

Recognizing the Patient Whose Account Is Doubted: An Epistemic Justice Framework for Interpreting Chronic Pain, Contested Symptoms, and Diagnostic Uncertainty in Clinical Care

Sofia Lindqvist¹, Maria Papadopoulou^{2*}, Ahmed El-Sayed³, Laura Mendez⁴

¹Department of Philosophy and Health Ethics, Stockholm University, Stockholm, Sweden.

²Department of Bioethics, Faculty of Medicine, Athens University of Economics and Business, Athens, Greece.

³Department of Medical Ethics, Faculty of Medicine, American University in Cairo, Cairo, Egypt.

⁴Department of Health Humanities, IE Business School, Madrid, Spain.

*E-mail ✉ maria.papadopoulou@aueb.gr

Abstract

Clinical care frequently requires decisions before symptoms are fully explained, diagnoses are secure, or competing interpretations have been resolved. In such settings, patients whose accounts concern chronic pain, medically unexplained symptoms, or other contested conditions may encounter a distinctive ethical problem: legitimate clinical uncertainty can coexist with credibility practices that progressively diminish the epistemic standing of the person reporting the symptoms. This article develops a conceptual framework for distinguishing uncertainty-sensitive clinical interpretation from epistemically unjust credibility discounting. Drawing on contemporary work on testimonial and hermeneutical injustice, institutional epistemic arrangements, chronic-pain experience, diagnostic uncertainty, clinical documentation, and bias in pain assessment, the analysis argues that epistemic justice cannot require clinicians to treat every patient claim as factually correct. Its more defensible demand is that patient testimony remain consequential, revisable, and capable of altering inquiry while evidence is assessed. Four features are central: defeasible credibility, inquiry proportional to unresolved uncertainty, interpretive openness to experiential knowledge, and preservation of the patient's capacity to influence subsequent assessment. Credibility injustice arises when uncertainty is converted into a comparatively stable presumption against the patient, especially where that presumption narrows inquiry, shapes documentation, or makes later testimony easier to disregard. The framework therefore treats epistemic justice as compatible with disciplined doubt while identifying conditions under which doubt becomes structurally self-reinforcing. It offers a basis for more precise clinical interpretation without replacing evidentiary judgment with automatic belief.

Keywords: Epistemic injustice, Chronic pain, Diagnostic uncertainty, Testimonial injustice, Patient credibility, Clinical interpretation

Introduction

Epistemic injustice has become an increasingly important lens for understanding how healthcare can disadvantage patients as knowers, particularly where professional authority, interpretive resources, and credibility are

unevenly distributed. A recent scoping review documents a broad healthcare literature describing epistemic injustice across professional practices and patient interactions [1]. Yet the extension of testimonial and hermeneutical injustice into clinical medicine is not conceptually straightforward. Healthcare routinely involves incomplete evidence, conflicting reports, uncertain causal explanations, and diagnostic revision. Nielsen and colleagues therefore caution that familiar philosophical formulations require careful qualification when applied to clinical judgment [2]. The central problem is consequently narrower than whether patients are believed. It concerns how clinicians should interpret

Access this article online

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Received: 30 April 2026; Accepted: 04 August 2026

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How to cite this article: Lindqvist S, Papadopoulou M, El-Sayed A, Mendez L. Recognizing the Patient Whose Account Is Doubted: An Epistemic Justice Framework for Interpreting Chronic Pain, Contested Symptoms, and Diagnostic Uncertainty in Clinical Care. *Asian J Ethics Health Med.* 2026;6(2):35-44. <https://doi.org/10.51847/hPndOv1wSk>

accounts that may be sincere, clinically important, and epistemically vulnerable while remaining evidentially uncertain.

The ethical importance of that problem extends beyond the distribution of knowledge. Epistemic injustice may contribute to harms that implicate ordinary duties of nonmaleficence when patients are persistently prevented from contributing relevant knowledge about their own condition [3]. The conditions of communication also matter. Language barriers, for example, can restrict a patient's ability to participate as an epistemic agent even when no clinician intends to discredit the person [4]. Structural arrangements create an additional layer because clinical institutions determine which forms of evidence are readily recorded, which professionals possess authority to interpret them, and how experiential reports move through systems of care. Work connecting disability studies and medical sociology shows that epistemic disadvantage can therefore emerge through organizational and social arrangements as well as through individual credibility judgments [5].

At the same time, the concept loses explanatory value if every disagreement, diagnostic delay, or adverse clinical interaction is redescribed as epistemic injustice. Empirical work on medical records provides evidence that credibility-related language can be patterned. Beach and colleagues found racial differences in the use of linguistic features associated with disbelief and judgment in clinical notes, demonstrating that credibility practices can leave observable traces in documentation [6]. Such findings establish a legitimate reason to examine credibility allocation, but they do not by themselves reveal why a particular clinician discounted a particular claim. Arcila-Valenzuela and Páez show how difficult it can be to infer testimonial injustice from an isolated credibility judgment without adequate evidence that identity-linked prejudice produced an unwarranted credibility deficit [7]. A further distinction is required between an epistemic wrong and the harms that may follow from it; the two can overlap without being analytically identical [8].

The argument developed here begins from these constraints. Clinical interpretation must allow uncertainty to remain uncertainty. A clinician may question an explanation, seek corroborating evidence, revise a working diagnosis, or regard some elements of testimony as more reliable than others. Epistemic injustice emerges through a different problem: the patient's status as a contributor to inquiry is weakened in

a way that exceeds what the available evidence warrants. The practical task is therefore to identify when doubt remains defeasible and inquiry-generating, and when it becomes a comparatively durable credibility deficit that changes whose account can influence what happens next.

Epistemic injustice in contested clinical accounts

Clinical credibility is allocated within relationships that are already structured by differences in expertise, authority, documentation access, and institutional role. These differences are often justified; clinicians possess training and responsibilities that patients do not. Problems arise when legitimate professional authority becomes a mechanism through which some forms of knowledge are systematically insulated from challenge. Bueter and Jukola show that institutional patterns of medical dominance may produce epistemic injustice even within ostensibly collaborative healthcare teams when the structure of professional authority determines whose knowledge is treated as authoritative [9]. Social identity can interact with these arrangements because credibility judgments are made in social contexts rather than in an epistemic vacuum [10]. The relevant question is therefore not whether professional asymmetry exists, but how that asymmetry affects the evidentiary consequences of a patient's testimony.

Repeated dismissal provides one route through which credibility can be eroded. Analyses of medical gaslighting describe interactions in which patients experience persistent invalidation and may come to doubt their own interpretive competence or avoid further help-seeking [11]. Yet contested diagnosis cannot itself function as evidence that testimonial injustice has occurred. Byrne's analysis of myalgic encephalomyelitis/chronic fatigue syndrome illustrates both the usefulness and the danger of applying epistemic-injustice concepts in settings where medical knowledge is itself unsettled [12]. When the evidence base is uncertain, the clinician's inability to confirm a patient's proposed explanation may be entirely defensible. The ethical issue becomes sharper when uncertainty about diagnosis is transformed into a broad presumption that the patient's descriptions of symptoms, functional effects, or temporal patterns are untrustworthy.

Chronic pain makes the distinction especially important because the meaning of a diagnosis can be simultaneously legitimating and incomplete. Qualitative work on fibromyalgia describes diagnosis as capable of validating suffering while leaving major explanatory

uncertainty unresolved [13]. Such situations can generate several forms of epistemic failure, and they should not be treated as interchangeable. De Souza Campos and De Luca-Noronha argue directly that some inadequate clinical responses to chronic-pain reports are better characterized as failures of inquiry or as distributive epistemic problems than as testimonial or hermeneutical injustice [14]. Their challenge is important because it shows that a clinician may fail a patient epistemically without necessarily assigning an identity-prejudiced credibility deficit. An encounter in which the clinician accepts that the patient is suffering but does not pursue relevant questions differs from one in which the same testimony is discounted because the patient is regarded as unreliable. The corrective response should differ accordingly.

Poorly understood and underdiagnosed conditions add another source of vulnerability. Rosàs Tosas argues that patients with rare or poorly understood diseases can face distinctive epistemic disadvantages because the interpretive resources required to make sense of their experiences are unevenly available [15]. Intersectional analysis of endometriosis similarly shows how disease

recognition can interact with age, gender, and socially established expectations about whose symptoms fit accepted clinical categories [16]. Menstrual pain offers a related example in which normalization and impoverished interpretive resources may affect how pain reports are understood and credited [17]. These contexts elevate the risk of credibility distortion, but they do not establish injustice in advance of the encounter. Social position and disease invisibility are better understood as background pressures on interpretation whose ethical significance becomes clearer when they alter inquiry, credibility, or the patient's ability to contribute evidence. The resulting distinctions are clinically consequential. A patient whose account is doubted may be experiencing a testimonial credibility deficit, an interpretive-resource problem, an inquiry failure, an institutional authority problem, or some combination of these. The same observable outcome—such as diagnostic delay—can arise through different epistemic mechanisms. Clinical interpretation therefore requires a mechanism-sensitive vocabulary rather than a single label for every unsuccessful or distressing encounter.

Table 1 summarizes the distinctions discussed above.

Table 1. Distinguishing epistemic failure patterns in contested clinical accounts

Interpretive failure pattern	What happens to the patient's account	Role of diagnostic uncertainty	Signal that epistemic standing is being lost	What could remain clinically legitimate	Corrective interpretive task
Patterned credibility deficit	Testimony is assigned less evidentiary weight because the speaker is treated as less trustworthy	Uncertainty becomes a reason to distrust the person rather than a property of the clinical question	Similar reports repeatedly receive diminished weight despite continuing relevance	Critical evaluation of consistency, plausibility and alternative explanations	Keep credibility defeasible; require reasons for discounting testimony that remain revisable
Hermeneutical shortfall	Available concepts fail to represent or communicate the patient's experience adequately	Uncertainty reflects gaps in shared interpretive resources	Clinically important experience becomes difficult to name, document or connect to recognized categories	Acknowledgement that available diagnostic language may be incomplete	Preserve descriptive detail while diagnostic categories remain unsettled
Inquisitive inertia	The account is heard but does not generate proportionate follow-up questions or investigation	Uncertainty persists because inquiry is prematurely attenuated	Recurrent symptoms cease to produce new inquiry although material questions remain unresolved	Limiting low-value investigation when further testing is genuinely unlikely to alter management	Distinguish justified investigative restraint from failure to pursue relevant unresolved questions
Institutional authority asymmetry	Experiential knowledge is subordinated because formal roles determine which evidence counts	Organizational routines can stabilize one interpretation despite persistent uncertainty	Patient knowledge repeatedly disappears as information moves across professional or organizational boundaries	Role-specific decision authority and evidentiary standards	Maintain traceable routes by which experiential evidence can influence later interpretation
Pre-emptive exclusion	Testimony is treated as irrelevant before its content has been	Diagnostic or classificatory assumptions decide credibility in advance	The account cannot alter the working interpretation	Prior probabilities and established diagnostic criteria	Ensure that prior classifications guide interpretation without making contrary

	adequately considered		regardless of its content		testimony epistemically inert
Uncertainty- sensitive disagreement	The account is taken seriously while some claims remain unconfirmed or contested	Uncertainty is explicitly represented and periodically reassessed	Patient testimony continues to affect questions, documentation and follow-up despite disagreement	Provisional conclusions, differential diagnosis, corroboration and justified skepticism	Sustain scrutiny without converting uncertainty into a stable presumption against the speaker

Chronic pain, credibility, and diagnostic uncertainty

Chronic pain presents a demanding test of this distinction because diagnostic uncertainty is often genuine. It can persist even after substantial investigation and can involve disagreement about etiology, mechanism, prognosis, or the relationship between symptoms and measurable pathology. Interviews with young people with chronic pain and their parents show that negative investigations do not necessarily resolve uncertainty and that previous encounters, explanatory communication, and the perceived adequacy of a diagnosis influence how uncertainty is experienced [18]. A broader review of diagnostic-uncertainty communication in primary care similarly indicates that uncertainty is not a single informational deficit. Its effects depend partly on how clinicians communicate what is known, what remains unresolved, and what will happen next [19].

The temporal dimension is important. People seeking care for low back pain describe uncertainty as something that can extend across an entire care trajectory, encompassing questions about diagnosis, future function, treatment, and whether clinicians possess an adequate explanation [20]. Pediatric chronic-pain research further suggests that the clinical encounter itself can alter diagnostic uncertainty by affecting whether an explanation seems coherent, whether the patient's account is validated, and whether remaining uncertainty feels tolerable or threatening [21]. The epistemic relationship is therefore dynamic. Clinical evidence influences credibility judgments, while credibility practices can influence what information is volunteered, recorded, investigated, or reconsidered later.

This feedback becomes particularly important when patients encounter repeated rejection. A qualitative study of medically unexplained chronic pain in Japan found that experiences of dismissal and inadequate listening could contribute to silence around pain narratives [22]. Qualitative work with people living with chronic pain has likewise associated medical gaslighting and epistemic injustice with changes in agency, self-understanding, and relationships with healthcare [23]. Reflections grounded

in the experiences of people with chronic pain reinforce the importance of treating experiential knowledge as relevant to person-centred care even when it does not independently settle the diagnostic question [24]. These findings do not justify a universal causal claim that disbelief inevitably causes withdrawal. They do, however, identify a clinically important possibility: credibility practices can change the future evidentiary environment. A patient who has repeatedly learned that certain descriptions will be dismissed may provide less detail, delay disclosure, or avoid further attempts to communicate uncertainty.

Pain assessment is also vulnerable to socially patterned interpretation. The increasing use of technological tools does not eliminate this problem. Katz and colleagues argue that AI-assisted pain assessment still requires epistemic humility because computational measurement cannot simply substitute for the first-person character of pain experience [25]. Experimental evidence independently shows that observers can underestimate pain in ways associated with race and gender and that targeted behavioral training can reduce measured bias under study conditions [26]. Research on pediatric pain perception likewise demonstrates racialized differences in how observers interpret and respond to pain signals [27]. Large-scale and experimental work on pain management has also documented sex-associated bias in assessment and treatment decisions [28]. These studies do not establish that every discordant pain judgment is unjust. They show why a clinician cannot assume that skepticism is socially neutral merely because it is expressed in clinical language.

A defensible account must therefore keep two possibilities open simultaneously. First, chronic pain and contested symptoms often involve legitimate uncertainty, and clinicians remain responsible for evaluating competing explanations. Second, the interpretation of first-person evidence can be distorted by credibility practices that are only partly related to the underlying evidentiary merits. Treating these possibilities as mutually exclusive produces two symmetrical errors:

epistemic injustice may be ignored whenever objective confirmation is incomplete, or ordinary clinical uncertainty may be redescribed as injustice whenever the patient's preferred explanation is not accepted. The more precise task is to identify how uncertainty is handled.

An epistemic justice framework for clinical interpretation

The distinction becomes operational when clinical interpretation is treated as an ongoing allocation of evidentiary weight rather than a single binary act of belief. Large-scale analysis of more than thirteen million clinical notes found racial differences in language that supported or undermined patient credibility, indicating that credibility can be patterned and recorded within routine documentation [29]. The relevance of such findings lies less in proving prejudice in any individual note than in demonstrating that the language of credibility has institutional persistence. Once a characterization such as “poor historian,” “claims,” “insists,” or another credibility-laden descriptor enters a record, it can influence how subsequent clinicians approach later testimony. Documentation therefore has the potential to convert a local judgment into an epistemic inheritance.

Patients can respond to exclusion by creating alternative sites of knowledge and recognition. Qualitative research on Long COVID peer-support groups shows how people who have experienced dismissal may use peer settings to validate experiences and reconstruct confidence in their own accounts [30]. Large-scale analysis of online Long COVID communities likewise documents patient-made knowledge networks through which experiential observations, interpretive resources, and emerging categories are collectively developed [31]. Such communities do not possess automatic epistemic authority, and shared conviction cannot substitute for clinical validation. Their significance is different: they demonstrate what happens when people who experience deficits in institutional recognition build alternative infrastructures for making their experiences intelligible. Clinical interpretation therefore needs a way to preserve patient epistemic standing while uncertainty remains unresolved. Work on communication of diagnostic uncertainty offers concrete clues. In developing a framework and electronic tool for primary care, Khazen and colleagues found that patients and clinicians valued explicit acknowledgement of uncertainty, meaningful engagement with the patient's concerns, and a plan for

follow-up rather than simple closure of the diagnostic question [32]. Philosophical analysis of diagnostic classification identifies an additional danger: testimony can be excluded pre-emptively when a category or prior assumption determines in advance that what the patient says cannot count as relevant evidence [33]. Although that analysis arises from psychiatric classification, the underlying boundary is applicable here. A prior diagnosis, absence of confirmatory testing, or existing chart characterization may legitimately shape interpretation; it becomes epistemically problematic when it renders contrary first-person evidence incapable of changing the inquiry.

The proposed framework therefore rests on four linked requirements. The first is defeasible credibility. Patient testimony should enter clinical reasoning with sufficient standing to matter, while remaining open to corroboration, contradiction, revision, and contextual interpretation. Defeasibility works in both directions: clinicians may revise their confidence in the patient's account, and they must also remain capable of revising skepticism when later information warrants it. This requirement responds directly to the attribution problem identified in philosophical critiques of testimonial injustice [7]. The ethical failure is not disagreement itself. It is a credibility judgment that becomes resistant to relevant counterevidence or derives its stability from factors insufficiently connected to the evidentiary merits. The second requirement is inquiry proportional to unresolved uncertainty. An uncertain account need not trigger unlimited testing, yet remaining questions should generate a level of investigation, observation, follow-up, or explanation proportionate to their clinical significance. The rival account of inquisitive inertia is important here because it shows how a clinician can accept that a patient is suffering while still failing epistemically by not asking or pursuing the questions necessary to understand the problem [14]. Inquiry therefore provides one of the clearest discriminators between disciplined skepticism and credibility discounting. Responsible doubt asks what evidence would change the current interpretation. A closed credibility judgment often leaves no comparable route for revision.

The third requirement is interpretive openness. Chronic and contested symptoms may not fit available categories cleanly, and diagnostic language may lag behind patient experience. Interpretive openness requires clinicians to preserve descriptive information that does not yet map neatly onto an accepted explanation. The purpose is not

to privilege experience over biomedical evidence. It is to prevent limitations in existing concepts from erasing clinically relevant observations before their significance is understood. The clinical encounter can alter the experience of uncertainty itself [21]; maintaining interpretive openness gives unresolved evidence somewhere to remain clinically visible.

The fourth requirement is preservation of epistemic consequence across time. A patient's testimony retains epistemic standing only if it can continue to influence later assessment, documentation, and reconsideration. This is where individual interpretation and institutional practice meet. Large-scale disparities in credibility-related documentation show how chart language can carry judgments beyond the original encounter [29]. Fair interpretation therefore requires that uncertainty and credibility remain revisable in the record as well as in the clinician's mind. A disputed account should not become progressively easier to disregard simply because earlier doubt has been documented.

These four requirements yield a specific criterion for identifying the transition from legitimate uncertainty to epistemically defective discounting. Doubt remains compatible with epistemic justice when the patient's account continues to have **evidentiary consequence**: it can alter questions, prompt appropriate reassessment,

qualify documentation, or change the working interpretation if new information emerges. Doubt becomes more ethically concerning when uncertainty is repeatedly converted into a standing credibility deficit that reduces the account's ability to generate those consequences. This distinction avoids treating credibility as an all-or-nothing entitlement. It protects scrutiny while preventing skepticism from becoming self-validating. Communication practices provide one practical test. Explicitly acknowledging uncertainty, stating what evidence supports the current interpretation, identifying what remains unresolved, and specifying what would justify reassessment preserve a route by which the patient's testimony can continue to matter [32]. The framework therefore does not ask clinicians to suspend judgment. It asks that judgment remain epistemically answerable to evidence that includes, but is not exhausted by, first-person testimony.

The resulting structure is neither a hierarchy of evidence nor a one-way pathway from patient report to diagnosis. It is an interpretive field in which evidentiary appraisal, social credibility pressures, institutional documentation, and the patient's capacity to contribute knowledge interact. **Figure 1** represents these relationships while distinguishing evidence-supported relationships from the article's proposed synthesis.

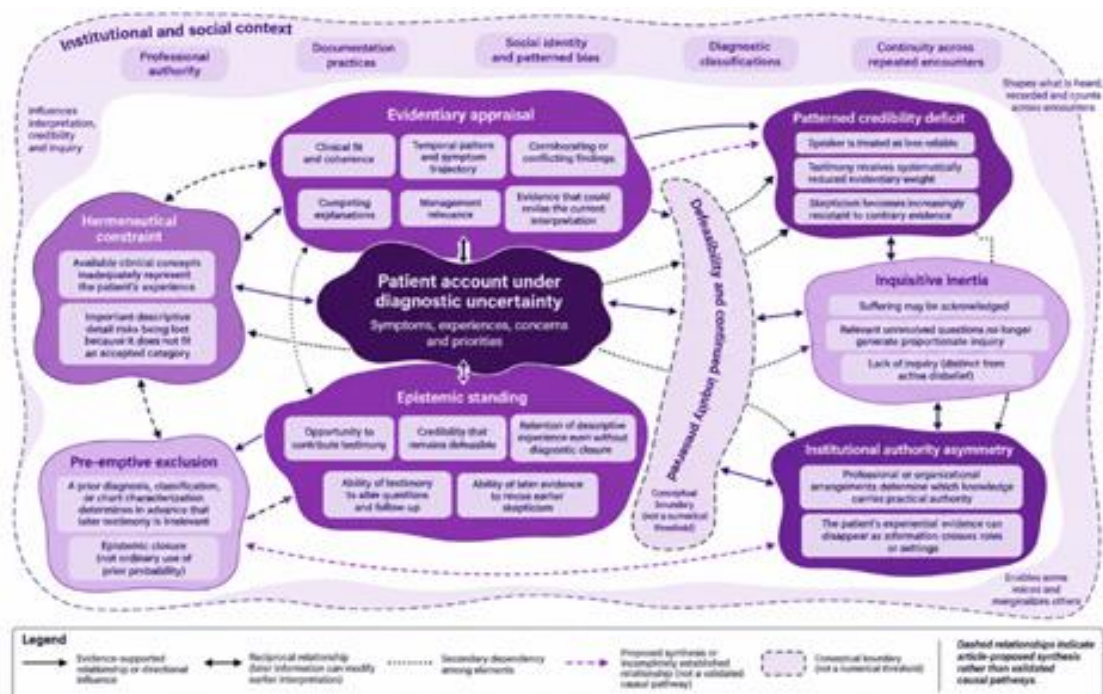


Figure 1. Clinical doubt becomes epistemically unjust through different routes: credibility loss, interpretive constraint, inquiry failure, and institutional exclusion

Clinical implications

Epistemically responsible care does not require clinicians to eliminate uncertainty before acting. It requires uncertainty to be represented in a way that leaves the patient's account capable of influencing subsequent reasoning. Research on diagnostic-uncertainty communication indicates that patients respond not only to the existence of uncertainty but also to whether clinicians explain what is unresolved and how it will be managed [19]. In chronic-pain encounters, validation and explanatory communication can similarly affect how diagnostic uncertainty is experienced [21]. Practical uncertainty communication should therefore identify the current interpretation, its evidentiary limits, the questions that remain open, and the circumstances that would justify reassessment. Stakeholder work in primary care supports acknowledgement, engagement, and explicit follow-up as components of such communication [32]. None requires the clinician to endorse an unconfirmed diagnosis.

Documentation deserves comparable attention because credibility judgments can outlive the encounter in which they originated. Linguistic markers associated with disbelief have been identified in clinical notes [6], while experimental studies show that race and gender can affect observers' pain judgments [26]. Racialized differences have also been demonstrated in pediatric pain perception [27], and sex-associated disparities have been found in pain-management decisions [28]. Large-scale electronic-

record analysis further shows that credibility-supporting and credibility-undermining language can be patterned across racial groups [29]. These findings justify scrutiny of descriptions that characterize the patient rather than the evidentiary status of the claim. Where uncertainty is the problem, the record should preserve uncertainty as uncertainty: what was reported, what evidence supports or conflicts with it, what interpretation remains provisional, and what future evidence could alter that interpretation.

Reassessment also requires continued inquisitive responsibility. Some failures in chronic-pain care are better understood as inadequate inquiry than as straightforward testimonial injustice [14]. Conversely, patients who repeatedly experience rejection may reduce or alter subsequent narration [22], and chronic-pain accounts describe consequences for agency and engagement when patients experience persistent epistemic invalidation [23]. Person-centred care therefore requires attention to how experiential knowledge remains usable over time [24]. Epistemic humility is particularly important when technological tools appear to offer a more objective substitute for first-person pain reports [25]. The appropriate clinical discipline is neither automatic acceptance nor reflexive skepticism. It is a practice in which disagreement remains reasoned, documented, revisable, and responsive to information the patient can still contribute.

These differences are summarized in **Table 2**.

Table 2. Clinical markers separating uncertainty-sensitive interpretation from credibility discounting

Clinical task	Uncertainty-sensitive interpretation	Credibility discounting	What remains open to revision	Consequence for the patient's epistemic role
Receiving the symptom account	Treats the account as clinically relevant while distinguishing description from causal explanation	Treats unresolved explanation as a reason to reduce trust in the account itself	Symptom description, interpretation, diagnosis and causal account	Patient remains a contributor to the evidentiary record
Asking further questions	Uses unresolved uncertainty to determine what additional history, observation or follow-up is proportionate	Repetition of symptoms no longer generates meaningful inquiry	Working hypotheses and significance of new information	Patient testimony can still change the questions asked
Documenting uncertainty	Records what is reported, what is uncertain, and why the current interpretation remains provisional	Converts uncertainty into durable characterizations of reliability or motivation	The charted interpretation and later assessment	Future clinicians inherit an open question rather than a settled credibility judgment
Explaining disagreement	States why evidence does not presently support a conclusion while acknowledging clinically relevant experience	Communicates disagreement as evidence that the patient's account is unreliable	Evidentiary weighting and explanatory hypotheses	Disagreement does not remove the patient's standing as a knower

Reassessing over time	Identifies findings or developments that would justify revising skepticism or the diagnosis	Earlier doubt becomes self-confirming and later testimony is interpreted through it	Credibility judgment, differential diagnosis and management	Later evidence can recover or alter evidentiary weight
Using tests or decision-support tools	Treats measurements as one contribution to interpretation	Treats apparently objective output as capable of replacing first-person evidence	Relationship between measured findings and lived symptoms	Patient knowledge remains relevant where tools are incomplete or indirect

Results and Discussion

The central claim of this framework is deliberately narrower than a requirement to believe patients. Clinical medicine could not function if testimony were insulated from evidentiary scrutiny. The more defensible requirement is that doubt remain defeasible: capable of being revised by later testimony, examination, investigation, temporal development, or a better explanation. Philosophical work on healthcare epistemic injustice warns against assuming that every credibility conflict satisfies the conditions for testimonial injustice [2]. Identifying such injustice in an individual case requires more than observing disagreement [7], and epistemic wrongs should not be collapsed automatically into their downstream harms [8]. The chronic-pain literature sharpens this point because failures of inquiry may sometimes explain poor care better than a direct credibility deficit [14]. Epistemic justice therefore concerns the quality and revisability of interpretation, not the elimination of professional judgment.

The framework also makes credibility a temporally and institutionally distributed phenomenon. Organizational structures influence which kinds of knowledge acquire authority [5], while professional dominance can determine whose account is practically consequential inside multidisciplinary systems [9]. Outside formal care, patients may respond to exclusion by constructing alternative epistemic communities, as studies of Long COVID peer support [30] and patient-made knowledge networks demonstrate [31]. Classification itself can also constrain testimony when prior categories render some first-person information irrelevant before it is evaluated [33]. These mechanisms suggest that credibility cannot be located solely inside a clinician's attitude. It can become embedded in records, routines, classifications, and expectations that shape subsequent encounters.

This extension requires restraint. Evidence supporting the framework is heterogeneous: philosophical analysis establishes conceptual distinctions; qualitative studies illuminate patient experience and interactional processes;

experimental studies demonstrate possible biases in pain perception; and observational record studies identify patterned language or decisions. None validates the framework as a causal clinical model. Reports of medical gaslighting and epistemic harm show why repeated dismissal warrants ethical concern [11], while qualitative chronic-pain evidence demonstrates serious consequences described by affected patients [23]. Person-centred analyses likewise support attention to experiential knowledge [24]. Large electronic-record studies demonstrate credibility-related patterning without revealing the mental state behind each documented expression [29], and uncertainty-communication research identifies promising practices without proving that any single strategy prevents epistemic injustice [32]. The framework should therefore be treated as a disciplined interpretive synthesis whose relationships remain open to empirical testing.

Repeated encounters nevertheless create a clinically significant possibility: earlier doubt may change what is documented, later clinicians may inherit that framing, and patients may alter what they disclose after experiencing dismissal. Under those conditions, credibility can become progressively self-stabilizing even though the original uncertainty remains unresolved.

Conclusion

Patients with chronic pain and contested symptoms can be wrong about the causes of their experiences without being unreliable witnesses to those experiences. Clinicians can also remain appropriately uncertain without committing epistemic injustice. The ethical boundary lies in what doubt does to the patient's capacity to participate in continuing inquiry. When skepticism remains defeasible, generates proportionate investigation, preserves descriptive experience, and can be revised by later evidence, it remains compatible with responsible clinical judgment. When uncertainty instead hardens into a standing credibility deficit that narrows inquiry, shapes documentation, and progressively

reduces the evidentiary consequence of subsequent testimony, the patient's epistemic authority is compromised. Epistemic justice in contested clinical care therefore requires neither unquestioning belief nor the abandonment of professional expertise. It requires disciplined interpretation in which uncertainty remains explicit and revisable, while the person living through the symptoms remains capable of changing what clinicians know.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

References

- Hornyak-Bell E, Thomas A, Chrestensen A, Quaiattini A, Lavoie P, Caty ME, et al. Epistemic injustice in healthcare professional practice: A scoping review. *Soc Sci Med*. 2026;394:119040. doi:10.1016/j.socscimed.2026.119040
- Nielsen KM, Nordgaard J, Henriksen MG. Fundamental issues in epistemic injustice in healthcare. *Med Health Care Philos*. 2025;28(2):291-301. doi:10.1007/s11019-025-10259-6
- Della Croce Y. Epistemic injustice and nonmaleficence. *J Bioeth Inq*. 2023;20(3):447-56. doi:10.1007/s11673-023-10273-4
- Peled Y. Language barriers and epistemic injustice in healthcare settings. *Bioethics*. 2018;32(6):360-7. doi:10.1111/bioe.12435
- Mladenov T, Dimitrova I. Epistemic injustice as a bridge between medical sociology and disability studies. *Sociol Health Illn*. 2023;45(6):1146-63. doi:10.1111/1467-9566.13479
- Beach MC, Saha S, Park J, Taylor J, Drew P, Plank E, et al. Testimonial injustice: Linguistic bias in the medical records of Black patients and women. *J Gen Intern Med*. 2021;36(6):1708-14. doi:10.1007/s11606-021-06682-z
- Arcila-Valenzuela M, Páez A. Testimonial injustice: The facts of the matter. *Rev Philos Psychol*. 2024;15(2):585-602. doi:10.1007/s13164-022-00662-w
- Dunne G, Kotsonis A. Carving at the joints: Distinguishing epistemic wrongs from epistemic harms in epistemic injustice contexts. *Episteme*. 2025;22(2):425-38. doi:10.1017/epi.2023.62
- Bueter A, Jukola S. Multi-professional healthcare teams, medical dominance, and institutional epistemic injustice. *Med Health Care Philos*. 2025;28(2):219-32. doi:10.1007/s11019-025-10252-z
- Khan M, Ewuoso C. Epistemic (in)justice, social identity and the Black Box problem in patient care. *Med Health Care Philos*. 2024;27(2):227-40. doi:10.1007/s11019-024-10194-y
- Shapiro D, Hayburn A. Medical gaslighting as a mechanism for medical trauma: Case studies and analysis. *Curr Psychol*. 2024;43:34747-60. doi:10.1007/s12144-024-06935-0
- Byrne EA. Striking the balance with epistemic injustice in healthcare: The case of Chronic Fatigue Syndrome/Myalgic Encephalomyelitis. *Med Health Care Philos*. 2020;23(3):371-9. doi:10.1007/s11019-020-09945-4
- Boulton T. Nothing and everything: Fibromyalgia as a diagnosis of exclusion and inclusion. *Qual Health Res*. 2019;29(6):809-19. doi:10.1177/1049732318804509
- de Souza Campos V, De Luca-Noronha D. Misunderstanding epistemic injustice: The case of chronic pain reports. *J Appl Philos*. 2025;42(5):1438-53. doi:10.1111/japp.70032
- Rosàs Tosas M. Epistemic injustice suffered by patients with rare diseases, poorly understood diseases, and underdiagnosed diseases, and the epistemic advantage granted by these diseases. *Med Health Care Philos*. 2025;28(4):693-705. doi:10.1007/s11019-025-10285-4
- Langmann E, Kainradl AC, Weßel M, Rokvity A. Endometriosis in later life: An intersectional analysis from the perspective of epistemic injustice. *Med Health Care Philos*. 2025;28(1):151-9. doi:10.1007/s11019-024-10245-4
- Mickiewicz AJ. Menstrual pain and epistemic injustice. *Med Health Care Philos*. 2025;28(3):401-10. doi:10.1007/s11019-025-10266-7
- Neville A, Jordan A, Beveridge JK, Pincus T, Noel M. Diagnostic uncertainty in youth with chronic pain and their parents. *J Pain*. 2019;20(9):1080-90. doi:10.1016/j.jpain.2019.03.004

19. Dahm MR, Cattanach W, Williams M, Basseal JM, Gleason K, Crock C. Communication of diagnostic uncertainty in primary care and its impact on patient experience: An integrative systematic review. *J Gen Intern Med.* 2023;38(3):738-54. doi:10.1007/s11606-022-07768-y
20. Costa N, Butler P, Dillon M, Mescouto K, Olson R, Forbes R, et al. "I felt uncertain about my whole future"—a qualitative investigation of people's experiences of navigating uncertainty when seeking care for their low back pain. *Pain.* 2023;164(12):2749-58. doi:10.1097/j.pain.0000000000002975
21. Neville A, Clemente I, Meldrum ML, Zeltzer L, Jordan A, Oberlander TF, et al. How the clinical encounter shapes diagnostic uncertainty in pediatric chronic pain. *J Pain.* 2025;32:105406. doi:10.1016/j.jpain.2025.105406
22. Okuhara T, Okada H, Yokota R, Kagawa Y. Listening to the silence of pain narratives: A qualitative study of epistemic injustice in patient-clinician communication on medically unexplained chronic pain in Japan. *Patient Educ Couns.* 2026;142:109402. doi:10.1016/j.pec.2025.109402
23. Côte CI. "It's shaking your entire construction as a human being": A qualitative analysis on epistemic injustice and medical gaslighting consequences in patients living with chronic pain. *J Med Philos.* 2026;51(4):307-26. doi:10.1093/jmp/jhag003
24. Gabathuler F, Würth K, Hodel M, Glässel A, Biller-Andorno N, Schwind B. Reflections on epistemic injustice to advance person-centred care through the experiences of persons with chronic pain. *J Bioeth Inq.* 2026;23(1):17-26. doi:10.1007/s11673-025-10457-0
25. Katz RA, Graham SS, Buchman DZ. The need for epistemic humility in AI-assisted pain assessment. *Med Health Care Philos.* 2025;28(2):339-49. doi:10.1007/s11019-025-10264-9
26. Ruben MA, Stosic MD. Documenting race and gender biases in pain assessment and a novel intervention designed to reduce biases. *J Pain.* 2024;25(9):104550. doi:10.1016/j.jpain.2024.104550
27. Haas SM, Mullin GJD, Williams A, Reynolds A, Tuexuntuoheti A, Reyes PGM, et al. Racial bias in pediatric pain perception. *J Pain.* 2024;25(9):104583. doi:10.1016/j.jpain.2024.104583
28. Guzikovits M, Gordon-Hecker T, Rekhtman D, Salameh S, Israel S, Shayo M, et al. Sex bias in pain management decisions. *Proc Natl Acad Sci U S A.* 2024;121(33). doi:10.1073/pnas.2401331121
29. Beach MC, Harrigan K, Chee B, Ahmad A, Links AR, Zirikly A, et al. Racial bias in clinician assessment of patient credibility: Evidence from electronic health records. *PLoS One.* 2025;20(8). doi:10.1371/journal.pone.0328134
30. Sarma N, Gage S, Hough CL, Hope AA. 'We don't have to prove to people how we're feeling': Understanding the role of peer support groups in countering epistemic injustices in Long COVID at a US centre. *Health Expect.* 2025;28(2). doi:10.1111/hex.70266
31. Ammari T. Patient-made knowledge networks: Long COVID discourse, epistemic injustice, and online community formation. *Soc Sci Med.* 2026;405:119593. doi:10.1016/j.socscimed.2026.119593
32. Khazen M, Mirica M, Carlile N, Groisser A, Schiff GD. Developing a framework and electronic tool for communicating diagnostic uncertainty in primary care: A qualitative study. *JAMA Netw Open.* 2023;6(3). doi:10.1001/jamanetworkopen.2023.2218
33. Bueter A. Epistemic injustice and psychiatric classification. *Philos Sci.* 2019;86(5):1064-74. doi:10.1086/705443