You’re just being dramatic: An account addressing women’s pain through the lens of trust, testimony, and communication

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Dedication

To the people in my life that have been silenced, ignored, and treated as inconsequential, know that I heard and saw you. And I continue to linger on your every word, captivated by the stories of those dismissed.

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Abstract

Chronic pain is a problem that affects millions of people living in the Western World, and women make up a large portion of this population of pain sufferers. Yet, women still have a difficult time receiving treatment for their pain. In this thesis, I argue that establishing a climate of trust can resolve some of the problems that prevent women from receiving adequate treatment during the diagnostic process. First, I examine the taxonomy on pain, limiting the scope of my research to two issues: (1) the stigma that comes from the over psychologization of women's pain and (2) physicians dismissing or devaluing women's pain. Then, I argue that these two issues result from a failure of trust and communication that results in two epistemic harms, namely testimonial injustice, and testimonial smothering. Lastly, I propose that we build a climate of trust based on Karen Jones' motive-based account of trust, which I argue should resolve the problem of communication and trust during the diagnostic process.

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A thesis isn't purely the work of any one individual despite my name being written on it. It is a collection of comments, remarks, counterarguments, and views from a pool of generous people, willing to give their time and effort to the process of creating knowledge. There are specifically four groups of people that made this thesis possible: my advisor, my past mentors, my inner circle, and everyone else along the way, who were open to hearing one woman discuss the pain of many others.

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Introduction

Chronic pain is common in the Western world (Breivik et al., 2006). In 2012, researchers at John Hopkins estimated that the total cost of pain is around 635 billion dollars in the United States alone (Gaskin and Richard, 2012, pp. 723). According to a Center for Disease Control (CDC) report in 2016, around 20% of U.S. adults (50 million people to be more precise) had chronic pain (CDC 2016). A further study conducted by the CDC found that, among the people with chronic pain, women were particularly affected (CDC 2019). Additionally, women are more likely than men to experience chronic pain (Hoffmann and Tarzian, 2001). They are also more likely to experience pain conditions, such as "fibromyalgia, migraine and chronic tension-type headache, irritable bowel syndrome, temporomandibular disorders, and interstitial cystitis" (Bartley and Fillingim, 2013, 52). Approximately between 75 to 90 percent of women are diagnosed with fibromyalgia (Arout et al., 2018, pp. 2). Untreated chronic pain can decrease a person's overall quality of life and well-being and cause further psychological distress (Dueñas et al., 2016).

Women especially have a difficult time receiving treatment for their pain. In a recent survey, Anke Samulowitz and others discovered that:

> Women, compared to men, received less and less effective pain relief, less pain medication with opioids, and more antidepressants and got more mental health referrals.. In the reviewed studies, women with chronic pain frequently reported being mistrusted and psychologized by their health-care providers. In a study from Finland, women wrote narratives about the process of getting back pain. The results showed that doctors did not take the women's pain seriously and that the doctor's neglectful attitude became part of the problem. (Samulowitz et al., 2018, pp. 8-9)

From this research, the question follows: *why are women not receiving adequate treatment for their pain?* I've outlined three reasons that prevent women from accessing proper treatment for their pain:

1. lack of research on women's health
2. the stigma of being emotional and the over psychologization of women's pain
3. physicians and/or other healthcare workers ignoring or devaluing testimony from female patients regarding their pain

Expanding upon the above list of reasons, I further explore issues (2-3) in depth, considering the issues of gender bias, communication, testimony, and trust, as it relates to women's pain and the phenomena of physicians improperly treating women's pain through misdiagnosis, testimonial dismissal, ignorance, and outright denial of treatment (see Fassler, 2015; Cottom, 2019; Marsh, 2021). I argue that the failure to treat women's pain in the diagnostic setting results from a failure in effective communication and trust between physicians and their patients.

On one hand, there is a failure in effective communication due to testimonial injustice and testimonial smothering. Testimonial injustice makes it difficult for physicians to trust their female patients' testimony on their pain, and testimonial silencing makes it difficult for patients to trust that their testimony will be heard, making it also difficult for them to be honest and accurate when reporting their pain. On the other hand, there is a failure to form a trusting relationship between physicians and patients as patients don't completely entrust their physician with their well-being, hiding knowledge and information that is needed to understand their pain. Improving pain diagnostics involves more effective communication and a better climate of trust between physicians and their patients.

Creating a climate of trust, which should aid in improving physician-patient relationships, will hopefully help to alleviate some of the problems that prevent women from receiving treatment for their chronic pain, particularly by improving personal relationships, and it should make communication easier. I argue that the model of trust as an affective attitude will provide a climate of trust that alleviates some of the problems—namely issues (2) and (3)—that prevent women from receiving treatment for their pain.

Chapter One: I outline the taxonomy of women's pain, laying out three key issues that prevent women from receiving pain treatment. I focus on two key issues that prevent women from being treated during the diagnostic process. I then set the foundation for Chapter Two where I argue that failure in trust and in effective communication is the reason for women not being treated for pain in the examiner room.

Chapter Two: Failure in trust and effective communication during the diagnostic process presents itself in the forms of two different epistemic harms: testimonial injustice and testimonial silencing. Testimonial injustice prevents physicians from hearing and trusting their female patients' testimony whereas testimonial smothering prevents women from trusting that their physician will believe their testimony. I discuss how the asymmetries and biases in medicine may hinder effective communication due to an underlying lack of trust on the part of the interlocutors.

Chapter Three: It is unclear whether people can choose to trust someone, but we can always advocate for a trusting stance, or what I consider to be a climate of trust. In this chapter, I argue in favor of Karen Jones' motive-based view on trust, which should make it easier for physicians and their patients to communicate with one another. I also argue against other models of trust, taking the stance that motivation should be a consideration when it comes to establishing a trusting relationship in the healthcare setting.

1. Taxonomy on Women's Pain

Lack of Research on Women's Health

The United States is one of the top producers in scientific and biomedical research, but before the U.S. Congress passed the National Institutes of Health Revitalization Act in 1993, there was no mandate to include women and minorities in clinical trials (National Institutes of Health, 2017). The standard body used in clinical trials tended to be 'male bodies'. This overarching problem of not incorporating more women in medical trials has contributed to a large gap in information regarding diseases related to the 'female body'. Since a large number of people that identify as women have a 'female body', this tends to be considered a women's issue even though there are certainly women (e.g. trans women) and intersex people who don't fit neatly into the dichotomous gender/sex category of men/women, often attributed to male/female (see Fausto-Sterling 1985). As a result, they are also affected by the exclusionary practices of clinical trials. If anything, this preferential treatment of the 'male body' as a standard model for the human body only reinforces the notion that we *should* diversify our clinical practice to include, as philosopher Kate Manne advocates, "bodies of a diverse range of trans, non-binary, and intersex people, who are chronically excluded from medical research" (Manne, 2020, pp. 135).

Caroline Criado-Perez, in her influential work *Invisible Women: Exposing Data Bias in a World Designed for Men*, highlights an overarching problem of women not being included or valued in the medical research process. Perez wrote that even now there are few to no courses geared towards understanding women's health. The author documents the inadequate educational training in medical school around the female body:

> A 2006 review of 'Curr-MIT', the US online database for med-school courses, found that only nine out of the ninety-five schools that entered data into the system offered a course that could be described as a 'women's health course'. Only two of these courses (obstetrics and gynecology classes taught in the second or third academic years) were mandatory. Even conditions that are known to cause the greatest morbidity and mortality in women failed to incorporate sex-specific information. Ten years later, another review found that the integration of sex- and gender-based medicine in US med schools remained 'minimal' and 'haphazard', with gaps particularly identified in the approach to the treatment of disease and use of drugs. (Criado-Perez, 2019, pp. 275)

The common response against the inclusion of women in clinical trials have been that though biological sex matters, female bodies are too complicated and complex to investigate. Their hormonal levels may interfere with the research. Simply put, women's bodies, as described by Criado-Perez, are "burdensome" (Criado-Perez, 2019, pp. 281). This attitude that female bodies are not worth investigating within medical trials have led to real-world problems for women, who are often not properly treated for a variety of diseases. For instance, the Yentl syndrome "has come to describe what happens when women present to their doctors with symptoms that differ from men's—they often get misdiagnosed, mistreated, or told the pain is all in their heads" (Samuel, 2019). This syndrome epitomizes the problem that arises when women are not included in medical research. Women are more likely to die from a heart attack because physicians are trained to observe the symptoms for heart attacks in the 'male body' and not the 'female body'.

Furthermore, research on women's health doesn't get the recognition it deserves, considering that it affects close to half the world's population. In recent news on the lack of research on women's health, people around the world were outraged by the lack of research on birth control after they heard the news that the blood clots from the Johnson & Johnson's Covid-19 vaccine were potentially linked to women's birth control (Mandavilli, 2021). When asked about this outrage by the New York Times, Dr. Eve Feinberg, a reproductive endocrinologist and infertility specialist at Northwestern University, was quoted saying, “They should be angry — women’s health just does not get equal attention” along with “There’s a huge sex bias in all of medicine” (ibid.).

Philosopher and author of the book *Self-Trust and Reproductive Autonomy*, Carolyn McLeod describes the situation as one where physicians are at a disadvantage when treating members from a marginalized group as opposed to members from a privileged background, writing:

> Most physicians are in a worse position, generally speaking, to understand the health care needs of patients who are oppressed than patients with privilege. They themselves usually live privileged lives that shelter them from the social and environmental constraints on health that many oppressed people face (e.g., barriers posed by poverty, pollution, violence, racism, ableism, etc.). Also physicians’ knowledge of how to treat medical conditions that manifest themselves differently among minority groups (especially women) is often vague or incomplete, since members of those groups tend to be excluded or underrepresented as subjects in medical research. With such gaps in medical knowledge, patients who are oppressed are probably best served by physicians who are honest about the limitations. Since the gaps narrow considerably for people who are multiply privileged (e.g., by class and gender), presumably those patients can trust authoritative and avuncular physicians most of the time. (McLeod, 2002, pp. 98)

In summary, there is a lack of training and research in women’s pain, which does a disservice to women’s overall health. In healthcare settings, physicians have a hard time understanding and trusting the testimony of their female patients when they come into their office seeking treatment for their pain. In the next section, I discuss the issue of physicians’ tendency to over psychologize their female patients.

Over Psychologizing Women’s Pain and Mistrust

In her book *Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick,* Maya Dusenbery mentions Cynthia Toussaint, founder of For Grace, an advocacy group for women in pain. Toussaint mentions how she would interview both men and women regarding their experience with chronic pain, noting that the one major difference in these accounts is that: men never have to defend their mental status when describing their chronic pain to physicians. They are automatically believed whereas women are usually disbelieved, even told that they are crazy (Dusenbery, 2018, pp. 412).

Dusenbery recounts the case study of Alexis, a woman suffering from chronic pain for years without any treatment in sight. According to Alexis' account, physicians would routinely give her a psychological test to determine whether her symptoms were linked to depression, anxiety, or any other mental disorder. While she never demonstrated any psychological disorder, that didn't matter as physicians continued to treat her for psychogenic symptoms. Dusenbery wrote:

> So, faced with pain they didn't understand, doctors would frequently suggest that Alexis's condition was psychogenic despite her normal psychological scores. Sometimes, since it was in the general vicinity of her uterus, her pain would be vaguely attributed to "female problems"—menstrual cramps or a "hormonal imbalance." Often doctors would simply say, "Well, we don't see anything wrong: you're fine," she recalls. "Well, I'm *not* fine; I'm in a lot of pain" (Dusenbery, 2018, pp. 395).

Cases like Alexis are tricky and expose the various difficulties when discussing pain because, in many ways, pain is still distinguished as either *physical* or *psychological* in origin. In reality, the picture of pain is far more complex and requires further extensive research on how pain can have both a physical and psychological basis. The over psychologizing of women's pain probably can be traced to hysteria, but not all its iterations, mainly just the recent development during the nineteenth century when hysteria was linked with mental disorder.

In the nineteenth century, psychoanalysis Sigmund Freud, influenced by French clinical neurologist Jean-Martin Charcot, diagnosed hysteria as a psychological or mental disorder rather than purely as a physiological disease rooted in 'female bodies' (Micale, 1995, pp. 27-28). For

Freud, hysteria was caused by psychological repression of traumatic events, relegating it away from being a physiological-based disease (ibid.). Hysteria has more than a 4,000-year-old history, appearing throughout different time periods from the middle-ages till even now (Kineta, 2006). For a long time, hysteria was rooted in the body. The concept of hysteria can be linked back to ancient Greece and Egypt. Philosopher Hippocrates coined the term *hysteria*, which derives from the Greek word *hystera,* meaning uterus (Tasca et. al., 2012, pp. 111; Micale, 1995, pp. 19). Greek physician Melampus was quoted, believing that "women's madness [was] derived from their uterus being poisoned by venomous humors, due to a lack of orgasms and 'uterine melancholy'" (Tasca et al., 2012, pp. 110).

As it pertains to the discussion on pain, physicians tend to over psychologize women's pain during treatment. Even now, women are seen as overly emotional. There is an assumption, either explicit or implicit, that a woman's pain is more likely to stem from a psychological root rather than a physiological basis. If we look at the history of hysteria in medicine, we can hypothesize that it continues to influence medical judgement regarding women's pain. So when physicians call women hysterical, they are probably working off of a historically long gender bias. To some physicians' defense, there have been studies that support the notion that women are treated more often for psychologically related issues than men, which may be explained for a variety of reasons from culturally related to biologically rooted explanations (Barnes, 2020).

Furthermore, pain assessment may be influenced by a belief that there is an 'underlying pathology' that is the cause behind the symptoms that women are experiencing (Dansie and Turk, 2013, pp. 19). The step towards diagnosis usually starts off with an assessment of the patient's history along with a physical examination. When necessary, there may be further tests and imaging procedures to ascertain the "presence of any underlying pathology that *causes* the symptom—the so-called pain generator" (ibid.) However, in the absence of an "identifiable organic pathology", the assumption is that the pain stems from psychological factors (ibid.). This assumption, along with the history of treating women's pain as 'hysteria', suggests that physicians have a tendency to over psychologize women's pain. That is, physicians often attribute women's pain as purely a mental disorder without taking any time and energy to further investigate the source of the pain. In an Aeon article, philosopher and author Elizabeth Barnes wrote a compelling piece documenting the over psychologization of women's pain with one line in particular capturing the essence of this problem: "Women's pain, it seems, is hysterical until proven otherwise" (Barnes, 2020).

Women are so used to being labelled 'emotional' that they will avoid vocalizing their own negative experiences with physicians out of fear of further perpetuating the stereotype that women are 'hysterical'. In "Brave Men" and "Emotional Women", a qualitative study of literature written on sex differences in pain authors, Anke Samulowitz and other found that physicians had a difficult time accepting the pain testimony of women (Samulowitz et al. 2018, pp. 8). This mistrust in women patients' narratives and subsequently female patients' negative encounters with physicians have sometimes led to psychological distress, which the patient cannot vocalize for fear of "an even greater degree of psychologization by healthcare professionals" (ibid.).

However, pushing women to get treated for psychiatric help isn't on its own a bad thing, but when it becomes a normalized response for medical professionals as a way to avoid spending further time and resources to figuring out the source of the pain, it becomes detrimental to their patient's health. It also makes effective communication and trust difficult. Simply put, women are less likely to give credible testimony under distress from the stigma of being labelled 'overly emotional'. They need a safe environment with a climate of trust that makes it possible to give essential testimony and feedback regarding their pain.

Dismissing Testimony

From chronicle accounts in think pieces like Tessie McMillan Cottom's "Dying to be Competent", we get cases of physicians dismissing testimony related to women's pain (Cottom, 2019). With the case of Tressie McMillan Cottom, a black sociologist who visited her obstetrics office after experiencing bleeding four months into her pregnancy, she initially was turned away despite having pain in her butt and having symptoms of bleeding. Later, when she returned after undergoing excruciating pain, they discovered through an ultrasound that she had two tumors, and she eventually had to give birth early to a daughter, who died shortly afterwards. Throughout her hospital visit, regarding her pain, she was met with contempt when requesting treatment by nurses, doctors, and an anesthesiologist–all of whom either disregarded or devalued her testimony (Cottom, 2019). She describes the problem as being perceived as incompetent, writing:

> Everything about the structure of trying to get medical care had filtered me through assumptions of my incompetence. There it was, what I had always been afraid of, what I must have known since I was a child I needed to prepare to defend myself against, and what it would take me years to accept was beyond my control. Like millions of women of color, especially black women, the healthcare machine could not imagine me as competent and so it neglected and ignored me until I was incompetent. Pain short-circuits rational thought. It can change all of your perceptions of reality. If you are in enough physical pain, your brain can see what isn't there. Pain, like pregnancy, is inconvenient for bureaucratic efficiency and has little use in a capitalist regime. When the medical profession systematically denies the existence of black women's pain, underdiagnoses our pain, refuses to alleviate or treat our pain, healthcare marks us as incompetent bureaucratic subjects. Then it serves us accordingly. (Ibid.)

From the ample testimonial accounts from patients in hospitals, there is a sense that physicians have a difficult time trusting the testimonial accounts of their female patients' pain reports (see Fassler, 2015; Marsh, 2021). These testimonial accounts have a standard narrative arc. There is usually a woman that enters a doctor's office, suffering from pain. The doctor misdiagnoses the female patient, sometimes running the wrong test. When the results come back as negative, they tend to dismiss the patient's pain as being motivated by some hormonal, psychological factor, or even outright lying. Even in the cases that they run the correct test or acknowledge that the patient's pain is warranted, by the time they acknowledge the patient's pain, a tremendous amount of psychological and physical harm has already occurred.

The denial of women's testimony on their own subjective pain experience showcases deep philosophical questions on trust, expertise, epistemology, and bias in testimony (i.e. epistemic injustice). In standard pain reporting cases, a patient ideally fills out a pain assessment, which the physicians then use as part of the diagnostic process.

Several scenarios can exist to prevent women from receiving treatment:

1. the physician may not be aware of the type of pain the patient is suffering from due to inadequate training caused by the lack of research on women's health, leading them to run unnecessary tests or treatments
2. over psychologizing their patient's pain due to a history of gender bias against women as emotionally volatile people
3. outright denying their pain or devaluing the extent of their pain

Scenarios 2 and 3 occur in the one-on-one and, in some circumstances, interpersonal interactions between the physician and patient. It is these communicative exchanges that determine the course of treatment for a patient's pain. Effective communication and trust between interlocutors throughout the diagnostic process and clinical trials is essential to treating women's pain. Failure in communication will result in women not getting the treatment they desperately need.

I think the root of the problem of women not receiving treatment for their pain during the diagnostic process is due to a lack of effective communication and trust between experts (i.e. physicians) and novices (i.e. patients). Namely, there isn't a trusting relationship that would allow for effective communication to take place due to bias and a lack of trust. Furthermore, physicians have a difficult time viewing women as credible knowers of their own pain experience, which is a problem because without effective communication during the diagnostic process, women are unlikely to get treatment for their pain. Effective communication is a necessary condition for pain treatment although not a sufficient condition because patients can still not receive treatment despite their presumably accurate testimony being accepted by the physician (i.e. lack in research makes it difficult to treat women's pain). Since effective communication is not a sufficient condition, it will not be enough to treat pain in all possible cases. My thesis does not seek to completely resolve the issue of women not receiving adequate care; that is beyond the scope of this project. Rather, I hope to provide a solution to alleviate some of the problems that continue to prevent pain treatment for women.

The next section will be dedicated to the issue of why effective communication and trust is essential to diagnosing pain.

2. Diagnosing Pain

In this section, I argue that women are not treated for their pain because of a failure in communication and a lack of trust. I discuss the epistemic harms that result from a combination of factors, including gender bias and a lacking relationship of trust. First, I argue that patients have an epistemic authority over the experiential knowledge of their pain and its existence. Thus, they are a credible knower in whether or not their pain exists although I recognize that they are not the expert in the domain of pain. When a physician fails to recognize their patient as knowledgeable regarding the existence of their pain by outright denying its existence based on identity-stereotype, they fail to hear their patient and end up mistrusting their testimony. When a patient, under the stigmatization of being ‘emotional’, ends up silencing their own testimony, they fail to give important information, mistrusting their physician’s ability to hear and care for them. Epistemic harm, in the form of testimonial injustice and testimonial smothering, prevents proper diagnosis, leading to women not being treated for their pain because of a failure in trust and communication.

According to the *Stanford Encyclopedia* entry on pain by Murat Aydede, there are two different interpretations of pain: (1) pain is in the body and (2) pain is a subjective experience. Pain as a part of the body attributes pain to being spatially located on a region on our body while pain as subjective experience situates pain as an emotional experience (Aydede, 2019). The view of pain as in the body works well with the pain that can be known as *nociceptive*, defined as pain caused by harmful stimuli that are detected by nociceptors around the body (Dusenbery, 2018, pp. 389-390). For instance, if a person is recovering from a burn incident, they are suffering from nociceptive pain, which is caused by some external harm done to the body. Nociceptive pain is easier for physicians to trust because it gives them some indication that a person has been harmed.

However, endothermic and other chronic pains that women suffer from may be pathological, so there are no symptoms indicating any damage done to the body or inflammation, ruling out external causes for the pain (ibid.). Pathological pain can be categorized into neuropathic pain and dysfunctional pain (ibid.). *Neuropathic pain* is triggered by damage to the nervous system, and *dysfunctional pain* is "pain in the absence of any injury, inflammation, or nerve lesion to explain it at all" (ibid.). In these cases, it is increasingly difficult for a physician to know for sure if a patient is in pain other than relying on their account. In the case of pathological pain, it is difficult and, in some cases impossible, to locate the pain on the body, suggesting that it is a subjective experience.

The medical community tends to use the definition of pain by The International Association of the Study of Pain (IASP), which defines pain as:

> An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage, and is expanded upon by the addition of six key Notes and the etymology of the word pain for further valuable context.
>
> - Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
> - Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
> - Through their life experiences, individuals learn the concept of pain.
> - A person's report of an experience as pain should be respected.
> - Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
> - Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain. (IASP 2020)

Despite the debate on the phenomena of pain, both views make the claim that the patient has some knowledge of their pain. So, it follows that the patient has authority over the existence of their pain, independent of whether or not it actually results in an injury located somewhere in the body, or it is purely dysfunctional with no external causes.

While patients may not know the root cause of their pain, i.e. whether it is neuropathic or dysfunctional pain, they have *experiential knowledge* of their pain and authority over its existence. The physicians, with their expertise in the domain of medicine, are supposed to be the expert with the know-how to diagnose and find the cause of the pain. In regard to expertise, another seminal position is that of John Hardwig (1985) where he argues that the novice should blindly and fully accept the testimony of experts, given that they themselves lack the proper training to evaluate the experts' knowledge. The issue with this account of expertise is that it wouldn't allow patients to have much say in the diagnostic process. They couldn't even claim that their physician is wrong because according to his account:

> With the exception-often an important exception-of such ad hominems, I see no way to avoid the conclusion I have proposed above: that the rational layman will recognize that, in matters about which there is good reason to believe that there is expert opinion, he ought (methodologically) not to make up his own mind. His stance on these matters will-if he is rational-usually be rational deference to the epistemic authority of the expert. (Hardwig,1985, pp. 343)

Instead of Hardwig's account, I will use Alvin Goldman's position to explain expertise because it offers a clearer and more concise view with the explanatory power to differentiate how the patient can have some authority on their pain without being an expert on the topic of pain.

Generally, in a physician-patient relationship, there exists *epistemic asymmetries* as the patient is usually *epistemically dependent* on the physician for knowledge regarding their health. It is a pervasive practice in our current social world to depend on experts and other authorities for knowledge as a part of the division of cognitive labor. However, in the context of diagnosing a patient's pain, this epistemic asymmetry and our dependence on physicians as the authority figure raises interesting epistemic and ethical questions concerning epistemic authority.

Philosopher Alvin Goldman defines an expert as "someone who possesses an extensive fund of knowledge and set of methods for apt and successful deployment of this knowledge [towards developing] new questions in the domain" (Goldman, 2001, pp 92). When discussing knowledge here, Goldman argues that an expert isn't someone with *comparatively* more true beliefs than others within the E-domain. E-domain is defined as the domain of expertise. Expertise, according to Goldman, isn't about possessing accurate information. Rather, it is possessing the know-how to address relevant questions in their respective domain with the expert possessing the relevant information on how to act on or convey a solution to a problem (ibid.).

Additionally, physicians are typically granted derivative authority, which, according to Goldman, are cases where the hearer has "*reasons for thinking* that the source's information, abilities, or circumstances put [him] in an especially good position to make an accurate claim" (ibid, 87). But, while physicians are experts in the E-domain of pain with the knowledge of how to address the issue of pain, they do not have access to the experiential knowledge of the patient's pain. That data on the existence of the patient's pain has to be given to the physician in order for them to evaluate and interpret that information to come up with a diagnosis.

This relationship, where the patient offers the raw data regarding their pain to the expert for them to then interpret and offer a solution, leaves the final say on treatment up to the whims of the physician. There is a knowledge gap occurring here. Since the patient lacks the know-how that is required in standard expertise, they do not necessarily have a full range of access to what the proper treatment ought to be. Acknowledging the lack of expertise, they must trust in the expertise of their physician in the domain of medicine to offer guidance on treatment.

However, patients are, at the very least, epistemic authorities on the existence of their pain. Authority is defined as a "triadic relation obtaining between a person x who has the authority (the bearer of authority), and another person y for whom x is an authority (the recognizing subject) and a domain of authority (the field)" (Scholz, 2009, pp. 189). Since patients are the authority to the existence of their pain, when physicians deny their patients' claim over the existence of their pain on nothing more than their identity, they are committing a testimonial injustice against their patients.

These *asymmetries* in this relationship leaves the power and interpretation up to the physician. Thus, physicians hold immense power in deciding from a patient's character and appearance whether they are a credible source. This raises problems with determining credibility as it can be an ethical issue concerning abuse of power when physicians refuse to treat patients based on prejudicial views regarding the kinds of people that experience physical pain. Physicians are committing wrongfulness to their patient epistemically if they are judging their patient's credibility based on superficial or prejudicial beliefs that are not relevant to assessing pain. Bias can and does play a role in whether or not women will receive treatment.

The role of bias in attributing authority is a relatively new and expanding area of philosophical interest in social epistemology. Miranda Fricker, in her seminal work *Epistemic Injustice: Power and the Ethics of Knowing*, documents that some people may be given more or less credibility based on their identity in the economy of credibility (Fricker, 2007). Women are more susceptible to being given less credibility, and that is clearly the case in some encounters with physicians. I argue, in the case of pain testimony, that women suffer from a variety of epistemic harms that interfere with effective communication and trust.

Communication

Effective communication involves the speaker and hearer cooperating with each other; thus, reciprocity is needed. Jennifer Hornsby argues this point:

> The fact that you have successfully told an audience something seems to rely on nothing more than you and her being parties of a successful linguistic exchange. I give the name of "reciprocity" to the condition which provides for the particular way in which successful illocutionary acts can be performed. When there is reciprocity among people, they recognize one another's speech as it is meant to be taken: An audience who participates reciprocally does not merely understand the speaker's words but also, in taking the words as they are meant to be taken, satisfies a condition for the speaker's having done the communicative thing that she intended (Hornsby, 1995, pp.134).

When doctors actively refuse to listen to countless women's accounts of pain, they are no longer reciprocal in a linguistic exchange with the patient. The patient (i.e., the speaker) cannot force their physicians (i.e., the audience) to listen or believe them. And the physician cannot force the patient to be open in communication.

Others responding to Paul Grice's work *Studies in the Way of Words* have argued that people enter into conversations with differing goals and motivations that may hinder cooperation (Grice, 1991, Pinker 2007). A prime example is the negotiation process where each party has specific goals in mind, making it difficult for each party to be completely transparent about their motivations or information they may have. Feminist epistemologists have further argued that when it comes to knowledge and knowledge production, a person's situated identity or membership within a given group can exclude them from dominant knowledge production and to be seen as 'knowers' (see Anderson, 2020).

Fricker expands on this idea that a person's social position can determine their ability to be seen as a knower in her discussion on bias in testimony. Our everyday exchanges with people rely on heuristics and stereotypes to give us quick ways to access people in a testimonial exchange (Fricker 2007, pp. 32). Stereotypes are generally neutral in reliability with some stereotypes being helpful whereas others are detrimental and harmful, like the stereotype that "Asian women are docile and submissive”. The harmful stereotype previously mentioned is a negative identity-stereotype, which is:

> A widely held disparaging association between a social group and one or more attributes, where this association embodies a generalization that displays some (typically, epistemically culpable) resistance to counter evidence owing to an ethically bad affective investment. (ibid, pp. 35)

This negative identity-stereotype can, according to Fricker, “distort a hearer’s credibility judgment: it distorts the hearer’s perception of the speaker” (ibid, pp. 36). Epistemic injustice is an intrinsic wrong as “[t]o be wronged in one's capacity as a knower is to be wronged in a capacity essential to human value” (ibid, 44). When one is undermined or otherwise wronged in a capacity essential to human value, one suffers an intrinsic injustice. These identity-stereotypes, in reference to women’s pain, are harmful in three ways: (1) *practically* (i.e. not being treated for their pain), (2) *epistemically* (i.e. disrupting access to true beliefs and research on women’s pain), and (3) *intrinsically* (i.e. women’s humanity being reduced).

The phenomenon of women not being treated for their pain reveals the problem of authority in pain treatment and the epistemic injustice that can easily arise from an interaction as mundane as going to the doctor. It further reveals the problem of silencing and what that does to those dismissed.

Physicians Ignoring Pain as a Form of Testimonial Injustice

The active silencing of female patients by their physicians brings up questions regarding not only authority, but the ways to which a person's social position can determine the extent that their testimony is taken into account by others. Communication between physicians and women regarding women's pain ultimately fails because the physician is overly imagined to be knowledgeable as a knower on the subject matter, and the patients (i.e. women) are seen as less knowledgeable (Fricker, 2007, pp. 30). The patient in question is suffering from what Miranda Fricker termed *credibility deficit* when the patient's testimony is diminished because the audience (i.e. the physicians) fails to hear their testimony. On the other hand, physicians, with their degrees and medical training, are given an *excess of credibility* regarding their knowledge of their patient's pain.

Fricker notes that while this excess can be disadvantageous, physicians are not harmed by their credibility excess. They are still safe in their position as a credible speaker. Their dismissed patients, on the other hand, are undermined as a credible speaker. Essentially, these physicians are taking into account a person's social position when determining their level of credibility. There are instances where taking a person's social position into consideration when determining their credibility would be advantageous and permissible, such as taking advice on how to be a better plant owner from an avid plant enthusiast. In the case of pain, it is not clear why a person's identity as a woman would matter in their testimonial account of their pain. Aside from the gender bias, the dismissal of female patients as credible knowers is a failure of recognition and constitutes as a form of epistemic harm where women are wronged in their 'capacity as knowers' of their own pain or pain level.

Prejudicial and negative attitudes towards women impact their ability to be heard, which constitutes a form of testimonial injustice. Fricker discusses two kinds of epistemic injustice: *testimonial injustice* and *hermeneutical injustice.* As Fricker wrote:

> Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experience. (ibid, 1)

Testimonial injustice occurs when physicians deny or refuse to hear a patient's testimony regarding their pain on the basis of stereotypes surrounding women's pain. Stereotypes may be neutral in nature as the definition of stereotypes is defined as, "widely held associations between a given social group and one or more attributes" (ibid, 30). However, in the context of pain testimony, it is a pervasive issue of grouping women with harmful stereotypes, with many of its historical foundation rooted back to when doctors would label women with hysteria. An example is that women are exaggerating their pain. These physicians have a hard time trusting that their patient is experiencing a pain that has a physiological basis. This dismissal of patients demonstrates a further problem of the lack of a trusting relationship between physicians and their patients. It is difficult to see how certain pain diagnoses are possible without effective communication and a trusting relationship of some sort.

There is also a historical *hermeneutical injustice* that continues to this day as women lack the concepts to describe things from sexual desire to symptoms associated with common diseases, such as heart attacks. Hermeneutical injustice deals with a lack of shared collective understanding. Since women were historically not allowed to actively participate in creating concepts and terminology in many different areas of knowledge, they are at a disadvantage when it comes to interpreting their experiences. Fricker (2007) famously used the case of sexual harassment as an example of hermeneutical injustice as there was no terminology or 'collective resources' to interpret cases of sexual harassment before it was coined in 1975. This lack of 'collective resources' makes it increasingly difficult for women to make sense of their experience.

Furthermore, the lack of studies on the 'female body' has left physicians in the dark when it comes to treatment for their female patients. K.C. Brennen, an assistant professor in neurology at Utah university, has reportedly told the New York Times, "Sex differences are the elephant in the room," further elaborating, "you want to have both male and female animals, because something that shows up differently in males and females might be a clue to how the disease works" (Rabin, 2014). Less knowledge about the female body prevents women from gaining the appropriate resources and knowledge regarding their bodies, leaving the interpretation up to the institution of medicine, which has historically excluded women from partaking and coming up with definitions and concepts. Hermeneutical injustice stems from a more systemic problem that cannot be resolved *solely* through better communication between physicians and patients.

Next, I discuss the ways to which the stigmatization surrounding women's pain affects their ability to trust their physician with knowledge and information, which in turn may make it difficult to trust physicians to care for them.

The Stigma of Being Emotional and the Over Psychologization of Women's Pain

Philosopher Elizabeth Barnes mentions a 2006 study on 3rd and 4th year medical students and physicians at a Hospital in New York (Barnes, 2020). In the first case, they were asked to diagnose two participants, a 55-year-old woman and a 45-year-old man, both of whom had the same symptoms typical of a coronary heart disease (CHD). Most of the diagnoses for both men and women were CHD in the first case. In the second case, the patients were reported to have the same symptoms as before with an added psychological symptom of stress. While the majority of the research participants (75% to be exact) continued to diagnose CHD for men, only 17% of the participants diagnosed CHD for women (Chiaramonte, 2006, pp. 261). Once psychological symptoms are introduced as a consideration, it becomes easier to diagnose them with a psychological disorder as opposed to a physiological one. Even in current times, hysteria may continue to influence physicians' judgements toward women's pain as they either explicitly or implicitly believe that women are emotional beings, riddled with diseases stemming from mental disorders. The knowledge of gender bias against women in the healthcare setting makes it difficult for women to be honest about their pain along with their negative encounters with healthcare providers.

As opposed to outright not believing the existence of a patient's pain, this epistemic harm is not necessarily caused by physicians not trusting that the patient is in pain. Rather, the problems lie with the patients who believe that their pain will be met with skepticism by their physicians. Aware of this stigma against women as being emotional as well as the likelihood of physicians diagnosing their pain as purely psychological, these women will smother their own testimony. They will adopt other methods of trying to appear credible instead of confronting their physicians about their bias. This form of testimonial silencing is based on a larger theory put forth by philosopher Kristen Dotson.

In a piece titled "Tracking Epistemic Violence, Tracking Practices of Silencing", Dotson (2011) expands on Gayatri Spivak's work on epistemic violence, arguing that epistemic silencing is an act of violence. Dotson demarcates two different forms of silencing, namely testimonial quieting and testimonial smothering. Testimonial quieting is closely related to Miranda Fricker's notion of testimonial injustice although it challenges it by arguing further that this epistemic harm (i.e. testimonial quieting) constitutes a form of epistemic violence. As mentioned earlier with Jennifer Hornby's discussion on reciprocity between speaker and audience, the speaker needs the audience to have "certain kinds of reciprocity". Mostly, the audience needs to be open and capable of hearing the speaker.

Epistemic violence in a testimonial setting, according to Dotson, is defined as "a refusal, intentional or unintentional of an audience to communicatively reciprocate a linguistic exchange owing to pernicious ignorance" (Dotson, 2011, pp. 238). Pernicious ignorance is "any reliable ignorance that, in a given context, harms another person" (ibid.). In the case of epistemic quieting, the audience fails to recognize the speaker as a knower. Dotson uses the cases of stereotypes against black women mentioned in Patria Hill Collins' work *Black Feminist Thought* (Collins, 2000) as an example of how stereotypes affect a speaker's credibility as a knower. These stereotypes surrounding black women reinforces and naturalizes mistreatment of black woman as Patricia Collins (2000) wrote:

> Portraying African-American women as stereotypical mammies, matriarchs, welfare recipients, and hot mommas helps justify U.S. Black women's oppression. Challenging these controlling images has long been a core theme in Black feminist thought...These controlling images are designed to make racism, sexism, poverty, and other forms of social injustice appear to be natural, normal, and inevitable parts of everyday life. (ibid. pp. 69)

For the purpose of my thesis, I take Dotson's notion of epistemic quieting to be close to Fricker's testimonial injustice, so I will mostly be using her theory on testimonial smothering to explain women's unwillingness to be open to communicating important information concerning their health and well-being with their physician.

To clarify, testimonial smothering is defined as "[the] truncating of one's own testimony in order to ensure that the testimony contains only content for which one's audience demonstrates testimonial competence." Dotson offers three circumstances that "routinely exist in instances of testimonial smothering which are actually tied to one another in ways that make them difficult to analyze separately; nevertheless [she] attempts to do so" (Dotson 2011, pp. 244). She identifies the following as those three circumstances:

1) the content of the testimony must be unsafe and risky;
2) the audience must demonstrate testimonial incompetence with respect to the content of the testimony to the speaker; and
3) testimonial incompetence must follow from, or appear to follow from, pernicious ignorance. (ibid.)

The first circumstance of testimonial smothering occurs when the speaker finds out that their testimony is 'unsafe' and could run the risk of failure due to the hearer's inability to find their testimony understandable—it also runs a further risk of having negative effects on the individual due to this 'unsafe nature' of the testimony. For instance, when women know that their physicians will tend to psychologize their pain, they will try their best to not confront their physicians about their negative encounters for fear of appearing 'emotional' and furthering the stereotype of the 'hysterical women'. Not reporting these encounters hurts women in the end and favors uncooperative physicians. Thus, female patients are in a double bind as they will be perceived as overly emotional if they discuss their distress, but not discussing their distress leaves them open to not being treated for their psychological symptoms (from the negative encounter) as well as preventing them from holding their physicians accountable for their misconduct.

In the second circumstance of testimonial smothering, when physicians are over psychologizing women's pain, they are committing a form of testimonial incompetence to the content of women's pain. Testimonial incompetence "refers to the failure of an audience to demonstrate to the speaker that she/he will find proffered testimony accurately intelligible" (ibid., pp. 245). Kristen Dotson uses the example of micro-aggression in the U.S. to showcase this testimonial incompetence:

> A conversation about race in the United States where the given audience demonstrates racial microaggressions against an African American speaker would be, for example, an instance in which an audience demonstrates testimonial incompetence with respect to potential testimonial content concerning corresponding topics on race… Microaggressions take on different forms. One of the forms is microinvalidations. A microinvalidation is "characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color. (Ibid, 246-247)

These patients don't trust that their testimony on their own is enough. So, in settings where they anticipate testimonial smothering, patients will try to make their testimony more intelligible to the physician, knowing that they may lack an understanding of women's pain. Some women may change their appearance and even perform their pain, knowing that physicians tend to discredit their testimony. A study conducted by Anne Werner and Kirsti Malterud showed that women would employ a diversity of tactics, including changing their tone and appearance, to make themselves appear more *credible*. They found:

> To sum up the findings, the women patients' activities during or before the consultations demonstrate that they have worked hard to make the symptoms socially visible, real, and physical when they consult a doctor. Their efforts reflect a subtle balance not to appear too strong or too weak, too healthy or too sick, or too smart or disarranged. This applies both to what they say and do, and how they appear through clothes, body, and manners when they consult the doctor. (Werner and Malterud, 2003, pp. 1414)

Through past experiences, these women exhibit signs of mistrust towards their physician's diagnosis on the best course of action in treating their pain. Even gathering massive evidence (i.e. past opinions from other experts) as a tactic cannot guarantee success in being perceived as credible. Werner and Malterud (2003) concluded that there are instances where these various tactics employed by the participants simply fail to establish their credibility, and, in such cases, these women would simply have to give up and change their doctor. So, when anticipating silencing and truncating their experience isn't enough, they simply give up and refuse to share their testimony with that physician any longer.

These physicians are unable to comprehend these women’s testimony out of ignorance. They are unaware of the stigmatization that women face for being ‘overly emotional’, along with the ongoing problem of healthcare workers' tendency to psychologize women’s pain. This epistemic harm caused by this testimonial injustice and testimonial smothering in communication between physician and patient hinders knowledge. As Fricker argues, testimonial injustice “damages the epistemic system [which] is directly relevant to social epistemologies such as Goldman’s ‘veritism’, for prejudice presents an obstacle to truth, either directly by causing the hearer to miss out on a particular truth, or indirectly by creating blockages in the circulation of critical ideas” (Fricker 2007, pp. 43). This failure in communication prevents women from having their pain treated because it prevents physicians from trusting patients’ testimony, and it prevents patients from discussing their pain fully to their physician in an accurate manner (i.e. testimonial smothering).

Epistemic harms committed in the form of testimonial injustice and testimonial smothering suggest that failure in communication between physicians and patients result from a combination of factors such as bias and trust. It is unclear to the extent that any one institution can solve the problem of bias. That is a part of a larger systemic and cultural problem. But we can certainly address the problems of trust in the physician-patient relationship. There are plenty of readings to suggest that this route is a strategy to resolve the issue of women not receiving treatment for their pain. Anke Samulowitz and others suggest that a trusting relationship could solve some issues of chronic pain:

> Evolving a theory on women and chronic pain, Skuladottir and Halldorsdottir showed that professionals could empower women by being wise, competent, caring, and building a trustful relationship with them. They could also reinforce gender norms via mistrust,

> disrespectful treatment, and making the women responsible for not being healthy. (Samulowitz, 2018, pp. 8)

We can try to create a better climate for trust that may help to treat patients despite the barrier that bias can have on testimony and trust for physicians and their patients. Establishing a climate of trust between physicians and patients may resolve this issue of women not being treated for pain during the diagnostic process, but it is unclear what that trusting relationship would entail.

In the next section, I advocate for a model of trust as an affective attitude which should help to establish a climate of trust that would solve the problem of women not being treated for pain due to failure to communicate during the diagnostic phase. My solution does not, however, address the more systemic problem. Rather it focuses exclusively on the failure of trust in the interpersonal relationship between physician and patient.

3. Developing a Relationship of Trust

As mentioned in the previous chapter, researchers Hafdis Skuladottir and Sigridur Halldorsdottir (2018) wrote that healthcare professionals could resolve some of the difficulties of treating women's pain through building a trusting relationship between their patients along with other considerations. I expand upon this idea to propose that we consider building a climate of trust, which should aid us in resolving some of the problems caused by ineffective communication and mistrust.

Now, there are still difficulties in choosing which model of trust we should use as a guide when creating a climate of trust. We can think of a climate of trust as an environment where we can cultivate trust, and I propose we can create this climate through adopting a standard of account of trust that physicians should aim towards. However, currently there is no census on what the standard account of trust entails. The nature of trust is a contentious topic, with many different camps arguing whether trust is an attitude, a belief, or responsiveness. Each view is outlined as follow:

1. *Trust as a belief*. Trust is a belief that the entrusted will fulfill what they were entrusted to do.
2. *Trust as an attitude*. Trust is an attitude of optimism on the goodwill and competence of the entrusted, who is in turn supposed to be moved by the thought of being counted on (Jones, 1996, pp. 9).
3. *Trust as responsiveness* (sometimes called normative-expectation theory). Trust is responsiveness; that is, the entrusted will respond appropriately to being counted on.

Examining each of these views on trust, I argue in favor of Karen Jones' will-based account on trust because it (1) offers an explanation on why attitudes or perceived attitudes matter in a trusting physician-patient relationship and (2) if the requirements for her account of trust is properly adopted than the issues of testimonial injustice and testimonial silencing will likely be resolved, thus making effective communication possible and resolving the problem of women not receiving treatment for their pain during the diagnostic process.

First, I briefly discuss the main criticism against my account by philosophers trying to create a theory of trust that captures trust in all its forms. I suggest that we instead create a climate of trust that aims at improving the physician-patient relationship rather than adopt a model that claims to be applicable in all instances of trust. Then I address the criticism that goodwill is neither a necessary nor sufficient condition for trust by using my "superstar physician" thought experiment to entice us to consider that for some of us; it is a consideration. I argue against other models of trust that do not take motivation into account as a condition required for trust. Lastly, I adopt Karen Jones' motive-based account and show that it could alleviate testimonial injustice and testimonial smothering, which I outlined as the main problems hindering women from receiving treatment for their pain.

In the next section, I use the example of the superstar physician to argue against creating a climate of trust that does not take attitudes or perceived attitudes into consideration as a condition for a trusting relationship.

Climate of Trust

Many philosophers working on the topic of trust will disagree with Karen Jones' motive-based account of trust. I think Jones' (1996) account of trust as an affective attitude highlights the complex nature of these medical relationships. Her account of trust requires that the trustee (physician) has an optimism of goodwill towards the trustor and that the trustee should be aware that they are being counted on and moved by that thought (Jones, 1996, pp. 9-11). Many philosophers have argued that goodwill is neither a necessary nor sufficient condition for trust. I agree with some philosophers who believe that it is viable for a patient to trust a physician who may not demonstrate any level of benevolence towards them. Thus, goodwill is not a necessary condition for *all* trusting relationships. However, it is difficult to find any theory of trust that will neatly accommodate *all* forms of trusting relationships that exist. Instead of proposing a theory that explains all forms of trusting relationships, I suggest we choose a view that would likely create a climate of trust between physicians and their patients.

One may argue that in some of these theories on trust (e.g., trust as responsiveness or trust as affective attitude), people cannot trust at will or choose to trust, so does it matter which view of trust we decide on. While we cannot act out trust, we can certainly create a stance that helps facilitate a climate of trust.

> Whilst it may not be possible to trust at will, the conscious adoption of a trusting stance is both possible and warranted as the burdens of misplaced trust fall more heavily upon patients than doctors....A trusting stance is central to the doctor-patient relationship. Some degree of trust is necessary to create a climate in which honest communication may flourish. Trust allows patients to express their concerns without fear of being disbelieved or disparaged. Over time, the presence of trust facilitates the development of deeper doctor-patient relationships, which may be necessary for certain types of care, such as disclosure and management of sensitive or potentially stigmatizing problems. When a patient is trusted, her experiences are validated, and her competence recognized. This can lead to an enriched view of beneficence which incorporates the patient's expertise into the conception of her best interests (Roger, 2001, pp. 77- 78).

Now I propose we examine the case of the superstar physicians as an example to showcase why attitudes and motivation *might* matter for patients and why we should want a climate of trust that includes goodwill.

Superstar Physicians and Goodwill

Take the case of the superstar physician[1]. Pretend that you are in a simulated virtual game where you run a hospital with physicians and patients. You can choose certain character archetypes to work in your hospital, and one of those characters is the superstar physician. What you learn about the superstar physician is that this character entered medicine not out of an intrinsic desire to care for others. Instead, they were pushed by their overbearing parents to become a world-class doctor. At a young age, this character was constantly pressured to achieve success as their parents had a habit of living vicariously through their child. So, this superstar physician, while capable of exhibiting goodwill towards their patient—does not. In this game, there is another physician archetype, “the goodwill physician,” who lacks the motivation to be the best physician in the hospital but genuinely has an innate desire to care for others.

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[1] Professor Elena Pope came up with the general outline of the thought experiment, and I ended up using it in my paper.

As a player in the game, you must staff the hospital with either superstar physicians or goodwill physicians. You can choose to divide the number of characters in half, staffing half of the hospital with superstar physicians and the other half with goodwill physicians, or choosing other numerical combinations. The point of the game is to treat as many patients as you can, which is only possible if the patients trust their physicians. For trust to be possible, the patients must entrust the physicians to care for them, which may entail caring for their health, overall well-being, and body.

From this thought experience: *Are there any potential problems if a player decided only to fill your hospital with superstar physicians? If they only staffed superstar physicians, would that possibly affect the total number of patients they end up treating?* If the opponents of motive-based accounts are right that motivations of goodwill do not matter, then it should not be a problem for the player of the game to staff their hospital with only superstar physicians because it shouldn't affect the total amount of patients they end up treating.

However, some might opt out of filling our hospitals with only superstar physicians. We might have an eerily feeling that patients do not want to be cared for by someone who is mainly motivated to succeed. Some patients in the game might be turned off by a hospital staffed with only superstar physicians. However, even if we did not have that eerily feeling, we might still think it might be easier for patients to trust their physicians if they think they care for them. The best move instrumentally might be to staff a hospital with mostly goodwill physicians if the aim is to establish as many trusting relationships as possible.

Still, an opponent to the motive-based view of trust, proponents of the trust as a belief view might argue that it does not seem to matter if the superstar physician had goodwill towards us. It might be beneficial psychologically to have a kind physician, but it is neither a necessary nor sufficient condition for trust. Proponents of trust as a belief view argue that what matters to establish a trusting relationship is the probability that the physician will fulfill their responsibility to care for their patient. Diego Gambetta (1988) is cited to view that trust is a belief taken from his paper "Can we trust?". Gambetta's account of trust is defined as "the trustor's belief that the trusted person will respond positively to the choice of a trusting act in a trust problem" (Lahbo, 2020, pp. 148). Pamela Hieronymi employs a more straightforward definition of this view. She defines trust belief as "one person trusts another to do something only to the extent that the one trustingly believes that the other will do that thing" (Hieronymi, 2008, pp. 214). This account differs from the trust as responsiveness account and the trust as affective attitude account because both accounts view trust as an attitude different from belief.

The problem with this account is that it does not distinguish trust from mere reliance. For instance, in the case of women changing their appearance to appear more credible, they may believe that their physician will be more likely to believe their testimony if they appear sickly during their examination (see Werner and Malterud, 2003). After careful consideration, we *would not t*hink that these women, who are changing their appearances to appear credible, are in a trusting relationship with their physicians. We would say that they are relying on their physicians' habit of attributing credibility to sickly-looking women as a means to achieving credibility. This example showcases the problems of trust as a belief account in that it misses an essential aspect of trust. Namely, that *trust is not mere reliance*.

Annette Baier (1986) originally argues this point—that trust is not mere reliance—in her seminal text "Trust and Anti-Trust." Baier argues that we know when the presence of betrayal has violated trust as opposed to disappointment, the latter being the appropriate response in the case of mere reliance. Women who adopt a sickly appearance to convince their physicians that they are in pain might feel disappointed when their physicians fail to recognize that they are in pain because they relied on their physician's habit of offering treatment to women who appear sickly. They would not feel betrayed because betrayal is reserved for relationships involving trust.

Another objection might be that it should not matter if we choose the superstar physicians over the physicians with goodwill towards their patients because how would the patients even know that their physicians lack goodwill towards them. The opponents of the motive-based account may argue that what should matter in a trusting relationship should be responsiveness since we cannot determine someone's motivation. More importantly, they argue that these patients might well be open to trusting these superstar physicians because they are *responsive* to their needs and expectations, so it does not matter if these superstar physicians exhibit any form of goodwill towards their patients. This is the responsive view, and the *Stanford Encyclopedia* entry on Trust summarizes it as:

> The person trusting you expects you to have this reaction; in other words, they have a normative expectation that the "manifest fact of [their] reliance will weigh on you as a reason for choosing voluntarily to X" (McGeer and Pettit 2017: 16). This expectation is missing in cases of mere reliance. When I merely rely on you, I do not expect this fact (i.e., my reliance) to weigh on you as I do when I trust you (McLeod 2020).

To an extent, I agree with this view, as it is the second condition in the account of trust that I am advocating for. I think an account of responsiveness is important, and it is the second condition in Karen Jones' motive-based account on trust. However, I disagree with the notion that people do not take motivation into account when considering trusting others. There's evidence suggesting that female patients consider emotions, attitudes, tones, and motives when they convey information to their physician in the real-world setting. As mentioned in the case of testimonial smothering, patients have a difficult time conveying information to an audience that they anticipate will not be open to their testimony. Goodwill might make cases of testimonial smothering easier because goodwill is an attitude that shows benevolence which we tend to perceive as openness.

Furthermore, cases where *women smother their testimony* show that we can tell, to some extent, people's motivations towards us through what P. F. Strawson calls personal reactive attitudes. Personal reactive attitudes are, as he puts it, "attitudes belonging to involvement or participation with others in interpersonal human relationships" that include "resentment, gratitude, forgiveness, anger" (Strawson, 2008, pp. 10). To a large extent, these attitudes determine the sorts of readings or interpretations that we give to others' intentions. People may take attitude into consideration when deciding on being vulnerable. For instance, some women consider these reactive attitudes when evaluating the extent that a physician will trust their testimony.

Conclusively, I am not trying to argue for a motive-based account that will accommodate *all* forms of trusting relationships. I am mainly focused on a theory that brings out what female patients may be considering when they enter a trusting relationship. Moreover, the thought experiment is used as a tool to examine the question of whether motivation matters in a trusting physician-patient relationship. In the end, I reject two other non-motive-based theories on trust, showing that there are reasons to think that motivation of goodwill matters when developing a trusting relationship between physicians and patients.

In the next section, I explore the idea of establishing a climate of trust based on Karen Jones's motive-based account of trust. I argue that her account should resolve some of the issues hindering women from receiving treatment during the diagnostic process—namely issues (2) and (3).

Trust as an Affective Attitude

Trust, according to Jones, is to: (1) have an attitude of optimism on the goodwill and the competence of the entrusted and (2) have the entrusted be moved by the thought of being counted on. Trust under this account is not a simple belief. Rather, it is, as Jones puts it, an affective (i.e., emotional) attitude. Trust under this account cannot be willed, meaning we cannot choose to trust. In order to trust, we must be vulnerable to betrayal. If this model of trust is achieved, I think it should resolve the issue of testimonial injustice and testimonial smothering.

We want a climate of trust that allows for people to be vulnerable enough to experience betrayal. Of course, no one wants patients to be betrayed, but the potential for betrayal is an important indicator of a trusting relationship. An account of trust as goodwill would facilitate an even more open environment for patients to be vulnerable and open to more effective testimonial exchanges as well as betrayal. Since physicians tend to over psychologize their female patients' pain, these patients anticipating their physician's skepticism will withhold any information they think will be detrimental to their ability to be heard. Once we develop a trusting climate built on goodwill, we may resolve the issue of testimonial smothering.

Cases of testimonial smothering demonstrate that some women do take attitudes and motivations into account when deciding whom to trust. Carolyn McLeod illustrates this point, writing:

> [f]urther exploration into the nature of that attitude will reveal that it resembles an emotion, but not a belief, and an emotion that has particular perceptual and behavioral components. In trusting people, our attention is drawn toward features of their behavior that tend to confirm their trustworthiness, and we exhibit trusting patterns of behavior.

As previously discussed, when speaking to a physician, women may anticipate testimonial smothering ahead of time and employ drastic tactics to combat it based on the perceived ability of their physician to understand their testimony. Part of what causes testimonial silencing is this reading of the speaker's attitude towards the hearer. If physicians (hearer) demonstrate an attitude of goodwill towards the speaker, the speaker might consider it a sign of good faith towards their testimony, making it easier for the speaker (the female patients) to share their testimony and trust their physician with their bodies and knowledge.

Then from this optimism of goodwill, it is easier to see why a physician might be moved by the idea that the patient is counting on them. There are expectations for physicians to be competent and care about their obligations towards their patients in these relationships. Jones highlights this obligation:

> Isn't it enough for me to count as trusting my physician if I view her as a person of integrity and competence who cares about the interests of her patients? Why must I also expect that she will be responsive to my counting on her?" The answer is that we hope that what the physician takes to constitute acting with integrity and takes to constitute the interests of her patients will be, at least in part, shaped by the expectations of those patients. And if a physician refuses to allow the expectations of her patients to shape her understanding of what, here and now, good medical practice consists in, her patients would not be justified in trusting her. (This explains why a physician might have reservations about having someone as her patient: if she feels that she will have objections to living up to her patient's expectations, she will think it difficult to maintain the proper relationship of trust) (Jones, 1996, pp.10).

For physicians to be responsive, they would have to know what their patients wanted from them, listening to their needs and concerns. If they are responding to these needs, then it is unlikely for testimonial injustice to be possible. For physicians to be shaped by their patients' expectations, they must be cooperative, making it very unlikely that they would dismiss their patient's testimony. The requirement of knowing their patient's expectations and taking them into consideration requires that physicians listen to their patient's testimony with openness and care—this makes testimonial injustice an unlikely occurrence between physician and their patients. After all, they need to hear what our needs are to respond to them. The problem of silencing in this relationship is less likely to occur as successful communication is a necessary component to establishing a relationship of trust.

Taking these considerations together, the norm for a trustworthy relationship between a physician and their patient ought to be that both parties act in goodwill towards one another and that the thought will move the trustee (i.e., physician) that their patient is counting on them. Other accounts on trust disregard this attitude, along with the important role it plays in creating a relationship of trust between patients and physicians.

Jones' account may not work for other cases of trusting relationships, but, in this instance, it works well as a guide towards trying to create a better trusting relationship between physicians and their patients. It also explains why attitudes or perceived attitudes matter for trust and within the field of medicine while alleviating the problems posed by testimonial injustice and testimonial smothering.

As shown, a climate of trust—where the norm for a trusting relationship between physicians and patients should be modeled off Karen Jones' motive-based account of trust—could mediate some of these issues. When we put the onus on physicians to consider their attitudes and responsiveness to their patients, they will probably develop better trusting relationships with their patients. In the act of being more attentive towards their patients, they will have a better chance of coming off as open and responsive to their patients, making it easier for patients to engage in communication with their physician. I have argued that Jones's account can accommodate some of the things we may consider in a trusting relationship, focusing heavily on the role that motives play in the way we deliberate about trusting someone. In conclusion, this model of trust allows for the work that needs to be done to achieve more accurate information on patients and their pain by enabling a trusting relationship that is needed for physicians and patients to better communicate with one another.

Conclusion

My thesis was an argument in favor of establishing a climate of trust based on goodwill and responsiveness, which should help physicians and their female patients communicate effectively with one another in order to work together towards treatment for chronic pain. The problem that I addressed in this thesis was: *how can we address the phenomena of women not receiving adequate treatment for their chronic pain during the diagnostic process?* In Chapter One, I outlined the various potential problems that makes treating women's pain difficult, which included:

1. lack of research on women's health
2. the stigma of being emotional and the over psychologization of women's pain
3. physicians and/or other healthcare workers ignoring or devaluing testimony from female patients regarding their pain

I focused my research on points 2 and 3 because it pertains to the diagnostic process. I identify these two problems as being related to communication and trust during the diagnostic process.

Then, in Chapter Two, I discussed how the failure in communication and trust makes it difficult for physicians to treat women's pain. I introduced two epistemic harms that make communication difficult: (1) testimonial injustice and (2) testimonial smothering. I argued that physicians harm their patients when they dismiss their testimony solely on the basis of an identity stereotype. And in turn, these female patients, anticipating this dismissal, will resort to either not discussing their pain with their physician or they will truncate their own testimony as to only include information that they think their physicians will be more likely to understand. Both these epistemic harms are caused by a failure in effective communication and trust.

Lastly, I address this failure in trust and communication by advocating that we create a climate of trust based on Karen Jones' motive-based view on trust. This view took motives into consideration, which is something I argued is needed to establish a trusting relationship between physicians and their patients. I also showed how establishing a relationship of trust could resolve the epistemic problems of testimonial injustice and testimonial smothering because it would make it easier for patients and physicians to trust each other. Additionally, I hypothesized that this trusting relationship might be enough for both parties (i.e. physician and patient) to effectively communicate with one another. Once effective communication is achieved, we should resolve the problem of women not being treated for their pain during the diagnostic process.

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