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Disciplining Pain: Masculinity and Ideologies of Repair in a Colombian Military Hospital

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Abstract
Colombia, a country at civil war for over 50 years, has one of the highest rates of landmine injury in the world. This article is based on ethnographic research conducted at the Amputation and Rehabilitation Unit of Bogota's Central Military Hospital. Through an ethnographic description of surgical amputation and rehabilitation, I examine medical understandings of vitality and masculinity in respect to the senses – primarily that of pain in the act of amputation.

Keywords
amputation, Colombia, masculinity, medicine, military culture, pain, rehabilitation

8 a.m. rounds. Wearing their white coats and suits, the three orthopedic surgeons from the amputation and rehabilitation unit gather at the receptionist's desk in the center of the orthopedics unit. White-walled and lit by halogen, the unit is one large square, with a row of doors lining its perimeter. The surgeons pick up their clipboards, glance over their files, and proceed towards the patients' quarters. I follow as we enter a room full of wounded soldiers. Wrapped in gauze, many men wait weeks for surgery. Meanwhile, their amputations remain open. The surgeons explain to me that it is important to leave an amputation site open for several days or even weeks to

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prevent further infection. The amputation site cannot be closed too early, because the surgeon may then accidentally trap dead and infectious tissue inside the body, resulting in the need for multiple follow-up surgeries. The open amputation is routinely observed, even though wrapping and unwrapping the gauze causes cries of pain and grimaces from the patients. As antibiotics take effect in the body, surgeons look to distinguish exposed dead tissue from tissue that may be salvaged.

We walk between the two rows of beds, about 15 on each side. The wounded men's gazes follow us. In the last bed on the far left, a young soldier is looking out the window towards the sprawling city, green mountain peaks, and massive clouds. The young man's foot is dressed in white gauze. The surgeons ask him how he's doing and he answers, 'Okay,' in a soft voice. One says, 'Okay, let's have a look at this foot.' They undress his foot and reveal the fleshy wound. The bone is exposed. The patient squints his eyes in pain. They carefully re-dress the foot and pull out three X-rays. 'The landmine completely crushed the bones of your foot,' one doctor tells him. 'It is impossible to repair it. There's no way to reconstruct the foot's arch. If you keep your foot, you will live a life in pain. You'll never be able to walk on it again. It will be necessary to amputate right here' – he points at the boy's mid-shin – 'and that way, you can wear a prosthesis and you will be able to walk again comfortably.' The young man erupts in a wailing cry. The doctor continues: 'Do you agree to the amputation?' Between his sobs, the patient manages to say, 'Yes, yes.' At this point, I find myself choking back my own tears. I grab the boy's arm, not knowing how to react. By the look on the surgeons' faces, I instantly realize I have done something inappropriate.

We exit the room.

As we descend the stairs towards the surgical unit, one of the surgeons confronts me about my response to the first patient. 'What's wrong? Did you identify with the victim?' he asks in a sarcastic tone. 'You might think that we are being cold, but we have to be straightforward and honest. You can't get emotional or show any ambivalence towards a decision that is being made. That's worse for the patient.'

I say nothing in response. Then he tells me, 'Get your video camera. We're going to the surgical unit.'

A legacy of its decades-long civil war, Colombia is one of the most landmine-affected countries in the world. Military, paramilitary (AUC), and leftist guerillas (FARC and ELN) clash over political power, territory, and natural resources against the backdrop of an illicit narcotics trade. From 2004 to 2009, I conducted ethnographic research in Colombia with people who strive to rehabilitate themselves and others after landmine injury. As an anthropologist, my approach to perception, human action, and embodiment is to see these phenomena as historically, politically, and economically contingent but nonetheless real – people live cultural values in their bodies and minds every day. I also produced a documentary film. During my fieldwork, I filmed many ethnographic encounters, including some scenes that I describe in this article, namely a surgical amputation conducted at Bogota's Central Military Hospital's Amputation and Rehabilitation Unit.

At the heart of this research is an examination of the implications of a new concept of rehabilitation – one that focuses on repair and insists on achieving full and even enhanced 'human' capacity. Using ethnographic description alongside historical accounts of anesthesia and its use in medicine and medical research, I examine medical understandings of vitality and masculinity in respect to the senses – primarily that of pain in the act of amputation. I examine masochistic tendencies promoted within ideologies of repair where rehabilitation, through delayed gratification, promises that with time and hard work, the patient will eventually earn a future 'normalcy' and re-integration into Colombian society. In this article I argue that the promise of normalcy through delayed gratification is elusive at best; the persistence of pain in daily life after amputation destabilizes the entire enterprise of rehabilitation as a capitalist form of consumption and economic expansion.

The scientific approach to the study of life, or vitality, has generally been divided into two paths of inquiry – that of natural law and that of human intention. Both paths, however, preclude bodies that are symbolically indeterminate and whose physiology destabilizes gender and sexual norms. Conceiving vitality as either an artifact of natural law or human intention fails to account for the intersubjective world of meaning where pain and pleasure, male and female, and desire and disavowal are entangled and steeped in deep cultural play (Geertz, 1973). By bringing some of the ethical dilemmas,

complexities, and intersubjective experiences related to pain and amputation to light, I hope to inspire more open discussion about ideologies of repair. Perhaps if these matters are more openly discussed, we can soften the burden of masculinity and disavowal that weighs on patients and their surgeons, whose experience of pain goes largely ignored in corporate, medical, and humanitarian depictions of prosthetic rehabilitation.

In her seminal work, *The Body in Pain*, Elaine Scarry (1985) uses textual analysis to argue that people use language to objectify another's pain in ways that obscure the experience of pain, which has no referential object. She states that physical pain 'not only resists language but actively destroys it' (1985). For Scarry, pain unmakes the world, which must be remade through imagination. In a more positive light, however, pain can also be seen as a state of vitality resignified through play destabilizing the fantasy of the sadist/masochist binary within the scene of surgical amputation. It is not that pain is in opposition to imagination, but rather pain is a destabilizing force that takes queer form and opens the world to humor, connectivity, and expression.[1]

My aim is to open a conversation about pain to see how it can be understood in multiple ways, even deviant ways. The able-bodied male surgeon who manages pain through a rational version of science is a fantasy, albeit a powerful one that reproduces and values modern desires for repairable male bodies. Disciplining pain through anesthetics, surgical techniques, and disavowal can be efficacious, but it does not eliminate pain and suffering altogether. For this reason, I argue that it is worthwhile to recognize pain as a destabilizing force that patients appropriate and share through deviant humor, complaints, and poetics. To support my arguments I juxtapose ethnographic encounters with historical understandings of anesthesia and pain within the medical establishment.

Rationality, Masculinity, and Managing Pain

Bogota, 1872. Wearing his white surgical coat, the empirical healer[2] Miguel Perdomo places the images of protective saints around his operating table. A ray of sunlight shows through the clouds, hitting the surface of the silver operating table. Quiet and subdued, Perdomo's patient lies in the middle of the table. Perdomo has crossed the

entire country performing painless surgery and now he stands at the nation's capital in between the President's Palace and the Palace of Justice. A crowd gathers at the Plaza de Bolivar to witness the event. The onlookers are unsure if they are about to witness magic, divine providence, or the making of modern medicine. Meanwhile, within the echelons of the Universidad Nacional, elite theoreticians and physicians with medical degrees from France sneer at the quackery of empirical healers who supposedly fake painless surgery (Sowell, 2001). It is unclear what substances, if any, Perdomo used to induce painlessness, but early documents show that before Perdomo, South American Indians and their colonizer Pizarro valued the elimination of pain and used coca leaves to induce a kind of anesthetic effect. Workers stuffed their mouths with coca to endure the pain of the cold shafts in the gold and silver mines (Quevedo, 2008).

While university physicians protested that Perdomo was a quack, his admirers described him as a 'godsend' and his practices as 'high surgery because he desire[d] to relieve humanity's pain' (Sowell, 2001). Debates ensued over the value of the 'empirical' medicine represented by Perdomo versus the 'rational' medicine practiced by university physicians. While rationalist medicine 'acquired an aura of modern truth' through formal anatomical clinical instruction, empirical healers derived and legitimized their knowledge from self-experience. While Bogotanos were disputing whether or not Perdomo's painless surgery was real, American and British doctors were busy debating the appropriateness of using anesthetics in surgery. Unfortunately, historical analyses of Colombian medicine are limited, but historical records do show that Colombian physicians often received medical training in France and other European countries, and participated in an international dialogue within medicine. Given such connections and the effects they undoubtedly had on Colombian medical practices, it is relevant to explore briefly what we know of attitudes toward pain and painlessness in mid-19th-century Britain and the United States.

New York, 1826. Felix Pascalis draws his amputation knife. The patient screams. The pain is metallic like disarticulated pictures and memories sucked into a single spot in time. The patient moans as a river of blood pours out of his stump and floods the floor of the surgical theatre. Pascalis applies a hot iron to cauterize the wound. His patient wails and Pascalis is terrified and satisfied all at once. His

patient possesses enough animal spirits to survive. The surgeon's assistants leave with the bloody amputated limb. Later that day, Pascalis attends a medical conference. He stands at the podium and begins his address, 'It is, therefore, our axiom that the greater the pain, the greater must be our confidence in the power and energy of life' (Pernick, 1985). According to the mid-19th-century surgeon, if a patient wailed loudly, he possessed enough anima, or animal spirits, to survive amputation.

By the mid-1800s, surgeons no longer venerated animal spirits, vitality, and pain, but shifted their concerns to effectively eliminating pain and suffering by using proper dosages of anesthesia. Still, concerns persisted. Critics maintained that the use of anesthetics in formal medicine had 'caused great suffering', since physicians more easily made mistakes when patients were unconscious: sometimes doctors removed the wrong limb or administered too much anesthetic and killed their patient. When scandals emerged about physicians raping anesthetized women, feminists protested. Others argued that unconscious patients were less able to hold physicians accountable for mistakes and violations, and many patients became addicted to anesthetics like morphine and ether. Most Americans saw it as 'artificial', because it removed the patient from the surgical process. In other words, ether alienated the body from the person, giving the physician the power to do things to a patient's body without the patient knowing it. Finally, skeptics questioned whether ether produced anesthesia or merely amnesia and doubted whether or not one could ever know what someone else was 'really' feeling. Despite these concerns, however, by the 1890s, most physicians had come to regard anesthetized surgery as standard practice and most patients did not protest its use for radical surgeries like amputation (Pernick, 1985).

Political and economic changes also fueled the standardization of anesthetized surgery since 'the ability to subdue noisy, disruptive, and uncooperative patients was an increasingly important advantage as hospitals and asylums grew larger and more efficiency minded' (Pernick, 1985). Late 19th-century surgeons wanted to elevate their status within medicine and felt it was necessary to make their practice more efficient as hospitals grew larger. The surgical community decided to draft professional standards and used anesthetics as a means to do that. While it was difficult to measure a patient's

screams, an anesthetic was a substance that could be divided into doses and charted. Since anesthetics were quantifiable, they lent themselves to standardization and allowed doctors to quantify subjective experiences like pain. With a new public consciousness around human suffering, surgeons began to seek 'rational' ways to minimize harm by weighing *benefits* and *risks* (Pernick, 1985).

This newly found rationality through the power of anesthesia allowed surgeons to assert masculine power and achieve elite status within medicine, and likewise it allowed patients to give the gift of submission. As Marcel Mauss (1990 [1950]) has shown, gifts are not free; generosity is entangled with shame and obligation. Anesthesia transforms an otherwise bloody, painful, intimate, and immediately visceral act into a sterile procedure that disavows the erotics of wounding and denies the patient any memory of the event. One can conceptualize amputation surgery as simply saving a life, but it is not just that; amputation surgery involves multiple surgical procedures and a careful shaping of the body in an attempt to normalize it, or to aspire to what Rosemarie Garland-Thomson (1997) calls the 'normate' – 'the social figure through which people can represent themselves as a definitive human being'. In the context I describe, I would extend 'normate' to the social figure through which men claim proper male identity, through having an adequate limb. In the military surgical and rehabilitation unit, surgeons repaired male bodies by further wounding them; sometimes surgeons fragmented and lengthened patients' bones, using screws that protruded outside the skin which the surgeon tightened and loosened – a procedure originally invented by a Colombian surgeon and now performed in US Veteran Affairs surgical units (a conversation I had with a surgeon at Walter Reed VA Hospital in 2006 confirmed he had learned the technique at Bogota's Central Military Hospital during a week-long course there).

The oscillation between wounding and reparation and authority and submission pervades other arenas of Colombian military life, especially in the ways the military construct manhood and masculine power. For example, military training before deployment shares a similar ritual structure to that of rehabilitation, even though rehabilitation is a form of care whereas training is more often associated with discipline. Colombian sociologist Adolfo León Atehortúa Cruz (2005) analyzes Colombian military training as a set of rituals that

literally and metaphorically strip soldiers of their clothing. During initiation rituals, soldiers must remove civilian clothing in public and stand naked in front of their peers as they are humiliated and made submissive to military orders. Once military authorities decide the new recruit will follow orders, he is then allowed to don the military uniform, boots, and handle a gun. In Cruz's study, many young soldiers described feelings of masculinity and superiority once they donned their uniforms. Similarly, many soldiers described to me how they endured pain in the rehabilitation unit, so that they could don a prosthesis and perform masculine roles within their family units. Interestingly, rehabilitation and objectification of their bodies within the hospital setting also destabilized masculinity as patients recognized that masculinity carries its own artifice and performance, using mass-produced commodities as props – prosthethic limbs that enhanced their capacity to stand up, walk, and appear as able-bodied men. In this context, reification profoundly disciplines the body and reproduces heterosexual binaries between male and female; it also denaturalizes gender binaries and allows for new forms of subjectivity, pleasure, and power.

Entering the Surgical Unit

The large statue of Christ's bloody body draped over the three Marys is a striking image to encounter when one enters the surgical floor of the military hospital. Dr Chavarro makes an offhand comment to me about Mel Gibson's rendition of *The Passion* and its resonance with surgery. To my mind, Gibson is an odd and controversial character, so I'm not quite sure how to make sense of the doctor's comment. He then explains that a soldier's amputation is a sacrifice. Passion. Blood. Sacrifice. Theatre. Torture. Saving Lives. By this point, I have already spent many months in the amputation and rehabilitation unit, intensively shadowing the surgical team. When I go to sleep after a full day of fieldwork, images of amputations, mangled bodies, and paddy wagons full of soldiers being taken off to war fill my dreams. The smells of surgery spread into my mouth. I suddenly awaken to darkness, fear, and sadness. By morning, I'm back at the hospital on surgical rounds, my fears transformed once again into passionate curiosity. I want to understand the ways the surgical team understands their practice and the

ways the soldiers understand their limb loss as both meaningful sacrifice and painful torture.

We make our way across the unit towards a set of double doors that lead into a corridor lined with operating rooms. A nurse greets us as we enter. I follow her to the women's dressing room, where I lock up my belongings, don scrubs, and prepare my video camera. She leads me to the operating room where Dr Chavarro will perform a reconstruction of an amputated limb. Before Dr Chavarro enters the room, the anesthesiologist, the nurses, and the resident prepare the patient. They hook him up to monitors and begin administering the anesthetic. He is stripped naked, transferred to the metal operating table, and attached to an array of beeping machines. An oxygen mask is strapped to his face. The resident stands next to the patient's body, staring over it with his hands clasped as if in a moment of silent prayer.

Dr Chavarro enters the room. He reviews a large stack of notes as the medical staff continue to prepare the operating room and the patient. He then has a conversation with the anesthesiologist. The patient begins to moan. Dr Chavarro looks in irritation at the anesthesiologist, who fumbles around with the tubes of the patient's IV and says, 'Which tube is it? Here, we will add some more,' as he hands a large syringe to the attending nurse. The patient is still moaning. 'There, there. We will take care of this.' I see Dr Chavarro looking straight at me through my LCD screen. He says, 'Follow me.' I go with him and the resident as he washes his hands, fingers to elbows and back again, several times. We enter the operating room again. The patient is anesthetized and most of the staff leave. The patient's body and face are now draped in blue sheets; only his leg emerges from the blue covering. The resident washes the residual limb with an iodine solution that suds up and mixes with blood. He then wipes the limb clean. The nurse dresses Dr Chavarro in his surgical gown and gloves. The surgical team is ready to begin.

For the next three hours, the surgical team irrigates the amputation site with a forceful spout of water. They remove dead tissue with a laser that sends up a smell of burning flesh, wisps of smoke, and an acute, high-pitched buzzing sound. They carefully shape muscular flaps that neatly pull over the flesh and cushion the severed tibia. They pull and cut nerves. Finally, they stitch the muscle flaps and skin, creating a rounded stump with a drainage tube poking out. The

surgical team leaves the operating room before the patient awakes; nurses roll the patient out of the room to the orthopedics unit. Here, the patient regains his consciousness, slowly, to the euphoric haze of morphine.

In her reading of Walter Benjamin's artwork essay, Susan Buck-Morss (1992) suggests that alienation and anesthesia are the sensual conditions of modernity. She describes the architectural design of the modern surgical theatre, which comprises an anesthetized patient who is treated as an object, the surgeon who claims all agency, and the onlookers (often students) who observe the surgery behind a pane of glass. Buck-Morss compares this design to a movie theatre where an audience looks at the phantom image projected onto the inanimate screen – a synthetic unity comprised of fragments that disguises and disavows the actual labor and materials required to assemble it. In this sense, anesthesia depersonalizes and objectifies the patient, making him or her subject to the surgeon's authority. This temporary state of passivity and objectification is not all bad – most people would not opt out of anesthesia while undergoing amputation given the choice. Yet, as Buck-Morss points out, anesthesia has its insidious side; it permits concealment of the surgeon's identity, which can become a point of tension between doctors and their patients. Foucault (1994) has described how doctors and the medical apparatus (from scientific research to corporations to the mass-produced medical products patients consume) often conceal the mechanisms by which they construct diagnosis, prescriptions, and medical interventions as a means to assert control over their subjects; Foucault writes that secrecy makes the inherent violence within the medical procedure and potential abuse of power more tolerable to the patient.

Some weeks after I observed Dr Chavarro's surgical reconstruction of an amputated limb, he told me he was angry with the anesthesiologist who had not properly dosed the patient; he hoped never to work with the anesthesiologist again. The patient's moans had profoundly disturbed Chavarro. Dr Chavarro also told me that sometimes patients awake after amputation and reject the medical team because the patient blames the military for his loss. Although Dr Chavarro is a civilian, as a surgeon at the military hospital he represents military authority. Dr Chavarro explained that the patient will sometimes reject not only the surgeon, but also medical rehabilitation altogether. The team tries to manage rejection toward any particular

surgeon by informing the patient of the decision to amputate as a group. After amputation, a patient sometimes asks which surgeon has amputated his limb, and the surgeons purposely avoid answering this question. They feel that if the patient knows which doctor has removed his limb, he might develop a resentment that could impede that surgeon's efforts to provide follow-up care. Anesthesia then not only subdues the patient's pain (most patients appreciate this), but also allows the surgeon to conceal his identity and its association with the act of amputation (a point of tension in the doctor/patient relationship).

Reparation, Modernity, and the Male Body

While anesthesia does eliminate suffering in invaluable ways, it is also true that quantification of pain and suffering is a fantasy that denies what the actual act of amputation does to the patient and, to a certain extent, the surgeon – it dissolves the boundaries of the body, fragments the self, and re-establishes bodily boundaries through a radical reorganization of nerves, muscles, skin, and sensorial and symbolic pathways. Chronic pain alters individuals' subjectivities and disrupts efforts to repair and reconstruct the male body, troubling binaries of nature/culture, mind/body, male/female and pleasure/pain. The men I encountered in my fieldwork experienced their bodies as objects to look at and manipulate, and as a sense of self that shapes and is shaped by everyday life, social expectations, and unstable desires. Some men were able to approximate a kind of transcendence of the body through sportsmanship but most did not. Sometimes they compared their bodies to cars and the prosthetist's workshop at the hospital to a car repair shop, but these comparisons were made in jest and accompanied with laughter. Their comments and jokes suggested feelings of ambivalence towards incorporating mechanical objects into the body rather than an affirmation that their bodies were actually repairable things.

The expression of chronic pain disrupts the surgeon's control over another's body. In the rehabilitation unit, patients often joked about the pleasurable and erotic sensations they experienced when medical staff touched and massaged their residual limbs, an everyday practice in the unit, used to relax muscles, soften scar tissue and assess healing and pain. In this context, surgeons, physical therapists, and their

patients inadvertently 'invent new possibilities of pleasure with strange parts of their body' – a phenomenon Foucault (1978) has described in sadomasochist contexts (Pitts, 2003). While medical staff at the military hospital would most likely not characterize their work as sadomasochistic, their work nonetheless shares some of the transgressive aspects of sadomasochism.

I do not want to suggest that Colombians are alone in some bizarre and complicated formation of subject and object relations. In anthropological literature, studies have shown cross-culturally that people often enact rituals (from mortuary cannibalism to ceremonial gift giving) that involve both literal and symbolic destruction of spirited objects followed by repetitive attempts towards reparation of the destroyed object (Battaglia, 1992; Mauss, 1990 [1950]; Stephen, 2000). In other words, ritual destruction and aggression is followed by attempts to restore the vitality of the killed object. In psychoanalytic literature destruction and reparation of love objects is fundamental to western imaginaries of the person (Klein, 2004 [1928]; Klein and Riviere, 1964).

In this article, ritualized destruction and reparation serve as an analogy for partially understanding conceptions of vitality, masculinity, and modernity in the Colombian military. During the time of my fieldwork, the Colombian Campaign Against Landmines reported that only 5 percent of civilian claims for rehabilitation care after landmine injury were processed and that most women injured by landmines were abandoned and left to die in minefields. Civilian bodies – those of women, children, and the elderly – are denigrated as useless. On the other hand, soldiers' bodies injured in combat become sites for extraordinary feats and medical consumerism. The military, corporations, medical establishment, and the larger Colombian body politic deem injured military bodies to be repairable; social expectation pushes injured soldiers to overcome limitation. Colombian soldiers are more oppressed by social expectation than neglect.

Like the contemporary Colombian body politic, modern scholars such as Arendt and others admired the ancient Greek construction of the western political figure based on a value of transcendence. Colombian media have widely covered the Colombian military prosthetic wearers' attempts on, and eventual triumph over, Latin America's highest mountain peak, Aconcangua. Likewise the Colombian military medical corps has created a program to train athletes who

wear prostheses so that they can compete in the Paralympics, which means they often exclude veterans with cognitive disabilities, since they are less likely to get corporate sponsorship (in comparison to those who wear prostheses) and are much more difficult to train in competitive sport (Cohen, 2012).

For the ancient Greeks, the body is animal, feminine, and degenerate and therefore only the male body can only be admired because of the Greek belief that the male body has transcendent capacities. In Ancient Greece, the ideal male body transcended animality through sport. In disagreement with Arendt and other modern thinkers, Wendy Brown (1988) argues that Greek glorification of excellence – the ability to surpass human limits – is ultimately alienating because it involves annihilation of communal politics and the value of caring for other people. In Greek transcendence, the man must outdo his peers – existence is dependent upon a politics of superiority and constant competition. So, unlike injured civilians whom the Colombian state actively excludes from rehabilitation, soldiers are urged to overcome injury and pain so that they too can repair their status as true and real men and 'repair the denigration of the nation's image', as one Colombian general explained to me.

Like modern thinkers' admiration for the ancient Greeks, the Colombian state has its own anxieties around modernity and a desire to overcome animality. During La Violencia (1948–54), Colombia's bloodiest civil war, Colombian nationals commonly depicted the human body as dismembered and rearranged. During La Violencia, Liberals and Conservatives disputed over how boundaries between the church, the Colombian nation-state, and national territory should be drawn. In this war, combatants shot their victims in the head, cut up their bodies with machetes and displayed human remains in macabre configurations – tongues pulled through slit open throats and severed limbs inserted into torsos. What belonged inside the body was placed outside of it and what belonged outside it was stuffed back in. Rumors about mutilated bodies spread like wildfire throughout Colombia's countryside.

Since Colombian peasant understandings of the human body did not clearly distinguish animal body parts from human body parts, perpetrators mutilated dead bodies after killing them to desecrate any semblance of the victim's humanity. These surreal disfigurations of

the body frightened the victims' kin and neighbors away from land property but did not stop people from talking about them. People learned an intricate set of classifications to describe each form of desecration – the Neck Tie (tongue pulled through esophagus), the Flower Vase (all limbs were removed and stuffed back into the thorax), the *Picar Para Tamal* (the dead body was diced like meat used to stuff a corn tamale) – that were and still are common knowledge in Colombia. These grotesque bodily configurations that inhabited everyday talk and hearsay alienated rural people from their own understandings of the human body both experientially and anatomically. The human figure and human death lost their universal character and brought survivors of La Violencia into a peculiar relationship with what it means to be human and what it means to be mortal. In other words, during La Violencia, death and the human figure became de-naturalized, estranged from one's own embodied sense of self.

In Colombia, acts of killing metaphorically and literally transformed their human victims into animals via forms of dismemberment. Colombian anthropologist Maria Victoria Uribe (2004) describes how today the 'faunalization of the Other's body' continues to allow perpetrators to kill without moral ambivalence. The thinking goes, if the Other is an animal, then he can easily be butchered and consumed as one. These kinds of mutilation undo the world – literally – not in an existential way, but in the most mundane, personal, and bodily way. If dismemberment is associated in the Colombian imaginary with animality, anesthetized surgical amputation stands for a striving towards modernity and humanity.

Pain as a Mechanical and Chemical Field of Operations

Different from the perpetrators of violent dismemberment, Dr Chavarro told me that one of the main roles of the surgeon was to minimize pain for the patient as he adapted to his prosthesis. One way the surgeon did this was by constructing a 'good' residual limb – one that had proper length, proper cushioning of the bone with flaps of muscular tissue, and proper scarring. The nerves, however, were the sites to treat acute pain. To prevent phantom pain, for example, Chavarro frequently prescribed nerve blocks, anesthetic drugs injected directly into the nerve trunk to block the

pain pathway to the brain. According to Chavarro, once the pain pathway was blocked, the brain would not receive the impression of pain and therefore pain would not leave a phantasmagoric trace. His ideas are reflected in modern British notions of the nervous system. With regard to pain, neuroscientist Charles Sherrington (1906) was the first to coin the term 'nocioceptors', or nerve endings in the skin that detect pain. In Sherrington's view, the body possessed a regulatory analgesia system constituted by pathways and integrated within a chemical field. The body's endorphins, for example, bound to the body's opioid receptors and reduced the intensity of pain. Other chemicals, meanwhile, assisted in intensifying pain as a response to dangerous stimuli. The body was not a container of animal spirits any more, as imagined by our 19th-century doctors; rather, it was constituted by integrated systems of mechanical and chemical fields that identified and regulated risks. Modern neuroscience no longer regarded pain as a life force that healed; pain was now seen as a mechanical warning, a sign of potential harm to a specific region or entity in the body. Here, again, Chavarro did not see the nerves as the container of an animating force; rather, he used the word *impresión*, or impression, to describe pain's effect as similar to the way a fingerprint leaves a mark on soft matter. In Chavarro's description, this soft matter is the brain.

The other method he used to minimize pain involved pulling and cutting nerves, a method I observed when I filmed the reconstruction surgery. Dr Chavarro went to great lengths to explain to me how the invisible impulses and agents that travel through structures of nerve cells (cells that are invisible to the unaided eye) relate to the tangible nerves that the surgeon cuts.

> The nerve is like a little cable that has a bunch of little wires called 'axons' that carry impulses. To perform nerve repair, I cut all those axons that are inside the neural tube. The axons retract and disappear. The organism eats the cells. This process is called degeneration. But there comes a time when the axons stop degenerating. They begin to grow until they arrive at the site where they were cut. When they arrive there, they try to continue to grow and find the other nerve ending to re-channel the tubes. For a successful nerve repair, one hopes for nerve growth because nerves return to the place they need to arrive. Sensitivity and motivity return.

Here, Chavarro metaphorically describes nerves as a cable of wires. Like an electronic cable, nerves generate a current, or *impulses.* If the nerve is seen as being like an electronic cable, the language of *repair* seems natural. It would be odd to speak of repairing a person, but once the elements of the body are conceived of as discrete, somewhat mechanical units, such language seems reasonable. Cables, for example, are repairable things. At the same time, Chavarro's nerves exert an agency beyond the consciousness of the patient. They not only *carry* impulses, they also *find* exact locations in the body. *They return to the place they need to arrive.* In the case of nerve repair, the generating and degenerating capacities of nerves are positive. Growth allows motivity and sensitivity to return to the affected body part.

The capacity for nerves to regenerate themselves, however, can also wreak havoc in the body. They can cause pain.

> When you cut a nerve too close to the surface of the stump and it begins to grow, not only does the nerve look for where it can channel but it also forms a little ball if a bunch of fibrous tissue cells like blood vessels arrive there. That little ball is called a neuroma. Neuromas are among the most frequent complications in stumps that produce pain. When you hit your elbow, you feel a shooting pain. This is what a patient feels at the tip of his nerve when stimulated. Since one knows that neuromas always form independently, the surgeon pulls and cuts the nerve so it ends up way inside the soft tissue. Then, even if the patient stimulates his nerve, he won't be bothered by it. But if the neuroma ends up near the surface, any external stimulus will generate shooting pain. That pain is horrible. You become paralyzed. You can't move. So the way to manage a nerve is precisely to pull and cut it. It retrogrades and does not form a neuroma, or it forms but it stays deep inside the body's tissue and does not bother the patient.

Since nerves act independently, according to Chavarro, the surgeon's role is to prevent nerves from causing patients pain. Pain is difficult to repair because pain treatment does not return one to a prior state. In nerve repair, the hope is that sensitivity and motivity will return. With pain, there is nothing to restore or return to. The aim is to eliminate it. Despite pain management techniques such as repairing and cutting nerves, patients still experience pain as they begin to incorporate prostheses into their bodies.

My conversations with Dr Chavarro about nerve pain help in considering the ways in which a contemporary working surgeon conceives of the body and mitigates some of the complexity and destabilizing qualities of pain expressed in the unit. Chavarro operates within a war context, where the prevalence of amputation demands a very immediate and concrete approach to pain. Dr Chavarro also embraces modern ideas about the body and its nervous system. He talks about nerves as if they have a mind of their own, not unlike Charles Sherrington's conceptualization of nerves. For Chavarro, pain is fundamentally a sensation residing in the nerves and a thing to be eliminated. Within his laboratory, Sherrington managed to exert control over his research subjects, all of whom were animals. He killed the lab animals by severing their cerebellum in order to better isolate pain and other sensory pathways. However, unlike Sherrington, Chavarro's aim was to keep his patients alive. Living flesh and patients who regain consciousness after surgery create a complex arena in which to deal with pain. Patients intertwine material and symbolic understandings of pain, even while doctors attempt to isolate pathways and depict pain as a mechanical response to dangerous stimuli.

Anthropologist Jean Comaroff (1985) wrote that 'the body is not merely capable of generating multiple perceptions; it also gives rise to contradictory ones'. For surgeons like Dr Chavarro, nerves were the primary sites for pain: in the rehab unit, pain was a more complex phenomenon. The ability to amputate body parts and integrate new ones into the body is not a seamless process. The surgeons at the military hospital focused on the site and type of pain they could control. For their part, the patients expressed their pain in grimaces, screams, and laughter, and ritualized it in a manner that allowed them to claim the rehabilitation process as their own.

Prostheses and Pain

Prostheses generally are not easy to adapt to, and it was not uncommon for novices in the rehabilitation unit to complain of intense pain. Once the medical staff had completed their observations of patients in the rehab unit, a patient would sometimes say, 'Doctor, the limb socket is bothering me here,' pointing to the place where the limb socket curves around the side of the patella, occasionally jabbing into

the side of the knee and causing pain. The surgeons would try several things to discover what caused the pain. They would tighten and loosen the pyramid screws and ask the patient if he felt better. They would then have the patient sit down. With his hands, the surgeon would move the patella around and ask the patient to bend his knee in various directions, asking if it hurt. Sometimes the patient would pull back and yell 'Ai!' in pain. Eventually, the surgeon would prescribe changes to the prosthesis, which usually involved reshaping the limb socket or adding more cushion. If the surgeon determined that the pain was caused by bone growth or nerve sprouts, he sometimes prescribed surgical intervention to cut the bone or nerves.

Patients in the rehabilitation unit showed physical therapists, physicians, prosthetists, kin, friends, and lovers that their prostheses caused them pain. They expressed it through wincing faces, guttural sounds, profanities, or explanations like '*Me duele aqui*' ('It hurts me here'). Many times, the young men in the rehabilitation unit would curl their bodies into a fetal position and yell '*calambres*', or 'cramps', a sign that a current of pain was shooting through the body from the residual limb. These yelps and cries usually made them the butt of jokes among the other soldier amputees, who would sneer at the pain sufferers' lack of manhood.

While such humor might seem sadistic to an outside observer, it was striking to note that the pain sufferer eventually would join in the laughter. Because *calambres* is a painful experience shared by most of the men in the group at one time or another, it was understood that the joker and the butt of the joke would undoubtedly trade places at some point. More immediately, the joker would often quickly be made the butt of a joke himself. To 'punish' the jokester, the physical therapists would command him to lie down and say, 'Okay, now it's your time to do stretches and lift weights.' Then the group would roar in laughter and banter. To subvert the physical therapists' authority, the men would crowd around and say, 'Wait, I want my massage today,' with flirtatious smirks on their faces.

Within Bogota's Central Military Hospital, the division of labor is gendered within a binary heteronormative logic of masculine male/feminine female. All the physicians, high-level officers and patients (with the exclusion of one woman military nurse) I encountered were men. The prosthetist was also a man. The psychologists and physical therapists (with one exception) were women. Surgeons often

feminized their male patients, while they strived to remake injured soldiers into productive and economically viable men. During prosthetic revision where medical staff observed the progress patients made by having them walk with their prostheses, the surgeons would often laugh and say '*Ahora la pasarela* [Now the catwalk]' as if their male patients were fashion models showing off for their male able-bodied doctors. Despite protest, the military even required injured soldiers to display their wounded bodies at Colombia's annual international fashion show in Medellin, ColombiaModa, in 2005. Patients often referred to themselves as children relearning how to become adult men and often expressed concerns about returning home to their families and losing their status as 'men'. Nonetheless, the rehab unit was often jovial, filled with hilarity and queer humor about pain, breathing life into the otherwise sterile environment of the rehab unit.

Conclusion

Anesthesia has created a world in which surgeons can perform multiple reconstructive surgeries; those surgeries, in turn, have encouraged the development of ever more sophisticated prosthetic technologies. While there are clear humanitarian benefits to reducing the pain of surgery and outfitting people with limbs that increase their mobility in the world, it's also the case that reconstructive surgery has now become central to the social, political, and economic structure of Colombia. The capacity of surgeons to perform 'painless' surgery makes corporate profits from prostheses seem less exploitative, and perhaps distracts us from paying more attention to the violence that causes such widespread injury.

By recognizing the polyvalent nature of pain, perhaps biomedicine could learn from the patients I encountered in Bogota's Central Military Hospital rehabilitation unit. What effects would come about if pain could be seen as something generative and meaningful rather than something to simply eliminate? Perhaps a reformulation of what modern notions of 'integration' would result where the fantasy of a mechanical body in need of repair through the elimination of mere disturbances could be problematized. Deviance, political resistance, and pain do not have to be wholly ignored or disciplined; rather, attending to the material, symbolic, and historical aspects of pain could lead to a generative questioning of cultural norms and political

formations that are far too narrow and destructive and perpetuate a never-ending state of war in Colombia.

Rather than disavow that which makes dismemberment possible and deny the sexual undertones of sadomasochistic desire, perhaps we can treat our analytic lenses like prostheses and turn towards the very processes that render us senseless, awaken our receptivity to the outside world and thoughtfully consider our connectedness and responsibilities to one another and unpack the burden of compulsory masculinity.

Poetry is often associated with passivity; in the 'soft act' of stringing words together, however, we discover the complexity and ambiguity inherent in daily experience in all its rich symbolic and aesthetic force. For this reason, I will end by sharing a poem written by Dario Jaramillo Agudelo entitled, 'Desollamientos'.

Without a foot my body still loves the same,
And my soul departs to the place I no longer occupy,
Outside of me:
No, there are no symbols here,
The body accommodates to passion,
And passion for a body that loses its fragments,
And my body continues to be whole, without unscathed mysteries,
Against death I have my gaze and my smile,
I own the hug I give my friend,
And the anxious deaf throbbing of my heart.
Against death I have the pain of my foot that I do not have,
A pain so real like death itself,
And a great desire to be caressed, to be kissed,
To know the name of a tree that haunts me,
To inhale that lost perfume that I chase,
To hear songs that I remember in fragments,
To caress my dog,
That my phone will ring at six in the morning,
To continue in this game.

The pain of limb loss continues to inspire different ways Colombians conceptualize their minds, bodies, and worlds. One day in 1989, while visiting the rural countryside, Colombian writer and professor Dario Jaramillo Agudelo stepped on a landmine. After four

months of being unconscious and near death, he awoke to find that his foot had been amputated. His experience inspired him to write 'Desollamientos'. *Desollamiento*, which literally means, 'a stripping of the skin', recalls an inquisitional form of torture. Better known for his writing on Medellin, Agudelo's poem 'Desollamientos' won little acclaim until recent years when it became the focus of a feature story in *El Espectador*, one of Colombia's national newspapers, and was discussed on several radio shows. His work was re-contextualized within a newfound consciousness around landmines.

Intriguingly, Agudelo's poem offers a different understanding of pain from that of Chavarro's integrated nervous system. For Chavarro, pain needs to be eliminated from the system and from the patient's consciousness. For Agudelo, pain is what fends off death. He writes, 'Against death I have the pain of my foot that I do not have/ A pain so real like death itself.' Here, it is pain that allows his body to 'continue to be whole, without unscathed mysteries', even though the body 'loses its fragments'. The succeeding lines describe a more transient and elusive state – 'a great desire', 'the name of a tree', 'that lost perfume that I chase' – but it is the inclusion of these more transient states of desire that makes the *reality* of pain more salient. By the end of the poem, the body's centrality softens to the mundane aspects of everyday life, which continues despite the fragmented body, his transient passions, and the reality of his pain.

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Notes

1. Other anthropologists have noted similar responses to pain within medical settings cross-culturally (Kurzman, 2002; Livingston, 2012).

Anthropologist Jean Jackson's (2005) ethnography with chronic pain sufferers shows how chronic pain destabilizes the efficacy of western biomedicine, which aims to eliminate pain altogether. Performance artist and 'super masochist' Bob Flannigan had extreme pain inflicted upon him which he said allowed him to endure his cystic fibrosis and resist biomedical authority over his body (Siebers, 2010). He transformed the masochist position, where the patient with a chronic condition endures painful procedures in the hope of healing and normalcy, into a deviant one explicitly sexual and shocking. Although cystic fibrosis often proves fatal at an early age, Flannigan lived to 43 years of age. Flannigan literally used pain as a source of vitality.

2. At this time, the medical community in Colombia saw a division between theoretical medicine (which they regarded highly) and empirical healing (which they saw as quackery). The medical and scientific communities in Europe similarly constructed binaries between the university physician's theoretical medicine and the applied medicine of the barber surgeon. The advent of anesthesia was one way in which surgeons gained a higher status in medicine.

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