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POLICY FORUM: PEER-REVIEWED ARTICLE

Key Roles of Epistemic Humility in OB/GYN Care of Patients in Acute Non-Labor and Delivery Pain Care

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Abstract

This article considers ethical, epistemic, and clinical harms of normalizing, discounting, or dismissing patients' experiences of acute pain in non-labor and delivery obstetrics and gynecology (OB/GYN) settings. Discrediting patients' accounts undermines the therapeutic capacity of patient-clinician relationships, causes unjustified suffering, and may even contribute to life-threatening delays in recognizing and treating complications. This article urges OB/GYN practitioners to consider the ways in which structural and individual factors predispose them to discredit patients' testimonies and thereby contribute to epistemic and other harms. OB/GYN practitioners are encouraged to cultivate the virtue of epistemic humility and consider the role of patient satisfaction scores in evaluating care.

Inequitable Pain Treatment

Many clinicians continue to inappropriately respond to their patients' pain by making incorrect assumptions about patients in pain,[1] discounting patients' reports of pain,[2] or ignoring patients' pain altogether.[3] These problems are more pronounced for minoritized patients, who suffer widely documented health inequity in pain assessment, treatment, and care.[4,5,6]

Non-labor and delivery obstetrics and gynecology (non-L&D OB/GYN) settings are no exception. Non-L&D OB/GYN acute pain remains inadequately treated across settings. One example is postoperative care, wherein a high percentage of patients experience moderate-to-severe pain (over 65% in one study),[7] especially younger patients and those with preexisting chronic pain.[8,9] Both inside and outside the hospital setting, there is evidence that patients' reports of pain are minimized and that patients are judged as less than credible. Examples of such evidence include racial and ethnic inequities in postpartum pain care,[10] disparate post-laparoscopic pain prescribing by race and socioeconomic status,[11] racial disparities in the frequency of pain assessments in hospitalized gynecology patients,[12] and significant discounting of Black maternal near-miss survivors' reported pain levels (especially by experienced and male physicians).[13] In fact, many patients who survive a deadly pregnancy complication describe practitioners as discounting or ignoring their repeated reports of pain.[14,15] Normalized, discounted, and ignored OB/GYN pain contributes to patients' moral, psychological, and physical injuries, ranging from needless suffering to risk of premature death from missed underlying pathologies. As Hossain observed: in medicine, "[w]omen, especially women of color, are dismissed, sometimes to death."[16] While the harms that flow from discrediting patients are completely preventable, correcting for the myriad forces that conspire to undermine ethical decision-making in acute pain care requires understanding and intention.

Decisions about pain are both routine and medically, socially, and culturally complex. Structural, institutional, and individual forces play important roles in these decisions, which are especially prone to bias,[4,5] and can conspire to compromise mutual trust, clinician trustworthiness, and, ultimately, clinical decision-making. It is from this understanding that this article approaches the question of how practitioners and institutions should consider patients' experiences of acute pain in non-L&D OB/GYN care, as reflected in patient satisfaction scores that account for the subjective nature of pain. The short answer is they should consider patients' experiences of pain as fully accurate data points—that is, they should respect patients as knowledge experts about their own bodily sensations. The long answer is more complicated. For clinicians, lingering under the surface of this question are assumptions about patients' lack of credibility, even about their own bodies, experiences, and sensations (whether it's pain or satisfaction with care), as well as fears about legal risk. Fears of institutional and legal scrutiny for prescribing pain relief and for OB/GYN care decisions are particularly salient now. Nonetheless, practitioners still hold disproportionate power in the clinical space and rightly shoulder the burden of recognizing and ameliorating the harms of discrediting patients' reports of acute pain. As Lalumera writes: "Failing to recognize trustworthiness when the conditions exist or rendering a person [patient] incapable of being trustworthy in a certain scenario, are epistemic injustices with ethical impact."[17]

Epistemic Injustice

Decisions about pain are of an ethical nature because they are within the practitioner's control and will show or fail to show respect for the patient.[18] They also hold the promise of benefit and risk of harm. The justice implications are less often addressed but are also profound. Treating patients with acute non-L&D OB/GYN pain implicates both health justice—which requires what Wiley et al describe as "a probing and critical eye to root out the influence of classism, racism, and other forms of social and cultural bias"[19]—and epistemic justice, which requires treating others as trustworthy and credible sources of knowledge, especially about their own bodies and experiences.[20,21]

Epistemic injustice takes 2 forms. Testimonial injustice—being wronged as a "giver of knowledge"[20]—occurs when patients' first-person reports are discounted, discredited, or ignored because of practitioner bias based on the patient's lack of technical knowledge or the patient's membership in a stigmatized group.[22] Practitioners may judge patient reports as "full of irrelevant information," confused, irrational, emotionally laden, and "time consuming"[21] and thus justify discrediting them or ignoring them altogether (epistemic exclusion). The clinical space may, as Medina writes, "erode the epistemic respect that individuals … deserve, and … deprive these individuals of environments in which they can make sense of their experiences."[23] When discrediting is repeated and reinforced, it contributes to a second form of epistemic injustice—hermeneutical injustice, or being "wronged as a subject of social understanding."[20] The lack of collective knowledge and appreciation of marginalized groups' experiences is dehumanizing and leaves group members further discredited and with limited ways to adequately identify, process, and communicate their experiences. As problems are normalized and even erased, individual and structural harms are worsened and reinforced. Testimonial and hermeneutical injustices are fundamentally ethical problems that work together to inflict harm from without and within.

Epistemic Injustice in Clinical Encounters

Outside the hospital setting, 2 well-publicized situations of acute pain treatment illustrate epistemic injustice in non-L&D OB/GYN acute pain treatment.[24] The first concerns scores of patients who were discredited while reporting excruciating pain during egg retrieval procedures in some clinics; a subsequent investigation revealed that fentanyl had been replaced with normal saline over at least 5 months.[25,26,27] It is unclear why practitioners failed to act for months on myriad, repeated patients' (sometimes screaming) testimonies of procedural pain.[28,29] One patient described a postdiscovery "acknowledgement" by her doctor, who said, "What's the big deal? I mean, you ended up pregnant,"[29] at once discrediting the patient's own testimony and reinforcing the ideas that survived pain and trauma inflict no lasting harms, at least not for women who should be quiet and grateful in the clinical space—even in the space of practitioners who demonstrate untrustworthy behavior.

A second example is clinicians' persistent underestimating and discounting of pain during intrauterine device (IUD) insertion[30,31]—by an average of nearly 50% compared with patients' self-rated pain.[30] IUD placement is a painful and traumatizing experience for too many patients, especially when practitioners don't prepare patients for possible pain.[31,32] Some practitioners actually offer no analgesia,[31,32] especially cisgender men and more experienced practitioners.[33] Individualized care is lacking, even though reported pain levels are higher for patients who are younger, nulliparous, or with a history of anxiety or trauma.[32,34] The disconnect between practitioners' and patients' perceptions was explained by 2 medical students this way: "[d]uring our time on OB/GYN rotations, we regularly observed patients crying in pain after being told they would feel 'just a little pinch.' We found this inconsistency troubling, especially given the historical trivialization of women's pain in medicine."[35]

Recently, people have taken to social media to draw attention to this problem,[36,37] including patients who posted their real-time experiences of IUD insertion on TikTok—nearly 97% of whom communicated the painful nature of the experience, along with side effects.[37,38] Viral social media posts are not intended as, nor do they constitute, "objective" evidence (the type of knowledge privileged in medicine), although "objective" evidence of pain during IUD insertion has existed and been ignored for decades.[39] In fact, the American College of Obstetricians and Gynecologists website still recommends ibuprofen for the "temporary discomfort" that "placement of the IUD may cause,"[7,40] despite no evidence of its effectiveness.[39,41] In contrast, the social media posts showed people seeking to make sense of and communicate collective experiences that differed from the dominant practitioner narratives. The public outcry was an important step in remedying hermeneutical injustice and a powerful force in changing practices. Just this year, Planned Parenthood of St Louis Region and Southwest Missouri announced a sedation option for its patients.[42] In August 2024, the Centers for Disease Control and Prevention published new treatment guidelines acknowledging the pain associated with IUD placement and urging practitioners to offer pain management options.[43]

Exacerbating Epistemic Harm

Institutions and practitioners remain ethically and professionally obligated to minimize the harms of inadequately addressed acute pain. Institutions should interrogate policies, practices, cultures, and processes to identify and correct those that facilitate epistemic injustice.[21] Practitioners should also cultivate their own epistemic humility by, as Buchman et al write, "recogniz[ing] patient testimony and illness interpretations as epistemically privileged in determining the best clinical management," with the understanding that "medical decisions are almost always accompanied by uncertainty and that the testimonies of pain sufferers can help complete the clinical scenario."[22] Epistemic humility requires intentionality and metacognitive strategies to acknowledge and correct for assumptions, cognitive errors, and biases that create credibility deficits.

Furthering health justice requires not only epistemic humility but an understanding of the biases that increase the risk of epistemic harms, which are heightened in OB/GYN care wherein, Donnelly argues, "bodies are seen as fundamentally linked to reproduction and thus deemed fragile, hysterical, and in need of control."[44] Every OB/GYN patient (women, transmasculine, or gender diverse)[45] has faced some level of social subordination and gender-based health inequity,[46,47,48] including in the treatment of acute pain.[49] Those who are members of multiple racialized or minoritized groups (eg, Black transmasculine persons with a disability) experience intersectional harms from the compounding effects of group stigma, bias, discrimination, and oppression.[50] This compounding contributes to further discrediting, which may be exacerbated by the historical and cultural context of OB/GYN care.

The OB/GYN specialty developed in the context of racism and misogyny, and, historically, some OB/GYN practitioners (including nurses)[51] participated in unethical and dehumanizing practices, such as involuntary and unnecessary surgeries,[52] forced sterilizations,[53] and attributing greater fertility and lesser pain sensitivity to Black women.[54] Even today, they sometimes medicalize, pathologize, and racialize female reproduction and pain. As Norman explains in writing about pain, "[i]f women have become synonymous with hysteria, malingering, and hypochondria in the clinical setting, then it has far less to do with the natural inclinations of women and behavior than it does with the history of medicine."[55] And, even recently, some OB/GYN practitioners have participated in systems of oppression[56] by surveilling pregnant patients for law enforcement purposes,[57,58] engaging in unconsented pelvic exams without clinical justification,[59] and performing forced and coerced procedures.[60,61]

In this context, patient skepticism of practitioner trustworthiness and fidelity is understandable, especially in a post-*Dobbs* world, where, as Thompson et al write, "a person's womb [is] a public space, accountable to neighbors and authorities, and regulated by the courts and the medical profession."[62] For practitioners, too, post-*Dobbs* social and legal forces create barriers to therapeutic clinical encounters. OB/GYN care is increasingly overregulated and even criminalized,[63] which, superimposed on ever-escalating surveillance of opioid prescribing,[64] incentivizes practitioner skepticism of patients and worsens practitioner moral distress and clinical uncertainty.[63] Bias and cognitive errors thrive in these environments,[65,66] increasing the risk of clinical errors and patient harms that may extend beyond frustration, humiliation, and moral injury to physical suffering, injury, and even death from ignored symptoms.

Erasing Pain-Related Patient Satisfaction?

Patient satisfaction ratings in modern health care also have implications for the ethical treatment of OB/GYN patients in pain. Relationships between patients' numeric pain ratings and satisfaction are complex. For example, among patients with poor pain relief, satisfaction is positively associated with confidence in their clinicians' knowledge.[67] Attention to factors that improve satisfaction, which track epistemically humble practices, thus may improve care.

These findings are an important counterfactual to the reactionary narratives that tied patient satisfaction questions to excessive opioid prescribing in the last decade. Patient satisfaction scores were never associated with opioid prescribing,[68] despite the mythology surrounding them. Blame was assigned to patient satisfaction tracking through Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys[69] and to the hospital CAHPS (HCAHPS) particularly,[70] the results of which play a very small role in hospital reimbursement.[71] Nonevidence-based regulatory action soon followed. The original HCAHPS pain management dimension (dating from 2006) was targeted because its 3 questions asked if patients needed medication for pain during hospitalization, how well the pain was controlled, and how often the staff "did everything they could" to help with pain.[71] Without evidence but under pressure, the Centers for Medicare and Medicaid Services detached the pain dimension from reimbursement and replaced it with questions about communication effectiveness in 2018.[71] The revised questions—which only asked about the presence of pain, the frequency of assessment, and communication about treatment—would have provided good data, in part because effective communication and feeling trusted do increase satisfaction. Nonetheless, they were similarly doomed and removed in 2019.[72]

While subsequent studies have further established that neither opioid prescribing rates nor receiving opioids drive patient satisfaction,[73,74,75,76] the word *pain* remains absent from the HCAHPS. A handful of other specialized CAHPS surveys include limited pain questions—for example, the surgical care CAHPS asks about the quality of a surgeon's pain care,[77] and the outpatient and ambulatory service centers CAHPS survey includes 2 yes/no questions about the existence of and information provided about postprocedure pain.[78]

Nonetheless, the erasure of the HCAHPS pain dimension structurally reinforces the idea that patients' pain testimonies are nonexistent or insignificant. It also deprives practitioners and institutions of useful data, which makes dismissed pain easier to ignore. Erasure of the pain question serves epistemic injustice by communicating that inquiring about pain care is not necessary—either because pain neglect isn't really a problem or because the resulting harms are inconsequential.

Subjectivity as Unreliability

Why do some patients continue to suffer the epistemic injustice of having their testimony about pain discredited? One pervasive justification for discrediting patients' reports of pain is that pain is subjective—a word that is a euphemism for unreliable in the context of pain and used to rationalize discrediting patients.[22,71,79,80,81] This justification is puzzling because practitioners rely on subjective experiences all the time—their patients' experiences of insomnia, tinnitus, nausea, dizziness, and so on and their own experiences of auscultation of lungs, bowel sounds, and heart sounds, for example. Subjective knowledge as unreliable and untrustworthy is thus reserved for pain assessments in which it is subordinated to practitioners' objective assessments, which leaves patients rightly feeling betrayed.[22,79,80] Moreover, focusing on the subjectivity of pain centers the problem on (unreliable) patients instead of on the limits of objective knowledge and the delegitimizing actions of practitioners, institutions, and systems. It also reveals the way in which knowledge is privileged depending upon its source. Undermining the legitimacy of patients' accounts is an old problem for patients in pain looking for help in an American culture of entrenched moralism about pain and suffering that rewards stoicism and quiet tolerance as virtuous and regards testimony about pain as weakness. Especially for OB/GYN patients, this moralism is exacerbated by clinician bias (implicit and explicit) toward some patients and entangled with clinicians' fears of overprescribing and stigma around opioids and addiction. These forces conspire with institutional policies and laws (or beliefs about the law) to reinforce the view that patients are unreliable witnesses of their own bodies, experiences, and sensations, which reifies epistemic injustice in pain care.

Epistemic Humility and Respect

Practitioners can work to decrease epistemic injustice, decrease patient harm, and improve patient satisfaction in pain care by treating patients as trustworthy. Doing so requires trustworthy practitioner behavior and the cultivation of certain behaviors and virtues, such as respectful communication, epistemic and clinical humility,[82] and active listening.[83] Established tools for shared decision-making in acute pain care may also be helpful.[84]

Practitioners should presume patients' authority as experts on their own bodies, and when doubt creeps in, they should double-check their own assumptions before questioning a patient's veracity. Epistemic humility requires what Buchman et al describe as "critical reflection about the assumptions made about the trustworthiness of pain sufferers,"[22] including biases that lead to injustice and harmful clinical decisions.[85] Cultivating mindfulness and engaging in metacognition in interpreting clinical interactions can decrease bias and may improve clinical decision-making[86] and moral reasoning.[87]

Patients often tell us something is wrong before the objective signs catch up—acting on those reports can prevent delay and disaster, reduce suffering, and convey trustworthiness. The risks of discounting and discrediting are too great, including missing serious underlying problems. Practitioner hubris in the face of patients' and family members' concerns and reports is an enduring narrative in medical errors and close calls,[88] as well as in medical malpractice and licensure cases. On the other hand, the risks of accepting such reports as credible information justify a few moments of reassessment and discussion, and these efforts show respect, enhance the practitioner's credibility, improve patient satisfaction, and reduce the risks of epistemic and physical harms.

An epistemically humble posture of patients as expert of their own bodies is a clinical stance and virtue worth cultivating. As Saulnier explains: "being allowed to tell one's story and having that story heard and believed are goods unto themselves."[89] Institutions should consider whether the policies, environment, and culture encourage epistemic humility. If practitioners and institutions want to track their progress, they might consider asking themselves if they are taking patients at their word and asking patients whether they were treated as authorities on their own experiences, especially about pain. They could do so by adding voluntary questions to patient satisfaction surveys. As Bello et al explains: "especially in the stressful setting of acute pain relief …

decisions based on a patient's pain experience, values and expectations should represent the standard of care."[84] The only way to know patients' experiences, values, and expectations is to ask them, take them at their word, and act accordingly.

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