

Episode: *Author Interview: "Underrecognition of Dysmenorrhea Is an Iatrogenic Harm"*

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[bright theme music]

TIM HOFF: Welcome to another episode of the *Author Interview series* from the *American Medical Association Journal of Ethics*. I'm your host, Tim Hoff. This series provides an alternative format for accessing the interesting and important work being done by Journal contributors each month. Joining me on this episode is Dr Liam G. McCoy, a first-year neurology resident at the University of Alberta in Edmonton, Canada. He's here to discuss his article, coauthored with Drs Zainab Doleeb, Jazleen Dada, and Catherine Allaire, *Underrecognition of Dysmenorrhea Is an Iatrogenic Harm*, in the August 2022 issue of *The Journal*, [Inequity and Iatrogenic Harm](#). Dr McCoy, thank you so much for being on the podcast with me today. [music fades]

DR LIAM MCCOY: Tim, thank you so much for having me, and I extend the thanks here to my wonderful coauthors for all the hard work on this project.

HOFF: Absolutely. So, to begin with, what's the main ethics point that you and your coauthors are making in this article?

MCCOY: So, I think in order to break into this, we need to provide a little bit of the conceptual, theoretical background.

HOFF: Mmhmm.

MCCOY: So, we build on a feminist theory by the author Miranda Fricker, based on this idea of epistemic injustice or injustice related to people's capacity as knowers or to their use of knowledge. So, arising in the 1970s, she wanted to look at the role that knowledge itself played in oppression, focusing in her case on the issue of sexual harassment. So, she divides us into two categories. The first is testimonial injustice, which is perhaps more straightforward. It's being less likely to believe somebody's account due to their characteristics, such as somebody being less likely to believe a woman or believe a person of color, and to underweight their knowledge and its value.

Her second concept is that of hermeneutic injustice. So, hermeneutics is a philosophical term, which in this context can be understood as interpretation. So, her prototypical example is sexual harassment. She argued that before the concept of sexual harassment was identified and widely propagated in the 1970s, women who experienced situations that we would now define with that term often struggled to effectively interpret what happened to them, as well as to effectively respond to it. In her argument, the development of the concept enabled both that understanding at the individual level and that action at the collective level. And particularly relevant here is her insight that the very means that we use to interpret the world collectively, what she calls the hermeneutic resources, reflect relationships of power and oppression.

So, bringing this into the context of medicine, we see that there are a lot of steps in the medical process that we might describe as hermeneutic. The physician must interpret the history in the examination of the patient and align it with categories of normal and abnormal and categories of health and disease. But even further than this, patients themselves must be empowered to have access to those hermeneutic resources in order to recognize that experience is a) pathological in some way, b) something that the medical system will validate as such, and c) something that the medical system can effectively address.

And so, a really core example of this in our context is the example we bring up of Jane, who is a composite patient reflecting those that my three coauthors had seen in clinic over the years. And Jane is prototypically a woman who brings up a long history of dysmenorrhea in passing. When asked why she never sought care or never received care, she often remarks something to the effect of, "I thought everybody experienced that," or "that isn't the sort of thing you go to the doctor for," or "that isn't the sort of thing that we talked about." Despite severe dysmenorrhea being both pathological and often treatable, women like Jane lack access to the hermeneutic resources that are necessary to effectively interpret that experience and know when to seek help and know that help is something that can be available.

Occasionally, a patient like this or somebody else who menstruates may bring up an example of where they mentioned the issue and were rebuked in some way, reinforcing the notion that this sort of "women's problem" isn't something that would be addressed in the clinical context. And here, we finally get into that recognition of the role that the medical apparatus broadly, and I think physicians specifically, play in this process. While menstrual stigma is not entirely on the shoulders of the medical profession, the power of medicine in shaping cultural conceptions of illness is important to recognize. Misogyny and transphobia remain really endemic in medicine, both, I think, structurally and in individual clinical interactions. And so, despite that substantial prevalence and impact of dysmenorrhea, medicine has failed to effectively recognize it, to advocate for these patients, and to provide them with access to those hermeneutic resources to understand and act on and improve this condition. At its worst, medicine has actively acted to belittle and dismiss those patients that are concerned.

And so, I think, in summary, the first step to overcoming an injustice is recognizing it. And we feel that using Fricker's lens of hermeneutic injustice can help us to explore and understand this, I think, really important but underappreciated potential source of iatrogenic harm. That case study of dysmenorrhea offers perhaps the most prominent and clear example of this issue. And recognizing this as a hermeneutic injustice is really important because it's not simply enough for a physician to practice that testimonial justice and believe their patients. They also have to go further and recognize and respond to the ways in which those collective hermeneutic injustices can shape the clinical encounter and the ways in which your own actions may further rectify or exacerbate that injustice at both that individual and collective level.

HOFF: And what's the most important thing for health professions students and trainees to take from this article?

MCCOY: I think the most important thing to take from our article is that recognition that listening to your patients is essential. It's necessary, but it's not alone sufficient to rectify these harms. We've got to be aware not only of what our patients bring up, but also what they don't bring up because either they don't think we could help with it or they don't think

it was important, or they don't think it was something that could be medicalized in the first place. And I think here the framework offered by our work—and here I give full credit to Dr Duleep, who really developed this in detail—is very helpful. So, that first step is to recognize, making assessment for dysmenorrhea a regular part of practice and an active part of practice. Actually asking, “Are your periods painful,” rather than just asking generally about the previous period. Then we must validate. So, you need to recognize that your patient may be uncertain about discussing this topic and really make it clear that this is an appropriate issue to discuss with a physician, and it's not a place where stigma is going to be brought. Third, I think, is really important is this assessment. You examine the severity of the symptoms, and you consider possible treatment options if indicated or offer patient education around that. Fourth is informed. You need to explain your reasoning to the patient. And I think here is particularly where we can actively work to counter that hermeneutic injustice, telling patients that, yes, a certain amount of pain with menstruation is very common, but it's certainly not an essential fact of being a person who menstruates that you would have to miss a day of work every month, for example. And then finally, advocate. Working at that systemic level to increase awareness and understanding, to counter menstrual stigma, and to provide those hermeneutic resources that are so often restricted.

And I think with this last two, it's really important to recognize that the impact extends beyond that individual clinical environment. It can extend into a virtuous cycle. By empowering patients to better understand their agency with respect to this health condition, those patients can then tell their friends, tell their family members, and sort of work to spread those resources that patients can effectively interpret these experiences and seek and receive the help that they deserve.

HOFF: And finally, if you could add a point to your article that you didn't have the time or space to fully explore, what would that be?

MCCOY: Well, it's not a tangent we necessarily pursued, because I think the article was already quite theory heavy. But while this article focuses specifically on the case study of dysmenorrhea, I think it's really important to recognize that medicine has this hermeneutic power very broadly, that illness and wellness are constructed in an emergent way, often from these individual medical interactions. When a patient comes and describes a symptom to a physician, is that met with dismissal, or is that met with support and validation? And so, while these physiological differences and experiences exist in the world, we need to remember that disease is socially constructed.

And I think both as providers and as people more broadly, we need to recognize the power and agency we have here. Are we doing, how are we choosing to respond? Are we doing it in a way that promotes welfare or a way that isolates and shames? Are we—bringing it full circle to Fricker here for the final point and the focus of feminist philosophy broadly—when we construct illness, are we doing it in a way that promotes justice for all, or are we doing it in a way that further exacerbates existing oppression and causes some people to not have access to the medical resources they deserve?

HOFF: Yeah, all important points. I think I would point our listeners to our December 2018 issue, *Physician's Power to Name*. [theme music returns] Dr McCoy, thank you so much for being on the podcast and for your and your coauthors' contribution to the Journal this month.

MCCOY: And thank you so much for having me. It's been a wonderful experience working with your journal.

HOFF: To read the full article, as well as the rest of the August 2022 issue for free, visit our site, [JournalofEthics.org](https://www.journalofethics.org). We'll be back soon with more *Ethics Talk* from the *American Medical Association Journal of Ethics*.