

# Investigating Trust, Expertise, and Epistemic Injustice in Chronic Pain

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**Abstract** Trust is central to the therapeutic relationship, but the epistemic asymmetries between the expert healthcare provider and the patient make the patient, the trustor, vulnerable to the provider, the trustee. The narratives of pain sufferers provide helpful insights into the experience of pain at the juncture of trust, expert knowledge, and the therapeutic relationship. While stories of pain sufferers having their testimonies dismissed are well documented, pain sufferers continue to experience their testimonies as being epistemically downgraded. This kind of epistemic injustice has received limited treatment in bioethics. In this paper, we examine how a climate of distrust in pain management may facilitate what Fricker calls epistemic injustice. We critically interrogate the processes through which pain

sufferers are vulnerable to specific kinds of epistemic injustice, such as testimonial injustice. We also examine how healthcare institutions and practices privilege some kinds of evidence and ways of knowing while excluding certain patient testimonies from epistemic consideration. We argue that providers ought to avoid epistemic injustice in pain management by striving toward epistemic humility. Epistemic humility, as a form of epistemic justice, may be the kind disposition required to correct the harmful prejudices that may arise through testimonial exchange in chronic pain management.

**Keywords** Chronic pain · Epistemic injustice · Trust · Expertise · bioethics · Stigma

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## Introduction

Trust underpins human relationships. When one trusts another, one expects that the other is being honest and has good intentions. The provision of healthcare is grounded in trust and the trustworthiness of its professionals and institutions. In therapeutic relationships, healthcare providers (HCPs) are sought based on their epistemically privileged status—their expert knowledge, skills, and ability in addressing the health complaint. Despite a shared identification of the good—the health of the patient—the epistemic asymmetries between a HCP and a patient make the patient, the trustor, vulnerable to the HCP, the trustee.

The narratives of chronic pain sufferers provide helpful insights into the experience of pain at the juncture of

trust, expert knowledge, and the therapeutic relationship. In a medical culture that increasingly relies on objective indicators of disease processes, the clinical assessment of pain is challenging, particularly when the pathology, even if known, does not always correspond to the reported severity by the pain sufferer. Such subjectivity may prompt some HCPs to question the truthfulness of the pain sufferer's testimony, as symptoms may become viewed as embellished or contrived. When issues related to opioid management arise, such as addiction and overdose, pain sufferers may also be considered suspicious and untrustworthy. Since HCPs have the epistemic privilege to decide how patient narratives and symptoms should be managed, many pain sufferers report that their testimonies about their pain and experiences are discredited and considered irrelevant.

This unfair downgrading of credibility is what Miranda Fricker (2007) calls epistemic injustice, a type of harm that is done to individuals or groups regarding their ability to contribute to and benefit from knowledge. In particular, testimonial injustice happens when a prejudice causes a hearer to give less credibility to a speaker's testimony and interpretations than they deserve. Since there are major inequities in the prevalence, treatment, and outcomes for chronic pain across race, ethnicity, gender, and class, epistemic injustice may also be associated with distrust as well as broader patterns of stigma and social injustices. This coupled epistemic–ethical issue has received limited treatment in bioethics.

Drawing upon the social science and medical humanities literatures, we examine how a climate of distrust in pain management may facilitate epistemic injustice. We critically interrogate the processes through which pain sufferers are vulnerable to specific kinds of epistemic injustice. We examine how healthcare institutions and practices may privilege some kinds of evidence and ways of knowing over others. We argue that HCPs ought to avoid epistemic injustice by striving toward epistemic humility as a form of epistemic justice. Being epistemically humble means correcting for prejudicial credibility judgements by recognizing that medical decisions are almost always accompanied by uncertainty and that the testimonies of pain sufferers can help complete the clinical scenario. Importantly, an epistemically humble approach recognizes patient testimony and illness interpretations as epistemically privileged in determining the best clinical management.

## Trust in Healthcare

Trust is an essential feature of the therapeutic relationship, given that the provider–patient relationship is a “peculiar constellation of urgency, intimacy, unavoidability, unpredictability, and extraordinary vulnerability” (Pellegrino 1991, 84). As Annette Baier (1986) explains, when we trust another, we expect that the good will and competence of the other will govern our interaction as appropriate for the relationship. Trust is intrinsically important because it is a core characteristic that affects the emotional and interpersonal aspects of the physician–patient relationship (Hall 2005). In facing complex clinical information and navigating through the healthcare system, many patients are overwhelmed. They require assistance to understand their situation as well as to restore or maintain their functioning or well-being, and it is only when they trust their HCPs that these professionals can help the patients achieve their care goals (Ho 2011). As an instrumental value, trust is widely believed to be essential for effective therapeutic encounters (Hall 2005). Without assumptions of competence and goodwill, patients would unlikely allow close physical contact or agree to recommended treatments that may have significant side effects and risks. Patients trust HCPs when they believe in these professionals' qualification and motivations. Since HCPs are often gatekeepers of resources and are the only ones with the official credentials to treat patients, if they are not trustworthy, patients would be vulnerable to betrayal (Baier 1986; Rogers 2002). Motivations that are not based significantly on patients' welfare or may even counter their good are generally considered conflicts of interest that detract from the professionals' trustworthiness and undermine the fiduciary provider–patient relationship.

## Trust and Medical Expertise

Trust in the therapeutic relationship is often taken for granted partly because of two forms of epistemic hierarchy. First, professionals' specialized training bestows on them a substantial body of knowledge and skills in their clinical domain; the resulting epistemological gap gives *prima facie* reasons for patients who cannot adequately assess the evidence in this domain to accept HCPs' judgement about such data (Goldman 2001). Healthcare providers of all professional backgrounds, by virtue of their intensive and ongoing education and

practice, presumably have superior ability to accurately diagnose and determine a range of possible solutions for various medical problems. Laypersons generally lack comparable levels of specialized training or knowledge. Epistemic dependence in this context of “intra-method” epistemic hierarchy (Ho 2011) is arguably rational or even the responsible choice (Hardwig 1985).

Second, clinical methods have traditionally and systematically been seen as the most reliable methods in determining medical management strategies, creating and reinforcing an “inter-method” hierarchy by directly or indirectly conferring more credibility upon those who practice the privileged approach(es) (Ho 2011). In the age of evidence-based medicine, medical experts can arguably predict the respective health consequences from the use of various technologies or medications by appealing to systematic reviews of double-blind, placebo-controlled trials and meta-analyses. They can also utilize their knowledge and clinical skills to help prevent or reverse symptom progression. Lay patients’ beliefs in specialized areas are relatively uninformed, unreliable, and untested according to rigorous scientific standards (Hardwig 1985, 340). With both forms of epistemic hierarchy, HCPs are considered to be more credible than their patients to decide what medical options would be in the latter’s best interests.

When formalized or institutionalized, HCPs’ epistemic hierarchy also solidifies their social authority on the matter (Ho 2009). Medical experts’ opinion on health-related matters, including how chronic pain is to be diagnosed and treated, hold power to persuade individual and court decisions, public opinions or expectations, and healthcare policies. Being the authority on the matter, experts also have the prerogative to reject patients’ claims as not credible according to the former’s chosen scientific frameworks. While many well-intended professionals would also consult their patients regarding their needs and perspectives as part of process of obtaining informed consent, they are not bound to provide patients their desired interventions if they conflict with HCPs’ clinical judgement (Whitney and McCullough 2007). Their expert status bestows them the authority to override patients’ self-reported experience or preferred methods of management.

There are good *prima facie* reasons to entrust professionals’ clinical expertise in making treatment and related social decisions. Healthcare providers are members of the helping professions, and because the bioethical principles of respect for autonomy, non-maleficence,

and beneficence are generally accepted in Western bioethics (Beauchamp and Childress 2008), we take HCPs’ good will and commitment to use their epistemic advantage to patients’ benefit for granted. We generally trust HCPs, assuming that they would not subject patients to any unnecessary harm, and that they would diagnose and treat patients competently according to the latter’s interests (Hall 2001). At a social level, the ethical principle of distributive justice suggests that physicians also have a responsibility to allocate limited social or public resources based on sound evidence in manners that are fair and equitable (The Good Stewardship Working Group 2011).

Nonetheless, the processes of naming pain conditions, diagnosing patients, and determining appropriate interventions, even when employed by experts, are value-laden. Diagnostic and therapeutic processes are not simply clinical or technical exercises—they are also social and political processes. Our descriptions of pathophysiological and experiential phenomena depend on which clusters of signs and symptoms we see as constituting a disease and which we choose to interpret as irrelevant (Stempsey 2000, 98–100). Healthcare providers’ social environment, personal background, worldview, and other values also influence how they observe their patients’ symptoms, how they investigate and interpret their histories, what diagnoses they offer for reported and observed symptoms, and what among the increasing number of treatment options they recommend. It is within this complex combination of social and institutional structure, historical and economic realities, medical advances, as well as power relations that medical experts define issues and goals.

As respect for patient autonomy and informed consent become the ethical foundations of western healthcare, there is an increasing attention to patients’ own competence and role in contributing to treatment decision-making (Sandman and Munthe 2009). Since patients are the ones who experience their own symptoms and ailments, and generally have the most to lose in times of sickness, their assessment of their overall illness context and goals are now accepted as essential in shared decision-making, raising questions of how we should balance trust in HCPs’ expertise and trust in patients’ own perspectives and experience. Patients and others are expected to trust the experts’ competence and goodwill but not vice versa. Even though doctors generally assume that their patients are providing a relatively accurate account of their concerns, some

feminist bioethicists have pointed out that the latter's reports and motives may be distrusted (McLeod 2002), especially if their symptoms such as pain do not have a corresponding and accepted physical sign (Rogers 2002). Even as medical professionals generally attend to patients under highly specific circumstances (e.g., in clinics and hospitals) for very short periods of time, their "objective" assessments are often considered categorically superior to patients' own accounts. Patients who do not follow the HCP's clinical recommendations to overcome or manage their symptoms and conditions are often considered noncompliant and untrustworthy and may lose eligibility to financial or even medical assistance (Pfeiffer 2000, 98).

### Chronic Pain and Epistemic Hierarchies

Epistemic issues are at the core of what it means to experience pain. As Scarry (1985) famously noted, pain is simultaneously the most privately certain and publicly doubted phenomena. Undoubtedly, the difficulty pain sufferers experience in expressing pain is part of the problem (Biro 2010). Although pain can be shared intersubjectively (van Hooff 2003), it also has enormous capacity to destroy language and to silence it (Scarry 1985). Pain sufferers frequently report difficulty in communicating their pain to others, which, in the case of HCPs, can exacerbate the trust problems noted above.

Ethnographies and qualitative studies of chronic pain in Western contexts make clear that doubt and scepticism regarding the existence, scope, and legitimacy of pain are common and persistent. Such doubt flows from all participants in cultures of pain: HCPs, caregivers, fellow pain sufferers, and even pain sufferers themselves (Goldberg 2010). Although there are almost certainly multiple reasons why pain is a nexus of doubt and incredulity, pain studies scholars, providers, and pain sufferers themselves all identify the subjectivity of pain as a core factor.

But what does subjectivity mean in this context? The respective concepts of objectivity and subjectivity at play here have been insufficiently theorized in pain studies. The idea of objectivity itself has an important history, and its meaning in present parlance can be read according to that history and its influence on contemporary understandings. Here we track Daston and Galison's (2007) influential historical taxonomy of the idea of objectivity in the early modern and modern

West. The particular model that seems most directly to apply to assertions of the subjectivity of pain is what Daston and Galison identify as mechanical objectivity. This model has two central features: first, knowledge produced via natural investigation has its truth status determined by the extent to which the investigator's subjective influence is removed from the knowledge-making process; and second, the primary goal of the investigator is to represent the scientific object *just as* it appears in its most natural state—no matter how imperfect that object may be in such a state.

How does this apply to pain? We can see ideals of mechanical objectivity in the epistemic anxiety that stakeholders voice as to pain. Especially in chronic pain discourse, the natural object *does not* always reveal the truth of the assertion: the patient's symptoms do not correlate with any visible scientific object. Thus, pain defies the process of clinical correlation that is central to the anatomico-clinical method. When a person injured in a motor vehicle accident reports being unable to put pressure on their leg, and the HCP sees the fracture on the X-ray, the person's complaints can be clinically correlated with a dysmorphology. But chronic pain often frustrates this process—many, if not most kinds of chronic pain cannot be correlated with any underlying pathology. The epistemic structure of Western allopathic medicine—its claims to truth and veracity—depends on frameworks of clinical correlation and pathological anatomy. As physician-historian Robert Martensen (2004) explains, the "central reliance on anatomical learning is Western medicine's most distinctive knowledge-making characteristic." When chronic pain impedes the production of clinical knowledge by defying the easy objectification that is at the core of the epistemology of Western biomedicine, it becomes subject to doubt and scepticism. Epistemic agents cannot see the visible pathologies that correlate with this particular illness complaint. Often enough, this epistemic problem leads to metaphysical doubt regarding the existence of the illness itself.

Perhaps unsurprisingly, then, significant resources continue to be expended on efforts to 'visibilize' pain in the natural objects inside the body, those below what Foucault (1994) termed "the tissual surface." For example, a team lead by Tor Wager earned international headlines in 2013 for a study in which functional magnetic resonance imaging of the brain was deployed to successfully predict acute pain among the participants. Of course, Wager et al. cautioned that the study featured

a small sample, evaluated only acute pain stimuli, and was not remotely close to clinical validation (Wager et al. 2013). An accompanying editorial directly referenced the frames of subjectivity and objectivity noted above and highlighted the epistemic significance:

We comprehend our own pain only as a subjective phenomenon and recognize that the experience and affective display of pain differ from person to person and from culture to culture. Physicians are flummoxed by pain because of a paucity of objective manifestations and are reduced to using clinical instruments, such as the visual-analogue scale to quantitate pain. (Jaillard and Ropper 2013)

The authors of the editorial, however, contend that ultimately the pain sufferer remains the authority on the existence and nature of pain; another neuroscientist studying pain and neuroimaging voiced concern over the danger of an attempt to “rule out that somebody is in pain” (Kwon 2016, ¶2 under “Beyond the Blobs”). We submit that whatever utility may eventually be derived from the use of neuroimaging techniques as to pain, the true problem lies in continuing to legitimize the very epistemic processes that seem to fuel so much scepticism and doubt as to pain (Goldberg 2014). That is, finding the holy grail of an imaging technique that enables us to objectify pain merely reinforces the processes of objectification that are in part *responsible* for the epistemic injustice so many pain sufferers experience in their capacity as knowers.

### Epistemic Injustice

Fricker (2007, 2012) argues that a distinctively epistemic type of injustice occurs when people—individuals or social groups—may be wronged in their capacity as transmitters of knowledge. This kind of epistemic injustice is discriminatory and can occur in one of the following two ways. First, discriminatory epistemic injustice can occur when a person’s or group’s capacity as knowers is unfairly downgraded. A hearer’s prejudicial stereotyping causes the listener to attribute a reduced level of credibility to a speaker’s testimony than they otherwise would have given if the prejudice was not present. This does not mean that the speaker is always disbelieved but rather is taken less seriously. This unfair accusation is referred to as *testimonial injustice*. Second,

discriminatory epistemic injustice can happen when there is a gap in the economy of collective interpretive resources that disadvantages the speaker when they are trying to make sense of their experiences. This *hermeneutical injustice* occurs at a prior stage when someone experiences an event, such as sexual harassment, in a culture that lacks that concept. Fricker (2012) notes that epistemic injustice may also be of the distributive kind, where this is an unfair distribution of epistemic goods in society. We only focus on discriminatory epistemic injustices in this paper.

### The Relationship Between Epistemic Injustice, Trust, and Chronic Pain

Epistemic injustice, trust, and trustworthiness are closely linked. Kleinman (1988) observes,

... [i]f there is a single experience shared by virtually all chronic pain patients it is at some point those around them—chiefly practitioners, but also at times family members—come to question the authenticity of the patient’s experience of pain. (57)

Such questioning is associated with concerns about certainty as it relates to objectively unverifiable symptoms. Scheman (2001) refers to this phenomenon in relation to scientific objectivity as trustworthiness: objective judgements of clinical medicine are understood as judgements that can be rationally trusted. In the pain management context, the operation by which mechanical objectivity is mobilized as the primary criterion for trustworthiness raises questions about who or what should be trusted and under what circumstances.

Given the epistemic significance of the framework of mechanical objectivity, where pain does not necessarily have a corresponding and accepted physical signal, the pain sufferer’s testimony may not be considered epistemically competent. This is particularly likely in cases where the perceived severity of pain as reported by the patient seems far from a reliable account (e.g., the HCP suspects that the patient is malingering). Where uncertainty exists, HCPs may feel unconfident to address the patient’s pain needs or may be suspicious of the patient’s motivations for seeking care. Providers may resort to distrust of patients whose pain symptoms cannot be objectively verified. Where their experience is perceived to lack credibility, the pain sufferer might perceive the presumed scientific objectivity of medicine to be valued

more than their own lived experience (Rich 1997; Honkasalo 2001). These negative interactions may contribute to the perception by pain sufferers that they are being questioned as a trustworthy source of information (Marbach et al. 1990; Osborn and Smith 1998).

### Chronic Pain, Trust, and Identity-Prejudicial Credibility Deficit

In the clinical encounter, a pain sufferer is vulnerable to the expert HCPs actions that can have an impact—positive or negative—on their welfare. For example, a pain sufferer may be accused of lying about diverting prescribed opioids despite the lack of counter-evidence that demonstrates that diversion occurred. This illustrates the central case of testimonial injustice, what Fricker refers to as an identity-prejudicial credibility deficit. For this specific prejudice to occur, heuristics are invoked to assess the trustworthiness of another individual. An identity-prejudicial credibility deficit might unfavourably bias the HCP's judgement of the pain sufferer's narrative. If a pain sufferers believe that they have been given less credibility than they deserve, the pain sufferer may feel unfairly distrusted. This testimonial injustice is particularly problematic as it may impair the pain sufferer's ability to negotiate certain aspects of their care in the future.

People living with chronic pain have been considered systematically less credible in clinical encounters as compared to medical experts. Green et al. (2003) have documented that the credibility of the patient's report of pain is more likely to be questioned in socially marginalized populations, thereby raising questions of social justice. It is well established that the burden of chronic pain is greater for persons from disadvantaged socioeconomic groups than for persons from more privileged socioeconomic groups. Some HCPs may be more suspicious of certain requests of persons from marginalized populations, such as requests for an increased dose of opioid medications (Barry et al. 2010). Likewise, a person from a marginalized population may be suspicious about what the HCP thinks of a request and how his or her moral character is assessed (Govier 1997). This may be particularly relevant for pain sufferers who in previous healthcare encounters were accused of exaggerating their pain or malingering. Pain sufferers may feel confused and doubtful and both parties may be wary of the other, fostering mutual distrust (Miller 2007).

People living with pain—especially those without concurrent substance use problems—may not have experienced a distrusting therapeutic relationship when they first began to receive treatment. Given the climate of distrust in pain management, pain sufferers may quickly learn that their identity as a trusted patient in other healthcare relationships may not translate to the pain management context (Buchman, Ho, and Illes 2016).

### Narrative Accounts of Pain Sufferers

The interrelatedness of trust and discriminatory epistemic injustice in chronic pain management is supported by past humanities and social science research associated with trust and integrity of testimony. A study on public trust in healthcare by Calnan and Sanford (2004) suggests that a major influence of trust in the patient–provider relationship is the patient perception that healthcare providers take their testimony to be credible. It has been shown previously that not being believed or taken seriously is a common experience among those living with chronic pain (Jackson 1992; Clarke and Iphofen 2005; Toye and Barker 2010). Kleinman (1992) writes, what is “[a]bsolute private certainty to the sufferer, pain may become absolute public doubt to the observer. The upshot is often a pervasive distrust that undermines family as well as clinical relationships” (5). A desire to avoid “pervasive distrust” may be what really matters to persons living with pain, as they strive for their claims to be considered credible and their character considered trustworthy.

Werner and Malterud's 2003 study of female musculoskeletal pain sufferers provides a particularly salient example of distrust and epistemic injustice in the context of pain. The informants

... invested much work, time, and energy before or during the encounters in order to be perceived as a credible patient. By trying out various strategies such as appropriate assertiveness, surrendering, and appearance, they attempted to fit in with normative, biomedical expectations of what was “just right.” (1412)

Ethnographic research suggests that patients will rely on such strategies or “social performances” (Brodwin

1992, 72) in order for their testimonies to be perceived as trustworthy.

The effort to behave like a credible patient is only necessary where there is a substantial risk of being perceived as lacking credibility. Despite significant effort, the informants “repeatedly find themselves being questioned, particularly by doctors, and judged to be either not sick or suffering from an imaginary illness” (Werner and Malterud 2003, 1414). In this way, a lack of credibility is associated with a lack of trustworthiness. Of course, the fact that the informants’ pain defies objectification is a crucial part of what creates the credibility gap to begin with. Playing the credible—and trustworthy—patient is almost certainly easier where discrete, visible pathologies can be correlated with an illness sufferer’s complaints (Rhodes et al. 1999).

Moreover, this scrutiny and the efforts involved are also highly gendered, a vulnerability that is at the core of Fricker’s framework: some identities render individuals and communities more or less likely to be subject to testimonial injustice. Historians of pain uniformly agree that only some voices and narratives of pain tend to be heard in any given time and place (Moscoso 2012; Bourke 2014; Boddice 2015). When it comes to pain, the voices of marginalized groups such as women, children, and people of colour (Wailoo 1996, 2014) have long been silenced or ignored. These and other disadvantaged social statuses are therefore important markers of trust and epistemic injustice as to pain. Moreover, as Joanna Bourke puts it, the question of

... “whose pain is heard” is not only *correlated with* power differentials between groups ... patients considered to be “truly” in pain are also *directly constituted* by those differentials. The belief that not every person-in-pain suffers to the same degree is intrinsic to hierarchical systems generally. (Bourke 2014, 230)

Pain frustrates dominant models of mechanical objectivity within biomedical cultures. It evades the clinical gaze that stands as a powerful truth-making criterion in such cultures. For example, in her pain autopathography Lous Heshusius (2009) questions whether she might derive any benefit in being truthful to physicians about her pain. She narrates, “... we fear the doctor will not really believe us anyway, for how can we convincingly tell of this pain they can neither see nor measure?” (2009, 78). Two narrative examples from HCPs that

reinforce this view come from Buchman, Ho, and Illes’ study of trust and pain management. One physician participant stated, “... when I see a patient who has, you know, a pathological fracture on a X-ray ... if there’s something objectively definable it does change the way that I approach the patient” (7). Another physician reported, “we have all had experiences where ... there’s been a discrepancy between what [patients] report and what we see [on imaging]. And, unfortunately, it is a very distrusting relationship inherently” (Buchman, Ho, and Illes 2016, 7). It is therefore unsurprising that so many chronic pain sufferers have for so much of the modern era been wronged in their capacity as knowers, been subject to testimonial injustice. Moreover, like many instantiations, this form of epistemic injustice tracks closely social power structures, suggesting that already-disadvantaged groups are increasingly likely to have their pain delegitimized and doubted.

In addition, the link between epistemic injustice and patterns of domination and oppression suggest conceptual overlap with stigma; a phenomenon that is unfortunately all too common an experience for pain sufferers. Link and Phelan’s model of health stigma (2001, 2006) emphasizes the close connections between social power and patterns of stigma: Which groups are most likely to be stigmatized? And how severe will that stigma experience be? Link, Phelan, and colleagues working on their model have even taken to using the term “structural stigma” to emphasize the robust evidence suggesting that already-marginalized groups are disproportionately likely to experience stigma. Although obviously not all pain sufferers are marginalized—some would no doubt reject the label—many of the groups most likely to have their pain treated poorly are already subject to structural oppression. In the United States, for example, the elderly, women, veterans, and African-Americans are only a few of the social groups who endure worse treatment for their pain than members of dominant groups (Institute of Medicine 2011). Racial pain inequalities are particularly evident and troubling in the United States, resting on a long history in which Black bodies were regarded as subhuman and insensible to pain (Wailoo 1996, 2014; Hoffman, Trawalter, and Axt 2016).

### Toward Epistemic Humility in Pain Management

We believe that the participation of pain sufferers in the therapeutic dialogue has both epistemological and

ethical importance. We also argue that HCPs ought to repair damaged or lost trust with pain sufferers and correct testimonial injustices, by striving toward a disposition of epistemic humility. We believe that responsibility for epistemic humility is situated with the HCP more so than the pain sufferer given the power hierarchy in the therapeutic relationship. However, we also contend that pain sufferers, as participants in a relationship, also have responsibilities to demonstrate veracity and trustworthiness.

In the healthcare context, epistemic humility is an approach that calls for partnership and dialogue between patient and HCP in a deliberative decision-making process (Ho 2009, 2011; Buchman and Ho 2013). Epistemic humility requires HCPs to adopt a disposition, or an attitude, that allows room for balancing clinical evidence, professional judgement, and patients' perspectives. Epistemic humility is intentionally collaborative, as "both the HCP and patient are counting on each other in investigating a full picture of the patient's experience and determining the most appropriate management strategies" (Ho 2011, 117). While HCPs possess expert knowledge in pain management, they do not have direct access to their patients' experiences. In search of the most appropriate clinical approach, epistemic humility requires an inquiry into the patient experience. For example, the HCP can invite the patient to tell her story and embrace a willingness to incorporate the patient's narrative into her professional worldview (Atkins 2000).

Epistemic humility does not reject clinical expertise. Rather, epistemic humility encourages HCPs to consider the limits of clinical expertise, especially where there is uncertainty or incomplete knowledge about a clinical situation. Moreover, striving for epistemic humility does not require HCPs to trust all patients at all times—trusting unreflectively can be harmful. Instead, epistemic humility requires HCPs to demonstrate a genuine interest and inquiry into the patient experience, critical reflection about the assumptions made about the trustworthiness of pain sufferers, as well as prejudices that shape credibility judgements. Accordingly, epistemic humility is a commitment to continuous responsiveness to the patient's experience and recognition of the limitations of applying clinical expertise to different forms of clinical decision-making (Upshur and Colak 2003; Ho 2011). It is a process and practice that allows for the repair of damaged trust and the demonstration of professional trustworthiness.

Given that structural and psychosocial characteristics of the patient may influence HCP judgements about the claims of pain sufferers, a curious, morally self-reflective stance is critical to epistemic humility. By acknowledging the value of the pain sufferers' perspectives and providing patients with a constructive means of participating in their care decisions, a commitment to epistemic humility may help to minimize the power asymmetry in the therapeutic relationship and help minimize other forms of injustices that pain sufferers may face.

### Epistemic Humility as Epistemic Justice

Miranda Fricker (2007) defines epistemic justice as a hybrid epistemic–ethical virtue that a hearer possesses in order to counterbalance the impact of prejudice in their credibility judgements. Like most intellectual virtues, epistemic justice is acquired through repeated efforts of critical reflection. The virtuous hearer is "someone whose testimonial sensibility has been suitably reconditioned by sufficient corrective experiences so that it now reliably issues in ready-corrected judgments of credibility" (Fricker 2007, 97). Epistemic humility, then, may be the kind of disposition required to correct the harmful prejudices that might arise through testimonial exchange in chronic pain management.

Epistemic humility requires HCPs to critically evaluate the implicit assumptions inherent in the anatomical method, especially as this method categorically privileges certain kinds of knowing over others (e.g., the objective MRI results over the subjective patient testimony). Greenhalgh (2001) observed in her pain autoethnography that even though HCPs are not the experts about the patient's own complex illness narratives, they generally place their scientific and medical narratives in an epistemically higher position than patients' narratives. Indeed, Fricker (2007) points out that marginalized populations exist in an epistemically privileged position with regard to their own experiences of domination and oppression; as such, silencing their narratives strips already-disadvantaged groups of another form of agency and dignity. This is particularly critical insofar as pain management practices regard as virtually axiomatic the notion that the pain sufferer's subjective self-report is the most important tool in diagnosis. Perpetuating the established epistemic hierarchy and neglecting the lived expertise of the pain sufferer may communicate the message that pain sufferers do not



have an epistemically and morally equal claim in negotiating their care. Howard Brody (1994) has argued persuasively that one of the most powerful ways in which HCPs can wield their greater social power for good is by answering the illness sufferer's cry: "My story is broken; can you help me fix it?" Other scholars of narrative medicine such as Kleinman, Frank, and Charon have argued that creating space for illness sufferers to tell their stories can reduce power imbalances that nurture epistemic injustice.

In addition to acknowledging pain sufferers' lived experiences, a HCP who aims for epistemic humility can also reconsider the concepts and paradigms that drive the discourse and practice of pain management, including underlying epistemic and ethical assumptions. These discursive concepts include binary terms often used in pain management such as objective/subjective, legitimate/illegitimate, real/unreal, and normal/abnormal. Healthcare providers can also examine how continued use of such binary terms may continue to deflate the credibility of pain sufferers. One important part of contesting the use of these binary terms in clinical practice is for HCPs to be cognizant of how such terms may work as explanatory tools to prematurely discredit the patient's testimony and dismiss the patient's credibility as a trustworthy informant (Fricker 2007; Cohen, Quintnan, and Buchanan 2011). By recognizing that the line that separates binary terms is blurry, HCPs can critically evaluate and modify mistaken dichotomies accordingly.

### Challenges to Epistemic Humility

We have identified three potential challenges in motivating HCPs to adopt an attitude of epistemic humility in chronic pain management. The first challenge relates to the conflicting obligations HCPs face in providing care for patients living with pain, especially when the pain sufferer is also living with addiction and mental illness. As Geppert (2004) explains, many physicians struggle to treat chronic pain and prevent iatrogenic addiction in the midst of mixed messages from the government, professional organizations, and the media. What is more, the increasing public health crisis involving prescription opioids further complicates HCP duties and obligations. Such uncertainty about how to address risks associated with opioids challenges HCPs to provide both compassionate and adequate treatment, while also preventing harms. These conflicting duties

pose a problem for epistemic humility when a HCP may be inclined to adopt a default position of distrust with all patients after being "burned" by a deceptive patient (Crowley-Matoka, 2012; Buchman, Ho, and Illes 2016).

The second challenge is that epistemic humility requires the HCP to be empathic and compassionate in inviting the pain sufferer to tell their story. Physicians, for example, have historically been taught that empathy—a subjective attitude—was an impediment to clinical diagnosis, an objective exercise (Halpern 2001). Bearing witness to patient stories of pain and being responsive to them requires training and skill (Charon 2006), and even well-intentioned HCPs may not have the necessary clinical-emotional competencies. Recommendations to enhance empathy in medicine range from increasing humanities content in undergraduate medical education (Geppert 2008; Peterkin 2008) to exposing first-year medical students to classical texts, poetry, the arts, history, and philosophy (Shapiro, Morrison, and Boker 2004). However, these programmes have shown limited evidence of beneficial long-term impacts (Ousager and Johannessen 2010).

A third challenge in motivating epistemic humility is that caring for patients with pain can be demanding. Many providers are overworked and overburdened (Matthias et al. 2010). Opportunities to hold compassionate and empathic dialogues regarding the patient's pain concerns in an emotionally charged context can be limited. In short office visits, "physicians are expected to form partnerships with patients and their families, address complex acute and chronic biomedical and psychosocial problems, provide preventive care, coordinate care with specialists, and ensure informed decision-making that respects patients' needs and preferences" (Fiscella and Epstein 2008). Taken together, these factors may present obstacles in HCPs being able to possess epistemic humility.

Not all pain sufferers desire to be active participants in their care, and not all pain sufferers will be capable of contributing testimony in the way we have described. Since both the pain sufferer and the HCP's perspectives are necessary in constructing appropriate care plans, the pain sufferer's lived experience ought to be in an epistemic equilibrium with the expertise of the HCP. If such epistemic justice can be achieved, patients and HCPs may be able to engage in a bilateral and collaborative approach to pain management.

## Conclusions

This paper critically explored the juncture of trust, expert knowledge, and pain management, by highlighting how a specific form of epistemic injustice called testimonial injustice has become endemic to the care experiences of many pain sufferers. We argued that epistemic injustice may characterize the experiences of pain sufferers when they try to have their voices heard by expert HCPs, describe their lived experiences, or disclose their values and treatment preferences (Carel and Kidd 2014; Buchman, Ho, and Illes 2016). Concerns about the apparent subjectivity of pain and the tendency of such pain to frustrate processes of objectification that literally underpin the epistemic foundations of Western biomedicine also likely contribute to epistemic injustice of pain sufferers as well as a climate of distrust in pain management.

Ethically, it is critical that the discourse and practice of pain management do not continue to marginalize the voices of those who are considered to reside outside of the accepted epistemic community. If HCPs demonstrate a willingness to listen to and amplify the stories of pain sufferers, it may signify a commitment to epistemic humility, trust, and demonstrate that these individuals are valued members of the epistemic community. If HCPs correct for prejudicial credibility judgments, it may be one way to demonstrate trustworthiness and good will and ultimately epistemic justice in pain management.

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## References

Atkins, K. 2000. Autonomy and the subjective character of experience. *Journal of Applied Philosophy* 17(1): 71–79.

Baier, A. 1986. Trust and antitrust. *Ethics* 96(2): 231–260.

Bary, D.T., K.S. Irvin, E.S. Jones, et al. 2010. Opioids, chronic pain, and addiction in primary care. *The Journal of Pain* 11(12): 1442–1450.

Beauchamp, T., and J. Childress. 2008. *Principles of biomedical ethics*. 6th ed. New York: Oxford University Press.

Biro, D. 2010. *The language of pain: Finding words, compassion, and relief*. New York: W.W. Norton & Company.

Boddice, R. 2015. *Pain: A very short introduction*. New York: Oxford University Press.

Bourke, J. 2014. *The story of pain: From prayer to painkillers*. New York: Oxford University Press.

Brodwin, P.E. 1992. Symptoms and social performances: The case of Diane Reden. In *Pain as human experience: An anthropological perspective*, edited by M.-J. Delvecchio Good, P.E. Brodwin, B.J. Good, and A. Kleinman, 77–99. Berkeley: University of California Press.

Brody, H. 1994. “My story is broken; can you help me fix it?” Medical ethics and the joint construction of narrative. *Literature and Medicine* 13(1): 79–92.

Buchman, D.Z., and A. Ho. 2013. What’s trust got to do with it? Revisiting opioid contracts. *Journal of Medical Ethics* 40(10): 673–677.

Buchman, D.Z., A. Ho, and J. Illes. 2016. You present like a drug addict: Patient and clinician perspectives on trust and trustworthiness in chronic pain management. *Pain Medicine*, ePub ahead of print.

Calnan, M.W., and E. Sanford. 2004. Public trust in health care: The system or the doctor? *Quality and Safety in Health Care* 13(2): 92–97.

Carel, H., and I.J. Kidd. 2014. Epistemic injustice in healthcare: A philosophical analysis. *Medicine, Healthcare and Philosophy* 17(4): 529–540.

Charon, R. 2006. *Narrative medicine: Honoring the stories of illness*. New York, NY: Oxford University Press.

Clarke, K.A., and R. Iphofen. 2005. Believing the patient with chronic pain: A review of the literature. *British Journal of Nursing* 14(9): 490–493.

Cohen, M., J. Quintner, and D. Buchanan. 2011. Stigmatization of patients with chronic pain: The extinction of empathy. *Pain Medicine* 12(11): 1637–1643.

Crowley-Matoka, M. 2012. No one wants to be the candy man: Ambivalent medicalization and clinician subjectivity in pain management. *Cultural Anthropology* 27(4): 689–712.

Daston, L., and P. Galison. 2007. *Objectivity*. New York: Zone Books.

Fiscella, K., and R.M. Epstein. 2008. So much to do, so little time: Care for the socially disadvantaged and the 15-minute visit. *Archives of Internal Medicine* 168(17): 1843–1852.

Foucault, M. 1994. *The birth of the clinic: An archaeology of medical perception*. Translated by A.M.S. Sheridan. New York: Vintage Books.

Fricker, M. 2007. *Epistemic injustice: The power and ethics of knowing*. Oxford, U.K: Oxford University Press.

———. 2012. Epistemic justice as a condition of political freedom? *Synthese* 190(7): 1317–1332.

Geppert, C.M. 2004. To help and not to harm: Ethical issues in the treatment of chronic pain in patients with substance use disorders. In *Pain and depression: An interdisciplinary patient-centered approach*, edited by M.R. Clark, and G.J. Treisman, 151–171.

———. 2008. Why psychiatrists should read the humanities. *Psychiatric Times*. February 1. <http://www.psychiatrictimes.com/articles/why-psychiatrists-should-read-humanities>. Accessed May 31, 2016.

Goldberg, D.S. 2010. Job and the stigmatization of chronic pain. *Perspectives in Biology & Medicine* 53(3): 425–438.

———. 2014. *The bioethics of pain management: Beyond opioids*. New York: Routledge.

- Goldman, A. 2001. Experts: Which ones should you trust? *Philosophy and Phenomenological Research* 63(1): 85–110.
- Govier, T. 1997. *Self-trust and human communities*. Montreal and Kingston: McGill–Queen’s University Press.
- Green, C.R., K.O. Anderson, T.A. Baker, et al. 2003. The unequal burden of pain: confronting racial and ethnic disparities in pain. *Pain Medicine* 4(3): 277–294.
- Greenhalgh, S. 2001. *Under the medical gaze: Facts and fictions of chronic pain*. Berkeley, CA: University of California Press.
- Hall, M. 2001. Arrow on trust. *Journal of Health Politics, Policy and Law* 26(5): 1131–1144.
- . 2005. The importance of trust for ethics, law, and public policy. *Cambridge Quarterly of Healthcare Ethics* 14(2): 156–167.
- Halpern, J. 2001. *From detached concern to empathy: Humanizing medical practice*. Oxford, UK: Oxford University Press.
- Hardwig, J. 1985. Epistemic dependence. *The Journal of Philosophy* 82(7): 335–349.
- Heshusius, L. 2009. *Inside chronic pain: An intimate and critical account*. Ithaca: Cornell University Press.
- Ho, A. 2009. “They just don’t get it!” When family disagrees with expert opinion. *Journal of Medical Ethics* 35(8): 497–501.
- . 2011. Trusting experts and epistemic humility in disability. *The International Journal of Feminist Approaches to Bioethics* 4(Fall 2): 102–124.
- Hoffman, K.M., S. Trawalter, and J.R. Axt. 2016. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, 201516047.
- Honkasalo, M-L. 2001. Vicissitudes of pain and suffering: Chronic pain and liminality. *Medical Anthropology* 19(4): 319–353.
- Institute of Medicine. 2011. *Relieving pain in America: A blueprint for transforming prevention, care, education, and research*. Washington, DC: The National Academies Press.
- Jackson, J.E. 1992. “After a while no one believes you”: Real and unreal pain. In *Pain as human experience: An anthropological perspective*, edited by M.-J. Delvecchio Good, P.E. Brodwin, B.J. Good, and A. Kleinman, 138–168. Berkeley, CA: University of California Press.
- Jaillard, A., and A.H. Ropper. 2013. Pain, heat, and emotion with functional MRI. *New England Journal of Medicine* 368: 1447–1449.
- Kleinman, A. 1988. *The illness narratives: Suffering, healing, & the human condition*. New York, NY: Basic Books.
- . 1992. Pain and resistance: The delegitimation and re-legitimation of local worlds. In *Pain as human experience: An anthropological perspective*, edited by M.-J. Delvecchio Good, P.E. Brodwin, B.J. Good, and A. Kleinman, 169–197. Berkeley, CA: University of California Press.
- Kwon, D. 2016. The battle over pain in the brain. *Scientific American*, April 28. <http://www.scientificamerican.com/article/the-battle-over-pain-in-the-brain/>. Accessed June 2, 2016.
- Link, B.G., and J.C. Phelan. 2001. Conceptualizing stigma. *Annual Review of Sociology* 27: 363–385.
- . 2006. Stigma and its public health implications. *Lancet* 367(9509): 529.
- Marbach, J., M.C. Lennon, B.G. Link, and B.P. Dohrenwend. 1990. Losing face: Sources of stigma as perceived by chronic facial pain patients. *Journal of Behavioral Medicine* 13(6): 583–604.
- Martensen, R. 2004. *The brain takes shape: An early history*. New York: Oxford University Press.
- Matthias, M. S., A.L. Parpart, K.A. Nyland, et al. 2010. The patient–provider relationship in chronic pain care: Providers’ perspectives. *Pain Physician* 11(11): 1688–1697.
- McLeod, C. 2002. *Self-trust and reproductive autonomy*. Cambridge, MA: MIT Press.
- Miller, J. 2007. The other side of trust in health care: Prescribing drugs with the potential for abuse. *Bioethics* 21(1): 51–60.
- Moscato, J. 2012. *Pain: A cultural history*. Basingstoke: Palgrave MacMillan.
- Osborne, M., and J.A. Smith. 1998. The personal experience of chronic benign lower back pain: An interpretative phenomenological analysis. *British Journal of Health Psychology* 3(1): 65–83.
- Ousager, J., and H. Johannessen. 2010. Humanities in undergraduate medical education: A literature review. *Academic Medicine* 85(6): 988–998.
- Pellegrino, E. 1991. Trust and distrust in professional ethics. In *Ethics, trust, and the professions: Philosophical and cultural aspects*, edited by E. Pellegrino, R. Veatch, and J. Langan, 69–89. Washington, DC: Georgetown University Press.
- Peterkin, A. 2008. Medical humanities for what ails us. *Canadian Medical Association Journal* 178(5): 648.
- Pfeiffer, D. 2000. The disability paradigm. *Journal of Disability Policy Studies* 11(2): 98–99.
- Rich, B.A. 1997. A legacy of silence: Bioethics and the culture of pain. *Journal of Medical Humanities* 18(4): 233–259.
- Rhodes, L.A., C.A. McPhillips-Tangum, C. Markham, and R. Klenk. 1999. The power of the visible: The meaning of diagnostic tests in chronic back pain. *Social Science & Medicine* 48(9): 1189–1203.
- Rogers, W. 2002. Is there a moral duty for doctors to trust patients? *Journal of Medical Ethics* 28(2): 77–80.
- Sandman, L., and C. Munthe. 2009. Shared decision-making and patient autonomy. *Theoretical Medicine and Bioethics* 30(4): 289–310.
- Scarry, E. 1985. *The body in pain*. New York: Oxford University Press.
- Scheman, N. 2001. Epistemology resuscitated: Objectivity as trustworthiness. In *(En)gendering rationalities*, edited by N. Tuana and S. Morgen, 23–52. Albany, NY: SUNY Press.
- Shapiro, J., E.H. Morrison, and J.R. Boker. 2004. Teaching empathy to first-year medical students: Evaluation of an elective literature and medicine course. *Education for Health* 17(1): 73–84.
- Stempsey, W. 2000. *Disease and diagnosis: Value-dependent realism*. Dordrecht: Kluwer Academic Publishers.
- The Good Stewardship Working Group. 2011. The “Top 5” lists in primary care: Meeting the responsibility of professionalism. *Archives of Internal Medicine* 171(15): 1385.
- Toye, F., and K. Barker. 2010. “Could I be imagining this?”—The dialectic struggles of people with persistent unexplained back pain. *Disability and Rehabilitation* 32(21): 1722–1732.
- Upshur, R.E.G., and E. Colak. 2003. Argumentation and evidence. *Theoretical Medicine and Bioethics* 24(4): 283–299.

- van Hooft, S. 2003. Pain and communication. *Medicine, health care and philosophy* 6(3): 255–262.
- Wager, T., L.Y Atlas, and M.A. Lindquist. 2013. An fMRI-based neurologic signature of physical pain. *New England Journal of Medicine* 368(15): 1388–1397.
- Wailoo K. 1996. Negro blood as genetic marker: Thalassemia and sickle cell anemia in America to 1950. *Journal of History and Philosophy of the Life Sciences* 18: 305–320.
- . 2014. *Pain: A political history*. Baltimore: Johns Hopkins University Press.
- Werner A., and K. Malterud. 2003. It is hard work behaving as a credible patient: Women with chronic pain and their physicians. *Social Science & Medicine* 57(8): 1409–1419.
- Whitney S., and L. McCullough. 2007. Physicians' silent decisions: Because patient autonomy does not always come first. *American Journal of Bioethics* 7(7): 33–38.