Gunaratnam, Yasmin. "Pain." *Death and the Migrant: Bodies, Borders and Care*. London: Bloomsbury Academic, 2013. 133–147. *Bloomsbury Collections*. Web. 26 Apr. 2023. <<http://dx.doi.org/10.5040/9781472544414.ch-012>>.

Downloaded from Bloomsbury Collections, www.bloomsburycollections.com, 26 April 2023, 15:17 UTC.

Copyright © Yasmin Gunaratnam 2013. You may share this work for non-commercial purposes only, provided you give attribution to the copyright holder and the publisher, and provide a link to the Creative Commons licence.

Pain

'I had a strange pain, started in the whole of my body you know, sometime in here' she explains touching her breast. 'Sometime in, in whole of my body, was circulating like blood.'

Pain needs a body. It relies upon flesh to receive and to register it, to allow it passage. Pain can come and go. It can linger immobile in a tangible 'here', it can engulf or move throughout the body so that it is everywhere *circulating like blood* in the words of Fatima, a Pakistani asylum seeker with terminal breast cancer that had metastasized to her bones.

With these properties, pain defies the ancient notion of a 'proper sensible' in which bodily organs remain faithful to autonomous senses 'each sense yielding access to only a single aspect of being'.¹ Despite efforts to metaphorize pain as numbers (0 is no pain, 10 is unbearable pain), faces (smiles, grimaces), rhythms (continuous, spasmodic, stabbing) or intensities (mild, intense), a distinguishing feature of pain lies in its abasement of categories and in the deficiencies of available descriptors and metaphors. 'I can't describe it' is a recurring refrain of the patients that I have talked with. 'How can you evoke pain in an image?' the artist Donald Rodney has asked. 'You can be sitting next to me and say you feel pain, but how do I know . . . whether you are feeling pain or not, or if your pain is anything like my pain?'² The philosopher Paul Harrison believes that 'experiences of suffering are quasicontradictory experiences in that they tend towards the limits of experience, towards the unexperienceable and irrecoverable.'³

At the borders of symbolization, pain entails, or demands, Elaine Scarry would argue, the shattering of language.

Physical pain does not simply resist language but destroys it, bringing about an immediate reversion to a state anterior to language, to the sounds and cries a human being makes before language is learned.⁴

In Scarry's theorizing of pain as a destroyer of language, recognition is given to the role of pain translation and advocacy, to those such as physicians, where the success of the medical practitioner is dependent upon 'the acuity with which he or she can hear the fragmentary language of pain, coax it into clarity, and interpret it'.⁵ This work of pain translation and advocacy also exists in the social sciences where the demands of researching pain, distress, trauma and suffering have been given sustained attention.

What characterizes these social science discussions is the belief that pain and suffering can be produced by the social: by inequality, exclusion, injustice, powerlessness and persecution. It is perhaps not surprising that such forms of suffering can manifest at the end of life for migrants, where lives are looked back on, and selves and bodies can become both more salient and more vulnerable as illness progresses and also at different stages of the care pathway that involve varying degrees and rhythms of exposure. In a Swedish study, nurses reported how caring for refugees and for survivors of the Nazi concentration camps sometimes entailed closer attention to the routines and technical procedures of care. 'We had a patient who had been in a concentration camp' one nurse said '... it was awful of course ... talking about gas ... she had great difficulty in breathing and it was extremely hard and there were so many memories involved in it all. ...'.⁶ Cicely Saunders had also encountered similar experiences in her early work as a doctor in London in the 1960s. In an undated talk entitled 'The Problem Patient', Saunders presented a slide of Mrs P 'A patient with an extermination camp background who later developed severe depression with hallucinations, helped by E.C.T'.⁷

I have also found that at diagnosis common questions of 'Why?' and 'Why me?' can twist into 'Is it me?' Listen to this story from Mita, an Indian Hindu, Cancer Nurse Specialist, talking about an Indian Hindu patient with terminal cancer. The patient had been a teacher in India, a position that carries considerable prestige and status. In London he had applied repeatedly for teaching posts but had been unsuccessful. He ended up working in factories and then as a bus driver. Mita

I think it had an impact on how he dealt with his condition, because unfortunately his diagnosis had been quite delayed. For a year he'd been going backwards and forwards to the GP, telling him all the classic symptoms of what he'd got. He said 'I know I'm educated and I know I'm completely in the wrong box. I think they haven't treated me properly because I am who I am, because saying I was only good enough for bus driving, not for teaching and for the same reason they

didn't think I was important enough to be diagnosed early enough to be treated in the right way.'

Mita found it difficult to know how to respond to and alleviate her patient's feelings of anguish and injustice and how the different injuries seemed to flow into each other. 'I mean what can you say?' she asked into the air 'What can I actually say to him that's actually going to make a difference to him?'

In the study *The Weight of the World*⁸ first published in French in 1993, the sociologist Pierre Bourdieu used the term *social suffering* to name such experiences and to investigate the relationships between *la grande misère* – economic and spiritual impoverishment – and *la petite misère* or 'ordinary suffering'. *The Weight of the World* used ethnographic and interview methods, presenting its findings as a series of pen portraits in which there is a continuous overlapping between the social, the somatic and the 'spiritual' as Bourdieu calls it.

Louise B, an 80-year-old retired social worker, with degenerative arthritis, was interviewed by Gabrielle Balazs in a Parisian hospital emergency room as part of *The Weight of the World* project. Between 1965 and 1989 Balazs tells us 'the proportion of 60-year-olds or over in France has gone from 17 per cent to 19 per cent . . . more than three-quarters of people on their own aged 55 and over are women.'⁹ Against this cultural background of the feminization of old age and the increasing isolation of older people in French society, Balazs found herself witnessing Louise's first steps into an irreversible process of institutionalized care. Of the interview Balazs says,

The major problem revealed at the hospital is so painful that it cannot be completely articulated, or even thought: each time the interview brings her close to the truth of her solitude – she can no longer go home, her family cannot and does not want to take her in – she rapidly buries the lucidity that would kill her under a cascade of reassuring affirmations: 'I have friends,' 'I have caring people around me,' 'I'm lucky.'¹⁰

Because of the difficulties in expressing social suffering, sociological attentiveness to it has to be cultivated through 'active and methodological listening' Bourdieu argued.¹¹ In the study, interviewers often had a longstanding connection to, or at least some familiarity with, the research sites and the participants. It was a practice developed by the research team to reduce social asymmetries and the risks of a distanced denigration of those they were working with. Their goal Bourdieu tell us was 'to situate oneself in the place the interviewees occupy

in the social space in order to understand them as necessarily *what they are*.¹² Bourdieu's purpose in trying to confect an extraordinary attunement in the interviews was to cut through the 'we've already seen and heard it all' worldly-wise cynicism of the researcher, and to move towards a practical understanding of how social structures and histories could be felt in each research participant's 'idiosyncrasy'.

The feminist cultural theorist, Angela McRobbie, has criticized Bourdieu's study for its sentimentality, lack of thick description and methodological rigour.¹³ The careful documenting and exposition of the negotiation between subjectivity and objectivity and theoretical and practical knowledge that characterizes Bourdieu's empirical research, although present, are certainly more muted in this project. Instead, the pain translation and advocacy role of the researcher is emphasized and situated in her ability to give time, space and self to the research participant and 'like a mid-wife'¹⁴ to bring deeply buried suffering and discontent into the world of expression and understanding. 'Against the old distinction made by Wilhem Dilthey' Bourdieu contends 'we must posit that *understanding and explaining are one*'.¹⁵ In these and other qualifications, Bourdieu seems acutely aware of the controversial nature of his empirical approach to the study of suffering,

. . . at the risk of shocking both the rigorous methodologist and the inspired hermeneutic scholar, I would say that the interview can be considered a sort of *spiritual exercise* that . . . aims at a *true conversion of the way we* look at other people in the ordinary circumstances of life. The welcoming disposition, which leads one to make the respondent's problems one's own, the capacity to take that person and understand them just as they are in their distinctive necessity, is a sort of *intellectual love*. . . .¹⁶

The words *spiritual* and *love* emphasized so provocatively – and that leap off the page to the scholastic eye – point to the limits of the scientific intent of social research. In its place Bourdieu institutes sociology as a 'craft', an unfolding and unpredictable bridging work between the interviewer and research participant, which,

disposes one to improvise on the spot, in the urgency of the interview, strategies of self-presentation and adaptive responses, encouragement and opportune questions etc., so as to help respondents deliver up their truth, or, rather, to be delivered of it.¹⁷

Mindful of Angela McRobbie's critique of *Weight of the World*, there is something in Bourdieu's work – in the moment-by-moment improvisations, the communicating across differences in language and culture and the sense of witnessing the social birthing of painful experiences – that has relevance to my research experiences. So I have been especially interested in what Bourdieu and his colleagues were trying to get at with their flagrant, if ambivalent, detours outside of methodological orthodoxy and into the more-than-social.

In many respects a stubborn allegiance to, and focus upon the social constitution of pain and suffering is very much in evidence throughout *The Weight of the World*. This focus ensures that suffering remains firmly within sociological reach: social suffering can be comprehended, thematized and explained empirically. Yet there is also a more ambiguous recognition of how attentiveness to the *idiosyncrasy* of suffering can engender a move outside of disciplinary traditions, so that research relationships and practices overflow into such sublime matters as spirit and love that breach and offend scientific enterprise, categories and language.

Taking into account the long history of forensic attention to methodological practice that is the hallmark of Bourdieu's research, it seems to me that there is something more profound and artful going on than the 'sociological opportunism' that Angela McRobbie has read into the researchers' empirical rule-breaking.¹⁸ Drawing from my work in palliative care, I want to suggest that Bourdieu's forays into the more-than-social intimate a contact with the vitality and anti-thematizing qualities of pain and the impossibility of limiting the affects and effects of pain and suffering to one sphere of life and being. Ibrahim and his plans for a post-mortem lifeline to his son (see *Sweet Chariot*), June Alexander and the mysteries of faith (see *Moving On*) are among those whom I have in mind, where I have had to think about and follow stories outside the domains of the social and linear time.

That pain and suffering can be produced by and experienced across a plurality of social and bodily sites is not of course only a problem for the social researcher. In observing, talking to and now teaching care practitioners, my thinking about pain has also been informed by their stories and dilemmas. I will elaborate upon what I have been learning by bringing into conversation sociological accounts of 'social suffering'¹⁹ with what in palliative care is called 'total pain'. Total pain interpolates, and at times creolizes, physical, social, psychological and spiritual pain. It also gives recognition to pain that is accrued over a lifetime.

A distinctive value of the chorographic inventiveness of total pain is how it can allow for the assembling of diverse phenomena within its apprehending of pain. However, unlike a 'flat ontology',²⁰ it avoids a 'smear of equivalence'²¹ between entities by not presupposing that phenomena have corresponding states and by allowing for that which is insecure and/or withdrawn; lacking a referent and/or inherent stable qualities. As I understand it, although the withdrawn can sometimes fracture the present, what is withdrawn is not fully accessible in the here and now, because there are planes of life and being that can bypass consciousness and symbolization. The philosopher Levinas has described such relations as being 'diachronic'.²² Because life is marked by diachrony, Levinas has argued, we can never fully know either ourselves or others.

Total pain: 'All of me is wrong'

*I remember one patient who said, when asked to describe her pain: 'Well, doctor, it began in my back but now it seems that all of me is wrong,' and she then described her other symptoms. She went on . . . 'I could have cried for the pills and injections but knew that I must not. My husband and son were wonderful but they were having to stay off work and lose their money.' She was suffering a 'total pain' . . . It is, in a way, somewhat artificial thus to divide a whole experience but it may give an internal checklist on meeting a new patient.*²³

The challenges of alleviating the chronic pain that characterizes terminal disease preoccupied Cicely Saunders. She collected over a thousand patient case studies in the course of her work as a doctor, and used them, together with patient interviews, drawings, poems and paintings, to develop her ideas for hospice care and for pain alleviation. Saunders approached chronic pain as a 'situation' rather than an event, requiring practitioners to be 'attentive to the body, to the family and to [the] patient's inner life'.²⁴ Going against established medical conventions at the time, Saunders drew upon existing, but institutionally marginal practices, to advocate the regular giving of analgesics, including diamorphine, to keep chronic pain in remission, rather than administering analgesia in response to pain. And at the same time as giving attention to physical pain, Saunders returned time and again to the importance of listening to dying people and a concern with 'a whole experience suffered, endured, passed through'.²⁵

Publications by Cicely Saunders without some reference to case study examples, and/or the stories of dying people or caregivers are rare. The archive

of her work at King's College (London) is full of patient stories and hundreds of slides, poems and letters. Not all were collected for her clinical research. She was hopelessly curious about all forms of human experiencing and also the possibilities for inter-species learning about the alleviation of pain. She would follow up all manner of news reports and articles, once corresponding with a vet about his combined use of a morphine derivative and tranquilizer in the capture of square-lipped rhinoceros. In a file of transcribed conversations with patients, Saunders had collated a seemingly random collection of quotes that encompassed the sublime and the earthy; the sort of mundane yet magical fragments of life that are easily overlooked:

- Mrs H: 'It seemed the pains went with me talking'
Mr S: 'Doctor, I think its time I went'
Mr F: 'Doctor, I won't see you again. Goodbye and thank you.'
Mr G: 'This injection is fine and will last me – till tomorrow morning (when he died)'
Mrs I: 'I woke up and there were two of me'
Mrs C: Sister confiscates 'Lady Chatterley's Lover'
Mrs B: 'I'm bored underneath.'

Figure 12.1 Cicely Saunders with patient.

Courtesy: St Christopher's Hospice

In an article first published in 1963 on 'The Treatment of Intractable Pain in Terminal Cancer' Saunders wrote,

I once asked a patient who knew that he was dying what he wanted to see in the people who were looking after him. His answer, 'for someone to look as if they are trying to understand me' . . . It is indeed hard to understand another person but I always remember that he said 'trying'. He did not ask for success but only that someone should care to make the effort.²⁶

Working with and from patient stories, Saunders believed that the constituency and temporality of pain had to be approached as a complex, moving heterogeneity that included the social, psychological and the spiritual. Her focus widened from the genre of disease, and from biochemistry and drugs, to the imperative of treating the many symptoms of a terminal condition. In a letter to her brother Christopher in 1966, Cicely described with low-key, if weary, clarity the challenges that her 'integrated approach' faced in the exigencies of everyday medicine.

The main problem is, I think, that I am trying to talk about the art of medicine in a rather ill-fitting scientific dress but it is important to try and do this. I am very loth indeed to divide it up into two writings, one about the mental side of this type of pain and the other about the physical . . . I wanted to present it in a whole, in a form that the general physician and surgeon and student concerned with the care of these patients might possibly assimilate.

In the cosmology of Cicely's total pain, the plural phenomena of pain are allowed a mysterious ecology, tessellated and distinct, substantial and withdrawn, requiring multidisciplinary, but also experimental, care. 'If you listen to the tale of each one (symptom) and treat it separately, you will have so much less need for sedatives, tranquillizers and even analgesics.'²⁷ And while Saunders seemed to know that recognition of total pain would not always ensure effective pain relief, the effort of *trying* to respond to an-other's needs for care, even when one fails, remained significant to her for both the content and quality of care practices.

In similar ways to Bourdieu's *The Weight of the World*, Cicely Saunders' work with pain often strayed into matters of the immaterial and unquantifiable 'The spirit is more than the body which contains it'.²⁸

Unlike Bourdieu, Cicely Saunders' work with death meant recognizing irredeemable loss and the ultimate limitations of the bridging work of care in responding to differing constituencies, temporalities and scales of pain. For every success story in Saunders' writing – a patient whose emotional distress is

relieved by the right choice and dose of a tranquilizer – there was also sustained attention to those whose pain could not be understood or eased. Her notes about such instances are uncompromising, at times confessional: ‘Miss H – I never got to grips with the situation and had discomfort . . . Lack of communication on my part’ and for Mr H ‘We were not very good with bowels – and he remained miserable? Sh’d have been more honest.’

In the case of emotional distress Cicely has written ‘a good deal of suffering has to be lived through’. The role of the care practitioner in such circumstances is marked by a quintessential passivity ‘We are not there to take away or explain, or even to understand but simply to “Watch with me” . . .’²⁹ Here, a responsiveness to pain, and to that which might be unknown or withdrawn, is transposed into a non-acting standing-by of others. A receptiveness that the psychoanalyst and social work educator Margot Waddell has called ‘serving’.³⁰

In working between the quantitative empiricism of medical knowledge – observing, measuring, indexing, calculating, trialling – and what philosophers sometimes characterize as a fidelity to the unknown,³¹ Cicely Saunders’ notion of total pain reinstates care as a part of human adventuring requiring technical skills and expertise but also ‘negative capability’. Negative capability is the term that the poet Keats³² has used to denote the ability to tolerate incomplete understanding and mystery.

While not forgetting that the ‘total’ of total pain raises matters of medical imperialism and surveillance,³³ its domains and claims are not as totalizing as its name might suggest. Rather than signifying a closed system, total pain seems to point to the infinite, acknowledging that even with the recognition it can give to diverse registers and combinations of pain, it might never fully apprehend, control or alleviate someone’s pain.

It is difficult to find concise examples from my research that demonstrate this side of total pain as an inventive, artful care practice. A story that comes very close, is the ‘mattress story’, told by the community-based nurse Rachel (see page 132). In the story Rachel worked hard to find a not easily available pressure-relieving mattress for a double bed for an anxious Caribbean man and his wife. The man was finding it difficult to sleep and had refused medication to help him. The mattress that Rachel managed to find was able to bring the couple three to four more weeks of sleeping together. Time that Rachel hoped might ease and contain their impending loss and fears and help to build more trusting relationships between the couple and care professionals.

From the perspective of total pain the qualities of the mattress can be thought of as an emotional and material substrate, continuing to connect and support the

couple in Rachel's absence. As an affective subtending, the power of the mattress and its potential to relieve suffering is indivisible from its materiality; the extent to which its form and sensual qualities are themselves actants impressed by two variously suffering bodies, a cough, the physiology and metaphysics of sleep for a dying man and suspicion of professionals.

What captivated me about this story was how the offering of the mattress was both an inventive use of available resources *and* negative capability. Rachel could not verify the sources or different knots of pain that were involved in her patient's situation. She did not know for sure that the mattress would alleviate the man's pain and convey her recognition of the fear and anxieties that she felt this couple were living through. There were no clinical trials or evidence base that she could draw upon. Rather, Rachel's version of total pain was created and emerged from her relationship to the couple and out of some regard for materials and affects in their everyday lives. Such chorographic pain alleviation works off imagined interconnections between signs and the real. It seems cognizant of how emotions can materialize by 'sticking' to certain objects.³⁴ It also allows painful entities a non-presentness or mystery.

At first glance the basic tenets of total pain seem to operate much like a 'flat ontology',³⁵ one in which tumours as much as mattresses and coughs are recognized as contiguous, intra-acting components of pain. Indeed, emerging neuroscience investigations suggest that social and physical pain rely upon some of the same neurobiological substrates.³⁶ Yet, although total pain allows for such sharing it also leaves spaces for the effects of undisclosed and unfathomable entities that can defy the most bespoke titration of drugs or care-full listening. So in practice the 'total' of total pain can operate more as a provocation for care and as a tentative placeholder for a pluralized known and unknown.

Case stories

For me, the philosophy of total pain revitalizes social science discussions of the limits of understanding pain and suffering. It also raises questions of what might be at stake in the revisions and extensions to the empirical that I have suggested that total pain implies. These questions become less abstract when I apply them to my ongoing teaching with palliative care professionals. Consider what can happen in teaching when I use case stories generated from my research.

The case story of Maxine describes the end-of-life care of a 63-year-old hospice patient, a retired auxiliary nurse whose story I have documented in Chapter 4

'A Catch.' Maxine had talked to me in some detail, and over a period of months, about her life, recounting events of domestic and racist violence. In her stories Maxine was often more of a heroine than a victim, feisty and discerning. When admitted into the hospice for terminal care, she grew increasingly agitated. In the last days of her life, Maxine began to resist all hands-on care.

In multidisciplinary teaching sessions we discuss what might be involved in Maxine's situation. If it has not been raised, and drawing from the insights of feminist and psychoanalytic scholarship, I might suggest how histories of gendered and racialized violence are implicated in Maxine's anxieties about her body. In making sense of the care problematic, a doctor may layer my suggestions into what she has learned from 20 years of clinical practice and from evidence-based research: paranoia, agitation and hyper-sensitivity to touch and to noise can be caused by drugs and the biopathology of advanced disease. A social worker could draw upon pedagogies of anti-oppressive practice³⁷ and diversity training, relating the case story to his experiences of counselling survivors of war and women who have been raped, for whom physical care can be traumatic.

A crucial point is that the generation of these insights and possibilities is not about a semiotic expansion – a piling up of new symbolic categories onto existing knowledge in order to signify with greater accuracy, a previously unthought, but ultimately generalizable real. Neither is the aim to retrieve or to recover to the present a lost (explanatory) object of pain in Maxine's past. Rather, these interdisciplinary exchanges become highly focussed, contextualizing and specifying practices through which we can become variously sensitized to more possible registers of Maxine's pain, including those that elude us. In the process, it is attentiveness to the singularities of Maxine's situation that can produce shifts in what we think of as pain, so that the content of our experienced world expands.

This process is broadly akin to what Bruno Latour calls 'articulation', a bodily practice of 'learning to be affected by differences'.³⁸ It is a learning that does not rely upon an object/subject, nature/culture split or upon common, uncontested epistemologies. For Latour "The more you articulate controversies, the wider the world becomes".³⁹

Being affected to learn

Latour's *learning to be affected* is defined as a bodily practice and is relevant to the embodied thinking and practising of ethics in empirical research: how

might the attentiveness of research be articulated? There is a supplement that I would like to add. In my teaching and learning with care professionals it is apparent that we are already affected by our encounters with pain, suffering and vulnerability. At the same time there are aspects of entities and others that cannot be fully recuperated into a taught interdisciplinary or sensual affectedness. No matter how many different perspectives, experiences and levels of analysis are brought to the interpretation of Maxine's case-storied life, no matter how questions of disciplinary knowledge production are kept in sight, there are always aspects of her experience that are untranslatable. So while our worlds have expanded through our encounters with Maxine and with each other, we cannot claim to ever fully understand the sources, routes, levels, temporality and meanings of Maxine's pain.

And so within learning, to be affected, there is also the unintelligible and the undecidable. It is this unintelligibility – an empirical counterpart of the withdrawn in philosophies of total pain – that can become an inspiration for the bridging work of sociological attentiveness and the improvisations of methodology. In other words, there are circuits or relays of interdependence between learning to be affected and being affected to learn which gain traction and impetus from the things we cannot resolve, recover or connect, but which nevertheless have a status as a response.⁴⁰

'Incomprehensibility' Derrida writes '... is not the beginning of irrationalism but the wound or inspiration which opens speech and then makes possible every logos or every rationalism.'⁴¹ There are two notions of fidelity at work here: remaining faithful to the idiom and the milieu of what is unknowable, while also searching for and using every possible means by which to know it differently. I have in mind the commonplace but often under-described 'wounding' inspirations of empirical research: Bourdieu's struggles with the 'infidelities' of transcribing interviews – his admission that it took him over a decade (with repeated listening to an interview recording) to better appreciate the depth of the precarious existence of two farmers whom he had known personally for a long time. And there is my own turn to poetry and creative writing to evoke and commemorate non-linearities and enigma.⁴² As Graham and Thrift have recognized, despite its origins in failure and fault, in improvisation there is always the hope of a provisional responsiveness and learning.

Improvisation allows the work of maintenance and repair to go on when things may seem bleak and it takes in a whole series of responses, from simple repetition (such as trying it again) through to attempts to improve communication so as to

be clear exactly what the problem is, through disagreement over causes, through to complex theorizing, responses which are often the result of long and complex apprenticeships and other means of teaching. . . .⁴³

Of course we need to be careful about valorizing or embracing the unintelligible too readily. The unknown as beyond question risks becoming complicit with the mystifications that are part of the apparatus of social and political abjection.⁴⁴ We can also neglect the more mundane ways in which empirical inquiry can itself be 'dumb', stifled by a 'dramatically poor repertoire of sympathies and antipathies.'⁴⁵

Thinking about the status of what is inaccessible, mysterious or unlocatable is also to think about differential histories and scales of existence and how these histories and scales are rendered and approached – and always *in media res* – from different disciplinary perspectives. But, it is also to return to basics: to recognize that critical methodologies, as much as care, are driven by a desire (and for some, a responsibility) to oppose unnecessary suffering 'it is precisely the radical destructibility of life that makes it a matter of care.'⁴⁶ And so, the unintelligible for me is not so much a bounded territory or domain, an empirical no-go zone. Rather, it simultaneously signifies and problematizes the underlying drive of the attentiveness of social research as an imperative to uncover and to do something about unnecessary suffering.

Learning from the improvisations of dying migrants and care practitioners, I want to suggest that the unintelligible involves something more than being the opposite or absence of intelligibility. Carrying the capacity to put into motion, touch, interrupt and halt it is the very condition of future 'live'⁴⁷ empirical activity; a site of problem-making and accounting for. An opening to the creation of different methodological practices, knowledge and ways of thinking about the usefulness of what we do and also about what is 'sociologically unspeakable'.⁴⁸

I am still very much learning about the demands of doing research in painful settings. At this stage of my thinking there are two matters that I feel are important. First, attentiveness to a range of different materials out of which attempts at intersubjective bridging and communication can be produced, and which can exceed the social, the material and the temporally linear. And second the cultivating of an empirical sensibility that is hospitable to the withdrawn.