



AMA Journal of Ethics®

August 2022, Volume 24, Number 8: E740-747

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Underrecognition of Dysmenorrhea Is an Iatrogenic Harm

Zainab Doleeb, MD, Liam G. McCoy, MD, MSc, Jazleen Dada, MBChB, and Catherine Allaire, MD

Abstract

Many patients face years of recurrent and debilitating menstrual pain that affects their ability to work and study. Patients often normalize their severe pain as an expected part of menses. Both underrecognition and lack of awareness of available therapies for this remediable condition serve as a quintessential example of hermeneutic injustice. Hermeneutic injustice describes a structural lack of access to epistemic resources, such as shared concepts and knowledge. Pervasive menstrual stigma further discourages people with dysmenorrhea from discussing their symptoms and seeking health care. A lack of respect for women's experiences of pain in clinical encounters acts to worsen these issues and should be considered a source of iatrogenic harm. Health care workers can promote hermeneutic justice by preemptively destigmatizing discussions about menstruation and validating patients' concerns. On a systemic level, there should be greater awareness of dysmenorrhea and the various treatments available for it.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ available through the AMA Ed Hub™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Case

While taking a contraceptive history in clinic, Dr G's 55-year-old patient, JJ, remarks, "I wish I could have had an IUD when I menstruated." Dr G then uncovers a long history of JJ's painful menses with severe nausea, crippling cramps, and occasional fainting. JJ regularly missed at least a day of school or work each month.

"Did you see a physician when you had pain?" asks Dr G.

"No," said JJ. "Women didn't see physicians for that. I thought every woman had pain like me."

Commentary

Countless people who menstruate have spent many days of their lives curled in bed unable to partake in their normal activities while they unnecessarily suffer from a

condition that is often easily treatable. Exercise, acupoint stimulation (acupressure or acupuncture), relaxation techniques, heating pads, and ginger supplements have been shown to be effective.¹ In addition to nonpharmacological remedies, effective management options can include nonsteroidal anti-inflammatory drugs or hormonal treatments, such as oral contraceptive pills, patches, vaginal rings or hormone-releasing intrauterine devices.^{1,2} How many people who menstruate even know enough to recognize the abnormality of their condition? Or how many know that their physicians do have a medical term for it—primary dysmenorrhea?

Hermeneutics in Health Care

JJ is obviously aware of her own suffering, but, like all patients, she is faced with the difficult task of interpreting her experiences to assess whether her symptoms constitute a condition for which she may be able to receive medical treatment. Physicians, additionally, are tasked with determining the boundaries between normalcy and pathology. They must also classify a given patient's experience, then decide when and how to offer treatment.

Given the subtlety and complexity of experiences of illness and of describing it when seeking care, medicine has been characterized as a fundamentally hermeneutic, or interpretive, enterprise.³ A term taken from philosophy and literary analysis, hermeneutics examines the process of interpretation and assigning meaning during communication. In the context of medicine, hermeneutics refers to the process of interpreting the “text” of the patient's experiences and presentation.³ In order to engage in this process of interpretation, patients and clinicians alike must rely on the use of hermeneutic resources—shared meanings and concepts that are collectively determined.

The concept of hermeneutic injustice describes the ways in which systemic factors influence the content of hermeneutic resources, as well as who has access to them.⁴ Hermeneutic injustice robs individuals of the ability to put words to and understand their experiences.⁵ How can one seek care for a condition that is **not socially recognized** and for which there is no accessible vocabulary to describe it? How can people communicate their concerns when they lack and are even denied the necessary language to characterize them as abnormal to begin with?

In the rest of this article, we explore the underrecognition of dysmenorrhea as a hermeneutic injustice in health care. We focus on the ways in which epistemic injustice broadly, and hermeneutic injustice specifically, manifest in the health care context. We demonstrate the particular salience of this issue in the context of dysmenorrhea and seek to highlight the harms done to people who menstruate by the current status quo. Finally, we explore ways in which clinicians, educators, and the health system at large can act to counter this injustice and ensure effective and timely access to care for people with dysmenorrhea.

Epistemic Injustice

As conceptualized by philosopher Miranda Fricker, epistemic injustice refers to the structural and systematic exclusion of people from systems of knowing.⁴ There are 2 types of epistemic injustice: *testimonial injustice* and *hermeneutic injustice*. In the former, the testimonial claims of certain individuals are undervalued or dismissed due to their membership in a particular group. Examples of testimonial injustice include a corporate company board being consistently more willing to implement ideas suggested

by male executives than by female ones, regardless of the topic at hand, or a physician dismissing the pain of Black patients. In these examples, testimonial injustice could impede the career advancement of women in the corporate field and lead to additional suffering of Black patients, respectively.

Hermeneutic injustice, on the other hand, refers to a structural lack of access to epistemic resources (such as shared concepts and meanings) necessary to interpret one's own experience of the world. Fricker's quintessential example of hermeneutic injustice is sexual harassment. While women have long experienced unwanted sexual advances and inappropriate comments from colleagues, the lack of the concept of sexual harassment impeded collective recognition of this phenomenon. This deficit left many unable to effectively understand or explain their discomfort and to describe the harms done to them.⁴ The development of the relevant terminology allowed women to recognize their experiences as common and as part of a broader problem, enabling both personal understanding and collective action. While both testimonial and hermeneutic injustice are prominent in the context of women's health, we will focus upon the latter in what follows.

Hermeneutic Injustice

Health care is an environment that is particularly primed for hermeneutic injustice in that it tends to rely on complex and arcane jargon that is not readily and easily accessible to those outside of the medical hierarchy.⁶ Medicine's task of defining the boundaries of pathological and nonpathological traits and experiences is both descriptive and normative in nature. Its power over language, however, extends beyond the walls of the clinic and to the hermeneutic or interpretive resources drawn upon to understand health in any context.⁴ This hermeneutic power is reinforced through the epistemic privilege of physicians, which results from their expertise and knowledge. This hermeneutic power also arises from physicians' social prominence and their control over access to health care resources. Given medicine's hermeneutic power, a patient's experiences must be interpreted as "valid" by the physician and warranting of a diagnostic label to justify access to treatment resources.

The ways in which this power is used are influenced by historical and ongoing inequities that the structure of medicine embeds. While women made up nearly half of residents and fellows in programs accredited by the Accreditation Council for Graduate Medical Education in 2019,⁷ it is undeniable that misogyny features in the long legacy of women's exclusion from medicine at large, which manifests in the underrepresentation of women in senior roles.⁸ Gender inequities are particularly salient in the context of women's health. Medical research often fails to take hormonal cycles into account, and women continue to be underrepresented in clinical trials.^{9,10,11} In addition, physicians are less likely to be comfortable taking sexual histories and performing genital examinations on patients of the opposite sex.¹² Transgender patients, including transmasculine individuals who menstruate, are more likely to face stigma, disrespect, and mistreatment and consequently to avoid accessing care.¹³ Furthermore, there is evidence that women's **testimonials regarding their pain** tend to be discounted, with male physicians less likely to prescribe pain medication to female patients.¹⁴ When members of a community are systematically excluded from accessing or avoid seeking care, they and their community are effectively barred from accessing a collective hermeneutic resource through the health care system, which contributes to ongoing inequities. In this way, hermeneutic injustice may be recognized as a form of iatrogenic

harm with downstream clinical consequences far beyond the boundaries of the individual clinical encounter.

Dysmenorrhea and Hermeneutic Injustice

Unrecognized dysmenorrhea provides a clear example of hermeneutic injustice in the medical context. A systematic review and meta-analysis of 37 studies across different countries showed that 71.1% of 20 813 young women suffered from dysmenorrhea.¹⁵ Further analysis of smaller subsets of studies found that 20.1% of 11 226 women reported absences from school due to dysmenorrhea symptoms, and 40.9% of 5126 women suffered worse concentration.¹⁵ For adolescent girls, rates of dysmenorrhea may be as high as 90%, with 15% to 20% reporting it as severe or distressing.¹⁶ The impacts of dysmenorrhea are far from minor. A Dutch survey of 32 748 women found that 13.8% reported absence from work due to their symptoms, and 80.7% reported presenteeism with decreased productivity.¹⁷ Those who went to work despite their menstrual pain lost an average of 8.9 total days of productivity per year.¹⁷

Despite dysmenorrhea's prevalence, hermeneutic resources are sorely lacking. There is no standardized methodology for assessing dysmenorrhea's severity in both clinical practice and research, despite the fact that effective and affordable treatments exist.¹⁸ Moreover, there is a lack of recognition of the topic's importance, as an article published in 2011 reported that only 0.1% of pain articles dealt with this topic and only 0.5% of pain research funding went towards dysmenorrhea research.¹⁶ Further hampering patients' ability to describe painful menstrual symptoms is the lack of accessible and consistent terminology to describe pathological dysmenorrhea. Fricker showed how the naming of sexual harassment provided women with a common terminology, enabling them to view their experiences not as unique but as part of a broader problem.⁴ However, there is currently no term for severe dysmenorrhea that is used in everyday language.

Rather than drawing further attention to the topic, the great prevalence of dysmenorrhea contributes to its dismissal as invariably normal by both patients and clinicians. Many people who menstruate view menstrual pain as an expected part of menses and do not seek out medical care for symptom relief even if it impairs function.¹⁸ Research, mainly surveys and interviews, has demonstrated that women are hesitant to consult with physicians regarding menstrual issues, either because they are uncertain about whether their symptoms are normal or because they consider the issue unimportant even if it is recognized.^{19,20} In addition to being unable to appropriately characterize their experiences as pathological, many people with dysmenorrhea are unaware of treatment options, defaulting to the belief that dysmenorrhea is ultimately untreatable.²¹

Promoting Justice

Hermeneutic injustice is manifest when a collective epistemic resource belonging to one group is withheld from another group.²² Here, people who menstruate have inequitable access to medical concepts and terms to describe their experience of dysmenorrhea and to the knowledge to characterize it as both pathological and treatable. As the powerful possessors of medical knowledge, physicians have a duty to share this knowledge with the **epistemically excluded** groups of patients.

To rectify hermeneutic injustice, it is crucial to highlight and reinforce the power and agency of members of a marginalized population. The very act of diagnosis provides

patients with terminology to describe their own experiences and share them in a social context. For example, if JJ had recognized the abnormality of her symptoms, she would have sought care from a physician who would have diagnosed and treated her for severe primary dysmenorrhea. Consequently, she would have been empowered with the knowledge of and vocabulary to describe her condition and treatment and been able to share this information with her friends and relatives who might also have been suffering silently. In doing so, she would have expanded access to hermeneutic resources within her previously excluded group.

In order for any endeavors promoting epistemic justice to succeed, patients need to be provided with the concepts and knowledge to understand and communicate their experiences (hermeneutic justice), and health care practitioners need to believe the experiences of people who menstruate as interpreted by them (testimonial justice). In the case, epistemic justice is predicated on JJ's health care practitioner believing her symptoms (testimonial justice) and JJ feeling empowered to engage in destigmatized menstrual discussions within her social group. Both historically and to a lesser degree presently, a "menstrual etiquette" exists whereby women do not openly discuss their menstrual periods among each other or in popular culture due to a sense of shame and taboo.²³ By not discussing their symptoms, many people with severe dysmenorrhea are robbed of the hermeneutic tools to recognize their pain as abnormal.

As outlined below, there are a wide range of strategies that can be employed by health care practitioners to promote hermeneutic justice in the context of painful menstrual bleeding.

Recognize. Many patients who have delayed seeking treatment reported that they would have volunteered their painful symptoms earlier if their health care practitioner had probed them on a prior visit and asked about their menstrual cycles.¹⁹ Patient reluctance to report distressing menstrual symptoms can be overcome by clinicians proactively inquiring about them.¹⁹ During primary care visits, women are sometimes asked about their last menstrual period and the regularity of their periods. Adding, "Are your periods painful?" can create an opening for recognizing and treating dysmenorrhea. Within this context, safe, gender-affirming care should be provided to all.

Validate. Some people who menstruate worry that they will be perceived as being "whiny" if they report their symptoms and that their physician will dismiss their concerns.¹⁹ Clinicians should validate patients by informing them that their distressing symptoms are indeed an underrecognized medical problem for which treatments are available. Validating patients' pain is paramount both in this context and in general practice.

Assess. It is important to assess symptom severity in order to determine if more intensive interventions are indicated, to monitor for symptomatic improvement over time, and to evaluate treatment response. In addition to taking a general pain history on onset, location, quality, and other essential pain characteristics, clinicians should include follow-up questions to assess pain and its severity²⁴: Does the pain make it difficult for you to attend work or school? Does the pain make it difficult for you to concentrate on tasks? On a scale of 1 to 10, with 10 being the worst pain of your life, how painful are your periods?

Inform. Many patients state that had they known that hormonal contraceptives could be used for dysmenorrhea or that there existed other treatments, they would have sought care.²¹ Informing patients of available nonpharmacological and pharmacological options can not only benefit the patient directly but also hermeneutically empower patients to share their experiences and encourage others to seek out care. Patient education can be an effective tool in caring for adolescents, in particular, who have some of the highest rates of dysmenorrhea and may rely on peer-to-peer knowledge sharing.¹⁶

Advocate. Beyond the clinic sphere, it is important to advocate for greater awareness of severe dysmenorrhea and treatments available. This goal can be achieved by raising awareness through public health campaigns, especially within schools to better target adolescents. Introductory health classes on menstruation should include dysmenorrhea, examples of severe symptoms, different treatments available, and the importance of seeking medical care. Furthermore, efforts should be made to develop a common terminology for severe symptoms, either by bringing the term *severe dysmenorrhea* into the public lexicon or developing a more accessible alternative phrase. An adolescent who is hermeneutically empowered to recognize and manage dysmenorrhea is less likely to suffer later in life.

Conclusion

In cases of hermeneutic injustice, marginalized groups are denied equitable access to collective hermeneutic resources to interpret their experiences. The underrecognition and undertreatment of dysmenorrhea provide a prototypical example of such injustice in the medical context. Systemic inequities both within and beyond the health care context have contributed to an unjust normalization of severe dysmenorrhea. As a result, millions of people who menstruate suffer from substantial, even disabling, pain that they are unable to correctly attribute to a pathological condition that is remediable with appropriate medical care. In this way, hermeneutic injustice can be seen as an important source of ongoing iatrogenic harm. Recognition of this phenomenon would enable individual and systemic responses on the part of clinicians and health systems to promote hermeneutic justice within and beyond the clinical context.

References

1. Marjoribanks J, Proctor M, Farquhar C, Derks RS. Nonsteroidal anti-inflammatory drugs for dysmenorrhoea. *Cochrane Database Syst Rev.* 2015;2015(7):CD001751.
2. Hubacher D, Kavanaugh M. Historical record-setting trends in IUD use in the United States. *Contraception.* 2018;98(6):467-470.
3. Leder D. Clinical interpretation: the hermeneutics of medicine. *Theor Med.* 1990;11(1):9-24.
4. Fricker M. *Epistemic Injustice: Power and the Ethics of Knowing.* Oxford University Press; 2007.
5. McCollum J. Hermeneutical injustice and the social sciences: development policy and positional objectivity. *Soc Epistemol.* 2012;26(2):189-200.
6. Carel H, Kidd IJ. Epistemic injustice in healthcare: a philosophical analysis. *Med Health Care Philos.* 2014;17(4):529-540.
7. Boyle P. Nation's physician workforce evolves: more women, a bit older, and toward different specialties. Association of American Medical Colleges. February 2, 2021. Accessed April 28, 2022. <https://www.aamc.org/news-insights/nation-s-physician-workforce-evolves-more-women-bit-older-and-toward-different-specialties>

8. Ruzycki SM, Franceschet S, Brown B. Making medical leadership more diverse. *BMJ*. 2021;373(945):1-6.
9. Holdcroft A. Gender bias in research: how does it affect evidence based medicine? *J R Soc Med*. 2007;100(1):2-3.
10. Oh SS, Galanter J, Thakur N, et al. Diversity in clinical and biomedical research: a promise yet to be fulfilled. *PLoS Med*. 2015;12(12):e1001918.
11. Yakerson A. Women in clinical trials: a review of policy development and health equity in the Canadian context. *Int J Equity Health*. 2019;18(1):56.
12. Lurie N, Margolis K, McGovern PG, Mink P. Physician self-report of comfort and skill in providing preventive care to patients of the opposite sex. *Arch Fam Med*. 1998;7(2):134-137.
13. Kcomt L, Gorey KM, Barrett BJ, McCabe SE. Healthcare avoidance due to anticipated discrimination among transgender people: a call to create trans-affirmative environments. *SSM Popul Health*. 2020;11:100608.
14. Weisse CS, Sorum PC, Sanders KN, Syat BL. Do gender and race affect decisions about pain management? *J Gen Intern Med*. 2001;16(4):211-217.
15. Armour M, Parry K, Manohar N, et al. The prevalence and academic impact of dysmenorrhea in 21,573 young women: a systematic review and meta-analysis. *J Womens Health (Larchmt)*. 2019;28(8):1161-1171.
16. Berkley KJ, McAllister SL. Don't dismiss dysmenorrhea! *Pain*. 2011;152(9):1940-1941.
17. Schoep ME, Adang EMM, Maas JWM, De Bie B, Aarts JWM, Nieboer TE. Productivity loss due to menstruation-related symptoms: a nationwide cross-sectional survey among 32 748 women. *BMJ Open*. 2019;9(6):e026186.
18. Kennedy S. Primary dysmenorrhoea. *Lancet*. 1997;349(9059):1116.
19. Fredericks E. Short report: how family physicians can support discussions about menstrual issues. *Can Fam Physician*. 2014;60(3):e194-e196.
20. Ramos-Pichardo JD, Ortega-Galán ÁM, Iglesias-López MT, Abreu-Sánchez A, Fernández-Martínez E. Why do some Spanish nursing students with menstrual pain fail to consult healthcare professionals? *Int J Environ Res Public Health*. 2020;17(21):8173.
21. Chen CX, Shieh C, Draucker CB, Carpenter JS. Reasons women do not seek health care for dysmenorrhea. *J Clin Nurs*. 2018;27(1-2):e301-e308.
22. Anderson E. Epistemic justice as a virtue of social institutions. *Soc Epistemol*. 2012;26(2):163-173.
23. Pascoe C. Silence and the history of menstruation. *Oral Hist Assoc Aust J*. 2007;(29):28-33.
24. Durain D. Primary dysmenorrhea: assessment and management update. *J Midwifery Womens Health*. 2004;49(6):520-528.

Zainab Doleeb, MD is a first-year obstetrics and gynaecology resident at the University of Toronto in Ontario, Canada. She has a strong interest in global health and health equity.

Liam G. McCoy, MD, MSc is a first-year neurology resident at the University of Alberta in Edmonton, Canada. His research focuses on artificial intelligence and advancing clinical decision making.

Jazleen Dada, MBChB is a first-year fellow in maternal-fetal medicine at the University of Toronto in Ontario, Canada. She is passionate about surgical medical education and patient advocacy.

Catherine Allaire, MD is head of the Division of Gynaecologic Specialties at the University of British Columbia in Vancouver, Canada, where she is also the medical director of the Women's Centre for Pelvic Pain and Endometriosis.

Citation

AMA J Ethics. 2022;24(8):E740-747.

DOI

10.1001/amajethics.2022.740.

Conflict of Interest Disclosure

Dr Allaire serves on the advisory board of AbbVie. The other authors had no conflicts of interest to disclose.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.