemology (truth claims about reality), ontology (actual reality), and phenomenology (experience of reality)—seemed to blur. When the physicians opined about the emergence of chronic pain in young people, did they mean that Thais would continue to have the same bodies, but just be worse at tolerating them? Or might they actually have different physiological processes happening in their bodies due to how their bodies were trained? And why was it so dangerous to name something a disease unto itself (*rōk*) rather than simply a symptom of some other process (*`ākān*)? Was this naming capable of changing bodies, the experience of those bodies, or both? Or was it simply about the politics of treatment with a controversial substance, opioids?

COLLATERAL OBJECT, ANTI-ONTOLOGY

In this article, I use ethnographic data from Thailand to describe a particular landscape of pain and the possibility of treatment. These data are drawn from a year of fieldwork in Northern Thailand in 2015, during which I followed thirty individuals with painful bodies to their homes, clinics, monasteries, and workplaces, and conducted semistructured interviews with them, their families, friends, clinicians, and spiritual advisors. These interviews built on a decade of fieldwork on

end-of-life care in Thailand (Stonington 2020b). I present these data in an attempt to explain two interrelated inflection points that occurred in Suchart's story. The first happened on the day of his terminal cancer diagnosis, amazingly the "best day" of his life. Before then, his pain could only be labeled an "acute symptom," possible to treat with morphine in the hospital but not at home. And then, suddenly, doctors applied a new label to the process occurring within him, "cancer pain." This label implied a more solid and permanent reality, and with it came the possibility of ameliorating his discomfort with morphine.

The second inflection point was named by his physicians. Suchart's case had "made them wonder": should they have "been giving him morphine at home before?" With the possibility of this action, they also wondered about classification. Should there have been a category of pain that was neither the new solidly real category of "cancer pain" nor the prior way of addressing "acute pain" as a temporary symptom? Did the creation of "cancer pain" make inevitable the creation of a corollary object, "chronic non-cancer pain?" It is this collateral effect that I hope to understand in this article.

Social scientists of medicine have long shown that diseases, and even human bodies themselves, emerge historically. Bruno Latour (1984) famously described how the microbial theory of infectious disease reassembled preexisting scientific theories, bodies, and institutions into novel configurations. Margaret Lock (1993) mapped the confluence of conceptual models, bodily processes, and lived experiences that differentially constituted menopause in Japan and in the United States as indications of "local biologies." Ian Hacking (2002) described a historical moment in nineteenth-century France that precipitated the emergence and subsequent disappearance of states of dissociation and amnesia known as "fugues." These classics drew on a long tradition of thinking in the social sciences about how categories are made, transformed, and destroyed in relationship to one another (Bowker and Star 2000; Jasanoff 2004), as well as on a long-standing attempt to understand what Sheila Jasanoff (2004, 21) describes as "co-production," the processes that "continually reinscribe the boundary between the social and the natural, the world created by us and the world we imagine to exist beyond our control."

I use Suchart's and others' stories to extend thinking about local biologies and coproduction to two related phenomena. First, I trace how the emergence of one medical object, in this case "cancer pain," begged the question of another object, "non-cancer pain." I use the term *ontological collateral* to point to situations in which one object pulls another into existence. Second, I hope to understand how a potential medical object might be *prevented* from emerging, or whose

emergence might at least be *resisted*. Suchart's physicians put effort into keeping "cancer pain" from pulling "chronic non-cancer pain" into existence. To them, if "chronic non-cancer pain" were to become a "thing," it would disrupt the (newly stable) order of things, including the division of the world into opioid-treatable and not-opioid-treatable pain. It might also create more painful Thai bodies and/or weaker Thai constitutions, its effects spilling far beyond the boundaries of medical practice.

This constitutes difficult conceptual terrain. How can one ethnographically address something that is claimed not to exist, but that has a name and definition and is discussed constantly (Cohen 1998; McGovern 2017)? One might say that all objects or events come into existence in relation to other objects or events, and so all moments of emergence and creation are also necessarily moments of disappearance or destruction. To use the examples listed above: in Latour's account (1984), microbial theory needed to shut down competing theories of disease etiology as much as it needed to argue the existence of microbes themselves; in Hacking's (2002) account, "fugue states" needed to incorporate, reformulate, or discard prior categories (such as "hysteria" and "epilepsy") to come into being.

But how, moreover, can one make sense of something that is claimed not to exist but is assumed to be at *risk* of existing? Contemporary science and medicine are fraught with controversy over the reality, or "epistemo-legitimacy" (Dumes 2020) of various disease categories (Barker 2005; Murphy 2006; Dumit 2006). But in Suchart's case, the category of "chronic non-cancer pain" was not exactly contested; doctors did not consider it "unexplainable and as a result, unmedicalizable" (Dumes 2020, 9). Instead, they deemed its very existence a risk, a potentiality that most everyone was trying to avoid, even as it emerged as a reluctantly inevitable collateral object to the more accepted "cancer pain." Charis Thompson (2007) has described the process of "ontological choreography" as complex, rhythmically nested actions designed to bring particular social (including medical) realities into existence. Suchart's world seemed characterized by similar actions, but in his case, they were designed to *prevent* "chronic non-cancer pain" from becoming a reality. I use the term *anti-ontological choreography* to describe this—not to contest the existence of ontological activity, but to point out that it was oriented toward *non*being—a dance with reluctant players, resisting and watching as "chronic non-cancer pain" emerged, unbidden, before their eyes.

Let's take a moment here to address a complication: what if there is actually less pain in Thailand? There is good reason to think that pain is partly determined by one's understanding of and approach to it (Throop 2010; Buchbinder 2015; Gar-

cia 2015; Banerjee 2020). There is also no doubt that bodies are products of time and place, through individual life course histories, environmental exposures, differential social forces, and more (Lock 1993; Roberts 2017). In any inquiry about pain lurks what Hacking (1996) called "looping effects of human kinds"—in this case, the possibility that how one categorizes and conceptualizes the body may affect the body itself, and vice versa. I approach possible looping effects ethnographically, examining Suchart's physicians' own claims about the dangers of allowing Thais to loop toward more pain. Part of how they hoped to prevent this was by keeping certain kinds of pain from becoming legitimized categories and, thus, actionable and, hence, real. To protect Thai bodies and constitutions from becoming more like their Western counterparts, physicians and patients in Thailand worked to avoid the labels "chronic" and "pain" from becoming applied to problems. I map this work in the ethnographic sections that follow.

Much of the literature about pain concerns the entanglement of pain's categories with its treatability, both in Western (Good et al. 1994; Jackson 1999; Buchbinder 2011; Crowley-Matoka and True 2012; Hansen and Skinner 2012; Knight et al. 2017) and in global (Krakauer 2008; Livingston 2012; Banerjee 2020) contexts. In the contemporary global politics of pain, opioids always already seem problematic, due either to their ubiquity in rich countries or to their scarcity in poor ones, driving a fierce and confusing ethical debate about global opioid accessibility (Wailoo 2015; Knight et al. 2017). When Suchart's pain moved from "acute intermittent" to "cancer pain," his pain became treatable. If opioids had not been limited only to the latter, his physicians might not have been so concerned with the nature of his pain (Stonington and Coffa 2019; Stonington 2020b). And of course, nothing in opioids inherently ties them physiologically only to cancer, nor does a clean physiological basis exist on which to reify all "cancer" as a single kind of disease process—or for that matter, "cancer pain" as a unitary object (Livingston 2012; Banerjee 2020). Thus, the basis on which opioids became legitimate for use outside of hospitals in Thailand proved conceptually tenuous. Opioids, then, formed a major part of how pain threatened to overflow the disease category of cancer, precipitating "chronic non-cancer pain."

In what follows, I aim to show some features of the anti-ontological choreography around pain in Thailand. First, I provide the historical context of Thai Buddhism's relationship to pain, as well as the movements leading to the new category of "cancer pain" in Thailand. I then describe the process of how supposed "chronic non-cancer pain" has begun emerging as cancer's ontological collateral through an ethnographic analysis drawn from two locations: a community hos-

pital, where "chronic non-cancer pain" was prevented from existing; and a pain clinic, a site of collateralization or slippage toward "chronic non-cancer pain." The intent of presenting these two locations is to interrogate the dance of becoming and non-becoming, of advocacy and resistance playing out in the negotiation of categories, experiences, and bodily processes of pain.

BUDDHISM AND PAIN

An important historical backdrop for understanding recent transformations around pain in Thailand is the strong focus on pain in Buddhism, both in doctrine and in contemporary lived practice. The Pāli Canon, the original Buddhist discourse written shortly after the historical Buddha's life, consists of nested lists built from core tenets known as the "four noble truths" (Pāli: *cattāri ariyasaccāni*), which hold that "suffering" (Pāli: *dukkha*) arises from "attachment" (Pāli: *taṇhā*)—clinging to pleasant things and rejecting unpleasant ones. This attachment makes beings suffer by putting them at odds with the inherently transient and unsatisfactory nature of existence. In Thailand, pain has emerged as the core point to prove this teaching: it is wanting pain to go away, rather than the pain itself, that makes people suffer (Stonington 2015; Aulino 2019).

Early in my fieldwork in 2015, I had an informational meeting with Dr. Paiboon, the director of a small community hospital outside the city. When I explained my study, he exclaimed: "Ah, 'chronic pain,'" speaking the words in English. Then he took a beat, and echoed the refrain I had heard from others: "We don't have that in Thailand. 'Chronic pain' is a Western invention. We can say that something hurts, but pain itself is not a thing, it is a judgment."

When I looked confused, he pulled out a piece of paper and drew me a diagram of the human mind, in which the senses pick up sensations from the inner and outer world. There is then a reaction (positive, neutral, or negative) to each sensation, followed by judgment (desired or undesired). In a mix of English and Thai, he explained:

> Judgment is the interpretation of the sensation. It is affected by experience and meaning, crafted by karma, social relationships, childhood development, education, personality, behavior, so many things. "Chronic low back pain," [English] which they talk about in medical journals, is not a thing. If there is a disease, we treat it. But we're not treating the pain, we're treating the disease. Sometimes the pain is still there despite treatment. Then is it a dis-

> ease, or just life? It doesn't really matter. One must deal with the person's judgment.

This monologue offered a lay version of the concept of *dependent origination* found in the foundational Theravada Buddhist Pāli Canon, a description of the chain of events leading from sensory input from the world, filtered through the judging mind, eventually leading to suffering and the cycle of rebirth, either of the whole person in future lifetimes, or of the self in the present moment (Payutto 1995). Dr. Paiboon's use of the term "judgment" meant to encapsulate the agentive role that the human mind plays in generating suffering from pure sensory input. "The sensation is there," he explained, "but it is only if I identify with it that it will make me suffer. If I don't grab onto it, if I don't perceive it as 'I hurt,' my mind just notices that sensation is there, nothing more. 'I hurt,' is an error, a misjudgment."

Not surprisingly, then, there is often a complex relationship between religion and medicine as the relevant frames for approaching pain in Thailand. This fact was made clear to me by a charismatic monk I came to know during my fieldwork, named Pho Khao. He had been diagnosed with a tumor of the muscles of his lower leg, and had initially sought treatment. His physicians recommended an amputation; he agreed and was scheduled for an operation, but on the day of surgery, a large car accident in the city made the surgeons cancel his surgery. Pho Khao took this as a karmic sign and decided not to pursue any further treatment and instead to meditate his way through the pain until death. The cancer slowly ate through his leg, turning necrotic and infected, ascending into his abdomen and then through his lymph system into his entire body.

"Rather quickly after starting my practice," he explained during a sermon to his disciples, sitting with his rotting leg perched in front of him to drive home the undeniable reality of his pain, "I achieved a separation of mind and body. Now, my *leg* hurts." He prodded the necrotic and infected tissue, expressing pus for all to see. "But *I* don't hurt. There is pain, but I do not suffer from it." As he spoke, he beamed a joyful smile and laughed freely and easily. In the middle of his teaching, he stood to walk around, bearing weight on the affected leg to show that he could experience the pain without suffering from it.

Later in an interview he explained: "The key to transcending pain for me was to forego any treatment. If I decided to take even a paracetamol [acetaminophen], then it meant that part of me wanted the pain to go away, and BLAM, I would suddenly have it rush in upon my heart-mind [*čhai*] and I would suffer from it."

The concepts of karma and reincarnation add narrative trajectories to this pain/suffering distinction. One's pain, in a Thai Buddhist karmic logic, may result from one's past misdeeds, evidence of punishment by a being that one wronged in the past, including in a past life (Stonington 2020c). Because of this, many people in Thailand contrast the ordinary pain of life—flagged by the common phrase "life is birth, old age, pain, and death"—with severe pain that seems out of proportion, and thus may represent a particular karmic consequence.

This marks one point where medicine and Pho Khao's ascetic extremism diverged. This became clear to me when shadowing a group of surgeons seeing a series of patients who had recently undergone surgery, mostly for tumor removal. After we passed each patient, I asked: "Is their pain control adequate?"

Eventually the attending physician turned to me and asked: "Do Americans think that everything should be comfortable? These people are dying!" We all laughed at this poke at Americans, but then, seeing that I was genuinely interested, he continued:

> The global medical trend is to rate pain on a scale, and treat until it is gone. Recently, we do this more here, but I don't think it fits. If a patient has 0/10 or 3/10 as a goal, it is already a problem, already addiction. Pain is part of all things. Wanting 0/10 means looking outside oneself to escape reality. The mind is already addicted, before ever taking [medication]. But one shouldn't have 10/10 pain, either—that is too much for the mind! Maybe the goal should be 5/10!

As in many other world areas (Krakauer 2008; Livingston 2012; Banerjee 2020), the physician insisted that pain management needed to be moderate rather than totalizing.

This was supported by a classification of pain in which some pain was "just ordinary life," and attempting to escape it would result in further suffering. Other pain was so severe that one could not face it directly; beyond a certain threshold, capacity for insightful judgment declines. Many health professionals who echoed support of this understanding to me cited the Buddhist doctrine of "the middle way" (*matchimāpatippathā*)—the Buddha's observation that extremes lead either to clinging or to aversion and thus to suffering, and that therefore the path to enlightenment lies in moderation (Stonington 2011). They saw the goal of pain management as reducing extreme pain back to the middle, to the kind of pain meant to be faced by all of us. When asked about Pho Khao's approach, many health

providers and patients nodded in acknowledgment and then described it as too advanced, too difficult, or too extreme to have relevance for most "ordinary people." It seemed that in tension with asceticism, doctors saw their role as proffering a more universally achievable relief of suffering.

THE EMERGENCE OF CANCER PAIN

In an ethnography of cancer in Delhi, Dwaipayan Banerjee (2020) has traced the inextricable link between cancer and the emerging fields of pain management and palliative care in India. In that context, where curing cancer was largely a pipe dream but pain could be treated, pain became as or more real than cancer itself. This led to the structural substantiation of cancer pain as an entity, from funding to research to treatment centers. It also drew Indian scholars and practitioners to differentiate their own understanding of pain from that found in wealthy countries, claiming that it needed to be more holistically bio-psycho-social than purely physiological, and should thus be managed in more complex ways than with simple pharmacologic interventions.

A related history explains the emergence of cancer pain in Thailand, albeit with a Thai Buddhist inflection. In the 1990s, a series of events, especially the controversial death of a famous monk named Buddhadasa, brought national scrutiny to the use of aggressive hospital medicine at the end of life in Thailand (Stonington 2011, 2020b). A coalition of monks, lay activists, and prominent public-intellectual physicians began to advocate for allowing people to die at home, especially those with end-stage cancer whose outcomes were unlikely to improve with hospital care (Wright et al. 2010). But pain management emerged as a major barrier to home death, given that dying from cancer is often very painful and a painful death has disadvantageous consequences for one's rebirth. At the time, opioids were restricted to hospitals, and so the question arose whether there should be an exception to this rule for patients traveling home to die (Stonington 2020b). The prohibition of opioids outside hospitals pulled a host of other elements and actors into the choreography of pain at the deathbed, including imagined legal risks and fear of violent interference by police and military. Activists, speaking to those concerns, began to argue that part of what made taking opioids home a safe exception to opioid restrictions was the unique nature of cancer as a disease: both extremely painful and having a natural endpoint, it made long-term abuse and addiction unlikely. This argument required lumping all forms of cancer into a single category, drawing on a commonsense understanding among many Thais that cancer represents a specific moral-physiologic entity different from other diseases,

almost being-like in its autonomous and discreet physical nature, and possessing its own karmic history (Stonington 2012, 2020a, 2020c).

The surgeon who taught me about "the middle path" later explained the medicalized valence of this reification of cancer in an interview after rounds: "When cancer advances, it causes severe pain, the most severe of all. The goal is to relieve the pain enough for patients to be able to die peacefully and aware, to be able to practice meditation and study and understand the nature of things." Pain was considered epiphenomenal to a physiologic cause, and in this case, that cause was a single exceptional reified category of cancer, an entity so equated with severe pain that it stood in as a metaphor for the pain itself (Sontag 1979; Banerjee 2020).

Restrictive opioid policies are ubiquitous throughout Asia (Krakauer 2008; Wright et al. 2010; Banerjee 2020). In Thailand, they have been supported by broad public association of opioid pain medications with the history of opium cultivation and trade in the Golden Triangle, and the subsequent popularly supported war on drugs, including excessive police violence and extrajudicial executions (Kim 2020; Stonington 2020b). Combined with the Buddhist imperative to face the painful nature of human life without trying to alter it, this atmosphere drove a severe "opiophobia" in Thailand (Nagaviroj and Jaturapatporn 2009). The practice of not allowing opioids outside of hospitals proved much more complex than a matter of "illegality." Historically, no medical legislation has existed in Thailand to guide law enforcement, so that litigation has determined the boundaries between "legal" and "illegal." In truth, fear of litigation much more than accumulated case records have driven the establishment of such boundaries (Engel and Engel 2010). Not allowing opioids outside of hospitals was a matter simultaneously of social norms, recommendations of professional bodies, and fear of as-yet-undefined lawsuits.

Partly due to this ambiguity, a coalition of physicians, nurses, and pharmacists began advocating for patients' right to die at home by sending patients home with oral morphine, to some degree taking the moral and legal risk on themselves. These activists then began to present their actions to academic conferences and news outlets, explicitly challenging the status quo approach to opioids. A cadre of palliative care–oriented clinicians managed to push a policy through the hospital-accreditation bureau that allowed home opioids for so-called cancer pain. At the center of this movement was a small group of physicians trained abroad in pain management, including the doctors at the clinic where Suchart was prescribed opioids after his cancer diagnosis.

As soon as cancer pain became a viable policy category in Thailand, things began to shift again into a zone of questioning and debate, into what Michel Fou-

cault (1998) might have called a "problematization." Stories like Suchart's and others illustrate this problematization, an anti-ontological push-and-pull about what kinds of pain should and should not be "things."

THE HOSPITAL CLINIC: Erasing "Chronic" And "Pain" From Nongyao

Early in my fieldwork in 2015, I met a woman named Nongyao who navigated familial and bureaucratic structures in search of amelioration of symptoms in her legs. Nongyao's story brings into view the categorical, material, and clinical ways in which "chronic non-cancer pain" was resisted, sometimes actively, sometimes passively, from coming into being, the process I am calling *anti-ontological choreography*.

Nongyao was seventy-seven years old when I met her. Her lower back had hurt for much of her adult life. She had worked selling food at market, walking every day despite her pain. Around her seventy-sixth birthday, her walking slowly worsened without an inciting event. Eventually she could move only with extreme difficulty. To describe her pain, she used the word *rāo*, which translates as "the cracks that form in glass after it breaks but before it ruptures," and occasionally *plēp plēp*, which translates as "flashing, glittering, sparkling." She also said that her legs were "slow" (*chā*), which usually translates into Western medical terms as either "numbness" or "weakness." For a while, she confined herself to home. Eventually, her daughter and son-in-law forced her to go to the nearby district hospital, the same hospital where Suchart received his care and where I was conducting fieldwork.

At the hospital, she waited for several hours and was then called up to one of three "history-taking stations," small desks staffed by a triage nurse. On that day, the hospital processed about 400 outpatient visitors. With three history-taking stations, this meant the nurse had 1.3 minutes to take a history. She asked Nongyao, "What do you have, grandmother?" She notably left off the common particle *bāng*, a word used to invite someone to expand or list multiple answers. Nongyao's eyes were averted, saturating the scene with the emotion known as *krēng čhai*, a feeling of hierarchical inferiority.

"My legs hurt [*čhep*]," Nongyao responded quietly.
"Hurt in what way?" asked the nurse.
"*Rāo*," said Nongyao, "*plēp plēp*."
"For how long?" asked the nurse.

"Many years; worse in the last few weeks," Nongyao answered.

The nurse condensed this into a 2x2cm box at the top of a form as: "acute neuropathic leg pain, bilateral," in English.

It is worth pausing at this moment. The interaction with Nongyao, although foreshortened by the time pressure and the atmosphere of *krēng čhai*, nonetheless contained a great deal more information than was written on the nurse's triage form. Nongyao's pain had lasted years and recently worsened. This was cast as "acute."

While Nongyao was waiting to see the physician, I introduced myself, my research, and my consent process to her, and she agreed to let me join her for the rest of her visit. Eventually, she saw Dr. Tan, a young internal medicine physician. Dr. Tan had about four minutes for physical exam, data analysis, and orders. He now held Nongyao's one-page form in hand. He looked up at her as she hobbled into the room. "Your legs hurt, no?" he asked. She nodded. He came around the table and did a brief strength exam (pushing against the ball of her foot), then wrote "lumbar spondylosis" in English in another box labeled "diagnosis." He then wrote an order for paracetamol and a topical analgesic cream. Nongyao was guided out to wait for her medications.

This process, honing Nongyao's story into a few pieces of data, seemed routine and unproblematic to me at the time, something one might see at any hospital in an underresourced setting (Livingston 2012; Street 2014; Banerjee 2020). It was only later that I began to see how its nuances began to craft the available categories for Nongyao's suffering. I saw her again several months later when she returned to the hospital. She approached the history-taking station and repeated her identical story, except that now the worsened phase of pain had lasted several months, rather than weeks. The nurse wrote "recurrent acute neuropathic pain" into the box. Again, the word "chronic" did not appear, the episode modified from Nongyao's explanation to instead be represented as a second discrete event. This time she was seen by a different physician, who did not repeat the history or exam, but merely said: "We're already treating you for pain. If it doesn't improve, then it is likely just part of getting older."

When Nongyao arrived home, her daughter and son-in-law were waiting for her. When they learned that she had not been prescribed anything, they were upset and asked her what she had told the doctor. She told them that she had said that her pain had not improved.

Her son-in-law, clearly angry, said: "That was a mistake! Pain is not a disease [*rōk*]. You wasted their time, they are too busy for that. You have to go back and say something different. Tell them that your legs are slow [*chā*]!"

Nongyao returned to the hospital again the following week. This time, she told the history-taking nurse that her legs were "slow," and the nurse wrote in the box, "chronic lower extremity weakness," in English. This time the physician ordered an X-ray of the lumbar spine and a steroid injection into the area. Sitting in the waiting area, Nongyao said of this interaction: "My daughter and son-in-law will be pleased. The doctor took an X-ray this time—it must be a disease!"

This latter exclamation described more than the comfort and reification that come from engaging suffering with technology, what Mary-Jo Good (2001) has called the "biotechnical embrace." It was the product of a transformation of Nongyao's problem. She went to the hospital to seek help with her walking, saying that she suffered from a combination of pain and numbness/weakness that had been plaguing her for years. The hospital put this story through a series of transformations, determined by many things: documentation (a 2x2cm box!), temporal constraints (1.3 minutes!), as well as predetermined categories into which her story was allowed to fit ("acute," "neuropathic," "recurrent"). By her second visit, when her presentation no longer fit those categories, she was turned away, and told that her pain was "just part of getting old." She was then disciplined by her family, who said she had made the mistake of thinking that pain was a disease. And so Nongyao reformulated both her strategy and, to some degree, her own perception of the problem. When she returned, it was no longer for pain, but for "slowness," which was allowed to be "chronic." This was rewarded by the physicians with the more affirmational response of taking an X-ray and giving an injection. By the time she left, her problem no longer had the name "pain." This process constituted a rhythmically coordinated dance, some of it active, some passive, with the ultimate effect of preventing the words "chronic" and "pain" from attaching together to her problem.

I asked Dr. Tan to explain his decision-making for Nongyao. He grabbed a piece of paper to sketch a table (Table 1; original in English) while he spoke (in Thai sprinkled with English medical terms):

> Chronic mild pain is just human life. And there really isn't such a thing as "severe chronic pain" [English]. "Severe pain" [English] is from something, something real and "physiologic" [English], like trauma, or cancer, or infection. So if someone is in "severe pain" [English], I admit them to the hospital,

give IV morphine, and diagnose and treat the problem until it goes away. An exception is "neuropathic pain" [English], but that comes with other things . . . weakness, numbness, from some injury or physical process. I try treating those things. Of course, sometimes we're unsuccessful. Then people need to cope with those, too . . . And of course, if people start thinking of their "chronic moderate pain" [English] as severe, we'll have a problem.

Table 1. Dr. Tan's pain treatment paradigm

Type of Pain	Mild/Moderate	Severe
Acute	Diagnose/fix problem; treat pain with paracetamol	Admit to diagnose/fix problem; treat pain with IV morphine
Chronic	Life	Does not exist

Even his example of one kind of "severe chronic pain"—neuropathic pain—was only able to exist by virtue of other elements, numbness and weakness.

In Nongyao's case, the choreography performed by health workers served to bring one medical category into existence (neuropathic weakness), but seemed equally designed to *prevent* another medical category—to prevent "pain" and "chronic" from adhering to Nongyao. As with Suchart, it was not simply that Nongyao's pain was not "medicalized." In fact, the medicalization of her problem lurked as a potentiality everywhere, even given a blank space in a treatment paradigm table. Instead, processes were deployed to prevent the application of a particular category ("chronic" plus "severe"). Dr. Tan saw the difference between "moderate" and "severe" as one of interpretation, meaning that it was subject to erosion, and the distinction thus needed to be protected—or else "we'll have a problem," leaving open whether he meant a social, political, or practice problem, and thereby seeming to imply all of these.

Nongyao did not put up a fight in the face of chronic pain being erased from her, and in fact, she emerged as one of the choreographers of this process. In a later interview, she explained: "I've realized that my pain is a matter of the heart-mind [*čhai*], not of the body. For my weakness, the doctors have prescribed exercise. For the pain, I've realized that instead I need heart-mind exercises." The Thai phrase for "exercise" translates as "expending body energy" (*`ǭk kamlang kāi*), and in a clever wordplay, she had invented a new term, "expending heart-mind energy [*`ǭk kamlang čhai*]." One might gloss this response as a form of acceptance forced by lack of a solution to her problem, something one might see in many poor countries that produce painful bodies with few resources for medicalizing them (Livingston

2012; Banerjee 2020). But Nongyao's acceptance proved particularly Buddhist in its inflection: her unresolved pain did not become "world-destroying," as Elaine Scarry (1987) has charted in European history; nor did it require a purpose to obtain meaning, to become "suffering-for" instead of "mere suffering," as Jason Throop (2010) has charted for chronic pain in Yap. Instead, the universal and undifferentiated nature of the pain required her to train herself in a kind of repetitive action on her own mind, similar to that charted in other chronic care contexts in Thailand (Cassaniti 2015; Stonington 2015; Aulino 2019).

This same anti-ontological choreography occurred in many cases that I encountered. Lalida, a nurse with whom I spent a lot of time during my fieldwork, had developed over a period of several years what she identified as "severe chronic abdominal pain with acute flares," sometimes with diarrhea and constipation, but mostly just with debilitating aching. She explained:

> At work, people are unkind about it. They don't believe me. At first, they were sympathetic, and I got time off work when the pain came. But after a while, they started saying: "This can't be real! Is there something wrong with your intestines, or not? Why isn't it getting better? You just don't want to work. You can't deal with ordinary life."

For Lalida, it was not the pain that disturbed her coworkers, it was the combination of pain and chronicity. She elaborated: "If I could just say that it was severe chronic diarrhea, that would help, since people believe in chronic diarrhea. But it would be a lie. When it comes on badly, I usually don't have diarrhea. It just hurts."

Here pain, as in many other world areas, was caught up in a kind of personhood diagnosis (Buchbinder 2011). But Lalida's coworkers, like Nongyao's hospital, were not just concerned with characterizing what kind of person Lalida was; they were also enforcing the boundaries of what kind of pain was allowed to exist. Of the several dozen patients I followed during my fieldwork, all gave examples of this. At some point in the process of negotiating the possible medicalization of their pain, they were all told a version of "pain is not a disease, it is life." And beneath the statement lurked something beyond a matter-of-fact description of the nature of pain, something reaching into moral judgment and danger. Suchart's physician named this when he said that it would be "a dangerous path" to allow "chronic pain" to become a "thing." Lalida's coworkers did not just disbelieve her pain, they were afraid of it occupying a legitimate category, as though the category

itself represented a moral contagion (Keane 2017) that might spread, and might even result in more pain for everyone.

At the end of her monologue about the nonacceptance of her pain, Lalida added: "If only I had cancer, it would make this so much easier. I might die, but in the meantime, I could live an accepted life and be free of pain." By this she meant that she could treat her pain at home with chronic opioids. This statement felt striking, especially in the face of the usually assumed stigma of cancer (Sontag 1979; Banerjee 2020; Stonington 2020a). A glossed unified category of *cancer* had become a stand-in not only for severe pain but also for pain's treatability. For Lalida, like for Suchart, cancer seemed to provide a welcome exception from the otherwise rigid order of things. But there was something destabilizing in Lalida's suggestion, beyond just wishing for cancer. Just as Suchart's doctor had wondered if she should have given him morphine at home for his chronic (then non-cancer) pain, one might have wondered the same about Lalida: if her pain was so *severe* that it was blocking her ability to make spiritual progress, might not someone want to prescribe her some oral morphine, to make enough space in her heart-mind for the spiritual work needed to attain a higher "level of mind?" Wouldn't the optimal amount of pain have been 5/10 for her, even though she was not a cancer patient?

As Suchart's doctors explained, the category of "chronic non-cancer pain" had never arisen before the creation of "cancer pain" as a category, partly because opioids had not legally been allowed outside of hospitals. This previously made moot any discussion of the *severity* of Suchart's pain—any distinction between chronic severe pain and chronic low-level or moderate pain. But now that cancer patients could take opioids home, a new doubt hovered in the air, a companion to the creation of "cancer pain." One might say that the concept of "cancer pain" had a shadow or reflection, another object entangled with it: "non-cancer pain," kept at bay but waiting for a chance to rush in and occupy a place in the constellation of acknowledged medical categories. And of course, both this potential and resistance to it were driven by the promise and stigma of opioids.

THE PAIN CLINIC: Mechanisms of Collateralization

The epicenters of this burgeoning ontology (or more accurately, eroding *anti-ontology*) were a handful of specialty pain clinics in Thailand, including the one at Chiang Mai University where Suchart had finally received his fentanyl patch and oral morphine following his cancer diagnosis. It was very small, open only four mornings per week, and staffed at a given moment by one of three anesthesiologists. All three had trained abroad—in Australia, Canada, and the United States—

where they had learned, as one doctor put it, "both about the dangers of opioid epidemics and the problem of undertreating pain in developing countries." The clinic was originally founded to provide pain-management consultations for hospitalized cancer patients, who would be wheeled down from the inpatient wards to be seen briefly and have their medications reviewed. But the pain clinic physicians had subsequently become part of the movement in the late 2000s to create the category of "cancer pain" that would allow sending opioids home with patients on discharge (Stonington 2011, 2020b). Since then, the clinic had developed a largely outpatient population, most of them patients with terminal cancers who needed short-term palliation until death. But since beginning to address outpatient pain management, the patient population had slowly begun to shift to include patients without cancer.

A patient case can illustrate the forces involved in this change. Dao was a fifty-year-old woman who had had cervical cancer eight years before, with significant local invasion into her abdomen. She had arrived at the pain clinic in the early years of its activism around cancer pain, and was started on home oral morphine. Unexpectedly, her cervical cancer responded dramatically to chemotherapy and radiation, and she went into full remission. But despite this cure, her pain did not subside.

"We're not sure why her pain continued," explained one of the anesthesiologists. "Maybe damage to abdominal pain fibers from radiation? Regardless, her pain didn't change, so we've just kept treating it in the same way." Interestingly, although his physiologic reasoning was tied to the specific anatomy of Dao's tumor and its treatment, it did not prevent him from placing her original disease in the homogenizing category of "cancer."

Like at Nongyao's hospital, on each of Dao's visits, her medical history was taken down onto a history form, but unlike at Nongyao's hospital, the pain clinic's history-taking form had two pages devoted to the description of pain, including a diagram of the human body to locate the pain; a box to free-text the words that the patient used to describe it (Dao described hers as "dull aching," *tūr tūr*); a set of English words for the physician to circle to identify components of the pain (nociceptive vs. neuropathic); its duration (including acute, subacute, and chronic); and to free-text its cause. And thus Dao, who had arrived at the clinic for "severe subacute cancer pain" was now categorized on each visit as having "severe chronic pain." With cancer as a sort of gateway, she found herself carried over into a category of pain that had previously not been supposed to exist. And thus within the pain clinic, the boundaries between cancer pain and non-cancer pain began

to erode. What had initially begun as a form of activism, muscling a category of "cancer pain" into the policy landscape of Thailand, now began to slip more passively into another kind of change. Some of this resulted from the ambiguous legal landscape in Thailand: just as there had been no hard law against sending cancer patients home with opioids, pressure was able to mount in the clinician-patient interaction. This seemed for many to combine with religious ambiguity about what constituted the "middle path" and the distinction between ordinary and extraordinary pain.

The ascetic meditator Pho Khao, who might have been taken as an example that pain should not be medicalized, regardless of severity, was used instead by many as an example of the opposite, largely because his approach required such extremity. He had renounced his family, including his children to whom he had never again spoken, so that they would not make him wish for cure. And he had gone into isolation deep in the forest to devote himself to twenty-four-hour continuous meditation practice. How many people (whether or not with severe pain) could or would choose to pursue that kind of practice?

One of Pho Khao's disciples, named Phra Sangthong, another monk in his forties, had suffered for ten years with debilitating neck and arm pain. Though he maintained hope of ultimate liberation and continued to practice meditation, he had not achieved the separation between mind and body that Pho Khao proffered. He explained,

> Pho Khao is an inspiration, but how many of us can do that successfully? It likely takes many lifetimes of practice to attain the level necessary to separate mind and body. And also, Pho Khao has cancer, so there is an endpoint to his pain. For me, the rest of my life will have the same pain, every day, and probably onward into the next life, forever. It is relentless, and it fills up everything. The more I meditate, the more I suffer.

Phra Sangthong eventually found his way to the pain clinic, where doctors prescribed him a fentanyl patch and gabapentin (a pain modulator for neuropathic pain). When I interviewed his physician about her decision to treat his pain with strong medications, she said, "He has been working so hard on mastering the mind-body connection; it doesn't seem to be working for him. It's time to try another approach." A category that seemed impossible elsewhere had become available enough to be casually chosen as another thing to try, driven partly by Phra

Sangthong's clout as an avid meditator, taking the ascetic claim that his pain was "just part of life" off the table.

The pain clinic's power as a center of ontological potential, a location where categories and practices were made and disseminated, also constituted a kind of vulnerability. The clinicians at the pain clinic found this change stressful. One physician said, "This all used to be straightforward. People were dying of cancer, and we were helping them not suffer. Now every day I think, 'is this an exception or not?' And there doesn't seem to be a clear way to distinguish." The new porousness and ambiguity of what qualified as treatable pain had turned a morally clear advocacy into a murky and fraught communicative landscape (Buchbinder 2011; Crowley-Matoka and True 2012; Stonington 2020a).

There was also clearly a social landscape that determined who had access to "chronic non-cancer pain" and who did not. Although Thailand's universal healthcare system guaranteed that cost was not a barrier, discourses of class ran through narratives about pain. Suchart's physician, in his monologue about the nonexistence of chronic pain, described it as a social suffering born of modernization, afflicting an iPhone-pampered generation of Thai youth. This glorification of renunciation may appear unsurprising in country where Buddhist asceticism like Pho Khao's carries so much weight on the proper relationship between self, experience, and the material world. But the trope ran through many others' stories, including the coping strategies of patients with pain. One wealthy patient with lower back pain, who had been receiving opioids from the pain clinic, said: "If I had been poor my whole life, I think that my pain would be much easier to handle. Strengthening the heart-mind takes practice, and a life of poverty is a life of pain. If I had been poor, I could have built up endurance."

Unsurprisingly, the poor and working-class people I interviewed did not glorify poverty in the same way. One woman I interviewed from the community hospital described how pain came from poverty itself—how food insecurity had driven her to a level of worry about her body that compounded the pain and "made her suffer from it," implying that without the fear of starvation, she might not have hurt as much in her physical body. But she nonetheless claimed that both pain and poverty had trained her mind to be a "superhero," able to handle the pains of daily life. When I asked her if she had ever heard of the pain clinic, she said, "it doesn't quite sound like a place for people like me." This seemed particularly meaningful given that cost did not stand in the way of becoming a patient at the pain clinic. Although the clinic treated patients from across the class spectrum, a discourse of

class clearly proved central to its functioning: the nidus of creation for "chronic non-cancer pain" in Thailand had a middle-class inflection to it, regardless of cost.

CONCLUSION

The choreography in the pain clinic illustrates the relationship between two objects, "cancer pain" and "chronic non-cancer pain." The emergence of "chronic non-cancer pain" was framed as a side effect of the more active creation of "cancer pain." Dao's physicians did not say, "we think it is important to advocate for patients whose non-cancer pain is elsewhere unrecognized." Instead, they said, "her pain didn't change after cure, so we've just kept treating it in the same way." In other words, "chronic non-cancer pain" had begun to emerge as a kind of ontological collateral, a spillover from a more recognized entity. This was possible because of the pain clinic's role as a center of ontological possibility: its self-assigned role in creating "cancer pain" had tumbled into creating another category, the result of a passive absence of resistance rather than a resounding endorsement of the reality of "chronic non-cancer pain." Unlike contested illnesses in developed countries, such as chronic Lyme disease, chronic fatigue syndrome, or multiple chemical sensitivity, which are largely characterized by embattled camps of believers and skeptics (Dumes 2020), clinicians in the pain clinic simultaneously argued for both the nonexistence and the inevitability of "chronic non-cancer pain," as though it represented a potentiality (Taussig, Hoeyer, and Helmreich 2013; Morgan 2013), a collateral object yoked to the necessary acceptance of "cancer pain." It seemed to lurk in the human mind-body as something that must be resisted but would likely eventually erode through any barriers erected to keep it at bay.

Nongyao's and Suchart's community hospital was engaged in a more active resistance of the category of "chronic non-cancer pain." Not wanting to medicalize ordinary life, or somehow make bodies more painful by categorizing them in the wrong way, physicians and nurses deployed a series of operations, some active and some passive, to ensure that chronic pain could not become a patient's problem.

The understanding of "cancer pain" and "chronic non-cancer pain" was linked to a Buddhist understanding of the human mind as having inherent weaknesses that could manifest given the right conditions. And everyone—from Nongyao to the pain clinic's clinicians—felt it was their responsibility to protect Thais from that fate, though they simultaneously felt impotent at their ability to prevent it, to stop the slow erosion of Thai heart-minds. Connected to the individual psychology of pain was thus a social theory, an imagined deterioration of Thai society, of more

and more people wanting treatment for subjective ills, or inhabiting increasingly painful bodies.

This provides a snapshot of a moment within a much larger global transformation of the politics of pain and its treatment, of rivulets within a river of medical globalization (Tsing 2000). In Thailand, the initial move to treat pain as epiphenomenal to a physiologic process—yoking it to cancer as a singular, unified, undisputed "real" thing, a "disease"—could not be protected, and had begun to overflow its bounds, to confer on pain its own thinginess precisely because of, rather than in contrast to, its irresolution and ambiguity (Scarry 1987; Good et al. 1994; Crowley-Matoka and True 2012; Wailoo 2015).

From a birds-eye view, this process looked like medicalization, a steady march toward the expansion of pain categories and increasing use of opioids. But close ethnographic examination reveals a more nuanced process, in which those who one might assume to do the medicalizing were engaged in anti-ontological choreography, resisting the emerging inevitability.

Scholarship on the historically contingent emergence of disease categories, experiences, and bodily processes often focuses on processes of creation, coordination, and normalization, even when those processes are fraught with conflict or inconsistencies (Latour 1984; Hacking 1996, 2002; Mol 2002; Dumit 2006; Thompson 2007; Dumes 2020). The emergence of "chronic non-cancer pain" as a collateral object expands such constructionist approaches by demonstrating that construction can take place through refusal as much as through creation. It reveals how emergence can occur through porous boundaries, or how objects can be so entangled that they become yoked to a common force, to a churn pulling both intentionally created medical objects and their unintentional collateral objects along in a single wake.

ABSTRACT

Social scientists have long argued that medical objects (categories, bodily processes, and experiences) emerge in historically contingent ways. Based on ethnographic fieldwork in Thailand, I describe a special case of this: ontological collateral*, the emergence of one medical object due to its entanglement with another. "Cancer pain" recently became a widely accepted category in Thailand to permit the administration of opioid pain medications for cancer patients dying at home. But the category has proven porous, leading many to claim that they now must treat "chronic non-cancer pain" with opioids as well. Others characterize chronic pain as a Western invention, claiming that recognizing it will harm Thai bodies and minds. The result has been an* anti-ontological choreography*, a dance of becoming and resistance based on a*

collective understanding that categories, bodies, and experiences are so intertwined that they risk cascading into one another. [ontology; pain; medicine; Thailand; opioids]

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