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REDEFINING PATERNALISTIC PRACTICES IN WOMEN’S HEALTH: HOW DYSFUNCTIONAL TRUST RELATIONSHIPS IMPACT MEDICAL AUTONOMY OF FEMALE PATIENTS IN THE CONTEMPORARY CLINICAL SETTING

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REDEFINING PATERNALISTIC PRACTICES IN WOMEN'S HEALTH: HOW DYSFUNCTIONAL TRUST RELATIONSHIPS IMPACT MEDICAL AUTONOMY OF FEMALE PATIENTS IN THE CONTEMPORARY CLINICAL SETTING

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Arts and Sciences
at the University of Kentucky

By

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ABSTRACT OF DISSERTATION

REDEFINING PATERNALISTIC PRACTICES IN WOMEN'S HEALTH: HOW DYSFUNCTIONAL TRUST RELATIONSHIPS IMPACT MEDICAL AUTONOMY OF FEMALE PATIENTS IN THE CONTEMPORARY CLINICAL SETTING

Utilizing Trudy Govier's (1997) conception of social trust, this dissertation will provide a framework for understanding trust in healthcare relationships and highlight some of the ways that unequal power distribution and dependency, poorly defined roles, and institutions complicate trust between women and their providers. This framework will also explain how distrust, especially prejudicial distrust, leads to paternalistic attitudes on the part of providers. Paternalism limits patient autonomy because medical autonomy is constitutively relational. This means that insofar as distrust causes paternalism, it also damages autonomy. Through negative outcomes, this lack of autonomy can cause patients to distrust healthcare, which can contribute to a spiral of distrust between patients and providers. This dissertation will provide two contexts of how this distrust could play out in the clinical setting.

The first conception involves lying as a response to testimonial injustice. When providers give patients a credibility deficit and distrust them to testify about their symptoms, providers may engage in the paternalistic practice of dismissing or minimizing the patient's testimony in favor of their own assessment of the patient's lived experience. If this practice is institutionalized, it can lead to a phenomenon known as testimonial silencing, where patients feel hopeless about their ability to convey information and distrust providers to take them seriously. This dissertation suggests that in order to overcome this silencing and reclaim autonomy in the patient-provider relationship, patients may lie to providers, not to deceive them, but in order to convey accurate information in a way that achieves perlocutionary success.

The second conception deals with choice limitation in reproductive healthcare. In expanding the scope of reproductive coercion, it becomes evident that certain practices at the systematic or political level and at the clinical level should be defined as reproductive coercion. In order to explicate how reproductive choices, especially women's choices, are restricted in multiple spheres, I argue that reproductive coercion occurs at three distinct levels of engagement with society: intimate, clinical, and systematic. By focusing on the clinical setting, the dissertation can demonstrate how paternalistic practices in healthcare, brought on by distrust in patients as decision-makers, can coerce women into certain reproductive choices that run counter to their autonomous preferences.

KEYWORDS: Trust, Paternalism, Autonomy, Women's Health, Clinical Ethics, Reproductive Coercion.

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DEDICATION

To Michele, in memory of Austin.

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TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

The rights of women in the U.S. healthcare system are fragile, inadequately enforced, and open to constant change and political scrutiny. Compounding this issue is a discrepancy in health access and outcomes between men and women.[1] Yet, insufficient research has been done to address the difference in status between men and women as patients. For example, according to Merone, Tsey, Russell, and Nagle (2022) the difference in how medications affect female and male bodies is poorly understood because testing is done almost exclusively on male subjects (p. 49). They also point out that historically, women have been excluded from clinical trials based on fears about how untested pharmaceuticals could affect child-rearing bodies (Merone, Tsey, Russell, and Nagle, 2022, p. 50). Cisgender women continue to experience adverse drug reactions at greater than twice the rate of men (Zucker & Prendergast, 2020). Studies indicate that sex-specific side-effects and dosing recommendations are often not disclosed or peer-reviewed, despite legislation mandating the inclusion of female trial subjects (Zucker & Prendergast, 2020). Separately, though indicative of a far-reaching pattern of dismissal by researchers to account for sex-specific differences, a review by Cirrincione and Huang (2021) indicated that there have been no investigations into how sex-related differences in pharmacology can affect transgender people undergoing hormone therapy.

Even studies of medications specifically designed for female bodies, such as oral contraceptives, have failed to explain sufficiently all the side-effects women experience, and research to rectify these oversights is often delayed by decades. Despite being widely available since 1960, a study linking use of hormonal contraceptives with increased risk

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[1] According to WHO (2021), gender inequities “[pose] barriers for women and girls to access health information and critical services, including restrictions on mobility, lack of decision-making autonomy, limited access to finances, lower literacy rates and discriminatory attitudes of healthcare providers” (para. 11).

of depression was not published until 2016 (Skovlund et al., 2016). While this could be a failure to produce adequate ongoing research into oral contraceptives after their initial approval, it could be a symptom of indifference to the suffering of women. It is worth noting that the development of oral contraceptives was deeply connected to the eugenics movement and many of the initial studies were conducted on women of color and incarcerated or institutionalized women because many voluntary subjects would drop out of the studies due to unbearable side effects (Eig, 2014). Hormonal contraceptives for men were also considered but abandoned due to, among other reasons, the number of side effects, suggesting that because men demanded a higher quality of life, women would make better candidates for the pill (Grigg-Spall, 2013).

Further, the issue of symptom dismissal is still so ubiquitous that it has recently been termed "medical gaslighting".[2] Concerningly, women are particularly susceptible to this phenomenon. There are countless stories about missed diagnoses resulting from doctors dismissing a female patient's testimony about symptoms and pain, articles about dwindling access to basic health services, and cases where female patients feel pressured into making decisions that they may not understand or even want. In 2018, Hannah Catton was dismissed by ten providers who all told her that her symptoms of ovarian cancer were simply signs of stress (Edwards, 2022). Sophia Harris (2022) and her friend Tori were both misdiagnosed repeatedly by physicians who ignored their symptoms of ovarian cancer, which only has a 20% chance of being diagnosed in early stages. Fortesa Latifi (2021) was diagnosed with medical post-traumatic stress disorder after "two decades of experiences as a patient that left [her] distrusting of doctors," including dismissals of pain and symptoms, as well as explicit disregard for consent.

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[2] According to Fraser (2021), "gaslighting has been used by physicians to dismiss women's health problems, enforcing the misogynist stereotype that women are irrational and "hysterical," a prejudice that dates back centuries" (para.9).

When we put together the separate clinical experiences of medical gaslighting that distinguish female patients from their male counterparts, it becomes clear that there are systematic forces at play that make women vulnerable as patients across the healthcare system. Inconsistent policies about abortion and contraceptives at the political level make reproductive care especially difficult for women. However, inequality of access and care for female patients can be seen in all areas of medicine, from research to treatment. A failure to address this vulnerability has caused many women to lose trust in the medical system. Undoubtedly, many women simply accept unjust practices as the norm because they have no reason to think it could be better or assume that their negative experience is unique to their situation. However, there is a collective pattern that is historically rooted and culturally reinforced across the healthcare system that demonstrates a gender-based justification for distrust in healthcare.

The distrust women feel toward healthcare is only one aspect of the issue and treats distrust purely as an effect, not a cause of problems in the healthcare relationship. In reality, women's distrust in healthcare is only one point on a downward spiral of distrust in the patient-provider relationship. Both providers and patients engage in attitudes of distrust. This is evidenced by instances of paternalism in the healthcare setting. When providers do not trust patients to know or make good medical decisions, they may feel justified in acting paternalistically toward patients because they believe themselves to be better positioned to care for the patient's interests. This can look like rejecting symptom testimony that is deemed inaccurate or removing certain healthcare choices that the provider believes will not serve the patient's interests.

When the provider's distrust is unjustified, perhaps because it is caused by institutional prejudice, paternalistic attitudes become deeply problematic for patients. Because healthcare relationships are defined by power asymmetry, where patients are dependent on providers, medical autonomy must be understood as constitutively relational. Patients are only free to exercise medical autonomy to the extent that providers are willing to help them actualize their health goals. If a provider does not trust a patient with making health decisions, then their autonomy is diminished by way of paternalistic forces. In some cases, this may be justified and even structurally inherent to the relationship. However, if the provider’s distrust is unwarranted, then the patient is subjected to undue violations of their autonomy.

As seen with the cases of medical gaslighting above, unjustified distrust and the subsequent violations of patient autonomy can have devasting impacts on health outcomes. Even in cases where the stakes are not life or death, undue paternalism can have serious ramifications for patients. Consider a woman who seeks a sterilization to ensure they remain childfree. Suppose the provider refuses because they feel the patient is too young to make a decision like this and instead prescribes a contraceptive. If the contraceptive fails, the patient could be subjected to an unwanted pregnancy. Cases like this demonstrate not only the impact of provider distrust on medical autonomy, but also on a patient's life as a whole.

These negative outcomes push patients to distrust healthcare and we can begin to see the formation of a spiral of distrust. We can think of it as playing out in this way:

> -Your physician holds certain beliefs about women as patients that makes them distrustful of your ability to testify accurately or make good medical decisions for yourself.
> -Because of this, they engage in medical paternalism.
> -By extension, medical paternalism diminishes medical autonomy.
> -This in turn leads to bad outcomes.
> -These bad outcomes make you distrust your provider. But because healthcare is systematized, you extend that distrust to the institution of healthcare and anticipate negative outcomes for all your interactions with it.
> -You now approach healthcare with an attitude of distrust. Perhaps you delay care because you feel hopeless about healthcare’s ability to help you. Maybe you lie hoping to be heard by your provider.
> -In acting this way, you reinforce the provider’s beliefs about the trustworthiness of patients like you.
> -And so on and so on.

In this dissertation I argue that this spiral of distrust is what underlies many of the issues stemming from trust dysfunction in healthcare. Importantly, even though trust and distrust can extend in both directions of a healthcare relationship, the party most negatively affected by distrust in the relationship is the patient. Because the trust relationship between female patients and healthcare providers is often tenuous, violations of trust are more common and often have far-reaching consequences for women including, but not limited to, misdiagnoses, limited autonomy in the form of control over health plans, coerced decisions, and possibly even death.

This dissertation will analyze trust dysfunction in relationships between female patients and providers and argue that for many of the barriers women face in obtaining healthcare, distrust is the underlying issue. To do this, I will first establish the link between trust and medical autonomy in Chapter 1 by providing a framework of trust that can address the complications brought about by loosely defined roles, power dynamics, and institutions in the clinical setting. In doing so, the connections between trust and paternalism, paternalism and autonomy, and by extension, trust and autonomy, become apparent. Once this framework is established, I will give accounts of two separate autonomy violations brought on by unjust paternalism and how they play out in the healthcare setting. The first will be addressed in Chapter 2 and will deal in testimonial injustice, where patients who are silenced may attempt to reclaim autonomy in the healthcare relationship by lying to providers. They do so, not to deceive, but rather to testify in a way that can still achieve perlocutionary success despite not having illocutionary uptake. The second account will address, in Chapter 3, the issue of choice limitation in the context of reproductive health and argue that paternalistic approaches to reproduction can lead to reproductive coercion. In doing so, this dissertation will highlight some of the ways in which women's health is detrimentally impacted by trust dysfunction.

However, it is important to acknowledge the limitations in scope of this dissertation. Many, if not all, of the concerns that I will address regarding women's healthcare are also present, and compounded, in the cases of transgender people, non-binary people, immigrant women, women with disabilities, and women of color. While these groups are by no means excluded from this narrative, I acknowledge that to truly do justice to their specific experiences would require significant further, comprehensive analysis. Additionally, I recognize that as a white, cis-gender woman, I am not positioned to speak in the place of those with intersecting marginalized identities. I do hope, however, that my arguments about women generally might aid in developing arguments that are more specific to the experiences of these groups.

To avoid the mistake of painting an incomplete picture of the complex nature of medical disenfranchisement, I would like to establish the scope of this dissertation as addressing only a portion of the issue. The use of the word "woman" throughout this document has been carefully considered and found to be more appropriate, in terms of scope and situation within the field of philosophy, than alternatives such as womxn, womyn, or people with uteruses, as they each have varying exclusionary connotations and are not widely used. I am using "woman" largely as a gender term, not a sex term, though I recognize and appreciate the complexities involved with sorting these differences. Where appropriate, I intend to use neutral pronouns such as they/them.

CHAPTER 1. FEMINIST CONCEPTIONS OF SOCIAL TRUST AND THE CONNECTION TO MEDICAL AUTONOMY

1.1 Introduction

Trust is a critical element of practical human functioning. Though trust-focused philosophers differ in their accounts, they generally agree that trust is fundamental for human interactions and moral relationships. Sissela Bok (1999) states that “[w]hatever matters to human beings, trust is the atmosphere in which it thrives.” Lawrence Thomas (1989) states that “in the absence of genuine trust human flourishing is absolutely impossible,” (p. 34). Annette Baier (1994) claims that “morality, as anything more than a law within, itself requires trust in order to thrive, and that immorality too thrives on some forms of trust,” (p. 96). Trudy Govier (1997) states that “[l]ife is a boundless set of social interactions made possible by trust between and among people and, because that trust is precarious, sometimes made desperately complicated and tense by distrust and a lack of trustworthiness,” (p. 3). The importance of trust to the functioning of civilization and health cannot be overstated.

Trust is fundamentally situated within the context of relationships. When A trusts, they must trust a B, which places A and B necessarily in relation to one another.[3] This idea holds true even when we consider social relationships outside of our personal circle. We must trust other people’s accounts of reality to gain knowledge about the world and we must trust institutions and individuals to reinforce the social goods that comprise the foundational elements of society. Often, when trust is discussed, it is done so in the context of equals of the kind that would be capable of entering into a social contract. Assumptions

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[3] In instances of self-trust, one might say that A trusts A, which implies a sense of trust that is not relational. However, this distinction might not be as clear cut as it seems. Often, instances of self-trust are usually specified. For example, I trust my ability to accurately interpret the content of my experiences. B, in this instance is my interpretive ability.

of reciprocal trust also exist in these accounts, which then often treat trust and trustworthiness as two sides of the same coin. A trustworthy person expects to be trusted.

However, in dependency relationships between unequals, such as patient and physician, expectations of trust, like power, generally extend unilaterally. The provider holds the power and expects the dependent patient to trust them with that power. If the provider extends trust to the patient, it is considered a privilege, not an unconditional guarantee. In turn, the extent to which patients have power in the relationship, is dependent on the provider trusting them with that power. This dynamic means that within relationships of dependency, trust is a necessary condition for maintaining autonomy. In the context of healthcare, medical autonomy is constitutively relational, meaning that patients need providers in order to actualize their medical goals. If I need IVF to become a biological parent, I need a physician to perform it. If I want to ensure I never become a biological parent, I still need a physician to guarantee it. Constitutively relational accounts of autonomy recognize that no person is entirely independent and that as relational beings, our capacity for decision-making is shaped by our interactions with others. When autonomy is conceptualized as relational, consideration of the social reality of the individual making decisions is necessary (Gómez-Vírseda et.al., 2019).

Social dynamics can either enhance or diminish autonomy. When those in power trust or distrust their dependents to make decisions, the dependent’s autonomy is at stake. When given more trust, patients have more support to exercise autonomy. When distrusted, their autonomy is jeopardized because the provider might engage in medical paternalism, where they import their own values and beliefs about what is the right course of action as substitution for the patient’s. To put this differently, within the context of a dependent relationship with asymmetrical power distribution, a lack of trust in the dependent can lead to paternalism on the part of the powerholder, which in turn diminishes the dependent’s autonomy insofar as the powerholder is needed to exercise it. Social trust relationships in the context of dependency and unequal power distribution, and their effect on autonomy will be the primary focus of this account.

While much can be said about trust in personal relationships, the relationships I am most concerned with are those that take place in the social sphere, specifically, relationships between institutional professionals and vulnerable populations. Professionals hold powerful social positions as keepers of specialized knowledge and skills. Professionals in service vocations, such as physicians and lawyers, hold unique power over their clients insofar as they can directly and extensively impact autonomy, both within the context of the relationship and more generally in other aspects of their lives.

Medical professionals in particular have a high capacity to influence autonomy and depend on trust, extending in both directions, to do their jobs effectively. However, this trust relationship is constrained in a number of ways. Patients must trust providers to actualize their medical goals, but because of healthcare systematization, may only know the provider as a representative of institutions that may or may not be untrustworthy. Physicians must trust patients when they testify about their symptoms, values, and goals in order to provide accurate and appropriate care. However, patients are socially disadvantaged to the extent that they are not experts, and they are (typically) in need of care, making them vulnerably positioned in this social relationship.

Patriarchal prejudices compound this vulnerability for women and other marginalized groups, as they are inherently trusted less than white men as knowers and testifiers.[4] While different vulnerable populations experience this diminished trust in different ways and in varying degrees, I want to evaluate specifically the trust relationship

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[4] A study conducted by Nagle et al. (2014) found that men were perceived as more trustworthy courtroom witnesses than women. Zenger & Folkman (2019) found that despite women outranking men in nearly every other leadership category, men were seen as having more technical or professional expertise. In their study conducted to measure the impact race has on the perceived credibility of a speaker, Haut et al. (2021) "found that the participants who believed the speaker was White were significantly more likely to believe that speaker was telling the truth" (para. 38).

between women and their medical providers as a case in which diminished social trust constrains autonomy in potentially life-altering and/or detrimental ways. In laying the foundations of this trust relationship and how it impacts medical autonomy for women, this paper provides a framework for my subsequent exploration of two ways in which healthcare trust dysfunction damages autonomy. In the following chapter, I will discuss the issue of diminished testifying credibility. In the third chapter, I will discuss the problem of undue influence over decision-making and restrictions on choice expression.

The aim of this paper is to critically evaluate the connection between trust and autonomy in the context of healthcare, suggesting that female patients are susceptible to undue medical paternalism, which damages autonomy, because of sexist attitudes that erode the trust relationship between women and medical providers. To do this, I will first establish a framework of understanding social trust that can accommodate the distinctive complexities found in patient-provider relationships brought about by institutional forces and professional roles. In doing so, I will then demonstrate how, in the absence of trust, the power dynamics of the patient-provider relationship and poorly defined professional roles can lead to medical paternalism, which constrains autonomy.

1.2 Govier's Account of Social Trust

I will begin by giving a framework of social trust that can account for professional roles and institutional influence in trust relationships, in order to establish the dynamic of the healthcare patient-provider trust relationship and evaluate some of its unique complications. Govier's (1997) account of social trust, which claims that "[s]ocial trust and distrust are attitudes of people who live together and are boundlessly interdependent and vulnerable to each other," is an attempt to bridge some of the gaps in understanding trust relationships at various levels of public social interactions and can help explain some of the complexities of trust relationships in the healthcare setting (p. xi). As a point of clarification, Govier (1997) intentionally separates interpersonal trust from social trust, though some might use these terms interchangeably. Interpersonal trust is always based in some experience specifically with another individual, while some instances of social trust are not (Govier, 1997, p. 31). Social trust can explain the ways in which we trust professionals, government leaders, institutions, strangers, and systems. While Govier's (1997) account of social trust still deals explicitly in trusting other people, the space she leaves to account for trusting groups as well as individuals allows for more nuanced explanations of trusting social institutions and systems, which are at their core, still comprised of people.

What differentiates social trust from other forms of trust is the ability to consider trust relationships between people or groups of people who are essentially strangers, despite being interdependent. Unlike personal trust, social trust does not rely on intimate relationships or shared experiences and values. Rather, there is an expectation of circumstantial competency. If I have social trust with my banker, I expect them to count my money accurately and then deposit it in the safe, regardless of whether we have ever met before. But if I have personal trust in a friend, I hold certain beliefs about their attitude and disposition toward me that motivate them to act in a caring way. I am not necessarily making assessments about their competency as a friend and can usually forgive mistakes or harm because I trust that their motivations were based in an attitude of general care.

In situations where I am participating in social trust, I usually have less secure beliefs about other people's motivations or dispositions toward me because I do not know them intimately. To establish trust, I instead primarily rely on that person's competency regarding the specific circumstances we are in. When I withdraw money from the bank, I trust that the teller is competent enough to pull money from my account and not someone else's. When I take a class at the university, I trust that my instructor will teach the information accurately. I can rely on their circumstantial competence despite possibly having little or no information about their motivations or attitudes toward me personally. Under Govier's (1997) account, trust is not necessarily distributed across all situations (p. 5). I may trust the banker with my money but not with preparing food. Trust is not all-or-nothing. It is a threshold concept, and trust and distrust are often relativized to specific roles and contexts (Govier, 1997, p. 5).

Broadly understood, roles structure social relationships. They carry with them a set of expectations, norms, and moral obligations. As Dorothy Emmet (1966) states, "[t]he notion of a role has built into it a notion of some conduct as appropriate," (p. 40). The obligations incurred by a role, as opposed to more generalized obligations that we might call "natural" or even "universal," are derived from social customs and expectations of conformity specific to the social situation. Emmet (1966) suggests that a role "provides a link between factual descriptions of social situations and moral pronouncements about what ought to be done in them" (p. 41). Understood in this way, roles describe the facts of a relationship and certain expectations of norms of behavior (Emmet, 1966).

This creates a condition in which role morality is not universal in the sense that it applies to all people, but still impersonal in a way that the imposed obligations on the occupant of the role apply in the same way to all of its occupants, though not to those who do not occupy the role (Blum, 1993, p. 178). For example, the designated driver of a group of friends is universally expected to refrain from drinking alcohol, but the other friends in the group would not be held to the same standard. In fact, in this particular example, the role itself exists because of the differentiation of moral obligations in the social situation. Under views such as Lawrence Blum's (1993), the obligations that stem from roles can be viewed as "externally placed upon anyone who comes to occupy the role," and therefore may not reflect the role occupant's personal values, thus creating an 'impersonal' moral pull "entirely external to the person," (pp. 178-179).

Miranda Fricker (2012) conceptualizes this phenomenon as the tension between "individuals' private attitudes and attitudes held at the level of the group of which they are members," (p. 297). She points to the fact that social agents have "multiple social roles that generate distinct 'practical identities'," which can "generate role-specific reasons for action," (Fricker, 2012, p. 297). These practical social identities produce various relative commitments that can conflict with our personal values (Fricker, 2012, p. 298). To continue the example of the designated driver, the person occupying the role may not necessarily be the person most morally inclined to refrain from risky behaviors. They might personally value a good time over safe practice. But by agreeing to take on the role of designated driver, whether by choice or group pressure, they set aside their personal inclinations insofar as they would conflict with their role obligations. The social role, and the trust imparted on the occupant of the role, precedes personal identity.

Social trust, arrived at in this way, can then be viewed as successful or competent "role performance" within the "role set" that is completely separate from personal identity.[5] But Blum (1993) and Govier (1997) reject the idea that morally structured relationships, like those involving roles, are entirely impersonal. True social trust cannot be deduced to just competency in a specific role. In Govier's (1997) account, she evaluates various conceptions of social trust, a popular one being Erving Goffman's (1959) view of social life as people essentially occupying certain parts.[6] Similar to Emmet's (1966) notion of role performance, under Goffman's (1959) view, we position ourselves simply as play-actors fulfilling a social role and our interactions with people develop from a shared

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[5] From Emmet (1966), a "role performance" refers to the enactment of a specified relationship and "role set" refers to the group of relationships associated with a particular role.

[6] Govier's (1997) summary Goffman's (1959) view states that, "[a]s social actors we have a kind of 'front,' which has three standard parts: the setting or background, our appearance…, and our manner or style…As social actors, we offer a self-definition to an audience- those to whom we present ourselves. If the audience is willing to interact with us on the basis of this definition (or a substitute acceptable to it and us), we and our audience are in a situation of social trust" (p. 22).

understanding of normative expectations associated with that role. When I interact with the clerk at the store, I do so in a way that would be reasonable for a customer to act. Even in more familiar personal relationships, such as between mother and daughter or between neighbors, role playing is still a critical component of social interaction. My understanding of the obligations of my role might even supersede my personal feelings or attitudes when I take action in the context of the role.

In many ways, this conception of role-induced normative behavior rings true. The prevalence of code-switching seems to indicate some sort of an awareness of varying expectations based on a perceived social role at any given time.[7] But Govier is right to reject this as a full definition of social trust. Social life is not wholly composed of people acting out various roles, because we have a stable personality and identity apart from a constantly shifting and adapting series of roles (Govier, 1997, p. 23). Where Goffman's account may seem more intuitively appropriate is in the specific role of say, professionals. However even here an impersonal approach does not capture the full picture.

In recognizing social trust as neither personal nor impersonal, Govier's (1997) account of social trust can help us conceptualize the unique complexities of trust in the healthcare setting. First, it allows for a more nuanced approach to understanding multilevel factors of trust. We know that in most cases, relationships between patients and providers cannot accommodate the expectations of personal, or "thick," trust because we don't know our providers intimately.[8] Unlike personal trust, social trust does not rely on intimate relationships or shared values and experiences, which makes it more suitable for

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[7] Code-switching is generally conceived of as a linguistic phenomenon though its relevance to general social theory indicates that at some level, it can be used to define and structure a social interaction. See Peter Auer (1998).

[8] A common way of conceptualizing trust is as thick or thin trust. Thick trust deals in close personal relationships. Thin trust is applied to everyone else and only covers expectations of reasonable non-interference. Thick trust is given to close friends and family and all other instances of trust are generally considered to be instances of "thin trust," where there is a certain expectation of negative outcomes.

understanding healthcare relationships. However, accounts of thin trust are too minimal to capture these social interactions, because the trust we put in healthcare professionals requires more than just an expectation of non-interference.

Further complicating the classification of this relationship is the fact that healthcare relationships are also institutional. Accounts of interpersonal trust, which tend to be central in the understanding of social trust, can only accommodate the relationships between individual providers and patients. But in working with a provider, patients are also working with the institution of healthcare. Being able to account for trust in the institution, as well as the individual provider, is critical to understanding trust in contemporary healthcare as medical relationships have become significantly less personal with the systematization of health services. By not classifying social trust as interpersonal trust, Govier's (1997) account can accommodate some of the complications of trust relationships that involve both individuals and institutions, such as in the case of healthcare.

Additionally, Govier's (1997) understanding of roles in the social setting, specifically professional roles as they relate to institutions, can help identify how healthcare represents a particularly complicated case of social trust. First, the social role of patient and provider both carry with them certain inherent identity power implications. Patients are vulnerable insofar as they are ill or dependent on the provider for knowledge or care. The provider, on the other hand, is given more social power as a professional with specialized knowledge. Despite the fact that ideally, one of the aims of healthcare is to lessen dependency through medical intervention, the power dynamics of the relationship are structural, meaning the patient, in their role as patient, will always be in some state of dependency on the provider, in their role as professional. In all professional relationships the balance of power inherently tips in the direction of the expert. But in the healthcare profession the inequity is more extreme because of the nature of the dependency patients have toward their providers.

For many professions, the dependency is primarily knowledge-based. I depend on scientists for knowledge about things like the weather or chemical composition of my cleaning products. People rely on healthcare professionals for specialized knowledge as well, but that knowledge has immediate and personal stakes for patients. Healthcare is fundamentally a service vocation, where the aim is to serve the good of an individual (Blum, 1993, p. 179). More specifically, healthcare is a service vocation with life-dependent stakes, which creates a greater sense of dependency and gravity than would be found in other professional relationships. I might depend on a climate scientist to provide me with information about ice melt, for example, but I might need a physician to save my life.

While both roles in the patient-provider relationship come with certain normative expectations about how to behave in that role, the power dynamics of the relationship may make it difficult for patients to address role violations on the part of the provider. Because social roles are still occupied by individuals with stable identities external to that role, there is a sense in which the personal values of the individual influence the ways in which they perform that social role. The boundaries of professional roles, especially service vocations, can be poorly defined, leaving significant interpretive power to the professional in determining what aspects of the dependent's well-being are and are not within the scope of their care. Crossing these boundaries can cause distrust in the relationship, especially if the dependent's autonomy is diminished. However, because of the structural power dynamics of these relationships, dependents may not be in a position to prevent or address these violations. The following sections will address the issue of role boundaries in maintaining social trust, as well as other complications that make trust in healthcare relationships difficult, including the issue of institutional obligations, systematization of healthcare, and dependency in light of institutional prejudice.

1.3 Roles and Identity Power

In order to better understand how trust violations can occur within the context of social roles, we need to understand the structure of roles that are in the best position to cross boundaries in the ways discussed above. Often when we think of social roles, we think of our professional occupations. Much of our social identity is tied to notions of a career or vocation, which means that our professional identity can impact our personal identity and vice versa. Professionals can be given increased social power, which under Fricker's (2007) account of identity power, is "a capacity we have as social agents to influence how things go in the social world." This increased social power exists, not just within the context of their professional role, but also because that role imbues them with inherent social respect (p. 9). This increased social power holds certain moral obligations but can also be the basis of certain moral harms created within the context of the professional role relationship.

Blum (1993) is concerned with the types of moral obligations we incur through our professional roles. As discussed earlier, Blum (1993) acknowledges the impersonal nature of role morality but rejects the idea that it is entirely impersonal, arguing that "[t]here is a large range of types of action and motivation which fall neither on the side of the personal and nonmoral nor on the side of the purely impersonal and moral," (p. 174).[9] The personal-impersonal dichotomy of morality, which can be found in Kantian conceptions of moral duty, does not accurately capture the ways in which personal good and morally structured relationships are intertwined, especially when considering vocational roles. Blum (1993) uses the example of a teacher providing tutoring to an illiterate boy to demonstrate how the personal-impersonal understanding of roles, even in the context of a profession, fails to fully appreciate the complexities of moral obligations:

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[9] Blum (1993) rejects the "personal/impersonal" framework of moral obligation "as exemplified in the work of Thomas Nagel, Susan Wolf, and Norman Care."

> Kohl, then a secondary school teacher, was asked by some parents in a school in which he was teaching if he would give special tutoring to their son. The boy was 14 years old and did not know how to read. He was a large boy, angry, and defiant; his teachers did not know how to handle him. Kohl agreed to work with the boy two days a week after class. Kohl worked with the boy for several months. Kohl found him extremely difficult and never grew to like him personally. But eventually he helped the boy to begin reading. Kohl describes how he came to take a personal interest in the boy's progress as a learner and to find satisfaction in what the boy was able to accomplish under his tutelage. (p. 176)[10]

From this example, it can be said that Kohl did not personally benefit from tutoring the student nor did he have some impersonal moral obligation to assist the child. His actions were neither personal nor impersonal, but they were situated within his role as a teacher (Blum, 1993, p. 177). The morally structured relationship between teacher and student made Kohl's decision to tutor the student appropriate in a way that would not hold the same weight if he did not occupy the role of teacher. Yet, under Emmet's (1966) view of roles as a set of specified obligations, it is still not immediately clear that Kohl had a role-based obligation to assist the child in this way, as it is not explicitly listed as part of his job description.

Herein lies the distinction between roles (as conceptualized by Emmet (1966)) and vocations for Blum (1993). Anyone can fill a role, but for Blum (1993), "[t]he notion of a vocation implies that the ideals it embodies are ones that speak specifically to the individual in question," (p. 179). Because vocations are still roles, there is a sense in which the moral obligations that accompany a vocation are still impersonal to the extent they are "externally placed upon anyone who comes to occupy the role," (Blum, 1993, 178-179). However, as Blum (1993) states, "when a vocation exercises moral pull-e.g., the moral pull which Kohl feels toward helping the illiterate boy- it is not in this sense impersonal, for it is experienced as implicated in the individual's own sense of personal values (as

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[10] Taken from Herbert Kohl's (1984) *Growing Minds: On Becoming a Teacher.*

embodied in the vocation)," (p. 180). In this way, roles qua vocations can occupy a space between impersonal and personal.

In being situated in this way, there is room for the occupant of the role to exercise individual interpretation of what they understand as the "values, ideals, and traditions of [their] vocation," and how "[they] experience its moral pulls," which we will find has particular importance and implication in the healthcare setting (Blum, 1993, p. 180). While Blum (1993) is careful not to allow for subjectivism in vocational understanding, he does claim that there is significantly more room for interpretation in the case of vocations than roles because "the statement of ideals and values is at a much greater level of generality than a statement of role responsibilities," (p. 180).

As such, the scope of what is under the purview of those occupying the vocational role and the extent to which personal values and ideals should factor into normative expectations of the role are poorly defined. Further, these values and ideals can come to shape the actual role obligations of a vocation as they are normalized and institutionalized (Blum, 1993, p. 180). This seems to hold especially true in the case of vocations associated with a 'profession.' Govier (1997) describes professional roles as "occupational roles with special characteristics," which presume that "occupational skills are based on the possession of well-grounded theoretical knowledge that has practical implications of central importance," (pp. 78-79). Specifically, she is referring to occupations such as law, medicine, and science. These roles tend to be self-governing to an extent and set their own standards of practice.

Because of their specialized knowledge, professionals hold positions of implied social trust. But according to Govier (1997), "many people are uneasy about dependence on experts and professionals," because they feel vulnerable in the face of professional power and are "intimidated by specialized knowledge," (p. 77). Many point to extreme examples of corruption and abuse of power, or even incompetence, to explain this distrust;

but even in the face of good standards of practice, people still resent their dependency on experts. Govier (1997) states that, “those who cannot avoid relying on professionals often resent that dependence, complaining that the status and power of professionals exceeds what their competence and morality would warrant,” (p. 77). So, while extreme examples of violations of professional trust may cause the public to question or even temporarily lose confidence in professionals, the bigger, more prevalent issue may be one of overstepping poorly defined roles.

As social roles are often defined through our occupations, part of the way in which we build social trust is through executing those roles in predictable ways. I expect a specialized knowledge base, demeanor, and behavior from my mechanic that I would not necessarily expect from my dentist or philosophy instructor (Govier, 1997, p. 78). Deviations from these expectations might make me question the competence of a professional and diminish trust. While I should be able to accommodate certain variations in demeanor because I am obligated to acknowledge the professional as a full person, despite not knowing them outside their social role, I might have a sense of violated trust when the professional imports certain personal values into their professional role. As a teenager, when my pediatrician chastised me for chipped nail polish during a check-up, I immediately began to distrust him, not because he was not a capable physician, but because he crossed a personal boundary that was inappropriate in the structural context of his professional role and our social relationship.

Perhaps Blum would agree that this particular case transgresses the appropriateness of vocational interpretation, but it is difficult to say where that line gets drawn. Under Blum’s (1993) definition of “vocational care,” a professional, especially one in a service vocation, must care about their charge in their totality (p. 183). In the case of the teacher, for example, “[t]o be caring, the concern must involve some regard for the pupil’s overall good and a sense of how the good of learning the specific subject matter fits into the pupil's overall good," (Blum, 1993, p. 183). This is important insofar as it ensures that the professional views the charge as a person in their own right but provides little action guidance in terms of boundary-setting. Blum (1993) attempts to clarify this claim, stating that, "caring for one's charges as a whole person, and in that sense having some concern for all aspects of her good, is not incompatible with a (semi)specialization of sensitivity and concern on only some aspects of her good" (p. 184). He further states that depending on the vulnerability and intimacy of revelation by a dependent, a professional must exercise different sensitivities to "issues of trust, confidentiality, and betrayal" in different vocations (Blum, 1993, p. 184).

But this clarification seems to point to types of care that one ought to pay special attention to, not necessarily types that should be avoided. One potential consequence of Blum's view is that in an effort to care about the client in their totality (even their moral well-being), professionals may mistakenly expect or demand factors of personal trust in a situation that only warrants social trust. For example, a healthcare provider who distrusts a patient because they do not share similar values about reproduction would be importing expectations of thick or personal trust into a situation that should only require social trust. When considered in tandem with the unequal distribution of power between professionals and dependents, this sets up conditions in which paternalism thrives.[11]

Blum (1993) acknowledges that vocational caring is incompatible with rigid role definitions because "the charge's whole good must be the object of care," but there is a sense in which this idea of all-encompassing vocational care undermines trust (p. 185). Baier (1994) states that, "[o]ne way in which trusted persons can fail to act as they were trusted to is by taking on the care of more than they were entrusted with…," (p. 101). In a professional-dependent social relationship, there could be a disconnect between what the

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[11] Paternalism here is being defined as guidance or interference imposed on another for their own good (Bok, 1999, p. 204).

client views as appropriate in the context of the role and what the professional views as duties encompassed within their vocational obligations. This difference of boundary expectations could be a cause of distrust forming in the social relationship.

This seems especially true in healthcare and represents one of the ways that role identity makes trust in the provider-patient relationship difficult. Given that healthcare values are both deeply personal and at times, politically contentious, such as in the case of reproductive health, poorly defined boundaries in the healthcare relationship can lead to situations in which trust is violated because the provider imports certain values and beliefs about what is in the best interest of the patient into their professional obligations. There may be a disagreement about what is considered within the scope of the provider's care. Consider a scenario that we will return to in a following chapter of this dissertation: A young, unmarried female patient seeks a tubal ligation because they are certain they do not want to have children. The provider is concerned, given their age and marital status, that they will regret this decision in the future and instead offers a long-acting reversible contraceptive (LARC). The provider may believe that caring for the totality of the patient in this situation requires a concern for their potential feelings of regret and for the feelings of their potential future spouse regarding this decision. However, the patient may feel that this concern oversteps the bounds of the professional relationship and begins to distrust the provider, either in their ability or motivation, to help them actualize their health goals. This echo's Govier's (1997) concern that people resent their dependency on experts because the elevated social power of the professional gives them more relational power than what is warranted.

However, because of the structural dependency and power dynamics of the patient-provider relationship, the patient may not be in a position to determine the boundaries of the relationship. Insofar as the provider has the greater social power in the relationship, they are in the better position to set the normative expectations of the role relationship. So while the patient may feel that the concerns of the provider are unwarranted in the context, the provider might consider their concern a moral obligation of the vocation. Because social roles understood in this way are poorly defined, the boundaries of the social relationship may be interpreted differently by patient and provider. However, because the provider is in the position of power and by extension sets the terms of the relationship, the patient's boundaries may be violated without recourse, leading to distrust in the relationship.

Similarly, because social identities are closely tied to notions of our vocations, certain personal values or beliefs may be interpreted by the provider as being values or ideals of the vocation. In the context of women's health in particular, this can impact how providers understand the moral pulls of the vocation, which could lead them to make medical judgements that are in fact socially informed. Considering again, the case of the young, unmarried patient seeking sterilization, the physician's determination of the patient's candidacy for the procedure may not be based on medical factors, such as whether the procedure would be effective or safe, but rather on certain social factors that the provider considers of moral import. The provider makes a value judgement, based not on the medical virtues of sterilization, but rather on whether young, unmarried patients should be voluntarily sterilized in light of their social position.

The concern in healthcare is that the poorly defined role structure in tandem with the structural dependency of the relationship can lead to situations in which the patient's healthcare values and goals are substituted for those of the provider, and the dependent patient is left without a means of addressing the violation. The provider may only trust patients to exercise decision-making power to the extent that their values align. If they do not, the provider might distrust or doubt the patient's ability to make medical decisions for themselves and may feel morally justified in making certain medical decisions, or taking away access to certain medical choices, in the interest of what the provider perceives to be the patient’s overall well-being, which they may also take to include their moral well-being. This is known as medical paternalism and as further sections of this paper will show, has limiting and damaging effects on autonomy.

1.4 Systematization of Professional Roles

One might think that institutional oversight would solve the problem of paternalism and value importation because it systematizes the relationship between professional and client, leaving less room for interpretation and blurred boundaries of care. In *View from Nowhere*, Thomas Nagel (1986) envisions a world built upon impersonal morality, where “the great bulk of impersonal [moral] claims were met by institutions,” leaving individuals to focus on creating good lives for themselves (p. 207). Blum (1993), for his part, would claim that this is not ideal, as vocations “can comprise profound goods in a person’s life,” (p. 193). Fricker (2012) also states that, “very often the role-specific commitments may spill over into personal commitments, which can be helpful in shoring up our responsiveness to role-related obligations,” and that “if these roles are ethically significant ones, this can be part of a process of personal moral development,” (p. 298). In essence, the profession would stop being a vocation and become merely a job or role in the most basic sense.

While there is likely a lot of truth in Blum’s position, systematizing professional roles risks more than personal satisfaction in one’s career. In some instances, the professional may be given less trust if they are not backed by a larger group. A client may choose a larger law firm over an independent attorney because they believe that their resources are greater or standards are higher. But joining a larger group may also put constraints on the acting discretion of the professional, undermining the quality of their work and by extension, their credibility. Perhaps the law firm has a policy about overtime that prevents the lawyer from spending adequate time on the client’s case. Though Govier’s (1997) account of social trust allows for meaningful group trust, it is worth pointing out that interpersonal trust based on positive experiences between individuals will still produce a more robust trust relationship. In a situation where the professional is essentially acting as a representative of a collective, the capacity for interpersonal trust with a client is inherently diminished.

It may also be the case that a professional backed by an institution may lose trust simply by association. While it seems true under Niklas Luhmann's (1979) notion of "intersubjective agreement" that institutions can provide knowledge and authority in collaborative efforts to define 'truth,' by the same notion, failed institutions can undermine knowledge and/or the ability of the profession to serve the public. If people have lost trust in a corrupt government, they may also distrust scientists who work for a government agency, even if their work is peer reviewed. Perhaps the most prominent contemporary case of institutional distrust can be seen in the breakdown in the relationship between communities and law enforcement.[12] Individual officers might feel it is more difficult to fulfill their role commitments because of distrust in the justice system but not recognize that their commitments to the institution underlie the practical identity of being a police officer (Fricker, 2012, p. 297). Fricker (2012) specifically discusses the case of institutional racism in law enforcement specifically, stating that,

> The institutional vice [racism] stems from group members effectively committing to a practice of racial stereotyping by going along with that practice as a matter of workplace culture. The collective commitment to the practice thereby becomes part of the very practical identity of a police officer in that force. (p. 297)

So, while there are probably a few law enforcement officers who view their role in the context of a service vocation and attempt to personally embody the moral obligations that

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[12] The most egregious violations of trust occur within interactions between Black communities and law enforcement but interactions with the mentally ill, rape and domestic violence victims, and immigrants frequently go poorly, suggesting that as an institution, law enforcement is dangerous to trust for vulnerable populations.

should come with their profession, their affiliation with law enforcement as an institution undermines their trustworthiness regardless of how well they might be able to do their job. Often, the more closely a professional works with an institution, the more their role as representative of the institution overshadows or subsumes their other vocational roles.

In addition to being professionals in the service vocation of healthcare, providers are also institutional representatives. This fact underlies a second classification of role identity complicating the ability of providers and patients to build trust. Breaking this issue down further, there are at least three ways in which the role of providers as institutional representatives can make establishing trust with female patients difficult. First, while it seems obvious to consider providers as representatives of the scientific institution of medicine, they also act, willingly or unwillingly, as representatives of the political and social institutions that involve themselves in healthcare, whether that be through reinforcing social norms or through upholding legislation. This becomes especially problematic for patients made duly vulnerable by one or more marginalized social identities. To the extent it is dangerous for marginalized individuals to place trust in institutions, it is also dangerous for them to place their trust in a more institutionalized field of healthcare because they can be subjected to the same oppressive mechanisms that other institutions, such as justice or economics, standardize.

Women’s health can be viewed as a clear example of this concern, as their healthcare is deeply impacted by political institutions. In the first half of 2021 alone, 561 abortion-restricting pieces of legislation were introduced, with 83 being enacted (Nash & Cross, 2021). In many ways, political institutions utilize healthcare as a vessel by which to govern women’s bodies. When a state passes, say, an informed consent law that mandates physicians to describe embryonic anatomy prior to an abortion, the healthcare provider is put in the position of enforcing that legislation and in that capacity, acts as a representative of a political institution that is undermining women's bodily autonomy, which will strain the trust relationship between the patient and the provider.[13]

Some of this legislation, such as a recent Kentucky state bill that requires physicians to include a consent form that claims the effects of a medication abortion can be reversed, is not even rooted in scientific fact (Stracqualursi, 2022). This puts healthcare professionals in the position of having to uphold policies and practices that may run contrary to the knowledge given to them by their experience and expertise, further diminishing their credibility. Perhaps if the provider had an opportunity to build relationships with their patients outside of situations that are politically influenced, there could still be some level of preserved trust, but because of the way healthcare is systematized, this is likely not feasible. It is clear then that the role of healthcare professionals is complicated by the fact they are inextricably linked to political institutions and less capable of developing interpersonal trust relationships with patients.

While providers may be unwilling political agents in this sense and (even rightly) complain that the distrust that stems from this connection is misplaced, this is not the sole, or even the primary, factor contributing to breakdowns in trust between women and healthcare. This leads to the second way in which trust is complicated by institutional affiliations. Even when establishing professional trust solely on the basis of successful role fulfillment (such as Emmet's (1966) account), healthcare has a competency issue. Historically, women were excluded from clinical trials based on fears about how untested pharmaceuticals could cause birth defects. Women also experience adverse drug reactions at greater than twice the rate of cisgender men (Zucker & Prendergast, 2020, p. 3).[14] Even the effects of medication designed specifically for female bodies, such as oral

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[13] See van Dis & Choo (2019) for an example of this type of legislation.

[14] I say 'cisgender women' here because research on the rates at which transgender women experience adverse drug reactions is severely lacking.

contraceptives, have been poorly understood. Despite being widely available since 1960, a study linking use of hormonal contraceptives with increased risk of depression was not published until 2016 (Skovlund et al., 2016). A 2017 *Journal of the American Heart Association* study found that women suffering from cardiovascular disease had "higher excess mortality" rates compared with men partly because of delayed treatment due to misdiagnosis (Alabas et al., 2017). About 63% of women diagnosed with ovarian cancer in a given year will die from it, largely because a diagnosis takes, on average, six to nine months after initial consultations (Heid, 2019).

Healthcare professionals must also contend with a long history of violations of women's medical autonomy. Hysteria, considered a medical condition well into the 20th century, not only stigmatized normal sexual desire in women and justified the exclusion of women from positions of power on the basis of instability, but also stilted medical progress to the extent that physicians used it as a "catchall" diagnosis for any symptoms they did not understand (Pearson, 2017). The involuntary sterilization of institutionalized women, especially poor, disabled, and minority women, was pervasive throughout the 20th century and continues to be practiced on prison inmates in states like California (Stern, 2020). While thorough statistics are difficult to obtain, it is known that medical students frequently perform pelvic exams on unconscious patients without their consent (Friesen, et al., 2022).[15] This is of course not a comprehensive list of ways in which healthcare is complicit in the undermining of its own trustworthiness, but it does indicate that as an institution, healthcare has historically and continually provided women with reasons not to trust it.

Finally, despite this evidence of institutionalized oppressive practices, providers may be inclined to believe that public distrust stems from sensationalized cases of

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[15] A 2016 study done by ELLE magazine of 101 medical students from seven different schools claims that 92% of medical students report performing a pelvic exam on an anesthetized patient and 61% report doing so without explicit consent (Tsai, 2019).

individual bad actors. The gross misconduct of people like Kermit Gosnell, Larry Nassar, and John Coates III, and the deadly medical mistakes made by people like RaDonda Vaught and the Duke transplant team that worked on Jesica Santilian, can be viewed as examples of this type.[16] Per Govier (1997), these are the cases that professionals worry make clients unwilling to trust them because, "as they see it, media publicity about unrepresentative cases has rendered the public unnecessarily suspicious," (p. 77). While these cases undoubtedly reflect our worst fears about abused trust in professionals, it is not clear that these cases individually contribute to a prolonged distrust of the field. Govier (1997) states that, "[e]ven in periods where there has been extensive media publicity about dishonesty or outright abuse, professional standing still tends to carry a certain initial credit," (p. 82). To place the blame of professional distrust on these cases reveals an unwillingness to reflect on the oppressive institutionalized norms of the field and the role that professionals play in reinforcing them.

The practical identity of medical professionals is locally situated in their collective commitments (Fricker, 2012, 299-300). It is important to acknowledge the fact that professional institutions, including medicine, still operate with a significant level of autonomy and often set their own standards and norms of practice (Govier, 1997, p. 80). Baier (1985) elaborates further on this idea, stating that, "[b]eyond the rights, powers, duties, and responsibilities [of a professional] lie the convictions, sometimes inarticulate, of those who created those artificies [sic], or who accept a life structured by them" (p. 226).

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[16] For context, Kermit Gosnell was convicted of murder, manslaughter, and other medical-related crimes in 2013 in connection with unsafe and illegal practices discovered in his abortion clinic. Larry Nassar was convicted in 2017 of sexually assaulting at least 265 girls and women under the guise of medical care for athletes. John Coates III lost his medical license in 2022 and found liable for damages in the amount of $5.25 million after inseminating Cheryl Rousseau with his own genetic material without her knowledge in 1977. Jesica Santilian, an immigrant minor, died in 2003 after the Duke University Medical Center transplant team failed to check blood type compatibility and gave her mismatched donor organs. Former nurse, RaDonda Vaught, was convicted of murder in 2022 for the 2017 death of an impaired patient by accidentally injecting her with the wrong medication after overriding multiple safety protocols built into an electronic medication cabinet.

This includes "convictions about the sort of *persons* who should fill these and other roles our society offers," and "the sort of person the roles themselves should help nurture" (Baier, 1985, p. 226). In this sense, the institutional prejudices and oppressive norms that plague medicine, both historically and currently, begin and end with the professionals who occupy roles within the institution and uphold its standards. This is a third way in which the provider's institutional commitments can undermine patient trust.

The likelihood is that the distrust women have in healthcare does not actually stem from the most egregious examples of gross misconduct. Instead, the social relationship between female patients and providers suffers a 'death by a thousand cuts,' caused by numerous smaller instances of unanswered violations of trust and respect. Persistent and pervasive micro-injuries by individual providers can fuel negative expectations about interactions with the institution itself and vice versa, because in a modern system, the two are synonymous in many ways. So, the fear, not of what *could* happen in a worst-case scenario, but of what women believe *will* happen when they place trust in healthcare, is the problem. While the wrongdoings of people like Larry Nassar might be in the back of my mind when I seek medical care, I (and I would argue, most women) can rationalize well enough to accurately gauge the threat level the provider actually poses and set aside those fears. More difficult to overlook are the past experiences that inform my beliefs about the attitudes providers, as individuals and representatives of the healthcare institution, hold toward me as a female patient, and the ways in which they reinforce oppressive norms that exponentiate the vulnerability of medical dependency.

1.5 Institutional Trust

Because the vocational role identity of providers is becoming progressively more subsumed under their identity as institutional representatives, we need to understand how institutional trust factors into our understanding of social trust. Increasingly, social trust depends on institutional trust. Though fundamentally removed from the concept of interpersonal trust, institutional trust has the same logical structure and still entails a type of relationship. For Govier (1997), to trust an institution is to have “fundamentally positive beliefs and expectations about our interactions with it,” (p. 34). The primary difference here is that the trust is placed in a thing as opposed to a person. Depersonalized trust in this sense aims to simplify life by making it easier to generalize trust through the use of “trust devices” (Sellerberg, 1982). These devices, such as name-brand credit cards, warranties, terms and conditions disclosures, and FDA food labels, function to provide a basis of trust through association with a system or institution, rather than personal experience with an individual.

In many regards, institutional trust echoes the aims of philosophers like Nagel (1986), contractarians, and other system-focused theorists. By relying on procedures, rules, and systems, we are attempting to make impersonal the morally structured roles that work within the institution. But though bureaucracy can seem devoid of humanity, it is critically still developed and maintained by human beings. A failure to recognize the ways in which institutions are *not* morally impersonal can lead to permissively reinforced systemic oppression. A system designed to adopt the “view from nowhere” always favors the system’s creators, which is typically wealthy white men. Even de-personalized institutions are still subject to the prejudices of institutional actors who establish its culture. Social trust institutionalized in this way is significantly less risky for those with social privilege but represents higher risks for those facing institutional oppression.

With that in mind, in urban areas today, structured social interactions between professionals and individuals are often backed or regulated by institutions or large conglomerates. Even the grocery store on my street is part of a national chain of grocery stores. So when I trust that the food is safe, I am not putting my trust necessarily in the competence of the people who work at that store, but rather the policies and systems that the corporation has put in place to account for quality assurance. In some ways, institutional association lends credibility. In others, especially when considering political or social institutions, this association can have the opposite effect, increasing social skepticism and decreasing social trust. For better or worse, there seems to be some truth in the fact that the modern world depends on system trust, not personal trust, as a means of maintaining social structures.

This shift to institutional interactions as the primary basis of social relationships further complicates the roles of professionals, who leverage their vocational integrity as experts with specialized skills as the justification for their discretion and judgment in their respective roles. They derive their knowledge from institutions and often represent institutions through their work. So, in many ways, the institutional connection is embedded in the role itself. However, many professionals position themselves as being committed to their knowledge above all else, suggesting an implicit impartiality. Through connections to institutions, however, there may be a perception, correct or otherwise, that the professional also has commitments to institutions. The public they interact with may view them as functioning to serve the interests of power and be suspicious of their motives or capacity to be impartial (Govier, 1997, pp. 70-71). In a more extreme sense, the very knowledge that makes them experts might be undermined. As Govier (1997) states, “Knowledge requires trust; without trust, there is no knowledge,” (p. 70). When these experts also fulfill roles of service, as in the case of healthcare professionals, we lose more than knowledge when trust fails; we also lose vital social services.

The healthcare profession can represent a distinctly problematic case in which systemization and poorly defined roles make trust difficult. Modern conceptions of medical ethics attempt to side-step the need for trust through the implementation of institutional “trust devices” such as, “living wills, ethics committees, contracts between doctors and patients, monitoring boards and agencies to scrutinize doctors’ competence and procedures, the use of ombudsmen and other committees as intermediaries, and a strong emphasis on patient autonomy and informed consent," (Govier, 1997, p. 85). But these institutional devices fail to account for the ways in which individuals interpret principles, like autonomy and informed consent, and implement them in the context of professional relationships. For any successful working relationship between patients and providers, there must be some degree of trust that interpretations of these principles will be done in good faith. In this way, practices like informed consent and respect for autonomy are not alternatives to trust; they presuppose it (Govier, 1997, p. 85).

Complicating this dependency further is the fact that health, as an industry, has moved to a more systematic approach to treatment and care. Recent decades have depersonalized healthcare to the point where many patients can no longer develop any real interpersonal relationship with a specific provider, making personal or thick trust nearly impossible. One of the benefits of personal or thick trust is that it supports "substantial trust," which involves "making or maintaining judgements about others, or about what our behavior should be towards them, that go beyond what the evidence supports" (McGeer, 2008, p. 240). Substantial trust allows trust relationships to continue despite potential violations of trust or in the face of evidence of untrustworthiness. With a foundation of personal trust, healthcare relationships could insulate themselves against violations of trust because there would be expectations of care that supersede evidence of untrustworthiness.

However, it is no longer unusual for people to have little to no interaction with their attending physician (even a general practitioner). Some, like those who receive care from large group practices, may not even be scheduled with the same provider from appointment to appointment. This means that the patient-provider relationship might always be a relationship between strangers. Even if patients do see the same physician, studies indicate that a primary care physician spends about 10 minutes with their patients, though additional studies indicate that physicians and their staff are likely to overreport time spent with patients by about 4 minutes (Tai-Seale et al., 2007, p. 1872).[17] This systematization of healthcare is consistent with the transition to a greater reliance on institutional trust, or trust relationships between individuals and institutions rather than trust between two individuals, that has been seen in other professions in modern society. However, the nature of the dependency found in the patient-provider relationship, and the vulnerability it entails, makes the systematization of healthcare more high-stakes for the people served by the vocation, especially those facing marginalization.

1.6 Distrust and Paternalism

So far, I have set up the structure of the healthcare relationship and established why its unique social situatedness requires an account of trust that can accommodate relationships at interpersonal and institutional levels. Concurrently, I also established ways in which loose role structures and institutional commitments can create embedded complications in maintaining trust in the relationship, particularly when discussing healthcare relationships with historically marginalized groups such as women. The discussion of how trust is made difficult in healthcare relationships has focused primarily on reasons why patients might distrust healthcare. This is because certain structural realities of the healthcare relationship leave patients, especially those who are subject to institutional oppression, vulnerably situated. Patients incur more risk in trusting providers and are more detrimentally impacted when the trust relationship erodes.

Now, I am turning the conversation to how distrust plays out in the context of healthcare relationships. While the cyclical disintegration of this trust relationship stems from distrust on the part of both parties, and despite marginalized patients having more structurally embedded reasons for distrust, we must discuss the consequences of distrust

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[17] See Yawn et al. (2003) and Gilchrist et al. (2004).

in this relationship within the context of providers distrusting patients. This is because in many ways, the cycle of distrust turns on distrust on the part of the provider. In large part, this is because the provider has greater power to reactively influence how the relationship plays out in light of their distrust. This is true both in a direct sense, where the provider exercises power over an individual patient, and more broadly, as an institutional professional who can shape norms about how patients are perceived and trusted within the institution of healthcare. In this way, providers can contribute to institutional barriers to trust for groups of patients that are subject to specific social prejudices.

As stated previously, the loosely defined parameters of professional roles qua vocations leaves healthcare professionals with significant interpretative power in determining how to understand their vocational obligations and what aspects of a patient's well-being fall under their jurisdiction. Coupled with the inherent power dynamics of the patient-provider relationship, healthcare providers are uniquely positioned to exercise paternalistic influence. There is a direct connection between distrust and paternalism, as paternalistic attitudes stem from a belief that one cannot be trusted to know their own minds and experiences or make decisions that promote their well-being. If an individual was trusted to know and protect their own well-being, the need for paternalism would cease to exist. If a provider does not trust a patient to make what they take to be sound medical decisions, they may feel a moral pull originating from their vocational role to act paternalistically toward the patient.

Generally understood, paternalism involves some restrictions placed on an individual's ability to choose or act, under the guise of care. Bok (1999) states that, "[t]o act paternalistically is to guide and even coerce people in order to protect them and serve their best interests" (p. 204). This can include practices such as value substitution, where the paternalistic actor imports their own values or beliefs into a situation and unduly influences decision-making, or through withholding the choices available. While we typically think of paternalism as situated within the context of decision-making, it can also be found in situations that warrant knowledge and testimony, a topic that will be further explored in the following paper of this dissertation.

Limited and specialized paternalism, as within the context of healthcare or government, can be structurally inherent, expected, and occasionally even justified. Providers often place restraints on patient choice in the interest of their well-being and not only in obvious cases where a patient lacks decision-making capacity as a consequence of age or condition. Part of fulfilling their professional role responsibly involves exercising an authority to restrict patient choice in the interest of well-being. It is conceivable then, that certain notions of paternalism are to be expected within the structure of the patient-provider relationship. After all, the very need for the professional role of healthcare provider exists because patients lack the specialized knowledge needed to practice medicine effectively. While there are certain instances of paternalism that stem from an overstepping of boundaries that are unwarranted within the context of the provider's role, there are certain ways in which paternalistic attitudes are scope-appropriate and justified to the extent that the patient truly should not be trusted to make the decision on their own. However, paternalism can only be justifiable insofar as the distrust placed in that individual is justified. To the extent that the distrust is unjustified, so is paternalism, because it would be based in false beliefs about the individual's capacity to know and act in their best interests.

One of the more insidious and trust-eroding ways in which unjustified attitudes of paternalism manifest is in the form of providers not trusting women on the basis of unjust institutional prejudices, which exasperates the inherent vulnerability of patients, who are dependent upon providers and therefore in a position of unequal relational power. One way in which paternalism becomes unjustifiable is accompanied by moral wrongdoing, typically in the form of oppressive prejudicial attitudes. This means that women are uniquely susceptible to undue medical paternalism because of sexist attitudes about women's ability to make choices about their own lives. This paternalism is systemic and is reinforced by the politicization of female bodies. The same institutionally sexist attitudes that erode female patient-provider relationships are used to justify and reinforce coercive paternalistic practices in medicine.

1.7 Medical Dependency and Relational Autonomy

Concerns of how institutional prejudice can influence a patient's perceived trustworthiness are of great importance and carry high stakes for their ability to exercise medical autonomy. This is because the inherent structures of dependency in the patient-provider relationship makes medical autonomy constitutively relational, and to the extent that unjustified distrust can create situations of unjustified paternalism, a patient's autonomy is in jeopardy. This section will make explicit the relationship between trust and medical autonomy. If providers distrust patients, they may exercise paternalism within the context of the healthcare relationship, which has limiting effects on a patient's ability to express and achieve their health goals to the extent that the patient is dependent on the provider to assist in actualizing them. Where there is distrust in a dependency relationship, autonomy is at risk.

We need to get clear on what is actually at risk in health relationships marked by distrust. 'Autonomy' as a concept encompasses a broad range of things that may require different conditions and may be better understood through a division of parts. Catriona Mackenzie (2014) states that "the concept of autonomy involves three distinct but causally interdependent dimensions or axes: self-determination, self-governance, and self-authorization." Self-determination "involves having the freedom and opportunities to make and enact choices of practical import to one's life." Self-governance "involves having the skills and capacities necessary to make choices and enact decisions that express, or cohere with, one's reflectively constituted diachronic practical identity." Self-authorization "involves regarding oneself as having the *normative authority* to be self-determining and self-governing," (pp. 35-36).

Medical autonomy, at least in the sense of self-determination and self-governance, is constitutively relational, which is to say that "some social or relational factor(s) play an ineliminable role in the definition of autonomy itself," (Westlund, 2012, 62). The power dynamics of the relationship and the structured dependency of patients on providers means that medical autonomy must be understood as relational. Even in the most egalitarian patient-provider relationships, where a patient is only dependent on the provider in limited ways, the dependency power dynamics are structural and the healthcare relationship can be ongoing.[18] The need for continual prescription refills is a clear example of this. A woman taking oral contraceptives is dependent on the prescribing provider to continue to fill the prescription. The provider holds the power to make demands, such as frequent check-ins, or even withdraw the prescription as they deem appropriate. The provider may even be able to prevent the patient from stopping a treatment, such as with a refusal to remove an IUD.[19] As long as the provider is needed in their role as the possessor of specialized knowledge and skills and entrusted with the legal authority to perform specific procedures or distribute controlled substances, provide necessary treatments or therapies, and to execute beneficial procedures, the patient's autonomy is inextricably tied to and dependent on the medical professional.

One can exercise medical autonomy only insofar as the provider allows the patient to form and express preferences and values about their healthcare and realize those

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[18] It should be noted that I am not endorsing any normative claims about what constitutes a healthy person but just referring to a group of people that are not medically compromised in some way but still interacting with healthcare professionals as patients insofar as they require medical intervention to actualize some health or lifestyle goal.

[19] A small study done by Amico et al. (2016) demonstrates that most providers are not neutral about elective IUD removal, and some may even refuse to remove an IUD early.

choices. First, the provider must trust the patient to hold knowledge or make decisions regarding their care, and second, the provider must be willing to recognize the patient’s testimony or assist the patient in actualizing their decisions. If the provider refuses to meet either of these conditions, medical autonomy is not possible and the power dynamics of the relationship become even more imbalanced. How much power is given to the patient depends on how willing the provider is to trust them.

But unlike cases of interpersonal relationships, which are ideally built on personal trust and based in shared experiences and proximity, provider-patient relationships are sustained through social trust, which typically now looks more like institutional trust. Often, providers base the level of trust they are willing to give patients on generalized beliefs about competence and dispositions. In the absence of individual experience, these generalized beliefs would be formed by stereotypes, which is not necessarily wrong and perhaps even necessary for establishing a foundation of social interaction. Stereotypes can be considered in a neutral sense to the extent that they are empirically reliable (Fricker, 2007, p. 30). However, in the case of historically marginalized people such as women, stereotypes about social identity are usually informed by institutionally oppressive prejudicial attitudes. Autonomy is made precarious by institutional prejudices because relational autonomy is dependent on trust relationships. If there is no trust in the healthcare relationship, medical autonomy is made difficult to exercise. One of the reasons why patients are uniquely vulnerable is because illness or even just an inability to actualize healthcare values (i.e., unrealized medical autonomy) has a cascading impact on an agent’s ability to exercise autonomy in other areas of their life.

In the face of institutional prejudices, autonomy as self-authorization can be diminished through interactions with others who embody oppressive attitudes that undermine a person’s self-confidence and self-worth, as well as an ability to know and define themselves in the context of their goals and preferences. They may not think they deserve good things, or they may believe that they are incapable of getting them. In a more fundamental sense, they might not even be able to conceive of what something “good” looks like for them. In the context of healthcare, this may present as a belief that one will not be believed or taken seriously as a testifier (testimonial injustice), which creates a sense in which the patient is silenced; that is, they are unable or unwilling to express choices or preferences (Fricker, 2007, 2012). In the face of diminished choices because a healthcare professional is unwilling to provide certain options, the patient may also restructure their preferences to accommodate what they perceive as the available choices.

1.8 Conclusion

It is worth noting that I am not making a claim that patients, specifically female patients, are non-autonomous strictly because of the effects of their relationship to medicine, only that their autonomy is exceptionally dependent on the predisposed attitudes of their providers. Even in the face of medical paternalism and institutional oppression, patient autonomy in the United States would likely still exceed the necessary conditions for any minimalist conception of autonomy. Even if the patient would not be found autonomous in a “global” sense, they would likely, under a minimalist conception, have some “local” autonomy within the context of healthcare (Oshana, 2006).

In part, this is because concerns about autonomy have been of central importance in medical ethics for many decades. Respect for autonomy has been conceptualized in terms of both positive and negative obligations. Providers have a negative obligation to ensure that autonomous decisions are free of constraint by others and a positive obligation to share information and foster autonomous decision-making (Beauchamp & Childress, 2001, p. 64). This type of respect works largely from an ethos of noninterference. In practice, this primarily consists of ensuring informed consent, which actually works against efforts to analyze limitations on autonomy in healthcare because it assumes that medical decisions are contractually free of paternalistic interference (Dodds, 2000, pp. 213-214). But informed consent, like other institutional "trust devices," has the same shortcomings as other contractarian or rationalistic efforts to avoid dealing with trust relationships. It assumes that parties to the situation are equal, rational, and fully autonomous (Dodds, 2000, p. 214).

This narrow vision of respect for autonomy fundamentally misconstrues the nature of the patient-provider relationship, which can only be understood as rooted in practical dependency; noninterference is not an effective way of actualizing medical goals. It also "ignores the social circumstances and power relations that affect choice contexts," (Dodds, 2000, p. 217). It does not capture the experiences of women and marginalized groups and to that end, cannot be effectively applied as a moral framework for healthcare interactions between unequals. As Baier (1994) states,

> Men may but women cannot see morality as essentially a matter of keeping to the minimal moral traffic rules, designed to restrict close encounters between autonomous persons to self-chosen ones. Such a conception presupposes both an equality of power and a natural separateness from others, which are alien to women's experience of life and morality. For those most of whose daily dealings are with the less powerful or the more powerful, a moral code designed for those equal in power will be at best nonfunctional, at worst an offensive pretense of equality as a substitute for its actuality. (p. 116)

When we conceive of medical autonomy in a way that assumes equal distributions of power, we ignore critical elements of the patient-provider relationship and the social circumstances by which it is influenced. However, "[f]eminists have argued forcefully that autonomy is not only *compatible* with human embeddedness in social and personal relationships, but in some important respects *depends* on these relationships," (Westlund, 2012, p. 59). To the extent that this is true, medical autonomy needs to be understood as essentially relational, which is not fully recognized in an account that fundamentally situates autonomy in the right to noninterference.

This is not to say that relational autonomy has been entirely disregarded in medical ethics. Beauchamp and Childress (2001) try to make room for a relational understanding of autonomy to the extent of recognizing that individual choices can impact others and that people may choose to yield decision-making power to healthcare professionals. But in a critique of principlism, Anne Donchin (2000) points out that this is a very weak conception of relational autonomy and still fails to consider the ways in which patients may have no other choice but to yield power to providers because they are dependent on them in moments of crisis, such as illness. It still conceptualizes the roles of patient and provider as being essentially played by "independent contractors," which "fails to capture significant dimensions of relations between physician and patient, for sick people are vulnerable and dependent on the skill and sensitivity of their caregivers," (Donchin, 2000, p. 238). And while I understand the hesitation of situating autonomy as constitutively relational over fears that social-relational approaches allow for paternalism,[20] it seems evident that paternalism is already inherent to the structure of the medical relationship, at least in regard to the enactment of autonomous choices, if not also in their construction.

That paternalism exists in the patient-provider relationship is not in and of itself damaging to autonomy. The risk exists in patient-provider relationships that are defined by distrust, specifically distrust toward the patient on the part of the provider. Here, the provider might exercise undue paternalism to the extent that the distrust is unwarranted. The patient-provider relationship is complicated by the fact that trust is required on the part of both the patient and the provider, but is inherently unequal, with providers holding most of the power and typically setting the terms of the trust relationship. The relationship is structured in such a way that patients must trust physicians more than physicians need to trust patients.

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[20] See Holroyd (2009) and Mackenzie (2015).

Sexist attitudes present a real problem as perpetuators of cyclical distrust in this regard. Despite sexist attitudes providing legitimate grounds for women to distrust healthcare on the basis of diminished competency and reasonable negative expectations about being trusted themselves, the consequences of this distrust are minimal for the provider, though the patient could be further harmed as they will likely be less inclined to seek preventative or follow-up care. The provider may even use the patient's distrust as confirmation of their own attitudes of distrust (consider Julian Rotter's (1967) claims that a willingness to trust reinforces the perception of trustworthiness) and choose to withhold decision-making powers from the patient for illegitimate reasons.

Govier's (1997) account of social trust as an inductive attitude about the competence of others is useful for assessing the complexities of the patient-provider relationship because it allows for a conception of social trust as institutional trust which, for healthcare relationships, is essential because by the nature of the system, the real trust work must be done at an institutional level. If a patient lacks trust in the healthcare institution, then they likely cannot develop a solid trust relationship with the provider. Additionally, framing trust as an attitude allows space to point out unjust institutional prejudices that create distrust in women and other marginalized groups in the social setting. It is possible that the distrust that providers feel toward their female patients stems from institutionalized sexism, which in turn could foster tendencies of paternalism. They may demand more of the trust relationship than is appropriate for the setting and even import their own values into assessing the validity of medical decisions made by women. The nature of the connection that I am drawing in healthcare relationships of unequally distributed social and relational power is cyclical. Distrust can lead to paternalism which leads to diminished autonomy leading to further distrust and so on. Only within a conception of social trust and distrust in dependency relationships can there be a full account of medical autonomy that is inclusive of the experiences of women and other marginalized individuals in healthcare.

This paper makes explicit the ways in which unequal relational power complicate trust relationships, especially in the context of social relationships between professionals and clients. Healthcare relationships represent a unique case of social trust relationships defined by inherent and persisting unequal power relations and exceptional vulnerability. Institutions, both political and scientific, influence the dynamics of healthcare relationships, with historical and contemporary institutional sexism creating a competency issue that disrupts the ability of women to trust healthcare. However, the risks of this trust relationship are severely one-sided, and when these sexist prejudices create situations of undue medical paternalism, women's autonomy can be diminished. The following papers will explore two ways in which distrust in the patient-provider relationship can impact medical autonomy for women, first in the form of diminished testifying credibility and second, in the form of undue influence over decision-making and restrictions on choice expression. Additionally, what will be made more apparent in these papers is that diminished medical autonomy, and distrust as it pertains to autonomy violations, leads to bad health outcomes.

CHAPTER 2. LYING TO CONVEY TRUTH: LANGUAGE GAMES AND POWER DYNAMICS IN THE CLINICAL SETTING

2.1 Introduction

In "Feminist Conceptions of Social Trust and the Connection to Medical Autonomy," I suggest several explanations for why women distrust healthcare, from contemporary political influence and oppressive legislation to the historical narrative of healthcare's misdeeds toward women. I also suggest that healthcare has a practical competency issue when caring for women's health. According to one study, young women are twice as likely as their same-age male counterparts to be misdiagnosed with a mental health disorder when their symptoms are actually indicative of heart disease (Maserejian et al, 2009). Another study found that autistic boys are four times more likely to be diagnosed than girls, with women getting a diagnosis much later in life, if at all (Moss, 2022). A 2020 study suggests that women are also diagnosed with hemophilia 6.5 months later, on average, than men (Leonard, 2021). Further research shows that every year, 63% of women diagnosed with ovarian cancer will die from it, likely because diagnosis typically takes the better part of a year (Heid, 2019).

Aspects of this incompetency can be traced back to a fundamental lack of understanding of the female body, exacerbated by exclusionary research practices. The difference in how medications affect female and male bodies, for example, is poorly understood because testing has been done almost exclusively on male subjects.[21]

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[21] A literature review conducted by Merone, Tsey, Russell, and Nagle (2022) concludes that "Historically, medical studies have excluded female participants and research data have been collected from males and subsequently generalized to females and those who are intersex and do not have the reproductive anatomy characteristic of female or male" (pp. 49-50). While there a number of reasons why this may be the case, Merone, Tsey, Russell, and Nagle (2022) suggest that inherent biases exist in research because (1) it has been predominately conducted by male researchers and (2) the male body has been perceived as representative of the human species. The study also suggests that this bias has an adverse effect on women's health, giving the example of how undertreated myocardial infarctions more often result in increased major adverse events and mortality six months after admission (Merone, Tsey, Russell, and Nagle (2022).

Historically, women were excluded from clinical trials based on fears about how untested drugs could impact gestation. In turn, women still experience adverse drug reactions at greater than twice the rate of men (Zucker & Prendergast, 2020). While there are a number of variables that can contribute to this discrepancy, studies indicate that sex-specific side-effects and dosing recommendations are often not disclosed or peer-reviewed, despite legislation in the last 30 years mandating the inclusion of female trial subjects (Zucker & Prendergast, 2020). Even side effects for sex-specific medications, such as oral contraceptives, are poorly understood because research is either not conducted or delayed by several decades. To point, despite being widely available since 1960, a study linking use of hormonal contraceptives with increased risk of depression was not published until 2016 (Skovlund et al., 2016). Because of a lack of comprehensive research on female bodies, it seems reasonable to think that healthcare professionals would be less familiar with how they present symptoms or react to certain therapies.

However, this only accounts for part of the epistemic blind-spot in women's medicine and may only represent an empirical condition that aggravates the root problem, which I argue is ultimately one of trust. Women have been excluded from research in part because they are not trusted to adhere to protocols and produce reliable results.[22] For many of the same reasons, women are not fully in control of their healthcare, as their symptom testimony is often distrusted by providers, which is a form of medical paternalism. In March of 2019 articles began to surface of a 27-year-old woman who

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[22] Merone, Tsey, Russell, and Nagle (2022) state that, "[t]he research gap and the publication of misogynistic research may adversely affect female care and contribute to the negative perceptions of female hysteria and the gap in time to diagnosis experienced by many women. The androcentric history of medical research led to assumptions about women's health and response to treatments based solely on studies from male bodies," (p. 57). Some of the reasons for the exclusion of women as research subjects resulted from a fear that even women taking contraceptives would become pregnant and experience birth defects from the experimental drugs (Merone, Tsey, Russell, and Nagle, 2022, p. 50). Additionally, many researchers operated under the false belief that fluctuations in women's hormones would produce unreliable and inconsistent test results (Pratt, 2020).

visited urgent care on three separate occasions for a persistent cough. Each time, she saw the same doctor and each time he dismissed her symptoms as allergies or a cold. On the fourth visit, the doctor finally gave her an X-ray, where it was discovered that she had fluid in her lungs and a 13-centimeter mass on her diaphragm. She was then diagnosed with Hodgkin's lymphoma (Hein, 2019). Around the same time, Jennifer Lipman (2019) wrote a piece that chronicled the difficulties many women face in getting diagnosed by healthcare providers. One story claimed that it took years for doctors to finally take one woman's debilitating periods, inflammation, and exhaustion seriously enough to diagnose her with endometriosis (Lipman, 2019). In an overwhelming majority of the cases these articles and others like them presented, a woman sought care for her problem, testified about her symptoms, and was then dismissed or disbelieved repeatedly until the problem reached a level of severity that was entirely debilitating or life-threatening. The phenomenon is so ubiquitous that it was given a name: *medical gaslighting*.[23] To put it plainly, physicians do not trust women when they testify about their symptoms and in turn, reduce their competency as healthcare providers because they miss out on critical knowledge that informs their professional opinions and practice.

While some gaps in knowledge can be attributed to limited scientific understanding of female bodies, symptom evaluation is a critical step of the diagnostic process. One of the important aspects of symptom evaluation is assessing the truth status of symptom testimony. Symptom testimony can only aid in a diagnosis to the extent that the symptoms described are understood, by both provider and patient, to be accurate assessments of what the patient is actually experiencing. Inaccurate symptom testimony can be

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[23] The term *gaslighting* comes from the play-turned-movie, *Gaslight*. It refers to a form of psychological abuse where someone is led to doubt their own judgments, sanity, or perception of reality (Fraser, 2021). In the context of medicine, "gaslighting has been used by physicians to dismiss women's health problems,2 enforcing the misogynist stereotype that women are irrational and "hysterical," a prejudice that dates back centuries," (Fraser, 2021, p. 368).

dangerous and time-consuming because it can lead to misdiagnoses and the implementation of ineffective or inappropriate treatment. One would assume that patients are aware of the risks associated with inaccurate testimony and yet, studies indicate that patients lie to their providers at an alarming rate. Recent studies suggest that between 60%-80% of patients withhold information or outright lie to providers (Vogel, 2019). Given this fact, it would seem that providers are justified in their distrust of patient testimony. But this requires further evaluation, as the story may not be as straightforward as it appears.

Trust and distrust often self-perpetuate in reinforcing cycles. Trudy Govier's (1997) book, *Social Trust and Human Communities*, addresses the nature of trust between people in the public sphere, including how it impacts our roles as professionals, citizens, and consumers. She calls this trust "social trust." Because social trust does not operate in the same way as personal trust, which relies on intimate knowledge of other individuals, it is often understood as a generalized attitude. Govier (1997) states that we can expect "spiral effects" for attitudes of trust and distrust in others and in ourselves (p. 38). Govier (1997) provides two examples of trust spirals. The first is a positive trust spiral where a generally trusting person tends to regard people as benign and co-operative, unless given evidence to the contrary. Her "default state" is one of trust and in trusting people, she is often met in kind, thus confirming her hypothesis that people are generally trustworthy (Govier, 1997, p. 38). In the second example, the trust spiral works in the opposite direction, where a bitter and cynical person looks on people with suspicion, resentment, and a degree of fear. His "default state" is one of distrust and most people, finding him hostile, treat him with suspicion, thus confirming his idea that people are generally untrustworthy (Govier, 1997, p. 39). In both situations, the attitude of trust, as in the first case, or distrust, as in the second case, is reinforced through social interactions with others, suggesting that our initial attitudes persist unless confronted with clear evidence to the contrary (Govier. 1997). According to Govier (1997), this means that we are predisposed to persist in our generalized attitudes of trust and distrust because they are in many ways, self-actualizing in our interactions with others.

Applying Govier's (1997) understanding of social trust and distrust to the patient-provider relationship complicates the case of distrust in patient testimony in two ways. First, it calls into question the origin of distrust in the patient-provider relationship. If we take the situation at face value, providers distrust patients because patients lie about their symptoms and defensively distrust providers when confronted by that distrust. In this case, the patient's lie is what begins the spiral of distrust. Alternately, one could state that patients lie because they distrust providers to trust them in the first place. They anticipate being confronted with paternalistic attitudes that indicate a lack of trust in their ability to testify and make autonomous decisions about their healthcare. In this scenario, the lie is a consequence, not a cause, of the distrust spiral.

Secondly, in both of Govier's (1997) examples, the attitudes of trust and distrust were generalized, meaning that both agents went into social interactions with attitudes about individual people's trustworthiness derived from beliefs or stereotypes about how trustworthy people are generally. When we consider that providers are actually very bad at identifying lying patients, both over and under-identifying instances of lying, it seems reasonable to suggest that providers are informing their beliefs about patient lies on generalizations about human beings.[24] This results in a situation where patients may feel compelled to lie to their providers as a preemptive defense against the provider's generalized distrust toward them.

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[24] In "Lies in the Doctor-Patient Relationship," Palmieri and Stern (2009) cite the 1991 study by Ekman and O'Sullivan, which demonstrated that working professionals, including law enforcement, all perform no better than chance when asked to detect lies, to suggest that physicians cannot accurately detect patient lies. Jung and Reidenberg (2007) conducted a literature review that suggests that physicians could not tell the difference between real patients and "standardized" actors in the clinical setting, with physicians both failing to identify the actors and misidentifying real patients as actors.

It is this possibility, where the lie is a consequence of distrust, not the cause, that I want to explore. Specifically, I want to frame this around women's health because cases of testimony dismissal are pervasive in this context, and the generalizations that inform provider beliefs about female patients are steeped in stereotypes that are institutionally prejudiced. Breaking down the reasons why patients lie, a recent survey indicated that 31% of patients lie to their providers to avoid discrimination and of those 31%, 80% were women (Meszaros, 2020). When desperate patients believe that their symptoms will be overlooked or their testimony undervalued, they may lie about their symptoms in order to make their providers listen to and take them seriously. While I cannot account for all of the possible reasons that a patient would lie to their provider, one possibility I propose in this paper is that patients being subjected to institutional prejudice and distrust, such as women and other marginalized people, may lie in an attempt to overcome testimonial injustice and get the care that they need.

To be clear, lying to a healthcare provider could lead to dangerous and time-wasting misdiagnoses. However, I suggest that for many patients, this could be a last-ditch effort to obtaining proper care after repeated dismissals. When we analyze the asymmetrical power dynamics of the patient-provider relationship, it becomes clear that patients and providers do not play by the same rules of communication. Patients, especially those who are systematically oppressed, are playing at a disadvantage. Lying to or misleading providers might be the only way for some patients to be heard, taken seriously, and properly cared for, which may provide morally justifying conditions for lying.

This is a type of lie that I suggest may occur with relative frequency in the healthcare setting, where the falsity of the statement is, rather than dovetailing with the intent to deceive, in fact working to bring about a true belief in the hearer. The statement is false and likely perceived by the hearer as false, but the lie lacks the intent to deceive and is instead, intending to create a true belief in the hearer by way of what I call *compensatory lying*.[25] These lies are a result of cyclical distrust in the patient-provider relationship and could ultimately be rectified by improving trust relationships in healthcare. In this paper, I will argue that because of the impact asymmetrical power dynamics and distrust in healthcare relationships have on marginalized patients' ability to testify, patients who feel ignored, dismissed, or unheard by their healthcare providers may lie to or mislead those providers in order to be heard accurately when giving testimony, and suggest that these lies are morally justified and distinct from other forms of lying.

2.2 Power Dynamics and Testimony

Per Govier's (1997) account of social trust, testimony, or "what other people tell us," requires trust (pp. 56-57). When we believe people, we trust them on the basis of competency and honesty (Govier, 1997, pp. 57-58). Under ideal circumstances, lying or misleading would never be considered morally justifiable, let alone necessary for conveying truth. Speakers would be heard without prejudice, and their testimony would be assessed for credibility on the basis of how accurately it reflects the state of the world. However, relational power is distributed unevenly, especially in settings such as the patient-provider relationship. Therefore, any attempt to understand communicative speech acts within such relationships needs to account for the inherent unequal distribution of power and credibility. Any account of lying and misleading that assumes credibility is evenly distributed in most or all cases is too idealistic to account for the scenarios I am addressing here. This is because accounts that presume interactions between free and equal autonomous agents also suppose an even playing field for all agents in a given language game. This fails to address the issue of uneven social identity

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[25] Thank you to Tim Sundell who, through advising and feedback, helped establish the name of this phenomenon.

power dynamics and how they impact a speaker's ability to testify, thereby leaving no moral space for lying as a means of successfully passing on information.

Miranda Fricker's (2007) book, *Epistemic Injustice*, highlights the need for nuanced accounts of power dynamics when addressing epistemic and communicative capacities. Fricker (2007) states that, "identity power is an integral part of the mechanism of testimonial exchange[,] because of the need for hearers to use social stereotypes as heuristics in their spontaneous assessments of their interlocutor's credibility" (p. 16-17). What she is pointing out is that we use social identity stereotypes to make claims about a speaker's credibility in relaying information by way of everyday communication. Stereotypes do not hold moral value on their own and can broadly be defined as "widely held associations between a social group and one or more of attributes" (Fricker, 2007, p. 30). Neutral stereotypes then could be used without controversy as a means of assessing credibility if social group politics were free of prejudice and relatively even in terms of power distribution. However, Fricker (2007) suggests that prejudices, which can be understood as preconceived judgements, often epistemically suspect, which tend to hold even in the face of counterevidence, insinuate themselves most often through stereotypes (Fricker, 2007).

If the stereotype of a social group is imbued with prejudice, it can then work to diminish the group's identity power. Gender, race, and class all imply certain prejudicial stereotypes that can limit or enhance one's identity power. Fricker (2007) states that,

> if the stereotype embodies a prejudice that works against the speaker, then two things follow: there is an epistemic dysfunction in the exchange—the hearer makes an unduly deflated judgment of the speaker's credibility, perhaps missing out on knowledge as result; and the hearer does something ethically bad— the speaker is wrongfully undermined in her capacity as a knower (p. 17).

This is testimonial injustice, and for people with marginalized identities, the result is typically an unwarranted credibility deficit (Fricker, 2007, p. 17). Prejudices work to distort a hearer's perception of trustworthiness in the speaker and the resulting credibility deficit is unjustified. When the speaker is given a credibility deficit on the basis of prejudicial stereotypes and then has their testimony rejected on that basis, there is testimonial injustice. When the deficit is large enough, it can cause the hearer to reject the testimony of the speaker, and whatever knowledge was being conveyed can be left unheard (Fricker, 2007, p. 17). This can lead to the speaker being silenced. Fricker (2012) states that "when a speaker should be heard, but is not heard, he is silenced" (p. 290).

This problem stems from the fact that speech acts are communicative (Hornsby, 2000, p. 2031). In *How to Do Things With Words*, J. L. Austin (1962) developed a theory of speech acts as performative utterances. Speech acts are types of acts that both communicate information and perform an action. Assertions, questions, and promises are all types of speech acts because they convey information and perform an action. For example, if I state, "I will finish writing this paper," then I am expressing information (that I will finish this paper) and promising to do so. The promise-making feature of the utterance comes from its illocutionary force. Where locution refers to the literal utterance and its apparent meaning, illocution refers to what one does in uttering a locution, such as make a promise to someone (Austin, 1962). Perlocution refers to the actual effect of the illocution, such as convincing, appeasing, or informing someone. In addition to the implied and actual content of the utterance, Austin (1962) believed that illocutionary acts require certain contextual conditions be met in order to be successful. In the case of the promise to finish this paper, these conditions may include that I be in the position to make such a promise and that there is a hearer who is receptive to having this promise made to them. As Jennifer Hornsby (2000) states,

> A normal linguistic exchange involves (at least) two parties. So there being acts of saying requires not only abilities on the part of the speakers but also coordinated abilities on the part of hearers who are receptive to things being said to them (p. 2031).

Under Austin's (1962) and Hornsby's (2000) theories of speech acts, if the hearer is not receptive, any illocutionary act would be unsuccessful because there is no uptake of the act.

Uptake refers to the role of the hearer in the speech act. It is argued that in order for an illocutionary act to be successful, the hearer must respond with an appropriate uptake of the speech act. In order for me to successfully perform the illocutionary act of promising, the hearer of my promise must recognize it as a promise, accept that I am in the position to make such a promise, and receive the promise. If in response to my promise the hearer states, "You cannot make that promise," then uptake has not been secured and the illocutionary act has failed or misfired (Austin, 1962). When we consider the illocutionary act of telling associated with testimony, silencing occurs because the illocutionary act fails to land. In "Illocutions and Expectations of Being Heard," Maura Tumulty (2012) states that per Austinian theories of speech acts, "[a]n illocutionary act's being the act it is depends in part on its being perceived by its audience as an act of just that kind," and "[i]n the absence of uptake, it fails to be illocution the speaker intended, and will likely fail to be any illocution at all" (pp. 218-219). If a speaker gives testimony and the testimony is not believed, then they did not tell the hearer what they intended to tell them.

If this claim holds true, forces of social inequity and oppression can coalesce to prevent marginalized groups from performing certain speech acts that require uptake. Catharine McKinnon's (1993) claim that pornography silences women can be understood in this way. Hornsby and Langton (1998) elaborate on the claim by arguing that because pornography normalizes situations in which women initially say no to sex only to agree to it after further prompting, it can effectively prevent women from performing the illocutionary act of refusing by "undermining the capacity of hearers to grasp the illocutions that women are trying to perform," (Hornsby & Langton, 1998, p. 28). Without uptake of the refusal, the illocutionary act fails. This is referred to as illocutionary silencing (Hornsby & Langton, 1998).

Others, such as Alexander Bird (2002), argue that uptake is not necessary for illocution. Bird (2002) argues against Hornsby & Langton’s (1998) claim that when uptake fails, the illocutionary act did not take place. He posits that because there are (a) “(non-institutional) illocutionary acts of φing where no one recognizes the speaker’s intention to φ;” (b) “there are (non-institutional) illocutionary acts of φing where no-one recognizes that the speaker is φing;” and that (c) “there are (non-institutional) illocutionary acts of φing where the speaker neither has an intention to φ nor knows that she is φing,” Hornsby and Langton’s claim that uptake is necessary does not hold (Bird, 2002, pp. 8-9). In addition to providing examples of speech acts that can succeed without uptake (such as grumbling or gossiping), Bird (2002) suggests that efforts to associate illocutionary success with uptake may result from a muddled distinction between illocution and perlocution. So, in the case of a woman refusing sex, it may not be that the illocutionary act of refusing did not occur, but rather that the perlocutionary act of getting the man to stop his advances did not occur.

Tumulty (2012) agrees that Hornsby and Langton’s claim is too strong but still recognizes an important connection between uptake and illocutionary success. Rather than focusing the issue of illocutionary silence on whether uptake is actually secured via the hearer, Tumulty (2012) centers the problem of illocutionary success on the beliefs of the speaker, thus by-passing issues of illocutionary-perlocutionary ambiguity. She states that, “for at least one illocutionary act, telling, a speaker’s beliefs about the possibility of uptake matter to her ability to perform that act,” (Tumulty, 2012, p. 227). This means that for illocutionary acts like testifying, a speaker’s belief about the possibility of the act being successful matter to their ability to perform the act. While it is not necessary for the speaker to be certain that the act will be successful, she cannot be certain in her belief that it will fail. Tumulty (2012) argues that the “Not-Not Condition,” which states that a speaker “must *not* believe that it is *not* possible for her intended action to succeed,” must be met in order for a speaker to successfully tell (pp. 226-227). In other words, if a speaker does not believe that their testimony will be heard, and therefore does not believe that the testimony will convey information, then the speaker cannot intend to tell anything, they lose the ability to testify, and are effectually silenced.

This type of testimony silence, and the prejudice that creates it, is institutionalized and therefore pervasive across most, if not all, social interactions, including trust relationships in the context of healthcare. As I stated previously, healthcare providers hold the upper hand in communicating with patients. They are highly educated experts in their field who are sought out for that explicit reason. The very nature of the patient-provider relationship is one of expert and layman, helper and helpless. While this relationship exists primarily for the benefit of the patient, the uneven power dynamics make it difficult for patients to disagree with their doctors or advocate for themselves. The provider’s credibility is in many ways implicitly protected by the nature of their professional role, while the patient is given a credibility deficit in relation that can undermine their position as a knower of their own bodies, symptoms, or health goals. When the physician dismisses their testimony based on this unjust credibility deficit, they are silenced. Moreover, when patients are faced with institutionalized prejudice and stigma, there is an added element of difficulty in being heard.

When we consider the institutionalized silence and obstacles that many patients face when giving testimony, it seems obvious why patients might lie. While a 2009 NIH article claims that patients lie primarily to “avoid negative consequences, to achieve secondary gain (e.g., to obtain medication or disability payments), out of embarrassment or shame, or to present themselves in a better light (e.g., as dutiful and compliant),” it also states that “untruths are indicative of a basic hopelessness about the availability of genuine relationships” (Palmieri & Stern, 2009). This sense of hopelessness supports Tumulty’s (2012) notion of the Not-Not Condition as it pertains to testimonial silence (p. 226). If the speaker/patient does not believe that they will be successful in giving testimony to their providers, then the patient will not be able to testify and will experience silencing as a result.

That feeling of hopelessness leads patients to something of a desperate ultimatum: continue to be silenced or find an alternative way of testifying that would satisfy the Not-Not Condition. The risks associated with testimonial silence in these cases can quite literally be fatal, while the risks associated with lying are relatively minimal, as it largely leaves the patient where they started if unsuccessful. Through lies, a patient can reclaim some power in the relationship with their provider. In her book on lying, Sissela Bok (1999) affirms the idea that lying can increase the power of the liar, stating that, “[t]o the extent that knowledge gives power, to that extent do lies affect the distribution of power; they add to that of the liar, and diminish that of the deceived, altering his choices at different levels,” (p. 19). Lying then, is a means by which a patient can maintain a sense of autonomy and advocate for oneself within the existing prejudicial social power structures that unjustly leave them with a credibility deficit.

2.3 Language Games in the Clinical Setting and the Need for Compensatory Lying

Not all instances of testimonial injustice warrant lying as a solution to the silencing effect it has on the speaker. The healthcare cases that I address are uniquely situated to allow for lying in the moral landscape because the nature of symptom testimony is subjective and the state of affairs that it is designed to represent is fluid. Unlike other instances of reporting, such as for criminal proceedings or insurance claims, which are supposed to have clear cut parameters for what can be classified as a crime or accident and what cannot, pain reporting, for instance, does not. Even using the Wong-Baker scale,[26] what I consider to be a level-6 pain may be different for someone else. Moreover, proving pain, in any sort of quantifiable sense, is nearly impossible. This makes the parameters for classifying pain very vague and so arguably, the standards of precision in communicating pain should be rather low, and in turn, testimony about pain should be generally accepted at face value.

Yet, pain testimony can be held up as the paradigm case of the type of testimonial injustice that leads to patients lying to their providers. Consider the following scenario:

> *(2.1.)*
> Provider: *Using the Wong-Baker scale of 0-10, what is your pain level?*
> Patient (speaking truthfully): *My pain level is 6.*
> The provider then can choose to (i) accept the patient's testimony that they are experiencing level-6 pain or (ii) reject the patient's testimony that they are experiencing level-6 pain. The provider chooses (i).

In this scenario, which we can take to be an ideal interaction between a patient and provider, the provider believes the patient's testimony, that they are experiencing level-6 pain, to be true-enough. That is to say, both the patient and the provider recognize the definition of level-6 pain to be subjective but trust that their understanding of what constitutes level-6 pain is similar enough to be included in the set of propositions that they have agreed to treat as true. This set of propositions is known as the common ground and is updated in the face of successful conversations between interlocuters. So, in uttering "my pain level is 6," the patient performs the illocutionary act of telling and when the provider accepts the testimony, there is uptake and the act is successful. Additionally, there is perlocutionary success in creating a true belief in the hearer. That the patient is experiencing level-6 pain is added to the common ground and the conversation can proceed, likely ending with the patient receiving the care that they need.

Now instead, suppose that this conversation goes differently:

> *(2.2)*

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[26] The Wong-Baker pain scale uses both a numerical rating (1-10) and faces ranging from happy to crying to demonstrate pain levels.

> Provider: *Using the Wong-Baker scale of 0-10, what is your pain level?*
> Patient (speaking truthfully): *My pain level is 6.*
> The provider then can choose to (i) accept the patient's testimony that they are experiencing level-6 pain or (ii) reject the patient's testimony that they are experiencing level-6 pain. The provider chooses (ii) and (inaccurately) downgrades the patient's pain level to 3.

In this situation, the patient's illocutionary act misfires because there is no uptake on the part of the provider. We might not yet say that the patient has been silenced because they may not hold the belief that there is no chance of success, but the perlocutionary act has failed because the testimony did not create a true belief in the provider.

There may be a few reasons why the provider rejected the testimony. One explanation is that they have raised the standards of precision regarding what level-6 pain is. The notion of standards of precision stems from David Lewis' (1979) work on scorekeeping in a conversation. When a concept is vague, hearers can accommodate a speaker's statement as true enough by adjusting the standards of precision (Lewis, 1979, p. 352). Lowering the standards of precision expands the range of reasonable delineations, while raising the standards of precision contracts the range of reasonable delineations. In the initial iteration of our example *(2.1)*, the standards of precision are low enough so that the patient's claim of level-6 pain is true enough. However, in *(2.2)*, it is possible that the provider raised the standards of precision so that the patient's testimony fails to be true enough to be accommodated into the common ground.

It would seem that the standards can be lowered just as easily as they can be raised, but it more frequently occurs in the direction of the latter. While this may seem valuable for getting at a more accurate truth in a conversation, it can actually hinder the conversation's forward momentum. Using Austin's example "France is hexagonal,"[27] Lewis (1979) points out,

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[27] From *How to Do Things With Words,* Austin (1962) suggests that the truth value of the statement "France is hexagonal' is dependent on the circumstances and audience for which the statement is being made.

> Raising of standards, on the other hand, manages to seem commendable even when we know that it interferes with our conversational purpose. Because of this asymmetry, a player of language games who is so inclined may get away with it if he tries to raise the standards of precision as high as possible—so high, perhaps, that no material object whatever is hexagonal. (p. 353)

This idea can easily be applied to the topic of symptom testimony. In an ideal conversation, when a patient reports their pain level to be at a six (and the patient believes that they are reporting accurately), then the testimony should be considered "true enough" because the range of reasonable delineations of level-6 pain is so wide that it would most likely include the patient's symptoms. But because it seems to be easier to increase standards of precision, a player in a language game could raise the standards of precision to a level that would prevent the claim from meeting the necessary conditions of level-6 pain. It's possible that what providers have done is raise the standards of precision on pain testimony to an unfair level. A testimony of level-6 pain may never reach the status of "true enough' for the provider.

A second explanation is that there is some sort of dysfunction in the common ground. In order for the statement, "My pain level is 6," to have any meaning, there has to be some agreement about what constitutes level-6 pain. Because pain is, by nature, subjective, the precision standard should be left low, meaning that a wide range of delineations could constitute level-6 pain. However, even if the standards of precision are low, there still needs to be overlap in what the patient takes to be level-6 pain and what the provider takes to be level-6 pain. Even using a common scale, such as the Wong-Baker scale, there can be a lack of consensus on how level-6 pain presents in a real person. Providers, who may have seen some extremely high levels of pain in their professional role, might think that the intensity of pain needed to meet the threshold of level-6 pain is higher than what a patient might think it needs to be. There is evidence to support the idea that patients and providers assess pain in different ways. A comprehensive review of pain assessment studies by Seers, Derry, Seers, and Moore

(2018) found that an overwhelming majority of studies indicate that providers underestimate pain and that this tendency is more pronounced when assessing severe pain. Additionally, the difference between the patient's assessment and the physician's can be extreme (Seers, Derry, Seers, and Moore, 2018). In downgrading the patient's pain from a 6 to a 3, the provider may be imposing their standard of pain levels onto the patient.

A third explanation is that the provider simply does not believe that the patient is telling the truth. The provider may have reasonable standards of precision for pain testimony and their assessment of pain reflects generally held beliefs about pain intensity. However, for some reason, the provider does not trust the patient to testify honestly about their pain levels. If the patient's testimony is in fact an at-issue lie, which is to say that the patient knows they are lying and intends to deceive the provider through false testimony, then the provider could be justified in rejecting the testimony. However, in the cases discussed above, the patient was speaking truthfully about their condition, and so the provider's rejection of the testimony is unjustified. The patient then experiences testimonial injustice. The provider may provide a number of reasons for thinking the patient is lying, but one possible explanation is that their perception of the patient is distorted by prejudiced identity stereotypes that cause the provider to give the patient a credibility deficit.

While it is possible that one or more of these three explanations could be happening in patient-provider interactions, when the patient is a person with a marginalized identity, such as a woman or person of color, the social and historical context cannot be ignored. Medical gaslighting still happens with enough frequency to warrant naming and its primary victims are women. This implies that providers are, to at least some extent, informing their beliefs about patients through prejudiced identity stereotypes that in turn, strip patients of their credibility as testifiers. These prejudices may create an attitude of distrust in the provider toward the patient.

Now, let us consider another scenario where the patient presumes that prejudice will play a role in their clinical experience and that they will be met with a credibility deficit. Suppose prior to the conversation, the patient thinks, "because I am young and I am a woman, the physician will not believe me when I testify about my pain, and I will not get the care I need." Given their social identity, we can say that the patient has reason to believe this to be true. Perhaps they have also been met with distrust by providers in the past and expect this interaction to be no different. They do not trust that the provider will accommodate the testimony, or at least not accommodate it at face value. They believe the conversation will play out like this:

> *(2.3)*
> Provider: *Using the Wong-Baker scale of 0-10, what is your pain level?*
> Patient (speaking truthfully): *My pain level is 6.*
> The provider will reject the testimony and (inaccurately) downgrade the pain level to a 3.

In this case, the sentence uttered by the patient is still an accurate utterance of their experience but there is no illocutionary uptake. In holding the belief that their illocutionary act will fail, the patient is silenced insofar as they do not satisfy the Not-Not Condition.

At this point the patient must either accept that they are incapable of testimony and effectively silenced or find a way to still participate in the conversation and be heard. If they presume that the provider will downgrade their pain, they may be motivated to compensate for this downgrade in order to create a true belief in the provider and update the common ground. One way to do this is to anticipate that anything that would normally fall into the range of reasonable delineations for level-6 pain will not for this conversation and try to estimate the extent to which the provider will downgrade the testimony. So, if the patient estimates that any pain testimony they give at level-y will be deemed false or inaccurate and downgraded by x points to level-z, they can give testimony that adds x points to their pain to try to accommodate the provider's conditions for level-y. The conversation may look like this:

> *(2.4)*
> Provider: *Using the Wong-Baker scale of 0-10, what is your pain level?*
> Patient (lying): *My pain level is 9.*
> The provider then can choose to (i) accept the patient's testimony that they are experiencing level-9 pain or (ii) reject the patient's testimony that they are experiencing level-9 pain. The provider chooses (ii) and (accurately) downgrades the patient's pain level to 6.

An accurate statement of the patient's pain level is still 6. So, in claiming that the pain level is 9, the patient utters a lie. However, in anticipating the provider's intention to downgrade the pain level, they manage to create a true belief in the provider. Though the utterance is a lie, they have led the provider to arrive at the truth of what their testimony is attempting to convey. When they say nine (lie), they succeed in causing a belief in six (truth). The patient accepts that because of their credibility deficit, the illocutionary act of testifying will not secure uptake because the provider will not believe the testimony. However, the patient sees a path to perlocutionary success through a lie that could instill a true belief in the provider. The illocutionary act fails in order for the perlocutionary act to succeed. In doing so, the speaker manages to compensate for the preconceptions of the provider and update the common ground indirectly.

This is what I take to be compensatory lying. In these cases, certain assumptions about the common ground are made by the speaker prior to the conversation itself. It is not wholly uncommon to compensate in various ways for anticipated lack of understanding or trust in the common ground. A study on the attitudes and experiences of Black Californians and their interactions with healthcare found that Black patients modify both their behavior and speech in order to mitigate anticipated discrimination in the healthcare setting (Cummings, 2022).[28]

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[28] The study found that 32% dress more professionally than they normally would; 35% modify their speech or behavior when communicating with providers; and 41% signal to providers that they are educated and prepared to discuss their condition (Cummings, 2022).

Also, compensatory speech acts can be found in other areas of communication. For example, when people ask me where I am from, I often say that I am from the Chicago area, despite the fact that I do not believe I am from the Chicago area and people who are from the Chicago area would not consider Twin Lakes to be in the Chicago area. You might say that I am speaking loosely in that I am referring to the Chicago area as a broad stretch (within 75 miles of Chicago) of land. However, I am motivated by a belief that the listener would never have heard of Twin Lakes, so the statement "I am from Twin Lakes," would have no meaning to the listener and uptake would be impossible. The common ground of the conversation would remain the same and the conversation would not progress. By pointing to a location that I can more reasonably assume the listener knows, I am compensating for the listener's lack of knowledge and creating what I consider to be a true-enough belief in the listener for the purposes of the conversation.

The patient-provider case and the location case are similar in that the speaker attempts to compensate for what they take the beliefs or knowledgebase of the listener to be in order for the common ground to be updated and the conversation to continue. They differ in two important ways: First, in the location case, I could reasonably make a more accurate and successful illocutionary act if I were to take the time to explain in more detail where Twin Lakes is. The gaps in the listener's knowledge can be overcome with just a little more effort because the listener is presumably cooperative. In the case with the patient, the patient would not likely be able to overcome the beliefs of the provider because prejudiced beliefs typically hold in the face of counterevidence, and the provider's refusal of uptake flouts expectations of conversational cooperation. Secondly, both the question and statement in the location case are vague enough that the response could be considered reasonably true-enough, if not wholly accurate. It is not a lie. Twin Lakes is not closer to New York than Chicago, for example. In the patient case, the question is specific and warrants a specific answer- one that the speaker has in mind (6) and does not say.

The utterance is a lie, though this is complicated by its intent to create a true belief in the hearer.

2.4 Conceptual and Moral Definitions of Lying

Compensatory lies occupy unique conceptual and moral space. As such, it is important to understand how this phenomenon fits into existing philosophical frameworks on lying. Even its classification as a lie is not without controversy. Traditional definitions of lying are reflected in Arnold Isenberg's (1964) definition that "[a] lie is a statement made by one who does not believe it with the intention that someone else shall be led to believe it" (p. 466). This definition, and modified versions of it, share four common conditions. First, a lie must be a statement, which is taken to require the use of language. Second, the speaker must believe that the statement is untrue. Third, there must be a target of the statement, which is to say that the speaker must make the statement to someone. Finally, there must be an intent to deceive the recipient of the lie. The speaker need not be successful in their deception, but they must intend to deceive the hearer in order for the statement to be considered a lie.

If we accept the traditional view of lying, where the intent to deceive is a necessary condition of lying, then compensatory lies are not lies. Though the speaker makes a statement that they take to be untrue to someone else, the speaker does not intend for the hearer to believe the statement and so the intent to deceive is not present. Instead, compensatory lies would be understood as "non-deceptive untruthful statements" (Mahon, 2003). While compensatory lies share the feature of not intending for the statement to be believed with other non-deceptive untruthful statements, they differ in important ways. Unlike other non-deceptive untruthful statements, such as polite untruths, there is no innuendo or code that both parties operate with an awareness of. The speaker of a compensatory lie takes themselves to be lying and relies on the hearer to take them as lying as well, in order for the compensatory lie to be successful.

There is a philosophical camp that does not view deception as integral to the definition of lying. Some, such as Jennifer Mather Saul (2012), argue that sufficient counterexamples exist that demonstrate that the intent to deceive need not be present for an utterance to count as a lie. First, she uses the case of a witness who has been shown on camera to have been witness to a murder.[29] The jury has seen the tapes and the witness knows this. However, out of fear for his life, he says, “I did not see the murder” (Saul, 2012, p. 9). Saul (2012) argues that despite the witness not intending to deceive anyone, the view that he has lied on the witness stand holds. She further uses the case of totalitarian regimes forcing people to make statements that they, and everyone else, know to be false (Saul, 2012, p. 9). The examples she gives constitute “bald-faced lies,” which are “lies in which there is no intention whatsoever to deceive” (Saul, 2012, p. 8).

In order to recognize these instances as lies, Saul (2012) defines lying as the following: “if the speaker is not the victim of linguistic error/malapropism or using metaphor, hyperbole, or irony, then they lie if (1) they say that P; (2) they believe P to be false; (3) they take themselves to be in a warranting context” (p. 3). Importantly, the addition of a “warranting context” does much of the same work as the deception condition in traditional definitions of lying, without necessitating the intention to deceive the hearer. It limits the scope of utterances that can be constituted as lies by excluding things like jokes. Under Saul’s (2012) definition, one can only be said to be lying if they make a statement they believe to be false in a context they believe to warrant the truth. While there is some ambiguity in what constitutes a warranting context and what does not, Saul

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[29] Example first used by Carson (2006).

(2012) recognizes that most contexts are warranting contexts, and only very special contexts are not.

In the cases I discuss, where patients lie to their doctors in order to receive proper care and consideration, I argue that the intent to deceive may not be present. The patients may, in fact, lie in order to convey a truth in what they perceive to be a more accurate way. Consider again the patient who rates their pain at a six on a scale of one to ten. They want the provider to know their pain is at a six but know from past experience that if they say their pain is a six, the provider will downgrade their pain, likely because of a credibility deficit. To avoid having their pain dismissed as inconsequential, they report to the provider that the pain is at a nine, believing that the doctor will downgrade their pain level to a six. Through implementation of a compensatory lie, the patient's perlocutionary act of getting the doctor to assess her pain accurately is successful even though the locutionary act is undoubtedly a lie in a context that warrants truthful statements. The healthcare setting would certainly be considered a warranting context and so, even compensatory lies done in the clinical setting would constitute lies under Saul's (2012) definition.

That said, compensatory lies do not fit neatly into the category of bald-faced lies, despite the shared lack of deceptive intent. In compensatory lying, the possibility still exists that the speaker could be perceived to be telling the truth. I will discuss this issue later in the paper, but it should be generally understood that there is some subtlety and subjectivity to compensatory lies that is not present in bald-faced lies. The compensatory lie is not necessarily so far-fetched that it could not be mistakenly taken as truth. With bald-faced lies, the lie is generally so apparent, as with the murder witness who denies what has been caught on tape, that the likelihood of mistaken belief is practically null.

Building on this, in baldfaced lying, all parties know the speaker is lying, and all parties are aware that all parties know about the lie. When the witness lies to the jury, who he knows have seen the tapes, he knows that the jury knows he is lying, and the jury knows that the witness knows the lie has not been believed. It is generally known that all parties know about the lie and know that the lie has not been successful (no uptake). In compensatory lying, the speaker believes that all parties know that the speaker is lying and that the lie will not be successful. In the case of the patient who states that they have level-9 pain when they take themselves to really have level-6 pain, the patient believes that the provider will recognize the utterance, “My pain is level-9,” as a lie. But the hearer must not believe that the speaker knows in uttering the lie that the lie will not be successful. In other words, the hearer must believe that the speaker lied with an intent to deceive. The provider must not recognize the lie as a compensatory lie, or they may not make the appropriate adjustments to their assessment of the patient’s pain.

Finally, compensatory lies must intend to create a true belief in the hearer. While bald-faced lies may create true beliefs in the hearer or indirectly convey accurate information, it is not critical to the endeavor. Some bald-faced lies may just create confusion. The witness who lies on the stand does not provide any real additional information to the jury. They already know he witnessed the murder, and his futile refutation does not change this. They may just end up confused as to his motives in lying so ridiculously. In compensatory lying, there must exist an aim to create a new, true, belief in the hearer. The patient should not intend to confuse the provider with their testimony or lie aimlessly. Compensatory lying has clear objectives that are critical to the success of the conversation at hand.

Compensatory lies are functionally similar to St. Augustine’s notion of “altruistic lies” (Augustine, 1952 [395]; Fallis, 2009). In both instances, the speaker, in light of a lack of trust on the part of the hearer, lies in order to create a true belief in the hearer. In Augustine’s (1952 [395]) example, a man has knowledge that a certain road is overrun with bandits. He fears that his friend will take that road and is also aware that his friend does not trust him. Accounting for this, the man states that there are no bandits on the road, knowing that because his friend does not trust him, will take the contrary of his statement to be true and avoid the road (Augustine, 1952 [395], p. 57). The speaker utters a statement he takes to be false in order to create a true belief in the hearer. There is no intent to deceive and there is a clear aim to create a true belief in the hearer.

However, there are distinctions between the two types of lies. First, in *Lying*, Augustine (1952 [395]) is ambiguous as to whether this type of lie actually constitutes a lie. He poses the question repeatedly as to whether a lie told in this context without the intent to deceive constitutes a lie but does not answer the question directly in the chapter. At other points in *Lying*, Augustine (1952 [395]) suggests that the reason a joke is not a lie is because it lacks the intent to deceive. Additionally, in his later work, *Against Lying*, he states that “a lie is a false signification told with desire to deceive” (Augustine, 1952 [420], p. 160). While the question of whether Augustine’s example actually constitutes a lie in his mind remains, I position compensatory lies as unambiguous lies because a lie need not necessitate an intent to deceive, and because the cases of compensatory lying that I am concerned with exist within a warranting context.

Additionally, Fallis’ (2009) description of these lies as “altruistic” implies that the lie must be done with the intent of helping someone else. Augustine’s (1952) [395]) example would also suggest that whatever moral value the false statement has stems from it being done in the service of others. If this is the case, then compensatory lies differ from altruistic lies in this way as well. This is not to say that compensatory lies lack moral value, but rather that the moral value is rooted in different places. While the altruistic lie has value in its intent to save another (namely the hearer) from harm, compensatory lies are morally valuable in their ability to rectify epistemic harm caused by the hearer.

Finally, if Augustine were to recognize altruistic lies as lies, then they would not have moral justification. Augustine (1952) is clear that lying is never justified and that certain types of lies are only more or less bad. I hold that compensatory lies are morally justified because specific conditions must be met that are not necessary in altruistic lies. Specifically, the lack of trust and the credibility deficit that the speaker is subjected to by the hearer is unjustified. The friend of the altruistic liar in Augustine's (1952 [395]) example may have very good reasons for not trusting his friend. Why he is not trusted is not specified and it could be warranted on the part of the hearer to distrust the statements of the speaker. In compensatory lies, the speaker is subjected to testimonial injustice. The lack of trust is unwarranted and causes epistemic harm. Therefore, the lie is morally justified to the extent that the speaker is subjected to the harm and there is reason to believe that it is the best means available for conveying truth in light of this harm.

2.5 Risks and Further Moral Considerations

To reiterate, unjust prejudices can create spirals of distrust. When a hearer's beliefs about a speaker are informed by unjust prejudices, they may distrust them and, by extension, assign the speaker a credibility deficit. The speaker may recognize the distrust, and the prejudicial attitude that informs it, and distrust the hearer to communicate fairly with them. The hearer may see the speaker's distrust as confirmation of their initial attitude of distrust, and so on. At some point, the distrust becomes so pervasive, that communication becomes impossible because the speaker fails to believe that there is any chance of illocutionary uptake. This silencing is crippling to the speaker's autonomy because, as with the case of the patient, it could prevent them from testifying about their experiences or values, which could in turn limit their ability to actualize their goals or preferences.

In an effort to compensate for the preconceptions of the hearer and overcome testimonial silencing, the speaker may attempt to convey the information indirectly by making a false statement in the hopes that it will create a true belief in the hearer. In the case of the patient attempting to testify about their pain, they alter their stated pain level so as to compensate for the credibility deficit they anticipate the provider to assign them and indirectly reach consensus with the provider on what their actual pain level is. Though the illocutionary act still fails, it carves a path to perlocutionary success through a lie that could instill a true belief in the hearer. This is compensatory lying. Though it lacks the intent to deceive found in most lies, compensatory lying should still be considered lying because the speaker makes a statement they take to be false in a context where the truth is warranted.

Compensatory lying has the ability to rectify epistemic harm caused by unjust prejudice. Its moral value is derived from this fact, and it can be not only an acceptable method of communicating, but a morally right way of communicating under certain oppressive circumstances. That said, lying subverts the norms of cooperative linguistic interactions and carries moral risk, even in cases where the lie is done to remedy a harm. As such, the claim that compensatory lies are morally justified requires certain conditions to be met. I suggest that a lie should be properly understood as a compensatory lie and is morally justified if:

> *(1) Testimonial Injustice: The speaker is subject to prejudices that can unjustly influence their perceived credibility as a testifier.*
> *(2) Satisfies Not-Not Condition: The speaker is justified in believing that compensatory language is necessary for being heard by the hearer, and that the compensatory statement (the lie) would result in a successful interpretation by the hearer.*
> *(3) Truth-Seeking Mental State: The speaker does not intend to deceive the hearer and aims to only create a true belief in the hearer in the interest of being properly heard.*

If these criteria are met, then a speaker’s lie can be classified as compensatory, and their action can be said to be morally justified.

Even under these conditions, compensatory lying is risky. First, there always exists the possibility that the speaker misleads the hearer. Certain assumptions are made by the speaker regarding how their testimony will be received by the hearer. While the speaker must be *justified* in the belief that compensatory lying is necessary in order to be heard

(3), it may not always be the case that they forecasted accurately. Even if all conditions are met and the speaker is truly justified in believing that compensatory lies are warranted, the hearer may behave in an unexpected way, rendering the lie unnecessary and potentially problematic. Consider again the case of the patient seeking care for level-6 pain. If she states that her pain is level-9 and the provider, rather than adjusting the pain level to 6, takes the testimony at face value, then the patient has misled the provider about their pain level. Importantly, the patient still has not deceived the provider, as deception requires intent. While the compensatory lie-taken-as-truth would not be considered an accidental falsehood,[30] because the utterance was a lie, the false belief it creates in the hearer is accidental insofar as the speaker intended to create a true belief and failed. Nevertheless, in these situations, the speaker has lied, and the hearer is misled.

Similarly, if the speaker miscalculates the amount of compensation necessary, the hearer will be misled. When we consider the subjective contexts in which compensatory lies are found, it seems evident that the speaker can only measure in estimates. This is especially true in cases like pain testimony because (1) pain is inherently subjective and efforts to quantify it are still subject to individual interpretations of what the numeric thresholds should feel like and (2) the patient can only estimate how the provider might downgrade their testimony. While the patient might expect the provider to downgrade their pain level by three delineations, the provider might actually do so to greater or lesser extents. Because of the subjective nature of something like pain testimony and interpretation, there is some flexibility in assessing the perlocutionary success of compensatory lies. As long as the belief instilled in the hearer by the compensatory lie is true enough, where consensus is reasonably met, we would consider the act successful.

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[30] Accidental falsehoods are generally understood as either a false statement that the speaker believed to be true, or a true statement said with intent to mislead (Saul, 2012). Instances of accidental falsehoods are not lies because they do not satisfy the condition (2) they believe P to be false in Saul's (2012) definition of lying.

However, if the belief instilled in the hearer by the compensatory lie is significantly off, to the point that consensus cannot be reached, then the speaker has misled the hearer.

The risk of misleading the hearer is ever present when engaging in compensatory lying, but the risks of doing nothing to combat testimonial silencing can be far worse. Testimonial injustice diminishes autonomy. In the healthcare setting, where autonomy is relational, patient autonomy is dependent on functional trust relationships. In the absence of trust, patients are left with few options to express and actualize their autonomous health goals, the consequences of which are dire. As evidenced previously in this paper, medical gaslighting is a common phenomenon, especially for women and others with historically marginalized identities.[31] It has a silencing effect on testimony, both in the context of the individual being subjected to it and more broadly, as it is expected as an institutional norm. In dismissing or discrediting patient testimony, providers fail to recognize patient autonomy and increase the likelihood of bad health outcomes in turn. Missed diagnoses, misdiagnoses, and undertreatment are all consequences of medical gaslighting. The practical and moral risks incurred by engaging in compensatory lying may not even register for someone facing testimonial dismissal in potentially life and death circumstances. If viewed as the only recourse to overcoming testimonial silencing and being heard, compensatory lying is morally justified.

It does, however, pose long-term complications for trust relationships. First, insofar as institutional prejudices are not overcome, the success of the lie in overcoming testimonial injustice depends on it not being made known. That is, if the hearer knows what the speaker is intending to do or recognizes this type of behavior as something common to certain identities, then the compensatory lie will likely fail to be effective because the hearer will factor this into the credibility deficit they assign to the speaker. To

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[31] See pages 46-47.

use the clinical case, if the provider expects the compensatory lie from certain types of patients, the provider may downgrade the pain more severely to account for this (i.e. Instead of assessing level-9 pain as level-6, they may downgrade to level-3). Therefore, the success of the act requires it to remain covert, which has moral problems. Bok (1999) argues that moral justification cannot be obscured, arguing that moral justification cannot be exclusive or hidden because it must be capable of "public statement and defense," and that "[a] secret moral principle, or one which could be disclosed only to a sect or guild, could not satisfy such a condition" (p. 92)

To put it differently, this behavior likely would not pass Annette Baier's (1994) moral test for trust. Baier's (1994) expressibility test states that a trust relationship is dysfunctional if "knowledge of what the other party is relying on for the continuance of the trust relationship would…itself destabilize the relation," (p. 123). Further, she specifically points to concealment as an automatic trust destabilizer if it were to become known by both parties in the relationship. That's not to say that the relationship was functional prior to the introduction of the lie, but through an inability to be publicized, the behavior might destabilize the relationship further and ultimately make testimony even more difficult.

Building on this issue, compensatory lying could reinforce the very oppressive prejudices that necessitate it in the first place. Rather than working to change the attitude of the hearer, compensatory lies work with prejudice to create perlocutionary success. On the one hand, there is justice in employing the very forces that oppress one as a means of empowerment. On the other hand, this 'doubling down' serves to confirm the hearer's initial expectations about the interaction. This in turn, further perpetuates the spiral of distrust. So even if in the short term the patient is successful in reclaiming testimonial power through the lie, the long-term consequences could make it more difficult for them and others to achieve testimonial justice. In this way, compensatory lying is risky and potentially runs counter to broader efforts to overcome institutional prejudice, despite the potential for short-term mutual understanding and epistemic agency.

This problematic cycle of preconceptions and compensatory lying can create an institutionalized distrust in both patients and providers. Providers do not trust their patients to be honest in their testimony and patients do not trust their providers to believe them when they testify and so on. This generalized distrust is detrimental to the goals of healthcare and creates poor patient outcomes, like the ones mentioned in the beginning of this paper.[32] Further, the cycle reinforces institutionalized prejudice and can act as a catalyst for further oppression. In other words, though patients could be considered to exercise epistemic agency within a context of testimonial oppression when they lie in this way, the short-term success of the act likely acts against broader goals of testimonial justice and enhanced medical autonomy.

2.6 Trust as a Solution in Healthcare

Though both patients and providers contribute to this cycle, it is providers who are obligated to correct it. While cyclical causal relationships make it difficult to pinpoint an origin with which to place blame, the institutional prejudice precedes the patient's lie. The lie is a direct response to oppressive structures pervasive throughout healthcare, both historically and when situated within prevailing socio-political attitudes about the trustworthiness of women as knowers of their own experiences. Additionally, because of their privileged social position and increased power, providers are in a better position to affect the dynamics of the patient-provider relationship. The dynamics of the relationship also insulate providers against vulnerability and therefore, they risk less by attempting to break the cycle. This is not to say that there is no risk involved here for providers. In the

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[32] See pages 45-47.

context of pain management, especially, there are professional and legal risks associated with overprescribing medication.

That said, attempting to correct for epistemic dysfunction in trust relationships is still a worthwhile endeavor for providers. By establishing a climate of trust, they can open more accurate communication channels with patients and gain access to knowledge they have otherwise been cut off from. As with the case of caring for female bodies, by correcting epistemic blind spots, providers can fill gaps in their professional knowledge and by extension, their professional competency. Those in powerful social positions, such as healthcare providers, must take up the position of the epistemically subjugated and systemically oppressed, such as women, in order to rectify their own epistemic shortcomings.

As Fricker (2012) states,

> [I]f we want to achieve a full understanding of a human practice, social phenomenon, or pattern of relationships, then we must take up the point of view of those on the losing end. If *you* are the one doing the crushing…then not only are you not in a position to know what it is like to be crushed, but also- and this is a separate point- your *general* picture of the social world in which such crushings take place will be in an unhelpfully partial perspective, the perspective of the powerful. (p. 288)

This is a critical aspect of adopting what Fricker (2012) refers to as a corrective virtue of testimonial justice (p. 294). In *Epistemic Injustice*, Fricker (2007) identifies two steps that a privileged hearer must take in order to correct for testimonial injustice. First, in order to determine the impact of identity power on their credibility assessments of others, “they must be alert to the impact not only of the speaker’s social identity but also the impact of their *own* social identity on their credibility deficit,” (Fricker, 2007, p. 91). This requires what Fricker (2007) refers to as “*reflexive* critical social awareness,” (p. 91). The hearer must be cognizant of how the identity power dynamics of the relationship will impact their perception of the speaker’s credibility, as well as the impact on the speaker’s actual performance of the speech act (Fricker, 2007, p. 91). This reflexive critical awareness in the face of institutional prejudice is a prerequisite for “correcting for prejudice in one’s credibility judgement,” (Fricker, 2007, p. 91).

The second step of corrective testimonial justice for Fricker (2007) is the active revision of the initial credibility assessment in light of the conclusions brought about by the reflexive critical awareness. She states,

> When the hearer suspects prejudice in her credibility judgement- whether through sensing cognitive dissonance between her perception, beliefs, and emotional responses, or whether through self-conscious reflection- she should shift intellectual gear out of spontaneous, unreflective mode and into active critical reflection in order to identify how far the suspected prejudice has influenced her judgement. If she finds that the low credibility judgement she has made of a speaker is due in part to prejudice, then she can correct this by revising the credibility upwards to compensate. (Fricker, 2007, p. 91)

As Fricker (2007) points out, “the hearer’s obligation is obvious: she must match the level of credibility she attributes to her interlocutor to the evidence that he is offering the truth” (p. 19). In rectifying the initial (unwarranted) credibility deficit, the hearer corrects the testimonial injustice.

When applied to the issue of healthcare relationships, corrective testimonial justice can promote patient autonomy and foster trust. By acknowledging that many patients are subject to prejudiced stereotypes that are pervasive across social institutions and understanding the role that they, as authorities and persons of greater social power, play in perpetuating these stereotypes, providers can factor the patient’s identity power struggles into their credibility assessment. If, for example, the medical provider is male and the patient female, the provider must recognize how gender bias will affect his perception of the patient’s credibility and also try to understand what illocutionary obstacles the patient faces as a woman trying to convey information to a man.

This is not to say that all patients should be believed outright or given a credibility excess in light of their position. Rather, providers ought to consider these facts, as well as the immediate evidence that the patient is providing when assessing a testimony as either true or false. Testimonial justice involves trusting an agent's testimony to the extent that it is worthy of trust. If the patient-provider relationship has deteriorated to the point where the patient feels compelled to lie, as in the cases I describe above, this poses a problem because the patient's credibility as a testifier is (perhaps rightly) diminished by most standards.

In "Epistemic Trust and Social Location," Nancy Daukas (2006) discusses a notion similar to testimonial justice, namely the "epistemic principle of charity," where "members of an epistemic community typically extend to one another the presumption that they meet some threshold level of epistemic credibility," (p. 110). However, in order to be extended the epistemic principle of charity, an agent must be epistemically trustworthy, which requires one to be "open, honest, benevolent, and rational (in the sense that she is not self-deceived, and she successfully, consistently integrates her epistemic self-conception into her behavior)," (Daukas, 2006, p. 111). It is possible then, that the patient who resorts to compensatory lying would not be seen as trustworthy in this regard and instituting the second aspect of Fricker's (2007) corrective testimonial justice (credibility reassessment) would not accomplish much in practice.

As such, I suggest that an intermediary step is necessary. Therapeutic trust, or conscious efforts to provide people with opportunities to be trusted, often leads to people being more trustworthy (Govier, 1997, pp. 36-37). Studies indicate that our beliefs about others have a self-fulfilling character and that we have strong confirmation biases when seeking out evidence for our beliefs (Govier, 1997, p. 36).[33] By engaging in therapeutic trust, we can attempt to overcome confirmation biases that reinforce prejudices and disrupt cycles of distrust, such as the one I have brought attention to in this paper. While it may seem risky or even irrational for physicians to place trust in patients who they

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[33] From Mark Snyder's (1984) "When Belief Creates Reality."

perceive to have attempted to deceive them, therapeutic trust as a phenomenon is rooted in psychological fact and is rational to the extent that one would be able to rationalize the actions of the patient in the first place (McGreer, 2008, p. 250). As Victoria McGreer (2008) states in her account of hopeful trust,

> Let us grant, therefore, that this is a deep psychological fact about human beings: that individuals are very often empowered by interacting with others who believe in them, especially others who are willing to act in trustful reliance on what they can do or be, fuelled by the energy of what others hope for them. What does this imply about the rationality of hopeful trust? At least this: there is nothing rationally inappropriate about extending our trust to others beyond, or sometimes in defiance of, evidence of their prior trustworthiness, so long as our hopes for what they are capable of in light of our trust are rationally based. (p. 250).

By engaging in reflexive critical social awareness, a provider should be able to understand the position of the patient and the social situatedness that led to the lie. They may even begin to see the intent behind the lie. Through this practice, the provider can explain the previous untrustworthy behavior on the part of the patient and would then be rational in exercising therapeutic trust. In implementing this intermediary step, the hearer, or provider, moves naturally into Fricker's (2007) second step of corrective testimonial justice and can begin the process of attributing more credibility to the patient as a knower.

However, providers should make efforts to adopt more substantive trust whenever possible. Therapeutic trust is a practice in trusting others but does not represent an actual attitude of trust. One relies on therapeutic trust when they do not believe that they have a reason to trust that person (D'Cruz, 2019, p. 947). In some ways, therapeutic trust can be seen as misleading, insofar as its success relies on the trusted person believing that the trust placed in them is real (D'Cruz, 2019, p. 947). It can also be seen as paternalistic because the person holding the power in the relationship dictates the terms and extent of the trust that is warranted (D'Cruz, 2019, p. 947).

It is important to recognize that by engaging in therapeutic trust, providers are attempting to give the patient reasons to trust them, not the other way around. The initial lack of trust in the patient was unjustified and initiated the cycle of distrust that led to the patient’s lie. By demonstrating trust in the patient, the provider gives the patient reason to trust them in return. So, while therapeutic trust may be an inevitable preliminary step in rebuilding trust relationships where trust has been violated, it cannot be the end point if the trust relationship is to be successful. In effectively implementing the corrective virtue of epistemic justice, one may ultimately engage in humble or corrective trust, where one is aware of prejudices that may unfairly undermine one’s trustworthiness and attempts to disrupt belief patterns that reinforce those prejudices (Fricker, 2007; D’Cruz, 2019).

2.7 Conclusion

Because oppressed speakers cannot trust hearers to communicate with them fairly, they may see lying as their only way of avoiding being silenced. In the context of healthcare, this is indicative of patient disenfranchisement and points to serious inequities in the patient-provider relationship. An unequal social power distribution leaves some people vulnerable to testimonial injustice, in which they are unduly assigned a credibility deficit based on institutionalized prejudicial stereotypes. This can leave them silenced as they lose the belief that their testimony will actually succeed in conveying knowledge to the hearer. Out of hopelessness or desperation, they lie in order to be heard. If the speaker believes that whatever testimony they give will be dismissed or undervalued, they may adjust their utterance to try to convey a truth to the hearer on their terms. Though the utterance is a lie, the instilled belief is a truth.

The patient is morally justified in this utterance, insofar as they are attempting to correct an injustice, practice autonomy, and provide a truth about the state of affairs from within a system that does not reflect fair standards of communication in which trust and accommodation extend both ways. However, this cyclical institutionalizing of distrust in healthcare is not beneficial long term for patients or the goals of healthcare. For this reason, providers must take steps to break this cycle by acknowledging the social structures that work to silence patients, and actively limit their role in perpetuating it by practicing testimonial justice.

CHAPTER 3. UNDERSTANDING REPRODUCTIVE COERCION THROUGH A BROADER LENS

3.1 Introduction

Reproductive coercion has typically been understood to be a form of intimate abuse. The phenomena associated with reproductive coercion are prevalent at most levels of society, including within the healthcare setting. Agencies like the Center for Disease Control (CDC) have defined reproductive coercion in such a way that it is limited to interactions at the intimate level, which can manifest as pregnancy pressure or coercion, and contraceptive sabotage. In limiting the scope of reproductive coercion to the intimate level, the CDC fails to recognize that the attitudes and behaviors that contribute to reproductive coercion are present at nearly all levels of community.

In recent years, there has been more public awareness of reproductive coercion. In turn, there have been some efforts to frame certain restrictive policies around abortion care access as similar to reproductive coercion. Anthropologist Gianna DeJoy (2019) states that, "[r]eproductive coercion, a form of intimate partner violence, finds its structural-level twin in state policies on reproductive health care that are coercive in impact" (p. 36). DeJoy (2019) makes the connection between anti-choice policies and reproductive coercion, suggesting that not only are those who are most impacted by these policies also the most likely to experience intimate reproductive violence, but that these anti-choice policies stem from the same power dynamics and desire for control as intimate reproductive coercion. In making this claim, DeJoy (2019) effectively expands the scope of reproductive coercion to include policies and practices at the political or systemic level that impact reproductive autonomy.

While the contemporary political climate has lent a sense of urgency and importance to issues pertaining to abortion and access to reproductive healthcare, it has also created a narrow scope for addressing reproductive trauma. Much of the literature surrounding reproductive coercion acknowledges that the healthcare setting is the best place to identify and rectify instances of reproductive coercion but fails to recognize the ways in which healthcare itself perpetuates and participates in reproductive coercion. Typically, instances of reproductive injustice are classified as either systematic, such as institutional barriers to contraception and abortion, or intimate, as in cases of rape, partner violence and coercion, or partner contraceptive denial. Even under an expanded conception of reproductive coercion, there are gaps in the understanding of how the patient-provider relationship is imbued with the same power dynamics and desire to control reproductive choice. Through reproductive paternalism, a type of medical paternalism that stems from sexist attitudes about reproduction, certain clinical practices, such as contraceptive refusals and voluntary sterilization denials by medical professionals, can unduly impose the same restrictions on autonomy as anti-choice policies or intimate reproductive coercion. However, these violations of autonomy across social levels have been treated as disparate and unique when they can and ought to be treated as instances of "reproductive coercion."

This paper will discuss the current literature on reproductive coercion and propose that there are three distinct levels where reproductive coercion occurs: at the well-established intimate level, at the systemic or political level, and within the healthcare provider-patient relationship. Moreover, this paper will expand the definition of reproductive coercion to include certain practices in healthcare and law, talk in depth about the issue of reproductive coercion in healthcare, and identify instances of it. It will also address the issue of pro-reproductive bias and how it contributes to reproductive paternalism in healthcare, and demonstrate that this phenomenon has profound effects on autonomy. Finally, I will show that the behaviors and attitudes that fall under the term "reproductive coercion" inevitably have an impact on women's trust in healthcare.

3.2 Defining Reproductive Coercion

Currently, reproductive coercion is defined as a type of intimate abuse that involves attempts to control reproductive choice. According to the American College of Obstetricians and Gynecologists (ACOG) Committee Opinion on Reproductive Coercion (2013), this includes “explicit attempts to impregnate a partner against her will, control outcomes of a pregnancy, coerce a partner to have unprotected sex, and interfere with contraceptive methods” (p. 1). Commonly, this includes contraceptive sabotage, such as birth control tampering or condom destruction or removal; pregnancy pressure; and pregnancy coercion. While pregnancy pressure involves behaviors intended to pressure a partner into becoming pregnant when they do not want to be, pregnancy coercion traditionally involves threats or acts of violence against the noncompliant partner.

This phenomenon should not be confused with sexual coercion, which, according to ACOG (2013), includes a range of behaviors that a partner may use related to sexual decision-making to pressure or coerce a person to have sex without using physical force (p. 1). This includes threats to end the relationship, intentionally exposing the partner to STIs, or refusing to allow the partner to use protections against STIs. It can also include deception, intimidation, and manipulation. It is typical of predatory sexual relationships where the aggressor holds power over the victim, such as when an employer uses their position to pressure an employee to engage in sexual activity.

Because sexual coercion and reproductive coercion are both traditionally defined as forms of intimate partner violence, they are often linked. This is not necessarily the case, and in many ways underappreciates the multitude of forces that can influence reproductive choice. Still, there are indications that partners who are violent or coercive in other ways will also engage in reproductive coercion. According to ACOG (2013), “one quarter of adolescent females reported that their abusive male partners were trying to get them pregnant through interference with planned contraception” (p. 1). Additionally, 15%

of women suffering from domestic violence also reported birth control sabotage (ACOG, 2013, p. 2). ACOG (2013) further suggests that 66% of young mothers on public assistance, who were also victims of partner violence, experience birth control sabotage (p. 2). This shows that these behaviors can be similar to those used in pregnancy coercion and often occur simultaneously. However, though sexual coercion can, and often does, precede reproductive coercion, the two are still distinct.

This phenomenon disproportionately affects teenagers, young people, and victims of other types of domestic abuse (CDC, 2010, p. 48). Importantly, the demographic of people most likely to experience intimate partner violence, including reproductive coercion, is also most affected by anti-choice policies and most likely to experience inconsistencies in healthcare. Over half of abortions performed in the United States are on women in their 20s (Horton, 2022). Additionally, 75% of women who have an abortion are classified as low-income (Horton, 2022). In 2020, over 1 in 9 women of reproductive age in the United States were uninsured (National Women's Law Center [NWLC], 2021). According to the U.S. Census Bureau, the age group most likely to be uninsured is 19-34 years old (Conway, 2020). For young, poor women, especially women of color, the risk of reproductive coercion is significant. Differentiating reproductive coercion from other instances of intimate partner violence can better highlight other social forces that unduly influence reproductive choice.

What ACOG, the CDC, and others concerned with reproductive coercion fail to recognize is that many of the behaviors associated with reproductive coercion can be found at other levels of community, in addition to the intimate level. If reproductive coercion is understood as behaviors that attempt to pressure or coerce someone into becoming pregnant, create unwanted pregnancies, control the outcome of a pregnancy, or interfere with contraceptives, then it is clear that many elements of reproductive coercion can be found beyond the realm of partner-to-partner relations. As such, the scope of reproductive coercion needs to be expanded to include these phenomena when they occur outside of intimate relationships.

As stated earlier, because of a growing awareness of the term “reproductive coercion,” it has become more common to see it appear in conversations about abortion. DeJoy (2019) refers to anti-choice legislation as the “structural-level twin” of reproductive coercion (p. 36). DeJoy is right to make the connection between anti-choice legislation and reproductive coercion. However, the connection is not properly conceptualized. Rather than understanding these policies as *analogous to* reproductive coercion, they should be classified as *instances of* reproductive coercion because they are functionally designed to have the same effect. Anti-choice legislation attempts to control the outcomes of pregnancies or even coerce women into keeping unwanted pregnancies.

The clear purpose of anti-choice legislation is to limit reproductive self-determination. Writing for the Guttmacher Institute, Sneha Barot (2012) states that, “[a]t the state level, a growing list of abortion policies has been enacted, the underlying purpose and effect of which are to push reproductive decision making in one direction—toward pregnancy and childbearing. That such pressure violates the essence of anticoercion policies has never been acknowledged by conservatives…” (para. 13). A (failed) Ohio bill, introduced in 2019, even suggested that doctors should attempt to “reimplant” an ectopic pregnancy into a patient’s uterus (Garrand, 2019). Other laws, such as Kentucky’s requirement that women listen to the fetal heartbeat and that doctors describe fetal anatomy prior to an abortion, are designed to pressure, guilt, or arguably, force women into keeping a pregnancy (van Dis & Choo, 2019). The Kentucky law was upheld in a 2019 Supreme Court decision on the basis that the requirements were a part of the process of informed consent. However, others have argued that “the scripted material that a physician is required by law to read, word for word, to the patient is potentially unwanted, coercive and harmful” (van Dis & Choo, 2019). Barot (2012) further states that, “[u]nder the guise of informed consent, myriad laws have been enacted that require women to receive abortion counseling and information replete with inaccuracies and biases. The real purpose of these laws is not so much to inform women about the abortion procedure, as it is to dissuade them from having an abortion at all" (para. 14).

What this demonstrates is that coercive practices around reproduction are not limited to the intimate level. The CDC definition of reproductive coercion fails to recognize this because its scope is too limited. Even under the traditional definition of reproductive coercion, it seems evident that these practices, which are pervasive throughout state and federal systems, meet many of the basic criteria of reproductive coercion. The connection between anti-choice mandates and reproductive coercion is being recognized and discussed in more straightforward terms. DeJoy (2019) and van Dis & Choo (2019) both recognize that many of the state mandates around abortion are coercive in nature. Dejoy (2019) and others, such as psychologist Anne DePrince (2022), are concerned that anti-choice legislation acts as a barrier to preventing reproductive coercion and can even create situations of intimate partner violence. DePrince (2022) states that "[g]iven the links between reproductive coercion and intimate violence, abortion bans promise to worsen the awful problem of violence against women in the United States." While acknowledging the ways in which state-level practices assist in perpetuating reproductive coercion is critical, we need to recognize that these practices are coercive in and of themselves. Dejoy and others have established the correlation between anti-choice legislation and reproductive coercion, but I am arguing that it is necessary to take the additional step of naming these practices as reproductive coercion because in recognizing them for what they are (coercive), we can name and articulate the wrong-making feature, which is that these practices damage autonomy.

In addition to restrictive abortion laws, limiting access to contraception is another way in which reproductive coercion can occur at the systematic level. Age restrictions on emergency contraception, mandating office visits or prescriptions for birth control, and laws that allow insurance companies to opt out of covering contraceptives are other important ways in which reproductive coercion is present at the systematic level. Laws and clinical practices fall outside the scope of the CDC's definition of reproductive coercion. An expanded conception can accommodate these instances of reproductive coercion in addition to examples of intimate abuse. What has been established is that in addition to instances of reproductive coercion occurring at the intimate level, there is a corollary phenomenon at work within state institutions and legislation that is best understood as reproductive coercion. In an effort to reduce ambiguity in the term, I will refer to this type of reproductive coercion as *systematic reproductive coercion* and refer to traditionally conceived reproductive coercion as *intimate reproductive coercion*.

In addition to identifying manifestations of coercion in intimate relationships and at the systematic level, I will argue that reproductive coercion can also occur at the healthcare or clinical level. Though the methodology may differ, as governing bodies have the power to interfere with access to contraceptives, healthcare providers can also limit access to contraceptives and hinder reproductive control. Arguably, physicians have even more power than states in this regard, as they are integral to reproductive health and planning, and can unilaterally withhold options, such as sterilization or long-acting reversible contraceptives (LARCs), without significant oversight or recourse for patients.

I call this type of reproductive coercion *clinical reproductive coercion*. While many of the elements of what I consider clinical reproductive coercion are already present in the traditionally conceived definition of reproductive coercion, though outside its original scope, my aim in this paper is to demonstrate that the definition of reproductive coercion can and ought to be expanded to include some other clinical practices because clinical reproductive coercion damages patient autonomy in unique and previously unrecognized ways. In addition to contraceptive sabotage and interference, traditionally understood pregnancy coercion and pressure, and legal restrictions on access to reproductive care, certain healthcare assumptions, biases, and practices can be considered reproductively coercive. More specifically, this instance of clinical coercion is a form of pregnancy pressure. Through these assumptions, biases, and practices, providers can create a climate of pressure around reproduction for patients.

While it may seem that "coercion," as it is typically defined, is too strong a word to use when discussing interactions between patients and providers, this would not be the only area of healthcare where the word "coercion" has been applicable. The use of coercive interventions is not entirely uncommon, and occasionally unavoidable. For example, health decisions that impact public safety, such as the choice to be vaccinated, may be met with coercive tactics by providers. Physicians may deny care to patients who are not vaccinated or may require vaccination as a prerequisite for certain types of care.[34] That said, standard practice discourages behaviors that can be interpreted as coercive and goes so far as to condemn coercive practices on the part of physicians. However, the debate about the ethics of medical coercion largely focuses on whether coercive measures are ever justifiable, leaving answers about what constitutes a coercive action underdeveloped. Moreover, the issue of coercion in healthcare is primarily addressed within the context of treatment for public health, addiction, or mental illness.

Treating clinical reproductive coercion as a case of clinical coercion, generally understood, would likely result in an oversimplification of the issue. First, many of the more nuanced behaviors that I classify as coercive would not be addressed because a clear consensus on what constitutes coercive practices, specifically, has yet to be reached. This approach also fails to appreciate the special significance of reproductive healthcare as a

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[34] According to the American Medical Association (2021), "In emergency situations, physicians may not ethically refuse to provide care regardless of the patient's vaccination status (Principle VI). But it may be justifiable to decline to provide "routine care," such as an annual physical examination for an otherwise healthy patient" (para. 3).

contentious socio-political issue with a long history of being used to enforce or enact sexist, racist, and other oppressive ideologies.[35] Therefore, the complexity of clinical reproductive coercion necessitates its being addressed through its own terminology and treated as distinct from other forms of medical coercion.

I am using reproductive coercion to describe a specific type of phenomenon associated with the social pressures of reproduction. At the clinical level, this often looks like provider-initiated conversations about timeframes for family planning; refusals to provide certain, or all, types of contraceptives; and even instances of the provider, intentionally or otherwise, imposing their own values about reproduction onto the patient. What this means is that "reproductive coercion," under this model, encompasses a wide variety of circumstances that can vary in level of severity and scope of influence. Nevertheless, in order to clarify the broad concept of reproductive coercion, I will define it, and the three subclasses I have identified, as the following:

> *Reproductive coercion is the set of behaviors, attitudes, and practices that attempt or enable attempts to create unwanted pregnancies, control the outcome of a pregnancy, interfere with access to or tamper with contraceptives, coerce or pressure someone into conceiving, or unduly influence someone's decision to procreate. This can occur at the*
>
> - *intimate, partner-to-partner level (intimate reproductive coercion),*
> - *the political level (systematic reproductive coercion), and*
> - *the healthcare, patient-provider level (clinical reproductive coercion).*

Though not an exhaustive list, subclassifications of reproductive coercion and examples can be seen in this chart:

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[35] Examples of this include the 1974 South African family planning programs that were designed to reduce South Africa's Black populations (Kaufman, 2000), the forced sterilization of Black, Indigenous, and disabled women in the United States during the 20th century (Barot, 2012), and the use of forced gynecological exams in places like Qatar to prosecute women who engage in premarital sex (Santos, 2017).

Table 3.1 Reproductive Coercion Subclasses

Scope/Subclass	Intimate	Systematic	Clinical
Pregnancy Pressure	● Threats to end relationship, etc. if partner refuses to get pregnant. ● Ongoing pressure or coercion to conceive. ● Monitoring ovulation or menstruation. ● Pressure against sterilization.	● Politicizing/moralizing reproductive choices ● Incentivizing parenthood (tax credits, etc.)	● Assumptions around family planning. ● Unrequested recommendations around family planning (such as egg freezing).
Contraception Denial	● Birth control tampering such as hiding or destroying oral contraceptives. ● Removing or altering condoms without consent ("stealthing"). ● Lying about or misrepresenting usage of birth control.	● Contraceptive bans. ● Not covering contraceptives under insurance. ● Age restrictions for contraceptives and emergency contraceptives. ● Involuntary sterilizations or LARC insertions (incarcerated)	● Refusing to prescribe requested contraceptives. ● Voluntary sterilization refusals. ● Refusing to remove LARCs.
Pregnancy Outcome Control	● Pressuring or coercing a partner into continuing or terminating a pregnancy.	● Abortion bans. ● Legally mandating ultrasound viewings.	● Pressuring a patient into continuing or terminating a pregnancy. ● Abortion denial.

Some clinical practices should be categorized as *assistive reproductive coercion.*[36] These are practices that are not coercive in and of themselves, but rather perpetuate or create opportunities for other types of reproductive coercion. Some subclassifications of assistive reproductive coercion can be seen below:

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[36] Thank you to Julia Bursten who, through advising and feedback, helped establish the name "assistive" reproductive coercion.

Table 3.2 Assistive Reproductive Coercion Subclasses

Scope/Subclass	Assistive to Intimate	Assistive to Systematic
Pregnancy Pressure	● Requiring partner approval for sterilizations.	
Contraception Denial	● Failing to prescribe *appropriate* contraceptives when intimate reproductive coercion is indicated.	● Performing involuntary sterilizations or LARC insertions (incarcerated).
Pregnancy Outcome Control		● Legally mandated ultrasound viewings, describing fetal anatomy.

It may be the case that the practice itself is not coercive but that the provider misses specific indications that the patient may be experiencing reproductive coercion in their intimate relationships and advocates for treatments that can exacerbate the patient's circumstances. Alternately, the healthcare system, by way of legal obligations, may serve to reinforce systematic reproductive coercion.

To recap, I suggest that there are three distinct levels at which reproductive coercion occurs: partner-to-partner, systematic or political, and patient-provider. At the patient-provider level, I consider certain established practices in the clinical setting that can range in severity from pressure-inducing to manipulative to coercive. Some clinical practices are not instances of clinical reproduction per se, but rather instances of assistive reproductive coercion. The remainder of this article will discuss what reproductive coercion looks like at the provider-patient level, consider possible reasons as to why it continues to be pervasive in reproductive healthcare, and the impact these practices have on patient autonomy.

3.3 Pressure Around Family Planning

A common subclassification of reproductive coercion is pregnancy pressure. At the clinical level, one such practice centers around assumptions providers make about family planning. The concept of family planning with your primary care provider, though not necessarily new, has taken a more central role in preventative care for women in recent years.[37] Per the World Health Organization (WHO), family planning is defined as “the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through the use of contraceptive methods and the treatment of involuntary infertility” (working definition used by the WHO Department of Reproductive Health and Research [WHO, 2008]). Typically, this involves questions about

- whether you are currently trying to conceive and
- if not now, then when and
- whether you and your partner are experiencing difficulty getting pregnant.

This is usually followed by a prescription for the appropriate contraceptive, or STI (sexually transmitted infection) and fertility screening as needed. Undeniably, family planning is a healthcare good, both for individuals and society. It allows people to time births and control the size of their family in ways that fit their needs, prevents transmission of STIs, aids in fertility issues.

However, elements of the family planning practice can contribute to a climate of pressure around reproduction and pregnancy. First, consider the language involved in family planning, as stated in the WHO definition: “the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their

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[37] In the U.S., the 1960 USAID guidelines, the 1968 Foreign Assistance Act, and the 1970 Title X family planning program all aimed to increase access to family planning care. Additionally, the 1994 United Nations International Conference on Population and Development adopted a framework that pressured governments to support family planning initiatives that promote voluntary decision-making in reproduction (Barot, 2012).

births." (working definition used by the WHO Department of Reproductive Health and Research [WHO, 2008]). While it could be assumed that a desired number of children might be zero, this is not stated explicitly. Though minor, the phrasing of this definition allows for providers to operate within the mindset that a desire to not have children is only a present, temporary desire and that "waiting" is part of the plan to space and time the births of their children in accordance with their goals and plans. Essentially, family planning still involves an assumption that people want to be parents eventually.

This assumption can act as a barrier to certain contraceptive methods or a desired voluntary sterilization. If a provider assumes that a woman will want to be a parent eventually, they may think that LARCs are not a suitable option if she is over a certain age because she will need to get pregnant before the IUD expires. If she is young and unmarried, they may deny requests for tubal ligation outright. Without clear and concise language around reproductive choice, specifically around the choice to not procreate, provider assumptions and biases can impact the ways in which reproductive care is administered and influence which options providers recommend to their patients. These assumptions can impact patient autonomy by preemptively excluding them from certain options and information about reproduction.

Other elements of family planning that can become loaded with pressure involve the idea of a "biological clock" and the practice of egg freezing. Like other IVF treatments, mature oocyte cryopreservation was originally developed to be an option for women who were facing certain health issues that would impact their ability to conceive naturally. This included women facing chemotherapy and radiation for cancer, a treatment that could leave them infertile. By freezing eggs prior to treatment, they could potentially have the option to implant later. However, as more women choose to pursue higher education and postpone parenthood, egg freezing has become a popular method of preserving the option of future reproduction as women age, regardless of fertility status.

In fact, in recent years, egg banks and fertility clinics have begun targeting college students, suggesting that this treatment is a way to guarantee you can "have it all." This push toward younger clientele stems from a belief that fertility begins to decline by a woman's mid-twenties. While these companies and clinics attempt to persuade women with positivity surrounding the practice, they are not necessarily above using certain fear tactics to pressure young women into freezing their eggs. As a *New York Times* (2018) article states,

> Their messaging, generally friendly and fact based but in some cases alarmist in tone, varies from Ova's invitations to "freeze for your future," to Extend's more urgent "eggs are a nonrenewable resource." The exhortations are underscored by cheery images variously showing gaggles of young women gathered over drinks or ambling arm in arm down a city street. (La Ferla, 2018)

Capitalizing on the timeless social bias in favor of pregnancy and genetic parenthood, these clinics pressure young women into undergoing invasive, and potentially dangerous procedures, and investing money into a family plan they may not need or want in the future. When marketed in this way, a tool that can ensure reproductive self-determination becomes a vehicle of pregnancy pressure.

Under the right circumstances, family planning and procedures like egg freezing can be incredibly valuable for actualizing a patient's reproductive aims. It can preserve desired options for reproduction and eliminate unwanted possibilities that could interfere with a patient's short or long-term goals. By informing patients of options available to them, providers can enhance reproductive autonomy. However, if imbued with assumptions and biases, or if approached out of context, certain practices around family planning can create a climate of pressure around pregnancy, which is a form of reproductive coercion.

Similarly, under the right circumstances, clinical family planning can act as a barrier to intimate partner violence by creating a situation where providers can screen for intimate reproductive coercion. By engaging in family planning discussions with patients, providers can more easily screen for intimate reproductive coercion and other forms of intimate partner violence. DeJoy (2019) states that “[reproductive] clinics can be an invaluable safe space where providers can screen patients for reproductive coercion and intervene if necessary” (p. 45). According to ACOG (2013), “Family planning, clinic-based interventions that focused on awareness of reproductive and sexual coercion and provided harm-reduction strategies to address reproductive and sexual coercion reduced pregnancy coercion by 71% among women who experienced IPV” (p. 2).

However, if not approached with consideration, family planning discussions can become a form of assistive reproductive coercion. If providers invite or allow partners to attend appointments or seek consensus from partners for procedures such as sterilization, they may exacerbate ongoing instances of intimate reproductive coercion. In cases such as this, family planning fails in its objective to promote reproductive autonomy.

3.4 Contraception Denial

In the same vein, access to contraception is a vital component of family planning and intimate abuse prevention (IAP). Consider the following case:

> An unmarried, nulliparous female patient visits her primary care provider seeking to change her current oral contraceptive in favor of an IUD, citing efficacy concerns and a change in her living situation. She has just moved in with her boyfriend who wants to start a family. She is not sure at this point and worries her partner may sabotage her pills or pressure her to throw them out. The provider explains to her that because she is unmarried and has never had children, he believes that she is likely not a good candidate for an IUD. He tells the patient that oral contraceptive is highly effective when taken correctly and that she does not need to worry, ultimately advocating for maintaining her current contraceptive plan.

Though the provider may have reasons for thinking that the patient is better off with the oral contraceptive as opposed to an IUD, they have missed some indications that there might be some reproductive coercion happening at home, making the oral contraceptive riskier and more unreliable. By overlooking these signs, the provider may be increasing the likelihood that the patient becomes pregnant or is more successfully coerced. Situations like this are indicative of assistive reproductive coercion, where the provider might not be engaging in clinical reproductive coercion but is enabling or assisting in intimate reproductive coercion.

Discreet methods of birth control, such as IUDs or other long-acting reversible contraceptives (LARCs), might not only be appropriate, but necessary for some women experiencing intimate violence or pregnancy coercion. Oral contraceptives are more easily found and sabotaged by partners, making it easier to create an unwanted pregnancy. Yet, a study by Luchowski et al. (2014) suggests that as many as one third of obstetricians and gynecologists still believe that IUDs are not a suitable method of birth control for unmarried, nulliparous women, despite recent studies indicating that LARCs are safe for nulliparous women (as cited in Lohr, Lyus, & Prager, 2017, p. 530). ACOG (2013) suggests that "a significant portion of women and adolescent girls seeking reproductive health care services have experienced some form of IPV (intimate partner violence), reproductive and sexual coercion, or both" (p. 2). As such, it seems clear that access, not only to contraception, but to the right kind of contraceptives, is an important aspect of addressing intimate reproductive coercion. Oral contraceptives may not be a suitable option for women experiencing contraceptive sabotage from their partner. As the access point for contraceptive options most effective against tampering, doctors can be either an inhibitor or an enabler of intimate reproductive coercion.

However, it need not be the case that a woman is experiencing intimate abuse to make this case an instance of clinical reproductive coercion. Any instance in which a provider refuses to prescribe an autonomously requested contraceptive on the basis of non-medical factors, where it is not indicated, is an undue violation of a patient's autonomy. Withholding viable clinical options is medical paternalism, and it forces patients to make medical decisions in ways that may not reflect their actual goals, values, or needs. Of course, it can be difficult to know whether non-medical factors ought to play a role in the clinical setting as the cultural-medical line is often blurred. That said, a nuanced understanding of reproductive coercion can help mark that line more clearly.

3.5 Refusals for Voluntary Sterilizations

For many of the same reasons that denials of contraceptives can be considered reproductive coercion, refusals of voluntary sterilization on the basis of nonmedical factors might also be considered clinical reproductive coercion under an expanded definition. It is a common practice in medicine to deny patients access to voluntary sterilization procedures on the basis of age or social factors such as marital status. Doctors often express concern that the patient will one day change their mind or that their future spouse may want children. Until 2017, the ACOG (2007) committee opinion on sterilization emphasized the fact that sterilization “may have significant impact on individuals other than the patient, especially her partner,” and recommended that it be discussed with her “husband or other appropriate intimate partners” (p. 217).

The same ACOG (2007) opinion explicitly stated that providing young patients with sterilizations was unethical, even if the patient was of majority age. Often, providers will “bargain” with their younger patients who seek sterilization. For women, ACOG (2017) currently recommends that patient counseling always be provided prior to sterilization and that this counseling should necessarily discuss reversible alternatives, such as LARCs, which does not fully appreciate the fact that this is not what the patient requested.

Though the differences between the 2007 ACOG committee opinion and its 2017 replacement show significant progress in recognizing paternalism in reproductive healthcare, the language of the opinion does not go far enough in correcting for it. Importantly, it still leaves open the right of the physician to refuse voluntary sterilization requests on the basis of non-medical or social factors. Social indicators such as age, marital status, or nulliparity do not impact the medical efficacy or safety of sterilization and are therefore not medically based. However, non-medical factors play a significant role in determining qualification for voluntary sterilizations.

It is true that social factors are taken into consideration for other major procedures. For example, organ transplant candidates are screened extensively to ensure that the patient has the necessary structures in place to care for the organ during and after recovery. But sterilization procedures are straightforward and do not require the same level of extensive social support post-operation. The social factors in this case do not play a role in efficacy or safety. Rather, in many cases of voluntary sterilization refusal, the providers are not justified on these grounds because the fear of the patient’s regret should not be used as justification for overriding a patient’s autonomous choice.

As there is no medical basis for the advice, physicians should not counsel patients seeking sterilization to consider alternative, reversible pregnancy prevention methods. The side effects of contraceptives and sterilization are not the same. When taken correctly, the efficacy may be comparable, but the ongoing risk of user error with contraceptives needs to be considered. Additionally, there is the issue of continual dependency on providers to achieve the goal of remaining childless. Even with LARCs, patients must continue to monitor and replace the devices to ensure efficacy. With continually changing laws and attitudes about reproductive choice, a patient may have more reassurance and independence with sterilization. A provider’s decision to provide LARCs in lieu of a requested sterilization not only fails to recognize the autonomous choice of the patient, but also fails to accomplish the patient's ultimate health goals.

Further degradations of autonomy can occur by requesting that a spouse (or even a potential future spouse) be included in the conversation about sterilization. Providers may be assisting in intimate reproductive coercion, which disregards the individual’s right to bodily self-determination. This is especially true given that the age group (18-30) most likely to be refused as candidates for sterilization overlaps almost entirely with the age group most susceptible to reproductive coercion. Studies compiled by Rowlands & Walker (2018) indicate that one of the highest risk factors for reproductive coercion is being young, generally between the ages of 16 and 29. According to a report by bioethicist Christina Richie (2013), the most commonly given reason for sterilization refusals is that the patient is too young, meaning they are in their twenties. While both men and women of this age group are subject to sterilization refusals, women are often subjected to these refusals well past the age of 30.

Many of the reasons given for sterilization refusals must be recognized as non-medical because they are based on factors that do not impact efficacy or safety of the treatment itself. Justifications for voluntary sterilization refusals on the basis of non-medical factors can lead to discrimination against sterilization seekers in at least four ways:

- Sex-based: Women are more likely than men to be denied requests for sterilization (Conway, 2021).
- Age-based: Young people are more likely to be denied sterilization, despite being of legal majority age (Richie, 2013).
- Nulliparity: Childless women are more likely to be denied sterilization (Richie, 2013).
- Marital Status: Unmarried women are more likely to be denied sterilization (Conway, 2021).

These are the most commonly given reasons for sterilization refusals, despite the fact that none of these factors have any medical bearing on efficacy or safety of the procedure. Therefore, the practice of sterilization refusal on the basis of social factors can be seen as discriminatory and coercive. Importantly, refusals for sterilizations on these grounds are not cases of conscientious refusal, as the provider does not object to the treatment itself, but rather to providing that treatment to people of certain ages or social groups. The provider's justification is also paternalistic because the social value of having the potential to have children is prioritized over the patient's express autonomous choice. The provider substitutes their own values, or society's values, for those of the patient and their medical decisions are informed by this substitution. This value substitution reinforces biases and expectations about parenthood and therefore constitutes reproductive paternalism.

While the topic of voluntary sterilization for young adults is undoubtedly controversial, it warrants further inquiry and analysis. Arguments in favor of refusing sterilization focus primarily on the idea of choice preservation (Richie, 2013). By preventing or delaying permanent decisions about reproduction, providers allow younger, single patients to change their mind. This could be valuable for patients who are ambivalent, unsure, or uninformed about reproduction, but this refusal acts as an unjustified barrier for patients who know, with certainty, their reproductive plans. Because their reproductive plans are limited, so too is their autonomy. Medically, they are given fewer options and less control over their health outcomes. By extension, they have less general autonomy as they may have less control over important life choices, given the high stakes of reproduction and parenthood.

3.6 Pro-Reproductive Bias and Paternalism

It is important to note that the concerns over clinical coercion presented here are not indictments of reproductive medicine. Despite increased anti-choice legislation across the United States, advancements in family planning continue to make reproductive control more easily attainable than at any other point in history. Easily attained reproductive control in turn promotes autonomy and creates better health outcomes. However, it is important to note that healthcare is not immune to the reproductive bias that still today permeates society at all levels. Reproductive bias can be understood as the societal attitude and belief that people want, or should want to become natural, biological, genetic parents at some point in their life. The belief might stem from the historical necessity of procreation, the effects of religious doctrines encouraging unrestricted reproduction, philosophical positions such as pronatalism, or simply because an overwhelming majority of people are, or choose to become, parents.[38] Regardless, the bias, unconscious or otherwise, assumes that people will not only want to become parents, but will want to do it via a pregnancy containing their own genetic material.

It would be unrealistic to think that healthcare providers would be immune to these beliefs. Where it becomes problematic is when the provider substitutes their own (or society's) values for those of the patient. This is medical paternalism: a frowned upon former practice in healthcare that can essentially be summarized as "Doctor knows best." In recent years, paternalism has been replaced with vigorous respect for autonomy and an emphasis on patient choice. However, this shift away from paternalism has been more successful in some areas of healthcare than in others. While people have more reproductive options than ever before, certain practices, such as the ones mentioned earlier in this paper, are still imbued with paternalistic and pro-reproductive attitudes. These attitudes are not only present in most cases of reproductive coercion, but often enable it.

Consider refusals of sterilizations for young or single patients. The justifications used by providers refusing the procedure invite questions about paternalism. Offering temporary alternatives to sterilization, such as LARCs or oral contraceptives, can be considered paternalistic insofar as it rejects the patient's actual autonomous goal. Further, when the factors being considered as the basis for refusal are non-medical, questions about discrimination have to be addressed. It is unlikely that physicians who refuse sterilization on the basis of non-medical factors such as age, marital status, or nulliparity are ageist or singlist. However, it is important to recognize that these factors are not

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[38] A survey conducted by Duffin (2019) states that by age 40, only 15% of women in the United States are childless. As of 2018, less than half of women in the United States, aged 15-50 were childless, with 63.5% of childless women not having graduated high school (likely because they were still attending).

medically relevant and are used to justify exclusionary practices for certain groups of people.

More specifically, what makes reproductive medicine unique to the point that autonomous healthcare decisions can be overridden on the basis of social factors? Is there justification for treating reproductive procedures, such as voluntary sterilization, differently from other permanent or semi-permanent procedures in regard to age or capacity for consent? Many physicians cite a "fear of regret" as a primary concern about sterilization (McQueen, 2019). Regret counseling is almost always obligatory in cases of sterilization, regardless of age or marital status, even though sterilization regret is statistically low. A 2006 survey suggests that "most women who undergo sterilisation remain satisfied with their choice of a permanent method of contraception" (Curtis et al., 2006, p. 205). Even while accounting for young, nulliparous women, regret is statistically low.[39] A study of 23 childfree women reported that only one woman regretted her sterilization (Campell, 1999). While this is a small sample size, it is representative of other studies.

Fear of regret and regret counseling are not paternalistic or biased in and of themselves. It makes sense that physicians would want to make sure that patients are informed and certain about a permanent procedure that limits their options moving forward. The problem is that regret counseling and concerns about choice preservation only extend in one direction for reproduction. It appears the physicians, and society at large, do not fear that people will regret having children, only that they will regret not having them. Physicians do not require regret counseling for expectant parents or couples trying to conceive, though parenthood is a relatively permanent choice. This suggests that

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[39] According to ACOG (2017), "[a]pproximately 14% of sterilized women request information about sterilization reversal, though only approximately 1% of women obtain the procedure" (p. 111).

physicians selectively decide what types of reproductive decisions can be made with or without further evaluation, reinforcing the idea that physicians impose paternalistic attitudes, and possibly clinical reproductive coercion on their patients.

Moreover, the fact that there are generally no age limitations or mandatory counseling requirements for other permanent or potentially life-altering decisions further enforces the idea that there is an underlying social pressure to reproduce. 18-year-olds are encouraged to amass hundreds of thousands of dollars in student loans, though it is conceivable that someone may regret their education. Adolescents can join the military, though there could be substantial risk to their life. Mortgages, marriage, divorce, and parenthood can all be taken on, at any age in an adult's life, without much question or stipulation, but the choice to be sterilized is often met with disbelief and apprehension. I have yet to uncover a moral significance to sterilization regret, so I have to conclude that this fear of regret stems from a strong pro-parenthood bias. But more specifically, this is a bias toward natural, genetic parenthood, as sterilization does not actually prevent one from becoming a parent, only from conceiving naturally.

3.7 Effect on Autonomy and Trust

The biases, pressures, and coercive practices that can be found in reproductive medicine act in such a way as to limit women's autonomy, both directly and subversively. Medical paternalism and the value substitution that occurs when providers import their own values and beliefs onto the decision-making process of patients, is symptomatic of distrust in the clinical relationship. Because of the inherent power held by providers in the patient-provider relationship, patient medical autonomy is dependent on the level of trust they are given by the provider. The performance of medical autonomy is constitutively relational because the actualization of medical goals requires assistance from health professionals (Mackenzie, 2014; Holroyd, 2009). If the provider does not trust the patient to make their own decisions, then the patient is not in a position to actualize their autonomous goals. When considering reproductive healthcare, the consequences of reduced medical autonomy are far-reaching and potentially permanent. Cristina Richie (2013) contemplates the effects of refusals for voluntary sterilizations by stating that:

> Women who do not succeed in locating a doctor to sterilize them “remain deeply, desperately worried about unwanted pregnancy,” with some fearing that the availability of birth control might be limited in the future. For women who want sterilization and could not morally accept an abortion, unintentional pregnancy resulting from contraceptive failure would be tantamount to a forced pregnancy. (p. 38)

When we consider that Richie (2013) also suggests that primary motives for refusing sterilizations in young, unmarried women are not medically based, it seems clear that medical paternalism, understood as value substitution, can have deeply coercive effects on patient autonomy.

Additionally, this diminished autonomy can have consequences for a patient’s ability to self-govern. In the context of healthcare, this may present as a belief that one will not be believed or taken seriously as a testifier (testimonial injustice), which creates a sense in which the patient is silenced; that is, they are unable or unwilling to express choices or preferences (Fricker, 2007, 2012; Tumulty 2012). In the face of diminished options because a healthcare professional is unwilling to provide certain options, the patient may also restructure their preferences to accommodate what they perceive as the available choices. This is known as adaptive preference formation and is generally considered incompatible with a sense of autonomy qua self-governance (Elster, 1983; Mackenzie, 2014, 2015). As Benson (1991) states, “Feminine socialization has insinuated its lessons into their most stable views of what they are and ought to be as person” (p. 388). This means that women often accept or even embrace coercive standards regarding parenthood as part of their self-realization, suggesting that women may not even truly believe or realize that the option to not be a parent is available to them. Even those who do recognize it find difficulty in pursuing their plans. They are met with resistance to their choices and limited options for actualizing them.

Understandably, a lack of options and perceived resistance to their values can leave patients frustrated or even distrustful of their providers. Upholding reproductive biases in the face of a patient's autonomous choice is both coercive and paternalistic. Clinical practices that are coercive can clearly breed distrust between patient and provider. However, even legal obligations can impact the clinical trust relationship. Consider again, the Kentucky ultrasound mandate that requires providers to display fetal ultrasounds and describe images to women seeking abortions.[40] As the person performing these requirements, the provider will, at best, be associated with any psychological pain from the experience and at worst, be blamed. This will inevitably create negative associations, both with the provider and reproductive medicine on the whole, which can make trust in this context more difficult. Moreover, when providers fail to recognize or prevent intimate reproductive coercion (assistive reproductive coercion), they can further undermine the trust relationship they have established with their patients. While these practices, and the resulting distrust, can have a direct impact on a patient's reproductive health, the likelihood of this lack of trust having an impact on all aspects of a patient's health is significant. When people lose faith in healthcare institutions, they often forgo preventative care and delay visitations for injury and illness. This inevitably leads to bad outcomes and patient care suffers in the long term.

3.8 Conclusion

It is important to note that clinical reproductive coercion looks different for different people, and its consequences can vary in severity. Though I have primarily discussed

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[40] Note that Kentucky is not the only state to enforce an ultrasound mandate of this nature. According to the Guttmacher Institute (2023), as of February 2023, six states (Arkansas, Kentucky, Louisiana, Tennessee, Texas, and Wisconsin) require an ultrasound be performed prior to the abortion and that the provider must show and describe the image.

reproductive coercion within the context of people being pressured into parenthood, it can also exist in the reverse, with providers failing to assist people in their efforts to achieve pregnancy. Structural barriers exist to certain treatments like IVF, but provider bias can also be a factor. Additionally, racial and socioeconomic disparities serve a role in how reproductive coercion plays out.

Women of color are more likely to be pressured into sterilization or LARCs, while white women are more likely to be denied services like voluntary sterilization (Richie, 2013). State policies in the 1990s pressured low-income women into accepting sterilization or the Norplant implant in order to qualify for public assistance or as a means of avoiding incarceration (Howell et al., 2020). According to the National Institute of Health, there is strong support for the “Class” theory to explain racialized sterilization patterns. This theory suggests that racially marginalized women are more likely to be sterilized as a consequence of reproductive practices and policies designed to prevent women from having children based on the assumption that they cannot be supported (Shreffler et al., 2014). Sterilization in particular continues to be an issue for vulnerable populations with states still exercising involuntary sterilization efforts on female inmates. One hundred and forty four female inmates were sterilized by the California Department of Corrections and Rehabilitation among years 2005, 2006, 2012, and 2013 (California State Auditor, 2014). Additionally, reports indicate that many women, especially women of color, find it difficult to have their IUDs removed, with either providers dismissing their requests or insurances such as Medicaid denying coverage for removal (Howell et al., 2020).

When providers make assumptions about reproductive values or fail to understand how a patient’s circumstances may be influencing their decisions about reproduction, it can both further instances of reproductive coercion at home and create a climate of pressure around reproduction for the patient. This issue also brings up questions about the morality of providers refusing certain reproductive measures to patients based on non-medical factors. When age and social status become barriers to reproductive choice, patients may feel discriminated against, breeding mistrust between patient and provider, and often resulting in bad outcomes. Further, not recognizing indications of possible partner-to-partner coercion can also undermine the trust relationship between patient and provider. Opting instead for shared decision-making models, patient-initiated conversations about family planning, and emphasizing patient narrative about reproductive values and circumstances are all possible strategies for minimizing reproductive coercion in the clinical setting and beyond.

In order to deal with these issues appropriately and pursue practical solutions, we must first expand the definition of reproductive coercion to account for these phenomena. By expanding the setting to range from intimate to clinical to systematic, we can better identify and guard against instances of reproductive coercion occurring at many levels of society. The value of a conceptual term such as clinical reproduction is that it provides the flexibility to address a myriad of problems without pigeon-holing a specific treatment or practice. There are legitimate concerns about redefining a term used to fight intimate partner violence. Tarzia & Hegarty (2021) suggest that utilizing the term “reproductive coercion” as a continuum opens it to over-inclusivity and diminishes its effectiveness in addressing intimate partner violence.

However, since beginning this project, it has become more common to use reproductive coercion as a term to describe more systematic forms of violence and oppression. We are expanding the definition of coercion to include practices that may not have direct links to abuse or force. I argue that the term “reproductive coercion” is best understood as a unifying concept. Tarzia & Hegarty’s concerns can be resolved through the use of subclassifications of reproductive coercion that specify scope, context, and practices. In this way, we can address a broader range of coercive practices in more specific ways, while still capitalizing on the wide understanding of a unifying term. An expanded definition can provide a sound platform from which to discuss these issues and even make reproductive choices more readily available. In naming these practices, and recognizing the similarities and differences present in different social settings, we can better articulate the experiences of reproductive paternalism and the harms that result from diminished autonomy.

CONCLUSIONS AND FUTURE DIRECTIONS

An objective of this dissertation is to establish dysfunctions of trust as the root cause of many seemingly disparate problems in healthcare. The value in recognizing trust as the foundation of these issues is twofold. The first is a practical benefit. Ethicists and clinicians can stop addressing the many problems of women's health in a piecemeal way. Recognizing that ovarian cancer diagnoses take too long and implementing more thorough screening practices to try to solve this issue is a good practice that can help people facing ovarian cancer. However, it does very little to solve the issue of lupus diagnosis times. It also will not improve maternal mortality rates for Black women. Recognizing that there is a substantial trust issue that leads to bad outcomes across the board can lead to more effective long-term, wide-scope strategies for improving women's health.

The second upshot is a moral one. In categorizing the problem of poor outcomes in women's health as an issue of trust, rather than an issue of science, we place the responsibility squarely in the hands of healthcare. Ovarian cancer is not difficult to diagnose because it is mysterious. The delays in diagnosis stem from the fact that testimony about the symptoms of ovarian cancer are frequently overlooked because patient testimony is not trusted. By identifying prejudice and paternalism as exacerbating the problem of trust, we can call on providers and more importantly, the institution of healthcare, to be more reflective in their approach to women as knowers of their bodies and health goals.

Future work that builds on this dissertation can establish more explicit frameworks for repairing and building trust in women's healthcare. I point to therapeutic trust as an important intermediary step for building true, substantial trust (McGreer, 2008). However, further analysis of the risks associated with therapeutic trust, specifically regarding its potential for ongoing paternalism, is needed to better develop strategies for moving from therapeutic trust to the epistemic principle of charity (D'Cruz, 2019; Daukas, 2006). Other frameworks for developing trust must also address the issue of systematization in healthcare. Given that a reported 25% of patients state a lack of time spent with their provider is the basis of their distrust in healthcare, it is important to develop strategies that address the systematic barriers to developing better relationships in the healthcare setting (NORC, 2021).

However, before trust-based solutions can be implemented, further, more specified research needs to be conducted to fully assess how those with intersecting identities are affected by distrust in healthcare. As stated earlier, instances of reproductive coercion look different for different identities. For example, women of color are more likely to be pressured into sterilization or LARCs, while white women are more likely to be denied services like voluntary sterilization (Richie, 2013). Barriers to services like IVF can also be impacted by socioeconomic status. A failure to recognize the different ways that paternalism and prejudice influence healthcare could result in further instances of oppression. Therefore, future research should be done to differentiate instances of harm brought about by trust dysfunction, as with reproductive coercion, on the basis of factors such as race, sexual orientation, disability, gender identity, nationality, or religion.

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Institutions Attended

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Honors & Awards

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Publications

- Buchanan, C., Lincoln J., Chaudhary S., Graham, C., Van't Land, A., O'Dell, L., & Smith, C. (2021). Developing a Philosophy Summer Camp at the University of Kentucky. In Caire Katz (Ed.), *Philosophy Camps for Youth: Everything You Wanted to Know About Starting, Organizing, and Running a Philosophy Camp* (pp. 35-46). Rowman & Littlefield.

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