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A Subaltern Pain: The Problem of Violence in Philosophy's Pain Discourse

Abstract:

The scientific and philosophical approach to pain must be supplemented by a hermeneutics studying how racism has complicated the communication of pain. Such an investigation reveals that not only are non-white people seen as credibly speaking their pain, but also pain “science” is one of the ways races have historically been constructed. I illustrate this through a study of Frantz Fanon’s clinical writings, along with eighteenth- and nineteenth-century slave-owners’ medical manuals and related documents. I suggest that, with this history, what philosophers understand as the problem of pain is best framed as the problem of colonial violence.

Keywords:

IASP definition of pain, Frantz Fanon, subaltern, philosophy of mind, racism

In this essay I ask where non-white people stand in current discourses on pain in both philosophy and science. That conversation takes the International Association for the Study of Pain’s (IASP) definition as its starting point in defining pain as a subjective experience and then develops various epistemological and ontological puzzles. Under the IASP definition the presence of tissue damage might indicate a patient is in pain, but the “gold standard” for establishing pain in the public realm is the patient’s sincere first-person expression of suffering. However, non-white people rarely have their pain testimony received as sincere. As a result, the pain testimony is not heard. That is not to say the pain experience is not spoken at all. Rather, as I illustrate in the second half of the essay, one of the ways non-white people have been racialized is through an imperial representation of pain that claims non-whites are particularly resistant to pain, injury, and violence. Ultimately, my thesis states that

for a global majority of non-white people, the philosophical problem of pain is not an epistemological or ontological puzzle. It is instead the problem of racist and colonial violence. Insofar as the problem of pain falls in the jurisdiction of the philosophy of mind, this “core area” of the field should devote its resources to this problem.

I am not arguing that non-white people do not speak their pain in the same way whites do. My thesis is more specific in claiming that for the former demographic the relationship between pain, speech, and the subject is overturned. Rather than the subject’s expression of pain being taken at face value, thereby irrefutably establishing the existence of pain, non-whites have historically had their pain spoken for them. This is possible and even necessary once non-whites are racialized as innately confused and infantile or conniving and dishonest. This delegitimization of the voice in the clinical context is clearest in the works of Frantz Fanon, whose writing I explore in detail in section two. Yet, when science or the law have represented the patient’s pain it has rarely been honest. With the patient’s credibility destroyed, science and the law are free to step in and express the patient’s pain in his or her stead. Historically, this has meant that a particular subject, raced in a particular way, with a particular endurance for violence, has been spoken into existence. In the second half of the essay, I explore several moments in this history looking at the work of an eighteenth century British author named Charles White along with a slave-owner’s manual for treating slaves’ pain from the early nineteenth century. These cases illustrate how the representation of non-white pain is more than a description, since the purported ability to withstand pain only justifies more abuse.

Along with the authors I cite in what follows, Fanon being foremost among them, I am aligned with recent work that has questioned the exclusivity of the modern definition of pain and its consequences for clinical practice. The canonical article in this regard is a 1996 essay written by K.S.J. Anand and K.D. Craig arguing that, in tying pain to self-report, the IASP definition fails to apply to “newborn and older infants, small children, mentally retarded, comatose, demented, or verbally handicapped individuals, and all primate and non-primate animals.”¹ This criticism has led to a range of new methodologies in pain assessment better suited to each individual’s communicative capacity.²

In articles published in 2006 and 2009, Craig goes on to expand his concerns to include those, who “lack credibility.”³ However, without an understanding of the history of racism, it is not clear that Craig sees how these cases display a number of features making them asymmetrical to the pain of those who, like infants for example, are incapable of self-report. Above all, for those without credibility, the pain experience can be reported, but for various contextual reasons, that report cannot be believed. The deficiency is not with the patient’s ability to communicate, but rather with clinician’s ability to receive the testimony. The reasons for this are multiple, but one outstanding obstacle is the fact that over the past several centuries a global majority of suffering humans have been unjustly racialized as infantile, mentally disabled, insincere and conniving, or some combination of these denigrations, with the result of their pain testimony being effectively muted. Under these circumstances, no new techniques in pain assessment will alleviate this shortcoming since the deficit is on the part of the listener. Regarding this pain that cannot be heard, the question becomes what exactly is the pain of those who have been racialized as innately and hereditarily insincere?

1) K.S.J. Anand and Kenneth D. Craig, “New Perspectives on the Definition of Pain,” *Pain* 67 (1996): 3, [https://doi.org/10.1016/0304-3959\(96\)03198-3](https://doi.org/10.1016/0304-3959(96)03198-3).

2) See for example, Beverley Temple, “Pain in People with Developmental Disabilities: A Scoping Review,” *Journal on Developmental Disabilities* 18 (2012): 73–86; Richard W. Hall and Kanwaljeet J. S. Anand, “Pain Management in Newborns,” *Clinics in Perinatology* 4 (2014): 895–924, <https://doi.org/10.1016/j.clp.2014.08.010>.

3) Kenneth D. Craig, “The Social Communication Model of Pain,” *Canadian Psychology* 50 (2009): 22–32, <https://doi.org/10.1037/a0014772>. See also, Anne Werner and Kirsti Malterud, “It is Hard Work Behaving as a Credible Patient: Encounters Between Women with Chronic Pain and their Doctors,” *Social Science and Medicine* 57 (2003): 1409–1419, [https://doi.org/10.1016/S0277-9536\(02\)00520-8](https://doi.org/10.1016/S0277-9536(02)00520-8).

Before beginning to answer that question, I should define a term that will be unfamiliar to some philosophers and scientists studying pain today. The word “subaltern” was first used by Antonio Gramsci in 1929. It was subsequently taken up and further popularized in the 1980s by Ranajit Guha and Gayatri Spivak.⁴ My use of the word is indebted to Spivak insofar as she frames the problem of subalternity as largely one of representation. Specifically, Spivak defines the subaltern as those who do not speak and leave little to no historical trace. This is not to say that street vendors or inmates literally do not have a voice, but rather certain claims or acts (namely acts of decolonial resistance) cannot be recognized because they lack a valid institutional background against which the claims can be heard. Furthermore, Spivak argues that subalterns, unable to represent themselves immediately, must either work through a dominant imperial discourse, or more likely, be represented by a credible authority. However, Spivak points out, “representation” is equivocal in this context. On the one hand representation is descriptive. In this case it is a re-presentation, such as how money represents a certain amount of labor. Yet, representation also has a political connotation such as when one’s representatives advocate for the interests of their constituents. Subalterns not only cannot speak, but they are also subject to a sleight-of-hand wherein a purportedly objective imperial regime describes their condition in a way that advocates for further colonization and oppression. Thus, subalterns certainly lack credibility, but as the history of pain reveals, the situation is more complex. Specifically, I will be tracing this double movement whereby one is denied the ability to genuinely speak to the pain experience, and the pain is then spoken for him or her by a “credible authority.”⁵ And that credible authority consistently advocates for more pain and violence.

Because the silence of the subaltern is fundamentally owed to the limits of what institutional authorities are prepared to hear, the elimination of subalternity through fundamental shifts in our institutions is a common theme in subaltern studies. This essay contributes to that project insofar as I ask the philosophy of mind and pain researchers alike to confront their limitations and reformulate its understanding of the problem of pain so as to better address the experience of millions of others who occupy an institutional context precluding him or her from credibly testifying to pain. In fact, as I will argue at the conclusion of the essay, philosophy’s understanding of the problem of pain can only begin to take shape once the problem of violence has been denied. This makes philosophy’s orthodox approach to pain both secondary and ancillary when viewed through the eyes of the least favored.

I.

In 1979, the International Association for the Study of Pain requested a definition of pain from its subcommittee on taxonomy led by Harold Mersky.⁶ Pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue, or described in terms of such damage.”⁷ In a note added to the

4) For a history of the term see Marcus Green, “Gramsci Cannot Speak: Presentations and Interpretations of Gramsci’s Concept of the Subaltern,” *Rethinking Marxism* 14 (2002): 1–24, <https://doi.org/10.1080/089356902101242242>.

5) On the equivocity of representation see Gayatri Spivak, “Can the Subaltern Speak?,” in *Can the Subaltern Speak?: Reflections on the History of an Idea*, ed. Rosalind C. Morris (New York: Columbia University Press, 2010), 33. Some of these themes are recapitulated in Gayatri Spivak, “In Response: Looking Back, Looking Forward,” in *Can the Subaltern Speak?: Reflections on the History of an Idea*, ed. Rosalind C. Morris (New York: Columbia University Press, 2010); Gayatri Spivak, “Marginality in the Teaching Machine,” in *Outside in the Teaching Machine* (New York: Routledge, 2009).

6) See Harold Mersky, “Logic, Truth, and Language in Concepts of Pain,” supplement 1, *Quality of Life Research* 3 (1994): 74–76, <https://doi.org/10.1007/BF00433379>.

7) J.J. Bonica, “The Need for Taxonomy,” *Pain* 6 (1979): 250.

definition the authors make clear that pain is always subjective and need not be accompanied by tissue damage. Because of its subjective nature, pain that is reported without tissue damage must still qualify as pain: “there is usually no way to distinguish their experience from that due to tissue damage if we take the subjective report. If they regard their experience as pain, and if they report it in the same ways as pain caused by tissue damage, it should be accepted as pain.”⁸

The 1979 statement from the IASP is not without precedent. The science of pain had long been moving toward a more subjective approach.⁹ However, Ronald Melzack’s and Patrick Wall’s gate-control theory of pain revolutionized just how subjective pain actually is.¹⁰ In the wake of this work, the field generally accepts that psychological factors such as anxiety, cultural context, and patient memories influence how and if pain is experienced more than any external stimulus. Accordingly, the nervous system is not a passive conduit of information. It is best understood as “the substrate of past experience, culture, anxiety, and depression” actively shaping the pain experience.¹¹ The 1979 IASP definition responds to these breakthroughs of the mid-twentieth century, and although it has undergone some minor amendments, the 1979 statement remains authoritative.

If pain is “always subjective,”¹² one can begin to anticipate how the study of pain becomes entangled with problems of communication and patient testimony. For once pain is dissociated from physical injury, the most efficient way to make pain public in a clinical setting is for the patient to express the pain. Cunningham has even gone so far as to claim, “only effective communication of pain brings pain into existence.”¹³ Likewise Margo McCaffery writes, “pain is what the person says it is and it exists whenever he or she says this.”¹⁴ The conflation of pain and speech, such that the being of pain is speech, can be found scattered throughout the literature. And in spite of the fact that Murat Aydede does an exemplary job explaining that, according to the IASP definition, pain is an experience that exists independent of any communication, there nevertheless remains widespread agreement that the testimony to one’s pain is infallible and incorrigible.¹⁵

For example, I have already cited the IASP definition that states if patients report pain then, regardless of tissue damage, “it should be accepted as pain.”¹⁶ Aydede echoes this in writing that although pain is not identical to expression, “verbal reports may be the ‘gold standard’ for the evidence they provide for the presence of pain.”¹⁷ Elsewhere Aydede writes, “not only do people seem to have special epistemic access to their pains, they

8) Ibid.

9) For a brief history see Don Gustafson, “Categorizing Pain,” in *Pain: New Essays on Its Nature and the Methodology of Its Study*, ed. Murat Aydede (Boston: MIT Press, 2005). For a longer read, see Rosalyn Rey, *The History of Pain* (Cambridge, MA: Harvard University Press, 1995).

10) Ronald Melzack and Patrick Wall, “Pain Mechanisms: A New Theory,” *Science* 150 (1965): 971–979, <https://doi.org/10.1126/science.150.3699.971>.

11) Joel Katz and Ronald Melzack, “Measurement of Pain,” *Surgical Clinics of North America* 79 (1999): 231, [https://doi.org/10.1016/S0039-6109\(05\)70381-9](https://doi.org/10.1016/S0039-6109(05)70381-9).

12) Bonica, “The Need for a Taxonomy,” 250, [https://doi.org/10.1016/0304-3959\(79\)90046-0](https://doi.org/10.1016/0304-3959(79)90046-0). Merskey states pain should be understood “only as a psychological event.” Merskey, “Logic, Truth, and Language in Concepts of Pain,” 74, <https://doi.org/10.1007/BF00433379>.

13) Nance Cunningham, “Inclusion of the Nonverbal Patient: A Matter of Moral Emergency,” *Pain Forum* 8 (1999): 94, [https://doi.org/10.1016/S1082-3174\(99\)70052-8](https://doi.org/10.1016/S1082-3174(99)70052-8).

14) Keala Herr et. al., “Pain Assessment in the Patient Unable to Self-Report: Position Statement with Clinical Practice Recommendations,” *Pain Management Nursing* (December 2011): 230, <https://doi.org/10.1016/j.pmn.2011.10.002>.

15) Murat Aydede, “Defending the IASP Definition of Pain,” *The Monist* 100 (2017): 439–464.

16) Bonica, “The Need for a Taxonomy,” 250, [https://doi.org/10.1016/0304-3959\(79\)90046-0](https://doi.org/10.1016/0304-3959(79)90046-0).

17) Aydede, “Defending the IASP Definition of Pain,” 449.

seem to have a very special epistemic authority respect to their pain: they seem incorrigible, or even infallible about their pains and pain reports.”¹⁸ Christopher S. Hill emphasizes the priority of the first-person perspective over and against any third person judgments in writing, “it is important that we regard it as absurd to say that an agent is in pain in circumstances in which the agent is not aware of a pain, and that we regard it as absurd to say that an agent is not in pain in circumstances in which it seems to agent he or she is in pain.”¹⁹ Suffice it to say, pain is a personal experience that does not necessarily have a physical component. As such, its most reliable public expression is the patient’s voice, broadly construed to include nonverbal communication. Furthermore, the patient’s expression of pain is taken to be infallible.

Aydede makes a notable observation regarding the importance of patient testimony to a science of pain. He writes, “without the first-person perspective, one is forced to examine nociception rather than pain.”²⁰ One might interpret this as saying that precisely because pain is a subjective experience not tied to tissue damage, once the first-person perspective is absent, one is left with something resembling what Wall calls a “classical” approach to pain where pain is correlated with tissue damage.²¹ However, Aydede’s statement cuts deeper than that. Once the pain experience is not available, whatever the reason may be, clinicians are left to treat nociception, which is not pain in the modern sense. Again, pain is a subjective experience, a psychical phenomenon, unlike nociception, which is a physical response to stimuli.²² This means that without the first-person perspective, one is left with a veterinary science, or as the philosopher Robert C. Coghill writes, “this course is taken by the vast majority of scientists who use animal models to study the pharmacology, neurochemistry, anatomy, and neurophysiology of nervous system nociception and mechanisms thought to contribute in some way to the experience of pain.”²³ This creates a landscape positioning a pain medicine practiced among communicating humans on the one hand, and a veterinary science of nociception on the other. Given these fault lines, where does a subaltern pain stand?

II.

As I stated in the introduction, the IASP definition of pain has been criticized for the limitations it puts on those with limited cognitive and linguistic skills. In addition to Craig’s concern for those who “lack credibility,” Cunningham echoes this concern when he points out that under the modern understanding of pain, “pain is a relational event,” and for that reason, the study of pain is, at least in part, “one of political power” concerning who in that relationship holds power to speak and be heard.²⁴ While self-report is seen as the gold standard

18) Murat Aydede, “Introduction: A Critical and Quasi-Historical Essay on Theories of Pain,” in *Pain: New Essays on Its Nature and the Methodology of Its Study*, ed. Murat Aydede (Cambridge, MA: MIT Press, 2005), 4, <https://doi.org/10.7551/mitpress/5211.001.0001>.

19) Christopher S. Hill, “Ow! The Paradox of Pain,” in *Pain: New Essays on Its Nature and the Methodology of Its Study*, ed. Murat Aydede (Boston: MIT Press, 2005), 76.

20) Aydede, “Introduction,” 303.

21) Patrick Wall, *Pain: The Science of Suffering* (New York: Columbia University Press, 2002), 29.

22) See International Association for the Study of Pain, “Nociception,” IASP Terminology, last modified December 14, 2017, <https://www.iasp-pain.org/terminology?navItemNumber=576#Nociception>.

23) Robert Coghill, “Pain: Making the Private Experience Public,” in *Pain: New Essays on Its Nature and the Methodology of Its Study*, ed. Murat Aydede (Boston: MIT Press, 2005), 301.

24) Cunningham, “Inclusion of the Nonverbal Patient,” 110, [https://doi.org/10.1016/S1082-3174\(99\)70052-8](https://doi.org/10.1016/S1082-3174(99)70052-8). Elaine Scarry’s work is also relevant. See Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), 49 and 56–57. Also see Grant Duncan, “The Meanings of ‘Pain’ in Historical, Social, and Political Context,” *The Monist* 100 (2017): 514–531, <https://doi.org/10.1093/monist/onx026>.

of pain measurement, philosophers, scientists, and clinicians alike would be naïve not to acknowledge that self-report is only effective with a receptive interlocutor.

Craig certainly recognizes the importance of the audience to any self-report when he advocates for further analyses of not only the suffering patient's testimony but also the caregiver's ability to receive that account. He writes, "attention could also be directed to how others might assess pain, for example, those indifferent to suffering, those who diminish or derogate the person suffering by denying its reality, antagonists or enemies who would exploit the person in pain. These articles should be written."²⁵ However, Craig and other pain researchers and philosophers fail to recognize that these articles have been written for some time. Ironically, they are published, translated, and widely available, and yet these voices remain unheard in the pain debate.

Scarcely any writing could be more relevant to the problem of unheard pain testimony than that of Frantz Fanon. In my surveys of the literature covering the philosophy and science of pain Fanon's name has yet to appear, but he is nonetheless a canonical figure in anti-racist and decolonial thought.²⁶ In this section I argue that Fanon's work, particularly his 1952 essay, "The North African Syndrome" and 1959 essay, "Medicine and Colonialism," demonstrates a basic feature of subaltern pain. Reading Fanon in his historical context, one finds Arab Muslims' pain testimony is erased by a racist science that renders the patient innately insincere. If the distinction between a science of pain and a science of nociception is predicated on the first-person perspective, then once the Arab patient is denied legitimate testimony to the pain experience, then, as Fanon is acutely aware, the Arab is excluded from the medical science of pain. The patient is thereby relegated to a veterinary medicine, which is precisely what Fanon observes French doctors practicing in the colony.

Stationed in French Algeria, Fanon claims in the opening lines of "Medicine and Colonialism" that "with medicine we come to one of the most tragic features of the colonial situation."²⁷ Some context is necessary for this claim. In Algeria, the French occupation rode in on a nineteenth-century racial science depicting Arabs as primitive, undeveloped, and locked in a child's mindset. The medico-military apparatus saw a sweeping public health initiative as part of its *mission civilatrice*, and by the late nineteenth-century even the most rural areas of the country had a military physician.²⁸ During the Algerian revolution, which begins in Setif in 1945, French doctors were ordered to report any anesthetics or suspicious wounds to the police, effectively making the doctor's office a surveillance branch of the military.²⁹ Moreover, as the 1958 publication of Henri Alleg's *La Question* made known to the world, French doctors were essential in facilitating the torture of Algerians, keeping patients on just this side of death for them to endure more rounds of electrocution and drowning.³⁰ Thus, although medicine's stated aim is the alleviation of pain, the Western doctor cannot escape the fact that he or she arrives in the colony along with a police force and army enacting an agenda of constraint and domination on the indigenous population.

25) Craig, "The Social Communication Model of Pain," 23.

26) For a biography see David Macey, *Frantz Fanon: A Biography* (London: Verso, 2012). For a philosophical study of Fanon's clinical work, see David Marriott, *Whither Fanon? Studies in the Blackness of Being* (Stanford, CA: Stanford University Press, 2018).

27) Frantz Fanon, *A Dying Colonialism*, trans. Haakon Chevalier (New York: Grove Press, 1965), 121; Frantz Fanon, *Oeuvres* (Paris: La Découverte, 2011), 355.

28) Macey, *Frantz Fanon*, 215.

29) Britain's Prevent program, which asks doctors and nurses to look out for 'radicalized' Muslim patients, is described as follows: "Patients who don't trust their doctor or nurse may not seek advice from them, which could be potentially life threatening. Prevent moves people's focus away from care, treatment and support into areas that are police business: Counter-terrorism and surveillance." See Ruqaya Izzidien, "Prevent is the Virus, Not the Vaccine," *The New Arab*, June 15, 2018, <https://www.alaraby.co.uk/english/comment/2018/6/15/prevent-is-the-virus-not-the-vaccine>."

30) See Alistair Horne, *A Savage War of Peace: Algeria 1954–1962* (New York: NYRB Classics, 2006), 198–200.

In addition to this general atmosphere, the clinical analyses of Antoine Porot are particularly relevant. As the founder of the Algiers School of Psychiatry, Porot and his students reformed Algeria's mental health institutions in the first half of the twentieth century. Porot's approach to the "native mind" is flagrantly reductive and relies on stereotyping. In his 1918 "Notes de Psychiatrie Musulmane" Porot summarizes his Algerian patients, describing them as a, "group comprised of profoundly ignorant and credulous primitives for the most part, very different from our mentality and our reactions."³¹ According to Porot, the overriding trait of the Arab Muslim mind is its suggestibility and credulity, a result of the supposed submission and docility required by Islam. This leads to a number of hereditary pathologies including hysteria, perseveration, stubbornness, and a criminal inclination.³²

Porot also claims the Arab type relies on mimicry and simulation, since the Arab lacks a "motivating concept" that would direct his or her actions. This in turn manifests in an extreme awkwardness in European environments, because the Arab is ignorant of European customs and thus cannot easily repeat them. The end result is a "discordant" character, one that makes him or her difficult to comprehend because he or she has no will to express and only crudely repeats the ideas of Europeans he or she is incapable of understanding.

In his representation of the Arab mind, Porot makes communication, or the lack thereof, an innate race trait. To inherit an Arab mind is to be born with something less than a child's mind, and among other deficiencies, one is unable to express oneself. In this way, Porot has effectively silenced the Arab patient. "Scientifically" reduced to mimesis, the Arab cannot then communicate a sincere and authentic account of his or her pain. As a result, the first-person perspective is ignored, and Fanon understands the implications of this "tragic feature of the colonial situation" as well as anyone to date.

Since so much of Fanon's clinical work is directly in opposition to Porot, one can scarcely understand the former without a careful study of the latter. When Fanon addresses the Arab's difficulty in communicating his or her pain he surely has Porot's analyses in mind. Yet, beyond Porot's "mimetic Arab," there are a number of other ways in which the North African patient is silenced. Joanna Bourke has recently studied the simultaneous racialization of pain and the voice, but I want to focus on Algeria in particular to shed light on three ways in which the non-white patient's expression of pain is discounted.³³ One finds Arabs simultaneously represented as objects of a veterinary science, innate liars, and children incapable of understanding themselves. All three culminate in a historico-racial schema summarized by the slogan: "they cannot represent themselves."³⁴

On the one hand, Fanon illustrates how the colonized patient is cornered (*acculé*) or effectively imprisoned both in and out of the doctor's clinic. Given the situation I outlined above, it should not be surprising that the colonized patient cannot and will not communicate with a doctor. In fact, communication is one of the first things sacrificed in such a Manichean situation: "The colonial person who goes to see the doctor is always indifferent. He answers in monosyllables, gives little in the way of explanation, and soon arouses the doctor's impatience."³⁵ While Fanon's sociogenic analysis of this lack of communication reveals a discomfort with a military doctor actively participating in a violent occupation, the doctors themselves, Fanon reports,

31) Antoine Porot, "Notes de Psychiatrie Musulmane," *Annales medico-psychologiques* 9 (1918): 383.

32) Antoine Porot and D.C. Arrii, "L'Impulsivité Criminelle Chez L'Indigène Algérien – Ses Facteurs," *Annales medico-psychologiques* 2 (1932): 632–864.

33) Joanna Bourke, "Pain Sensitivity: An Unnatural History from 1800 to 1965," *The Journal of Medical Humanities* 35 (2014): 301–319, <https://doi.org/10.1007/s10912-014-9283-7>.

34) Frantz Fanon, *A Dying Colonialism*, trans. Haakon Chevalier (New York: Grove Press, 1965) 14; "Ils ne savent pas s'expliquer." Fanon, *Oeuvres*, 701.

35) Fanon, *A Dying Colonialism*, 126.

see the Arabs' inability to communicate as an innate race trait. In the spirit of Porot's analyses, general statements about Arab pain and the race's incommunicative nature are issued: "The pain in their case is protopathic, poorly differentiated, diffuse, as in an animal, it is a general malaise rather than a localized pain."³⁶ The race as a whole will not speak because, "these people are rough and unmannerly."³⁷ Tellingly, faced with a patient that cannot effectively communicate his or her pain, a medical approach to human pain, rooted in the first-person perspective is abandoned: "Fairly soon the doctor, and even the nurse, worked out a rule of action: with these people you couldn't practice medicine, you had to be a veterinarian."³⁸ And here one finds a patient that either will not communicate or cannot be believed. The doctor then defines that silence as a hereditary race trait of all Arab peoples. With an innate inability to communicate, the doctor operates on a kind of animal pain.

This analysis squares with what Fanon witnesses as a medical student in Lyon as well. In a 1952 essay he provides the etiology of a supposed phantom illness known as the "North African Syndrome". Fanon describes how an interaction begins with the French doctor asking where an Arab man feels pain. The patient's description is vague: "he tells about his pain.... He gathers it over the whole surface of his body and after 15 minutes of gestured explanations the interpreter (appropriately baffling) translates for us: he says he has a bellyache."³⁹ In this case the patient speaks. A voice is heard, but it cannot be listened to because, *qua* Arab, the patient is naturally, "a liar, a malingerer, a sluggard, a thief."⁴⁰ Elsewhere, Fanon reports that many French authorities believed Arabs were not sophisticated enough to even grasp the difference between truth and falsity.⁴¹ Moreover, the Arab is "a man-who-doesn't-like-work,"⁴² the member of "a do-nothing race."⁴³ Accordingly, the Arab patient speaks in an atmosphere of suspicion, one where they are supposedly always feigning pain to escape the workday.

From the patient's perspective, one is left with a pain without recognition. With neither a visible lesion nor a sincere voice, the patient is effectively without pain, and the experience he or she describes has no medical reality. According to the doctor, "the pathology invented by the Arab does not interest us. It is a pseudo-pathology. The Arab is a pseudo-invalid. Every Arab is a man who suffers from an imaginary ailment."⁴⁴ This attitude lays bare the fact that in addition to a pain that is "poorly differentiated, diffuse, as in an animal," the Arab is also cast into an imaginary world. In addition to his or her "animality," the Arab also imagines affects. In either case, the pain expression is never sincere and cannot meet the "gold standard" recognized by pain scientists and philosophers alike. Accordingly, the Arab is never the subject of a medical science of human pain rooted in a subjective experience. Instead, the Arab is subjected to, at best, a veterinary science.

There is one final analysis to add to these cases, and it most effectively highlights the unique problems of a subaltern pain. In summarizing the "Arab mind" and Arabs' innate inability to express themselves, Porot writes, "the depths of intellectual reduction through credulity and stubbornness brings the mentality of the indigenous Muslim close to that of a child."⁴⁵ And Porot goes further, adding that while the European child

36) *Ibid.*, 127.

37) *Ibid.*

38) *Ibid.*

39) Frantz Fanon, *Toward the African Revolution*, trans. Haakon Chevalier (New York: Grove Press, 1967), 5; Fanon, *Oeuvres*, 693.

40) Fanon, *Toward the African Revolution*, 7.

41) Fanon, "Conduites d'aveu en Afrique du Nord," in *Écrits sur l'aliénation et la liberté*, ed. Jean Khalifa and Robert JC Young (Paris: La Découverte, 2018), 429.

42) Fanon, *Toward the African Revolution*, 6.

43) *Ibid.*, 14.

44) *Ibid.*, 9.

45) Porot, "Notes de Psychiatrie Musulmane," 382–383.

presses questions and seeks reasons for events, acting like a young scientist, “there is nothing similar with the indigenous, even the intelligent ones.”⁴⁶ In addition to both animal and imagined illnesses, the Arab occupies a child’s world. Elsewhere, Porot declares the North African is mentally debilitated by a poorly evolved brain. Diagnosed with a hereditary diencephalic syndrome, the Arab is medically construed with a mental condition rendering him or her, “essentially vegetative.”⁴⁷ Be it on account of animality, imagination, infancy, or as a kind of bizarre vegetation, the Arab is never the kind of being to speak.⁴⁸ Certainly infants’ pain has been a point of discussion since Craig and Anand published their critique of the IASP definition of pain in 1996. The result of that debate has been an explosion of new pain assessment methods for infants and the developmentally disabled. Of course, these techniques are irrelevant to subaltern pain, since the subaltern’s difficulty in communicating pain does not arise in the same way. Unlike the infant, the Arab patient does speak, and Porot’s patients were often accompanied by a translator. However, that speech cannot penetrate a racist medical science that precedes that speech and renders it insincere, incoherent, and untrustworthy. Put simply, medicine wants to hear infants in pain but who cannot communicate. By contrast, in a racist society, one is faced with an infantilized non-white patient to whom medicine will not listen.

The solution to such pain difficulties cannot be found in new modes of expression, but rather new frontiers in listening. Such breakthroughs are synonymous with an anti-racist medical agenda, the sort which underlies Fanon’s entire political project. Yet, while so much effort has been made in recent decades to alleviate infant pain, I know of no medical school in North America addressing this kind of racism in pain management. In fact, a 2016 study reveals that Black Americans are still systematically undertreated for pain compared to their white counterparts.⁴⁹ The study found that a significant number of medical students believe Black people have thicker skin and other racist myths, which then influence how they would treat Black patients in pain *regardless of their testimony*. This should not only alert philosophers and scientists interested in pain to the continued relevance of Fanon’s writing, but it also highlights the fact that the so-called “gold standard” of pain assessment – the first-person perspective – is not consistently applied to non-white patients.

Aydede writes,

if we take the sincere subjective report of the patient who claims to be in pain despite no actual or potential tissue damage or despite the lack of any pathophysiological cause, and if the patient is not conceptually confused or somehow cognitively compromised or linguistically incompetent, the report would *indicate* the presence of an experience that is not distinguishable from an experience due to tissue damage... and this is evidently sufficient to establish that the patient’s experience is genuine pain.⁵⁰

This is an eloquent summary of the modern approach to pain. Yet, it edifies a racial blind spot if philosophers and scientists fail to acknowledge that “conceptually confused,” “linguistically incompetent,” and “cogni-

46) Ibid., 383.

47) Fanon, “Considérations ethnopsychiatriques,” in *Écrits sur l’aliénation et la liberté*, ed. Jean Khalifa and Robert JC Young (Paris: La Découverte, 2018): 424.

48) In a way, what Fanon develops is a kind of Orientalized pain. On Arabs not speaking see Seloua Luste Boulbina, *Les Arabes Peuvent-ils Parler?* (Paris: Blackjack, 2011).

49) Kelly M. Hoffman et al, “Racial Biases in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences Between Blacks and Whites.” *PNAS* 113 (2016): 4296–4301, <https://doi.org/10.1073/pnas.1516047113>.

50) Aydede, “Defending the IASP Definition of Pain,” 449.

tively compromised” are all currencies of racism and remain the tropes of a racist society. Accordingly, once nonwhites are locked in an a priori schematic rendering them cognitively compromised, their testimony to pain is confused and irrelevant to the clinician. For this reason, and this is very clear in Fanon’s recounting of his experiences in the colonial medical system, the non-white subject does not speak his or her pain. While the patient is neither an infant nor cognitively disabled but simply Arab, the voice testifying to pain is not sufficient to establish “genuine pain.” Insofar as the patient’s voice is not heard, he or she effectively cannot speak the pain. This is what I understand to be a subaltern pain and Fanon is among the first, if not the first, to establish its existence.

However, as I will detail below, the fact that the non-white patient does not sincerely speak to his or her pain does not necessarily mean the pain is not spoken. Because non-white people often cannot represent their pain, their pain must be represented. Historically, non-white people have had their pain spoken for, and, to a degree, have been racialized in terms of a certain way of enduring pain. In other words, one of the many ways science and medicine have established racial difference is by racializing pain. Tracing this history, one begins to see that for a global majority of non-white people the subject does not speak his or her pain and thereby establish its existence for others. Rather, a racist science of pain speaks the person into existence. As I argue at the conclusion of this essay, when viewed from below, so to speak, the orthodox relation between pain and language is overturned. This overturning brings about a more fundamental problem of pain the philosophy of mind has not begun to address. This problem is one of violence.

III.

In her recent book, *Medicalizing Blackness*, Rana Hogarth demonstrates how slaveholding societies in the eighteenth and nineteenth centuries develop a language of uniquely Black pathologies.⁵¹ On the basis of these supposed abnormalities, physicians are able to mark out purportedly permanent physiological differences distinguishing Black and white people. With the ultimate aim of defining Black people as a race perfectly and exclusively suited to slave labor, Western medicine edifies racial difference on the basis of a racial taxonomy of illnesses.

Although orthodox histories of pain overlook it, the racialization of pain follows a similar trajectory. In particular, physicians and scientists have defined non-white peoples in terms of a relative endurance for pain. What follows is an incomplete survey of this theme in the history of racism as I examine a few key authors involved in representing non-white pain. These representations are hardly innocent descriptions. Rather, assuming the subject cannot sincerely testify to his or her pain, physicians have defined non-white races in terms of an endurance for pain justifying and prescribing violence.

In this section, I first examine how skin color and skin sensitivity come to be linked in the late eighteenth century. This hierarchy of sensitivity is later coupled with the dogma of historical progress such that darker, less sensitive skin is characteristic of “primitives.” I then examine a counterexample wherein a Black woman’s voice is heard when she expresses pain in childbirth on the plantation colony. This exception proves the rule governing subaltern pain.

Above, I cited a 2016 study establishing that white doctors today still believe Black skin is less sensitive to pain. It is not uncommon to trace this thinking back to an 1851 work by Samuel A. Cartwright entitled, “Report on the diseases and physical peculiarities of the Negro race.”⁵² Although Cartwright does discuss Black pain

51) Rana Hogarth, *Medicalizing Blackness: Making Racial Difference in the Atlantic World: 1780–1840* (Chapel Hill, NC: University of North Carolina Press, 2017).

52) Samuel Cartwright, “Report on the Diseases and Physical Peculiarities of the Negro Race,” *Medicine and Surgical Journal* (1851):

in that work, he is not original. To gain a better picture of how long-standing and entrenched this thinking is one must at least include late eighteenth century studies of the nervous system. One might start with Philip Tidyman, a physician from Charleston, South Carolina, who in 1826 writes,

I have seen Negroes submit to capital operations with less apparent suffering than white persons similarly situated, and I have known them with much composure and fortitude to support the limb for the surgeon to amputate. Some of my medical friends in South Carolina have assured me, that in the course of their extensive practice among the Blacks, they have invariably found less nervous irritability among them than with their white patients. Mr. White, of Manchester (England,) informs us that he has amputated the legs of Negroes, who have themselves held the upper part of the limb.⁵³

Here, the pain tolerance of Black slaves is said to be owed to the dullness and thickness of the nerves.⁵⁴ On this point, Tidyman is very much indebted to his reference, “Mr. White.” That is Charles White, author of *An Account of the Regular Gradation of Man* published in 1799.

In this book, White appropriates the thought of the eighteenth century psychologist and metaphysician Charles Bonnet. In his 1770 *Palingenèsie Philosophique* and elsewhere Bonnet argues that nature is hierarchized according to more or less developed nervous systems that in turn deliver more or less nuanced sensations to the organism's mind.⁵⁵ Following a Lockean empiricism, wherein every idea is owed to a distinct sensation, Bonnet claims that non-Europeans' crude thinking is owed to their less stimulating environments and impoverished capacity to feel.⁵⁶ However, writing several decades before White, Tidyman, or Cartwright, Bonnet lacks an explicit theory of race and skin color. White's writing is notable in the history of pain for the way in which he connects skin pigmentation to the skin's ability to endure injury and suffer pain.

White connects pain sensitivity and skin color through an organ known as the “rete mucosum.” He is not the first to cite this mechanism in the context of race. Immanuel Kant, for example, writes extensively on the role of the rete mucosum in his 1785 *Determination of the Concept of the Human Race*.⁵⁷ White follows precedent in claiming the rete mucosum is the proximate cause of skin color and because it is thicker in Blacks, they are darker.⁵⁸ This thickness increases as one descends the chain of being. Moreover, White argues the rete mucosum is responsible not only for the skin's color, but also its sensitivity. In explaining how the rete mucosum protects the immediate organs of sensation, White states, “the thicker, therefore, those integuments are, the

691–715.

53) Philip Tidyman, “A Sketch of the Most Remarkable Diseases of the Negroes of the Southern States,” *Philadelphia Journal of the Medical and Physical Sciences* (1826): 314–315.

54) *Ibid.*, 313.

55) Charles Bonnet, *Contemplation de la nature*, vol. 1 (Hamburg: J.G. Virchaux, 1782), 36–37.

56) Charles Bonnet, *La palingénésie philosophique*, vol. 1 (Geneva: Claude Philibert and Berthelemi Chirol, 1769), 38.

57) Immanuel Kant, “Determination of the Concept of a Human Race,” in *Kant and the Concept of Race*, ed. Jon M. Mikkelsen (Albany, NY: SUNY Press, 2013): 125–142. In 1833, Thomas Wharton Jones defines the rete mucosum writing, “the rete mucosum is that part of the skin which is the seat of colour. In the skin of the negro, in which its structure is most easily studied, it may be distinctly observed to be composed of a brown substance interposed between two layers of a white colour, called by Gaultier, the internal and external albugineous tunics.” Thomas Wharton Jones, “Note on the Rete Mucosum of the Skin; With a Theory of Albinism,” *The Lancet* 20 (1833): 523, [https://doi.org/10.1016/S0140-6736\(02\)94844-0](https://doi.org/10.1016/S0140-6736(02)94844-0). For a survey of theories on the rete mucosum at the turn of the nineteenth-century, see David Brewster, *The Edinburgh Encyclopedia* (Philadelphia: Published by Joseph and Edward Parker, 1832), 661.

58) Charles White, *An Account of the Regular Gradation of Man* (London: Printed for C. Dilly in the Poultry, 1799), 101.

duller must be the sense of touch. It is no wonder then, that Negroes have not that lively delicate sense of touch that the whites have, since both the cuticle and the rete mucosum are thicker in them.”⁵⁹ This, coupled with a purportedly cruder nervous system, portrays a relatively insensitive Black race.

In this way, White provides a “science” of skin pigmentation such that the darker one is the duller one’s sense of touch becomes. Yet, I should be more precise. For White actually writes the thicker the rete mucosum, the darker the skin, and the skin is thus better able to, “defend them from injury.”⁶⁰ In other words, the darker the skin the more injury – and violence – one can “painlessly” endure.

The repercussions of this coupling of skin pigmentation with resistance to injury reverberates throughout the following centuries. When anesthesia is first used in 1846, it was already agreed upon that darker patients are less sensitive and should not be administered painkillers. And although white women were supposedly more sensitive, Black and Indigenous women were thought to be relatively immune to pain. In an 1817 article from the *London Surgical Review*, one reads non-white women, “will bear cutting with nearly, if not quite, as much impunity as dogs and rabbits.”⁶¹ Similarly, in 1894 Henry J. Bigelow concludes that “an intelligent dog” would equal or surpass “a bushman gravedigger Indian” in suffering during surgery.⁶²

My essay is limited to a brief survey, but suffice it to say, the notion that dark skin is less sensitive to pain and better equipped to handle violence is widespread, and by the twentieth century the racial hierarchy of pain sensitivity had developed to the point of becoming a veritable philosophy of history. René Leriche, writing in 1939, argues that the progress of civilization is necessarily accompanied by a greater sensitivity to pain such that, “the men of our time have become more sensitive to pain than their ancestors.”⁶³ As evidenced by the writings of pain researchers like Louis Bertrand or John Newton McCormick, this comes to mean that so-called “primitives” or those “stuck in the past” have an innate resistance to physical suffering. McCormick explicitly connects the dots between a “primitive pain” and a theory of history in writing, “the higher the life, the keener is the sense of pain. The savage can bear physical torture without shrinking; the dog or horse does not suffer as does the child; the child does not suffer as the man.”⁶⁴

It is curious that, shortly before Melzack and Wall’s pain revolution, Leriche can write, “above all, we must listen to our patients,”⁶⁵ and yet still participate in these a priori characterizations of non-white pain. This should alert philosophers and pain scientists alike to historical biases around who qualifies as an authentic patient and who credibly speaks their pain. As this very brief historical overview indicates, Fanon’s observations of how non-white patients are denied a voice is only half the story. That silencing, predicated on a racism that renders non-white patients innately dishonest and unbelievable, is coupled with a supremely credible and authoritative scientific voice that stands in place of the patient’s own expressions. Furthermore, this representation has never been an objective depiction. Rather, from Bonnet’s hierarchy of nervous systems, to White’s rete mucosum, to historical ideas about “primitive” pain, the marginalized subject’s pain is represented to advocate

59) *Ibid.*, 71.

60) *Ibid.*

61) Martin Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth Century America* (New York: Columbia University Press, 1985), 156.

62) H.J. Bigelow, *Surgical Anaesthesia: Addresses and Other Papers* (Boston: Little, Brown, and Company, 1894), 374.

63) René Leriche, *The Surgery of Pain*, trans. Archibald Young (Baltimore: Williams and Wilkins, 1939), 56.

64) J.N. McCormick, *Pain and Sympathy* (New York: Longmans, Green, and Company, 1907), 10–11; Bertrand, writes, “to gauge the patient’s powers of resistance one ought to know his race and nationality.” Louis Bertrand, *The Art of Suffering*, trans. E.F. Peeler (New York: Sheed and Ward, 1936), 119.

65) Leriche, *The Surgery of Pain*, 478.

or legitimate otherwise excessive violence and extreme injury. This formula, long in the making, is on display not only in the study from 2016, it guides practices throughout the subaltern universe.

Before concluding, I want to turn to one possible counterexample. It comes from a book authored in 1803 by a “professional planter”, entitled, *Practical Rules for the Management and Medical Treatment of Negro Slaves in the Sugar Colonies*. In a discussion of the pain of childbirth, the author encourages slaveowners to listen to expressions of pain. One reads, “if, in a more advanced stage of pregnancy, she complains much of pain in her head, with a heaviness of her whole body; and you have reason, from her robust constitution, to imagine that she abounds with blood, you may bleed her to the amount of four ounces.”⁶⁶ In this instance, a subjugated patient expresses the experience of pain (“she complains of pain in her head”), the complaint is registered as credible and she is treated. Compare this to a modern day philosopher of mind’s anecdote. Eddy Nahmias writes, “when my wife was pregnant, our birthing coach asked the class, ‘What is pain?’ I thought I might get to display some of my philosophical training, but alas, the correct answer was: ‘Pain is whatever she says it is.’”⁶⁷ On the surface, the two scenarios seem comparable: insofar as a pregnant woman’s expression establishes pain for a third-party clinician.

Nevertheless, a subaltern pain is always the product of its institutional context. One sees this in Fanon’s writing where Arabs’ pain cannot be heard by a clinic that functions as a branch of the military. In this case, the quote above from 1803 is found in a section of the book that begins as follows: “If you are anxious to increase the population of your estate by the breeding of your Negroes, as every man must now be, both from a better informed sense of duty, and the extremely increased price of African Negroes, you will bestow somewhat more attention to your women during their pregnancy.”⁶⁸ In this case, the way in which the pain testimony is heard is fundamentally different from the anecdote from Nahmias. The motivation behind the treatment is clear: reproduction is an efficient means of multiplying capital. *Partus Sequitur Ventrem*, the 1662 Virginia law defining slavery according to the mother’s status, made it possible to value a slave even before he or she left the womb, and the mother’s market price was determined in addition to the price of the fetus.⁶⁹ As “merchandise”, the woman thereby speaks as a “breeder”. The default position of ignoring her complaints runs the risk of a diminished labor force and lost capital. Moreover, in 1808 the trans-Atlantic slave trade is abolished, making the survival of “breeders” crucial to the expansion of the plantation colony. This means that the woman speaks to her pain in pregnancy only against an economic and legal backdrop forcing slavers to increase their labor force by new methods. Since nowhere else in the book does the author recommend one account for slaves’ first-person experience of pain, one can assume that without these conditions in place, the woman would fall back into, at best, a veterinary science of pain.

I am not prepared to argue that every instance of non-white pain is erased and represented in the interests of imperialism. Nonetheless, there are too many instances both throughout history and still operative today. The persistence of subaltern pain makes it nearly impossible for philosophers of mind to begin with a premise like “pain is what she says it is” without the implicit universality of that claim being challenged and provincialized. A study published only last year confirms that Black women are still less likely to be administered

66) Anonymous, *Practical Rules for the Management and Medical Treatment of Negro Slaves in the Sugar Colonies* (London: Printed by J. Barfield, 1803), 499.

67) Eddy Nahmias, “The Problem of Pain,” in *Pain: New Essays on Its Nature and the Methodology of Its Study*, ed. Murat Aydede (Boston: MIT Press, 2005), 308.

68) Anonymous, *Practical Rules for the Management and Medical Treatment of Negro Slaves in the Sugar Colonies*, 447.

69) See Dana Ramey Berry, *The Price for Their Pound of Flesh: The Value of the Enslaved, from Womb to Grave, in the Building of a Nation* (Boston: Beacon Press, 2017), chapter 1.

anesthesia during pregnancy, in spite of the fact that patients genuinely suffer pain.⁷⁰ Here, the patient's voice is erased and clinicians decide in her stead that she is not in pain due to Black women's supposedly wider pelvic bones. Furthermore, the case from 1803 demonstrates that in those cases when pain is heard as an authentic and sincere claim, one must be careful to ask what contextual elements are in place making her sudden credibility an advantage to the regime of white supremacy still governing society today. In sum, for a non-white global majority pain is rarely accepted as it is spoken. Rather, the pain is all too often represented to justify only more pain.

IV.

If, as Aydede maintains, the communication of pain is not pain itself but rather the gold standard for establishing a patient's pain in a clinical context, then that gold standard is out of reach for many who, in a racist society, are not recognized as sincere. As I have argued in this essay, the science of pain has long been intertwined with the politics of representation putting into question who can speak and under what institutional and economic circumstances. For the negatively raced individual in pain, "representation" takes on the dangerous ambiguity Spivak warns against. Denied honest or authentic testimony to his or her own experience, science describes the subject's pain in a clinical language, thereby representing the experience to a public medical audience. And yet that representation, posing as objective description, functions politically. In other words, it is an advocating brand of representation that races non-whites as innately capable of bearing tremendous pain. That is the implicit groundwork justifying not only poor pain treatment at the clinic but also outright violence in other institutional settings.

Beyond that observation, I want to conclude by posing a question to philosophers writing on the subject of pain. There are a number of recent essays about philosophy's exclusivity. These critiques are often directed at the canon and our field's systematic disbaring of non-European traditions since the boundaries of philosophy were redrawn in the early nineteenth-century.⁷¹ However, there is perhaps a more basic prohibition in the framing of philosophy's so-called "core areas" and the problems these areas typically address. Naturally, the pertinent example here is the philosophy of mind and its framing of the problem of pain.

For the most part, philosophers' interest in pain stems from its peculiar subjective nature. Pain seems to reveal that perception is not monolithic in the sense that pain does not refer to an objective state of affairs like normal perceptions of, say, an apple on a table. Given the presumed authority of the subject's sincere testimony, the claim that one is in pain is not open to defeating or counterfactual evidence in the way normal perceptions are. In addition to the epistemological puzzle, if pain is located "in the head", then this seems to open philosophers to an ontological problem of mind-body dualism with which many are uncomfortable.

These problems emerge from a modern definition of pain and, I have argued, an epoch of pain science from which many are excluded. In fact, to the extent that philosophy's problems of pain emerge from pain's subjective nature, that origin itself begins only *after* a subaltern pain has been prohibited from this discussion. In other words, only once those who have pain spoken for them are erased, consciously or not, can philosophers

70) Maria Do Carmo Leal et al., "The Color of Pain: Racial Iniquities in Prenatal Care and Childbirth in Brazil," *Cadernos de Saude Publica* (2017). See also Yolonda Wilson et al., "Intersectionality in Clinical Medicine: The Need for a Conceptual Framework," *The American Journal of Bioethics* 19, no. 2 (1990): 8–19, <https://doi.org/10.1080/15265161.2018.1557275>.

71) See Peter K.J. Park, *Africa, Asia, and the History of Philosophy: Racism in the Formation of the Philosophical Canon, 1780–1830* (Albany, NY: SUNY Press, 2013).

begin with the premise that, "third-person judgments are always trumped by first-person judgments."⁷² For this reason, because a subaltern pain must *first* be denied in order for philosophy to *then* frame its orthodox problems of pain, it seems that the erasure of subaltern pain and the problem of violence it bears is elementary.

In this essay, I have only just begun to trace the contours of this interdiction at the root of philosophy's problem of pain. In pursuing that route, one can begin to see that philosophy's other problem of pain, a more fundamental problem proscribed at the root of the orthodox problem, is a problem of racist violence. What is the nature of that violence? If races are defined in terms of their pain, does the nature of the violence differ from race to race? If the orthodox history of pain is such that it has become increasingly subjective over the course of recent centuries, where does a subaltern pain stand in that history? Under what conditions might Zubaydah's pain be heard as sincere? Are these conditions even possible? If a subaltern pain is to be overcome, if non-white pain is to be spoken and heard like any other, if the science of pain will refuse to relegate some to a nociceptive veterinary science, then philosophers and scientists alike must recognize that the problem of subaltern pain does not fit the frameworks currently devised to address pain. As I have argued, that problem of subaltern pain is best summarized as a problem a violence, and that problem results from an expression of pain that is not the patient's but rather a pain science that represents the non-white patient as uncommonly resistant to pain and thus uniquely suited to violent treatment. Philosophers and scientists alike must grant that problem the attention it deserves.

72) Hill, "Ow! The Paradox of Pain," 83.

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