Even the most scientifically reductionist view of the individual reveals that we are complex systems nested within complex systems. These interactions within and among systems are based and depend upon numerous variables of our (internal and external) environment(s). If we define ethics as a system of moral decision making, then it becomes clear that these decisions ultimately affect the situation(s) of managing our activities and relationships with others in our environment (in essence, our being in the world).

Given that ecology literally means a “...a study or system of wisdom and reasoning about the interrelation of organisms in their environment or place of inhabitance,” Owen Flanagan’s description of ethics as “human ecology” takes on considerable relevance and importance.

To approach the ethical issues, and various systems and techniques used to address and resolve these issues, then - pro Flanagan - it is crucial to recognize the effect of “environment” upon persons’ situations and actions...
In this essay we argue that any practical consideration of an ethics of pain medicine must also recognize 1) the effects of culture upon the event, phenomenon and experience of pain; 2) the distinctions that are evoked by the “culture” of medicine (versus the “culture” of patienthood), and 3) how geographic, social and temporal variances affect these cultural dynamics. We posit that

Во овој есеj докажуваме декa секоjа практичесна размиcлa за етикaта на медицина мора да ги препознаe 1) ефeктите на културата врz настанот, феноменот и искусувањетo на болка; 2) разликите кои ги предизвикува „културата“ на медицината (наспроти „културата“ на пациентствотo), и 3) какo географските, социjалните и временските
one cannot extricate persons from “culture,” and any attempt to define issues, problems, values, potential solutions and consequences that affect individuals and groups must frame this calculus within a cultural context, at least to some extent, otherwise it will likely be unrealistic.

**Cultural Effects upon Pain: Event, Experience, and Meaning**

Even if pain is solely considered as a neurophysiological event, the putative effects of culture cannot be ignored. Anthropologically, the relationship between culture and ecology is often considered to be reciprocal. Many environmental factors (e.g., geographical boundaries and limitations, climate, survival and salutogenic characteristics) have been shown to effect genomic frequencies, and the expression of particular phenotypes in aggregate groups of people. Selective pressures yielded elimination of certain genotypes in favor of others, expressing phenotypes that (through environmental, epigenetic modification) fortified these variations. These factors provided the basis for developmental trajectories that would 1) maximize the success of environmental interactions, 2) tend to produce predispositions to relatively common geno- and phenotypic patterns within defined regions that reflect this survivability, and 3) therefore be sustained and fortified within these environmental niches. Environment affects physiological development, maturation and function, promotes particular phenotypes, and ultimately may shape common functions of certain phenotypic groups.

Put more colloquially, nature is expressed via nurture, and common factors within the nurturing environment can affect patterns of neurologic activity and/or structure.
In this way, environments can “culture” groups of individuals, and cultures develop in response to, and to meaningfully affect environments. Moreover, keeping in mind that the boundaries between internal and external environment are somewhat arbitrary and interactive on a number of levels, then we must appreciate the effects of culture on individuals across biopsychosocial domains. Analyses of genetic and epigenetic influences have validated the effects of environment and culture on phylogenetic and ontogenetic patterns of certain physiological traits. The work of Mogil and his colleagues has shed light on genotypic predispositions to neural substrates that can give rise to (susceptibility and expression of) certain types of pain. 

Our ongoing characterization of pain as a spectrum disorder suggests that there are putative families (i.e.- clades) of genotypes and phenotypes that are differentially sensitive to environmental influence(s) for the expression of pain (thresholds, experience, and most likely cognitive/behavioral manifestations). Thus, while pain is a universal human experience, biopsychosocial influences of culture can alter the development of neural systems, cognitions and behaviors that affect the sensation of pain, its experience and its expression, respectively.
Such distinctions have been anecdotally noted since antiquity. Zborowski’s classic, yet methodologically (if not philosophically) flawed study of pain thresholds, perceptions, and responses in various ethnic groups was nonetheless important in that it shed light upon the possibility that various cultures could be susceptible to biopsychosocial influences that affect pain. Several subsequent studies revealed differences in sensitivity to, and expression of pain between various ethnic, social, and geographically distributed groups.

But it is important to heed A.L. Kroeber’s warning not to confuse “culture” with “a culture,” as the latter is connotatively prejudicial. Rather, we must consider “culture” as presciently described by E.B. Tylor over a century ago as “…complex whole” that can dynamically shape almost all aspects of human experience. Culture - as a complex whole - gives rise to identifiable groups that cluster together based upon geographic isolation, niche occupation, physiological functions, kin selection, and social characteristics and activities. It is these biopsychosocial effects and artifacts that promote and sustain beliefs, knowledge, and the resultant behaviors of individuals, and the groups to which they belong. These socio-cultural characteristics can determine accepted interpersonal roles, and modes of action and expression that can affect how the sensation of pain may be perceived, interpreted, communicated and treated.
Cultural Orientations of Patients and Clinicians: Knowledge, Beliefs and Realities

It is in this broader context that we must consider the effect(s) of culture on ways of understanding pain, the experience of patienthood, and the role(s) of pain medicine and the clinician. There is a reciprocal relationship between the sensation and meaning of pain.\textsuperscript{22} The subjectivity of pain reflects distinctions in neurophysiological processing of pain as a sensation, and neurocognitive interpretation of pain as an experience of the lived body.\textsuperscript{23-25} Given that cognitive constructs (i.e., meanings) are socio-culturally influenced, the perceived identity and impact of pain are often contextual.\textsuperscript{26} Elaine Scarry has claimed that pain can deconstruct patients’ lives and defy language.\textsuperscript{27} But to fully grasp the extent of these effects, it is important to understand 1) the life-world of the patient to determine how it has been deconstructed by pain, and 2) that this life-world is inextricably bound to the patient’s culture. As well, while pain may defy language, its experience compels communication in an attempt to communicate subjective suffering to others.\textsuperscript{28,29} We opine that the effectiveness of this communication is semiotically and semantically constrained by socio-cultural capacities and limitations.

We can conceive this potential communication as a Borromean interaction: the interplay of three domains whose relative intersection reflects both the extent of commonality and the possibilities for mutual engagement.\textsuperscript{30} As shown in Figure 1, such a Borromean interaction of 1) pain, 2) the pain patient, and 3) the

Културните ориентации на пациентите и клиничарите: Знаење, верувања и стварност

Токму во овој поширок контекст мора да ги земеме предвид ефектот (ефектите) на културата врз начинаране на разбирање на болката, пациентското искуство и улогата (употребата) на медицината за болка и клиничарите. Постои реципрочен однос помеѓу чувствуването и значењето на болката.\textsuperscript{22} Субјективноста на болката ги рефлектира разликите во невропсихолошкото процесирање на болката како чувство, а неврокогнитивното толкување на болката како искуство на живееното тело.\textsuperscript{23-25} Со оглед на тоа што когнитивните конструкти (т.е. значењата) се социокултурно под влијание, сфатениот идентитет и влијанието врз болката се обично контекстуални.\textsuperscript{26} Елејн Скери (Elaine Scarry) пласираше како искуство разликите на болката ги рефлектира разликите на пациентите и да му пркоси на јазикот.\textsuperscript{27} Но, за целосно сфатување на степенот на тие ефекти, важно е да се разбере 1) животниот свет на пациентот, за да се утврди како болката го деконструира, и 2) дека овој животен свет е нераскинливо врзан за културата на пациентот. Исто, додека болката може да му пркоси на јазикот, нејзиното искуство принудува на комуникација во обид за субјективното страдање да се искомуницира со другите.\textsuperscript{28,29} Ние тврдиме дека ефективноста на оваа комуникација е семиотички и семантички претензии од страна на социокултурните капацитети и ограничувања.

Оваа потенцијална комуникација можеме да ја сфатиме како боромејска интеракција: мегусебната поврзаност на трите домени, чие односно вкрушување го рефлектира и степенот на заеднички точки и можности за мегусебно ангажирање.\textsuperscript{30} Како што е прикажано во слицата бр. 1, таквата боромејска
Identities

clinician, dictates both the patient’s and the clinician’s attitudes and activities. Clearly, the patient and clinician bring their respective cultural influences and effects to the fore within the fabric of the clinical encounter. In this way, both maintain and manifest beliefs, knowledge, and attitudes about the nature and meaning of pain, disease, illness, personhood, and responsibility. Beliefs should

**Figure 1:** A Borromean depiction of the relationship of patient, clinician, and pain and its treatment(s). Each one of the rings represents a sphere that constitutes the multi-dimensionality of the particular entity. For patient and clinician, it represents the totality of their respective life-worlds, inclusive of culture, experience, beliefs, knowledge and attitudes. For pain and its treatment, the sphere reflects the objective entities, and its intersection with the patient and clinician represents the subjective (individual and cultural) characterization of this objectivity. The extent of alignment between patient, clinician, pain, and its treatment depend upon commonality of beliefs, knowledge, experience and expectations. Each and/or all can be affected by culture, either individually, or together.
not be minimized; to paraphrase Augustine, to believe is to understand, such that our individual conceptualization of the world allows and guides our ways of knowing, and colors our interpretations of life.\textsuperscript{31} For the patient, these beliefs may incorporate considerable “folk knowledge,” and may not be consonant with the beliefs upon which the epistemology of medicine is based.\textsuperscript{32} Thus, the beliefs of patient and clinician can ultimately enhance or disrupt the Borromean dynamics of the medical relationship.

With its defined set of values, attitudes, beliefs, meanings and even language and behaviors, medicine must be viewed as a socio-cultural force,\textsuperscript{33} and its power creates, and is upheld by, biopsychosocial asymmetries in the clinician-patient relationship. We believe that one of the tasks of the clinician is to lessen this asymmetry by decreasing the vulnerability of the patient through the empowering provision of care. So, if pain medicine is to fulfill the good of its professed task (i.e.-treating and healing the person made vulnerable by pain), then it is important for the clinician to not simply understand pain as object, but to understand how the objective event of pain is subjectively interpreted by, expressed in, and affects the culturally-nested patient.\textsuperscript{34}
Pain as Subjective “Creation” in the Interplay between the Real, the Imaginary and the Symbolic

What has been long underestimated in mainstream medicine is exactly this subjective dimension within the “event” of pain - especially in its close ties to intersubjective, culturally pre-formative patterns. It is the “subjectivity of pain” or “pain as the intimate subject” that has to be investigated in greater depth if patient-centered pain care is to make further progress toward a truly “subjective-objective” paradigm - not only in practice, but also in its philosophical and scientific foundations. In order to achieve such progress, the double etymological sense of the term “subject” has to be considered in its value for the concrete “event” of pain: 1) pain as the ontological “basis” (i.e.- from the Latin, sub-jectum, passive) of the ill subject, and at the same time 2) the “submission” (i.e.- Latin, sub-iacere, active) of the subject.

As the French psychoanalyst Jacques Lacan has noted, the subject’s experience seems indelible from patterns of unconscious “interpretation” that are “rooted” in its sensitivity and (self-)perception by cultural predispositions. There seems to exist, in fact, a second, even more narrowly conceived “Borromean knot” involved in the overall event of pain at the subjective level: the constitutive interaction and mutual relationship between patterns of imagination and symbolization that decisively contribute, if not create, the “real” event of pain. Both the imaginary and the symbolic order form the unconscious “basis” of the subject that experiences pain, and at the same time, both “submit” the experience of pain to largely meta-personal cultural laws.

Болката како субјективна „креација“ во међусебната игра међу стварното, имагинарното и симболното

Тоа што долго време беше потценувано во главната струја на медицината е токму оваа субјективна димензија во рамки на „настан“ на болка - особено во нејзината тесни врски со интерсубјективните, културно пре-формативните шеми. Токму „субјективноста на болката“ или „болката на интимниот субјект“ треба подлабоко да се испитува за пациентоцентричната нега на болката да напредува понатаму кон вистински „субјективно-објективна“ парадигма – не само во пракса, туку и во нејзините философски и научни основи. За да се постигне таков напредок, двојната етимолошка смисла на терминот „субјект“ мора да се мисли низ нејзината вредност за конкретниот „настан“ на болка: 1) болката како онтолошка „база“ (т.е. – од Латински, sub-jectum, пассив) на болниот субјект, и во исто време 2) „потчинувањето“ (т.е. sub-iacere, актив) на субјектот.

Како што има забележано францускиот психоаналитичар Жак Лакан (Jacques Lacan), искуството на субјектот се чини нераскинливо од шемите на несвесното „толкување“ кои се вкоренети во неговата чувственост и (себе) перцепција од страна на културните предиспозиции. Се чини дека доисто, всушност, втор, уште потесен „боромејски јазол“ вклучен во целиот настан около болката на субјективно ниво: суствинската меѓуигра и заеменот однос помеѓу шемите на имагинацијата и симболизацијата кои секако придонесуваат, ако и не го создаваат, „стварниот“ настан на болката. И редот на имагинацијата и тој на симболиката ја формираат несвесната „основа“ на субјектот којшто ја искусува како наш од имагинацијата и симболизацијата на болката како субјективна „креација“.
In other words, how the subject’s inherited culture produces an array of symbolic “concretizations” of the experience of pain – for example in the form of images, language, or behavior, which vary from individual to individual and from culture to culture and can all be seen as forms of “negotiation” with the experience and as an attempt to “integrate” it into the realm of its own ontological “real” - influences the perception and the experience of pain itself. On the other hand, it has been long known that the personal imagery of the subject not only mirrors and embodies the “events” of pain in a dreamlike way, but can also actively influence it, if appropriately controlled and enacted, to the extent that it may alter the very outcome of the illness and the respective healing process.

But it is neither one nor the other dimension of the “reality” of pain that singularly seems to be of decisive value in a more holistic ethics of patient-centered pain care. Rather, we posit that it is the dialectic of these two dimensions that must be considered. The traditional ethics of medicine are derived from the “modern” concepts of 19th and 20th century rationality and therefore still tend to apply dualistic models in which the main critical productivity is the analysis of the disproportions between the imaginary and the real (i.e. between the subjective “elaboration” of pain and its – often not corresponding - objective physical bases and origins).37,38 However, more recent “postmodern” approaches have added a third dimension to this constitutive dualism: the realm of the symbolic as being the decisive dimension
for the subjective “incarnation” of pain.39 Such a view can be sustained, at least partly, by considering that culture itself can be seen as a “Borromean knot” given that 1) it is constituted by those three “dimensions” of reality: namely, the real, the imaginary and the symbolic, and 2) it produces a subject “submitted” to the interplay between the dialectics of these dimensions.40

The “Subject of Pain” and the Lessons of the Placebo Experience

If pain identities are fundamentally “created” entities, then it becomes clear that patient-centered pain medicine will address treating “cultural subjects of pain,” rather than “patients with an illness producing pain.” One especially effective example of how such a culturally aware philosophy of pain care could be enacted may be revealed by study of placebo effects and responses.

At the most basic level, the placebo effect is a cascade of physical responses that are induced through some psychologically reactive (i.e.- “meaning”) response to a circumstance, place, action(s), or person.41-42 This seems to be possible exactly because of the central role of the personal imaginary of the subject and a desire to symbolically incorporate the “Other” as part of a first-person experience.43-45 Thus, it is a fake that is at the same time a reality.46 At the center of its effect lies not the question of “identity” in the strict sense - i.e.- if it is a fake or a reality - but rather the transformative power that can be enacted between these two poles. Thus, identities reveal themselves as being entities of (low
Понатаму, со оглед на тоа дека плацебо ефектите/одговорите успеваат да го искористат несвесниот обид на субјектот да ги обедини имагинарното и симболното и да создаде одржливо реално, на нив може да се гледа како на сублимит на уметноста. Плацебо ефектот е еден вид артефакт затоа што вклучува значења врзани за нешто уметничко и/или вештачко за да создаде нешто реално. Како такви, овие ефекти манифестираат еден вид „нулта вредност“ која постои во межуиграта меѓу имагинарното, симболното и реалното – во зависност од контекстот и толкувањето на оној којшто го искусува ефектот. Исто, плацебо ефектот открива донекаде криптични механизми и функции кои го одржуваат „постоењето“ на субективната стварност. Плацебо искуството особено може да ја расветли интимната димензија на болката. Може да се претпостави дека болката - како субјективна реалност која никогаш не може осем да се изрази со помош на симболното и никогаш не може целосно да се интегрира во канонот на имагинарно присутното на одредена култура - е принцип „создаден“ на сличен начин како што се генерира „плацебо“ ефектот и се „отелотворува“ во субјектот (и секако ова вусност можеби е причина за негативновалентните ноцебо одговори и ефекти).48, 49

Perhaps then, the cultural competence of the healing encounter is a matter of attunement to the “art of placebo,” and as such can be seen as the “art of boundaries” between the imaginary, the symbolic and the real, reflective of Martin Heidegger’s definition of the term boundary: “…not that at which something stops, but as the Greeks
Identities recognized, the boundary is that from which something begins its presencing.”

This is particularly true in pain care, given the subjective presence of pain to transcend boundaries of past, present and future; silence and voice, understanding and explanation, and self and other. These boundaries are, embodied by the reality of the subjective experience of pain and its objectification, and are in essence, what define the hermeneutic nature of pain medicine.

The Impact of Culture on Ethics

The conjunction of objective and subjective understanding provides a basis for 1) diagnosis, 2) considering those therapeutic options that are available, and 3) selecting those that maximize good outcomes in a specific patient. Obviously, these choices must both determine the contextual meaning of good (for the patient’s best interests), and direct its provision. The relief of pain - as the tangible good of the clinical encounter and the relationship of pain clinician and patient - must extend beyond the limited proximity of the clinical environment and affect the daily realities of the patient’s life-world. Therefore, it becomes apparent that each decision is at once therapeutic and moral, and the decisional process becomes one of ethical concern. But given the cultural plurality of contemporary society, how can these ethical decisions be made with any reliability?
We have argued that the structure of pain medicine entails a particular framework of responsibilities and obligations that define its intellectual, moral and practical articulation. These rules define what the practice is all about and establish the requirements that one must accept if they are to enter the field. These are far-reaching statements that conjoin pain management to a general philosophy of medicine that is built upon, and defines a core epistemology (i.e.- as a knowledge base, and ways of knowing), anthropology (as consideration of the factors that are involved with the conduct of pain care as a human enterprise), and ethics (as a formal, systemized analysis of moral decisions and the systems and processes involved in moral decision making). Hence, the “rules” explicate particular essentials of pain care, such as 1) the importance of knowing about pain and its effects, 2) an understanding of the multi-dimensionality of the person who is the patient, 3) the subjectivity of pain and the difficult yet critical necessity for inter-subjectivity, and 4) a knowledge of ethics as both a process and a set of tools. Simply, rules (1)-(3) determine what ethical processes and tools might be best suited for the specific circumstances, interpersonal relations, and task at hand. Obviously, any consideration or understanding of the person who is the patient must regard the relative effect of culture; but in actuality, the entire process, that is the rules themselves and our need and reliance upon them, does not transcend cultural influences.

The actual point of the described Borromean interaction is interpersonal, occurring between the clinician and patient. Given the clinician’s roles as steward of knowledge, and executor of knowledge and skill (in the
To be sure, self-awareness and -reflection are cornerstones of prudent, culturally sensitive care. Such self-reflection fortifies the clinician’s awareness of the importance that beliefs and values have in effecting the manifestations of illness, and patients’ intentions and actions in the clinical encounter. In practicality, this enables a clarified lens with which to view the patient, may facilitate culturally sensitive communication, and allow insight to patients’ beliefs, values and goals. By enhancing ongoing dialogue, clinician and patient establish a problem-solving relationship that supports mutual decision making, sustains the agency of patient and clinician, and may serve as a starting point for implementing values-based, and/or goal-directed pain care. Such sharing of perspectives, beliefs, knowledge, meanings,

на знаењето и вештината (во најдобар интерес на пациентот), ние тврдиме дека токму клиничарот има одговорност да ги искористи етичките пристапи кои 1) одговараат на неговиот/нејзиниот морален компас, 2) дозволуваат прецизна анализа на биопсихосоцијалните потреби на секој пациент и, со тоа, 3) го дефинираат и насочуваат обезбедувањето на (вистинска) и добра грижа. Ова повлекува нужност од етика заснована врз агент па иако се залагаме за пристапот ориентиран кон доблести, согледуваме дека етиката на доблести не може да функционира изолирано. Сепак, иако одредени интелектуални доблести овозможуваат разбиране на една култура и нејзините ефекти, а моралните доблести може да овозможат промисленоста да го насочува на вообичаено стремење кон доброто, доблестите мора да се ангажираат во одреден систем (и) кој ги задоволува непредвидливите елементи на околностите и лицата. Јасно е дека етиката на доблести налага испитување на верувањата и вредностите на една личност кон развивање на културно разбиране кое е неопходно за етичко разгледување.

Секако дека самосвесноста и авторефлексијата се темелат на промислената, културно чувствителна грижа. Таквата авторефлексија ја зацврствува свесноста на клиничарот за важноста на верувањата и вредностите за манифестациите на болеста, намерите на пациентот и дејствата во клиничкото случување. Во практиката, ова овозможува појасен поглед на пациентот, може да ја помогне културно чувствителната комуникација и да дозволи согледување на верувањата, вредностите и целите на пациентот. Со зајакнување на тековниот дијалог, клиничарот и пациентот воспоставуваат однос за решавање на проблеми кој поддржува заедничко донесување на одлуки, го одржува посредувањето на пациентот и клиничарот, а може да служи како
пояснительная точка для спроведения на такая грижа за боль-ка којашто се заснова врз вредности и која е насочена кон цели. Таквото споделување на перспективите, верувањата, знаењето, значењата и клиничките очекувања, може да создаде сојуз во кој на пациентот му е дадена моќ, а клиничарот е оспособен.

Една од критиките на овој пристап е дека секое целосно промислување на културните ефекти и разликите имплицира етички релативизам или субјективизам. На некое подлабоко ниво, ова е всушност етичка Скептицизам кој што поставува прашање дали една морална одлука може да биде правилна или погрешна и дали концептот за тоа што е „добро“ има некаква валидност. Спорната точка е во тоа што штом еднаш земеме предвид или допуштиме културна и индивидуална варијација, тогаш секое тврдење за тоа што го минува тестот на морална исправност станува одвај нешто повеќе од мислење или некаков обид за напредување, и/или регрутирање на други кон одредено гледиште. Не се согласуваме од неколку причини. Прво, секој пристап кон морално одлучување кој ги користи етичките системи мора да започне со прибирање и анализирање на факти кои се релевантни за околностите, прашањата и/или проблемите. Јасно е дека културата може да влијае врз (наклонетостите, верувањата, дејствата и слично на) лицата. Второ, секое морално разгледување мора да ги земе предвид вклучените агенти, не едноставно како објекти, туку како субјекти на одговорност. Трето, додека моралното разгледување ги промислува и премерува влијанието и значењето на културата и нејзините ефекти врз поединците, самот процес бара оттргнување (т.е. „отстапување наназад“ на рефлективна оддалеченост) за да се проценат овие фактори со споредување, и четврто, моралното and clinical expectations can create an alliance in which the patient is empowered and the clinician is enabled.

One of the critiques of this approach is that any full consideration of cultural effects and differences implies an ethical relativism or subjectivism. On a somewhat deeper level, this is actually an ethical skepticism that questions whether any moral decision can be right or wrong, and if the concept of what is “good” has any validity. The point of contention is that once we consider or allow cultural and individual variation, then any claim to what is morally sound becomes little more than opinion or some attempt to advance, and/or recruit others to a particular point of view. We disagree with this for several reasons. First, any approach to moral decision making an use of ethical systems must begin by obtaining and analyzing facts, relevant to the circumstances, issues and/or problems. Clearly, it is factual that culture can affect (the dispositions, beliefs, actions, etc. of) persons. Second, any moral deliberation must consider the agents involved, not simply as objects, but as subjects of responsibility. Third, while moral deliberation considers and weighs the influence and importance of culture and its effects on individuals, the process itself seeks to prescind (i.e.- “step back” in reflective distance) so as to evaluate these factors in balance; and fourth, moral deliberation is actually aimed at describing and defining the case, and molding attitudes toward certain actions. In this way, moral discourse and deliberation need not be about what is “true” or “false”, or even what is “right” or “wrong”, but rather what warrants rational consideration and supports reasonable action(s). Accordingly, some ethical approaches are better suited to ameliorating
the differences of culture and strengthening the voice of those who are marginalized. Feminist ethics have particular merit in this regard, at least in part, in that the feminist perspective directly acknowledges the overt and covert effects of relational asymmetry, and affords tools that both allow insight to this discordance and that may equalize capability and power.

But perhaps what is needed is a meta-ethics of pain medicine; a system that allows an overview and analysis of the ethical issues in pain care, and what, how, and why particular ethical approaches can be engaged to resolve these issues. The task is formidable, and is the focus of our ongoing work. As we approach specific pragmatic and moral issues in pain care, it is critical to ground each of these problems and their potential solutions to the realities defined by persons in culture. For if pain medicine is to be truly practical, it must acknowledge an increasingly global, pluralized world-culture, and offer care that is sensitive to our symbols, realities, similarities and differences.
Notes:


5. Ibid. ref. 3, 304.


7. Ibid. ref. 6.


32. Ibid. ref. 22.


48. Ibid. ref 43.


58. Ibid. ref. 56.


60. Ibid. refs. 23, 57.


64. Ibid. ref. 53.

65. Ibid. ref. 22.


