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Hysterical Women: Pain Bias and Epistemic Injustice in Medicine

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A b s t r a c t

Women are being let down by medical professionals. They wait longer for both pain medication and a diagnosis, and the results mean life or death in some cases. This article argues that epistemic injustice plays a significant role in maintaining gender bias in medicine. It explores the concepts of testimonial injustice and hermeneutical injustice to analyse the ways women are silenced by doctors, and the ways that women are not properly understood by medicine as a whole. Increasing awareness of the way that implicit bias can colour the treatment women get from doctors is one way to begin ensuring that women are provided with medical care that adequately looks after them.

[K e y w o r d s]: Epistemic Injustice, Testimonial Injustice, Hermeneutical Injustice, Bias, Medicine, Gender

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INTRODUCTION

There has been an insurgence of women's stories of medical betrayal in recent years. Anecdotal tales and empirical evidence shine a light on the hidden reality of the healthcare inequality women face. Studies point to a trend in medicine to dismiss women's pain as not as serious as men's pain. One such study found that women in emergency rooms are less likely than men to be prescribed opiate based pain killers. Additionally, even after the medication is prescribed, women wait longer than men before it is administered (Chen et al., 2008). Moreover, women are taken less seriously than men when they complain of pain (Hoffman and Tarzian, 2003). A particularly unsettling study discovered that women were more likely to be prescribed sedatives for pain, whilst men received painkillers, owing to the assumption that women's pain is often psychosomatic (Calderone, 1990). So why is women's pain not enough? Why are women suffering unnecessarily at the hands of medical professionals? In this article I will argue that one reason for this healthcare inequality can be explained by the philosophical concept of epistemic injustice.

Testimonial Injustice: 'Just calm down!'

Working in the fertile area between epistemology and ethics, Miranda Fricker coined the term 'epistemic injustice'. This concept served to articulate existing philosophical discussion which attempted to understand the ways intellectual insights and capabilities of marginalised groups are unfairly hindered. In other words, epistemic injustice is concerned with the ways people are harmed in their capacity as a knower. Fricker highlights two forms of this phenomenon: testimonial injustice and hermeneutical injustice. This section will focus on the former in relation to medical settings. Testimonial injustice 'occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word' (Fricker 2007, 1). To explain this, Fricker provides the example of a scene in *The Talented Mr Ripley*. Following the disappearance of her fiancé, Marge Sherwood tries to warn her future father-in-law, Herbert Greenleaf, that she (correctly) believes Tom Ripley has murdered him. However, Greenleaf silences Sherwood: "Marge, there's female intuition, and then there are facts" (2007, 9). Sherwood's identity as a woman causes Greenleaf to undermine her intellectual and rational capabilities. Owing to the harmful prejudicial stereotype that women are irrational, Greenleaf affords Sherwood a deflated level of credibility. Additionally,

Sherwood's credibility deficit is likely compounded by the excess credibility he grants the charming Tom Ripley. As David Coady explains, Greenleaf's 'undervaluing of the testimony of women (at least in certain contexts) is inextricably linked with his overvaluing the testimony of men' (2017, 63). Therefore, a testimonial injustice occurs when a person is not believed in what they say because the hearer holds a prejudice about the reliability of that 'type' of person. I will demonstrate that testimonial injustice may be a contributing factor to women's situated healthcare inequality.

The New York Times published a story last year about a young, black, expectant mother, Simone Landrum (Villarosa, 2018). She suffered incredibly painful headaches during her pregnancy which at first were put down to the stress of her turbulent relationship with her boyfriend. However, as the pregnancy progressed, Landrum noticed that her hands, feet and face were swollen. She felt so ill she was unable to work. When she voiced her concerns to her doctor, he brushed aside her complaints and recommended she take Tylenol for her headaches. She told the New York Times, "When I told him my head still hurt, he said to take more" (Villarosa, 2018). At a prenatal appointment Landrum complained of her intensified headaches and the pain she was in. A handwritten note left over from her appointment revealed she had a blood-pressure reading of 143/86 (Villarosa, 2018). Whilst not high enough to be of immediate concern, elevated blood-pressure combined with headaches, swelling and fatigue are all features of pre-eclampsia, a condition that can lead to serious complications for mother and child (NHS Choices, 2019). Landrum reiterated her complaints at the appointment, only to be told to calm down by her doctor. Over the next few days, her pain increased, and Landrum decided it was time to go to hospital. On the drive she noticed a wetness between her legs and assumed her water had broken. However, when she looked closer, she realized it was blood. At the hospital her blood-pressure read 160/100, causing the placenta to become detached from the uterine wall (placental abruption) (Villarosa, 2018). Mother's are at an increased risk of an abrupted placenta if they have a history of hypertension, something which should have been further investigated following Landrum's complaints at her pre-natal appointment. Unfortunately, Landrum's baby died whilst still inside of her, and if it were not for medical intervention she would have died as well (Villarosa, 2018).

In the above story, Landrum suffered testimonial injustice when she tried to convey the severity of her symptoms to her doctor. The doctor's response that Landrum just needed to calm down reveals the sexist prejudice that caused him to discredit her account regarding the amount of pain she was in. He falsely believed her pain to be psychosomatic owing to the prejudicial stereotype that women are sensitive, emotional and just need to calm down. Landrum's credibility deficit was likely aggravated by the excess credibility doctors are often afforded. Whilst I do not intend to downplay the expertise of doctors, I do wish to highlight the importance of doctors listening to patient's symptom reporting in medical exchanges. This is a chance for valuable information gathering which may assist medical professionals. The testimonial injustice Landrum suffered was so severe that her credibility was diminished even in the face of medical evidence that pointed to the possibility of pre-eclampsia. Landrum's testimonial injustice was likely further compounded by her identity as a black woman, and the racial bias that it entails. The New York Times reports that the mortality rate for black babies is more than twice that of white children (Villarosa, 2018). And it is not a question of education and income, because black women with advanced degrees are still more likely to lose a baby than white women with an eighth-grade education. This racial disparity leads me to believe that implicit racial bias may be downgrading the credibility of black patients. Consequently, testimonial injustice is likely at play. Caroline Criado Perez provides another example of medical dismissal in her book, *Invisible Women*. She tells the story of Kathy, a woman who struggled to control heavy menstruation. Her debilitating periods left her feeling so faint she could not stand. Medical professionals told her that she was 'simply struggling with anxiety' with one even saying to her, 'All your symptoms are in your imagination' (Perez 2019, 223). Luckily, Kathy ignored her doctor's dismissal and pushed for an ultrasound that revealed uterine fibroids that would require surgical intervention (Perez, 2019, 224). Medical testing eventually proved that Kathy was not anxious; she was anaemic (Perez, 2019, 224). Just as with Landrum, Kathy also suffered a testimonial injustice. Her insistence that doctors take her symptoms seriously was ignored by medical professionals who believed her to be suffering from mental health issues. She received a credibility deficit that situated her as a cognitively unreliable patient. Doctors belief that she was anxious led them to doubt the truth of her testimony.

Both cases show that before women got treatment they needed, their symptoms were first misunderstood as psychosomatic. Doctors gave both women an unfairly reduced level of credibility, and their insistence on locating both women's symptoms as psychological reveal an underlying belief that they were cognitively unreliable, or simply hypochondriacs. The image of the hysterical women is an onerous one to overcome. However, increasing awareness of the nature of implicit bias in medical treatment is the first step in countering it. If doctors are educated on the way that implicit bias can colour the way they perceive the testimony of patients, then they are in a better position to police their own behaviour. In the case of patients, if there is an increased awareness of testimonial injustice then they are less likely to suffer an epistemic loss in confidence and demand better care. But at its most simple, doctors just need to listen to women better. This sentiment is echoed in England's 2017 National Institute for Health and Care Excellence (NICE) guidelines regarding waiting times for endometriosis diagnosis. It takes an average of eight years for women to receive an endometriosis diagnosis, and the main advice provided by NICE to reduce this time was simple: listen to women (NICE, 2017). However, testimonial injustice is only one part of the epistemic injustice that arises in medicine. In the next section I will discuss hermeneutical injustice in relation to the lack of medical information we have about women.

Hermeneutical Injustice: The terra incognita of women

The director of the US Office of Research on Women's Health, Dr Janine Austin Clayton, told the New York Times: "We literally know less about every aspect of female biology compared to male biology" (Jackson, 2019). This is due to medical research historically assuming that male and female bodies were fundamentally the same in every way but reproductive function. This has roots going back to the Aristotelian belief that the female is a deformed male. Consequently, male bodies were studied as the norm and anything that fell out with that boundary was deemed abnormal (Marts and Keitt, 2004). Accordingly, sex differences have not been adequately researched and the result is that doctors are operating within a medical framework that is not designed to account for the differential reality of female bodies. Researchers have now found that sex differences are present in every tissue and organ in the body. This may mean diagnostic criteria and treatment may not work for women in an array of medical conditions. (Marts and

Keitt, 2004). As a result, excluding women from medical research means that doctors struggle to diagnose illnesses that present differently in women than men. There is a female shaped gap in our medical understanding. For example, recent studies into cardiovascular disease reveal that women are more likely to die following a heart attack than men. One reason suggested for this is that following a heart attack, women are 50% more likely to be misdiagnosed. This is because heart attack symptoms tend to present differently in women to men. Rather than the well-known symptom of chest-pain, women may not have any chest pain and instead present symptoms such as nausea, breathlessness and fatigue (Wu, J. et al. 2016). This is further compounded by new research which suggests that treatment procedures following a heart attack may not be as effective for women (Ridker et al.). This is likely because early cardiovascular research was conducted on men. Even now, women are not equally represented in research, making up only 25% of the research sample in trials ranging from 1987-2012 (Vitale et al. 2017). As a result, the underrepresentation of women in research has left our medical knowledge with huge gaps of understanding when it comes to women's health. The harm of this can be best explained through Fricker's concept of hermeneutical injustice.

At its core, hermeneutical injustice is an injustice of unequal participation. Fricker presents the example of sexual harassment to explain this concept. Up until the 1970s, there was no concept for 'sexual harassment'. This was likely since women occupied a diminished position within society and were unable to contribute to law-making and work guidelines in the same capacity as men. The result was that women on the receiving end of inappropriate behaviour struggled to understand what was happening. They were unable to communicate their experience of sexual harassment to others, as their accounts were often misunderstood as 'flirting' (Fricker 2007, 149-154). Consequently, hermeneutical injustice is concerned with the harms that are done when marginalised social groups are unable to contribute to the collective assortment of knowledge in the same frequency as dominant groups. The result is, there are gaps in our collective resource, such as the term sexual harassment, which obscure the experiences of marginalised groups from understanding. This may result in hermeneutically marginalised groups struggling to understand significant life experiences, grappling with ill-fitting definitions, or finding that they are unable to communicate their experience to others with any intelligibility. Therefore, women's situated

inequality and historic unequal participation in the construction of medical knowledge has left a gap in medical data. Medical pain bias can be understood as one giant hermeneutical injustice suffered by women. Owing to historic inequality of female entry into traditionally male professions, women have been unable to contribute to medical knowledge in the same capacity as men. The result is that women are often faced with an ill-fitting, or wrong, diagnosis. Women may struggle to effectively communicate symptoms to doctors who do not have the medical knowledge to adequately understand women. Hermeneutical injustice can render women's insistence that they are sick unintelligible to doctors. The only way to resolve this type of inequality is to attempt to fill in the gaps by increasing research that is conducted on women. Only then will we have more accurate diagnostic tools for doctors to accurately diagnose female patients. Additionally, as argued above, there needs to be an increased emphasis on listening to patients. If doctors are made aware of these gaps in medical knowledge, then they ought to also consider that female patients symptoms may only be difficult to diagnose due to a lack of knowledge, and not an unreliability on the behalf of the patient.

Conclusion

This article has demonstrated that healthcare inequalities are the result of long-standing practices of epistemic injustice. When women attempt to convey their symptoms to doctors, they are vulnerable to testimonial injustice and hermeneutical injustice. As a result, women receive different medical care than men in a wide variety of conditions. To resolve these inequalities, there are two changes that ought to be made. The first is to train medical professionals to be good listeners. In other words, educate them about the way implicit bias can seep into their perceptions of patients and alter the care they administer. This would allow for doctors to self-monitor their own bias and would hopefully alleviate the silencing that woman encounter. Secondly, women need to be included in medical research in more equal numbers. The only way that we can fill in these gaps is to try to know women better.

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