

## MANAGEMENT OF SUFFERING IN THE WELFARE STATE - a symposium on the political, social, psychological and medical meaning of chronic pain

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One of the central roles of the Welfare State is the redistributing of economic resources and public support among the citizens. In theory, everybody should contribute to the welfare system and in return receive a universal right to public support. However, far from all citizens are capable of working, and far from everybody has *real* access to the public support they desire. It is a political question how these duties and rights are distributed within society even though the question of a citizen's ability to work is often highly embedded in other professional disciplines such as the medical and other health-related professions. A main reason why citizens cannot maintain a job and need to apply for public support is often that they suffer from health problems, including pain, for which they seek medical, psychological or therapeutic help.

It is not in the hands of a doctor or a pain expert to decide how much pain a person should endure before he is entitled to receive public support. Instead it is the social authorities that determine who shall or shall not receive public support because it is a political and not an objective distinction that separates 'deserving' from 'non-deserving' applicants for public support. The distinction and the political tradition for solving the matter of entitlement, however, are both blurred and ambivalent. Several examples from different Welfare States (US, Holland, UK) show similar attempts to answer the question of entitlement by using medical knowledge as objective measures. Some 30 years ago in the USA, doctors were induced by the Administration to assist social workers in the process of determining entitlement to public support because of their clinical and diagnostic practice. This practice was interpreted by the political system as a way to justify through 'medical objectivity' the procedures and the evaluation of entitlement made by the social authorities. Even though the doctors objected by arguing that medicine is far from an accurate science capable of separating the 'worthy needy' from the 'non-worthy needy' applicants, they ended up as central tools in this political matter.

Until 2003, doctors in Denmark have had a similar central function in the public support system. After 2003 a policy shift occurred and a new law explicitly forbade doctors to make social evaluations of entitlement to public support. The public perception of the medical profession seemed to have changed, and doctors were no longer seen as professionals offering rational and objective knowledge but were suddenly framed as 'uncontrollable', political and always on the 'patient's side in discussions of entitlement to public support. In the public discourse on welfare services, doctors were portrayed as having an interest in gaining more

power over and more patients on public support. They were even accused of putting healthy people on permanent welfare deliberately by (mis)using clinical diagnosis as an instrument to do so on behalf of legal authority.

In Denmark, doctors no longer have the right to recommend pension or other kinds of public support and are - technically speaking - reduced to act as consultants for the social workers in these matters. But where does that leave specialized medical and psychological knowledge with respect to diagnoses that are still unclear and badly defined among lay people, e.g. when chronic pain patients are asked to document their pain as part of a request for public support? This is still an open question, which as a result make social workers develop a kind of lay man understanding of the diagnosis presented by the client in order to be able to evaluate entitlement. But without clinical experience or training in the understanding of what the different diagnoses mean for the individual and for his working ability, the evaluation is likely to be based on lay knowledge and moral judgment. The discretion used in case work is apparently reduced to a matter of sympathy with certain diagnoses and mistrust towards others. This practice makes some plagues and sufferings worse off than others, since some diagnoses are publicly well-known and accepted as illnesses, whereas other diagnoses, e.g. fibromyalgia, do not instill empathy in the social worker and hence are regarded as just a 'normal' irritation that should be tolerated and not 'used' as a malingering tool to gain public support.

Citizens who experience both chronic pain and a permanent need for help are (still) the 'hard cases' for the social workers to evaluate. The objective evidence is non-existing, the pain is real and the public empathy is at a minimum. And even though the number of citizens with e.g. fibromyalgia who apply for public support is insignificant, all current social work on entitlement seems to be born out of mistrust toward the client with chronic pain as if he or she was a case of malingering fibromyalgia/chronic pain.

Since the primary reason why sick people cannot work or function in their daily lives is likely to be the presence of pain, the main question of the symposium is: **How and to what extent does society expect the individual to tolerate pain?** In relation to this question, the symposium calls for both social, political, anthropological, psychological and medical reflections on plagues, pain and suffering: How should we study these phenomena and, not at least, how can they be treated? What do the medical professions say about pain, and when do pain and suffering transgress from being a clearly individual problem into a problem society should recognize as a malfunction allowing the patient public recognition and support?

**Symposium: "Management of suffering in the welfare State", Aarhus University, May 21 and 22, 2008**

Following this approach towards the puzzles of plagues, pain and suffering, the symposium also seeks to illuminate which other interests and agendas besides the public administration and the medical professions might play a role in defining the understanding and meaning of pain. What are the interests and perspectives of insurance companies and medical companies? What is the insurance market for pain and suffering, and what medical products could fit the average chronic pain patient? How are the clinical categories constructed and expanded in order to reflect such interests? In the end such perspectives bring questions into light of whom or what decides what is regarded as disease and what is seen as normal plagues? How are interplays and conflicts of such interests as the bureaucracy, the doctors, the insurance companies and the medical companies organized in society and how autonomic is the individual doctor, psychologist or pain therapist, when such categories and boundaries are defined?

The symposium sets forth the above-mentioned perspectives on pain and sufferings in the Welfare State, but these are not exclusive. Other related themes and approaches are welcomed as well.

The symposium will take place at Aarhus University, Aarhus, Denmark, May 21 - 22, 2008.