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Whose pain is taken seriously? linguistic credibility, gendered expression, and diagnostic inequality in Indonesian clinical encounters

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ABSTRACT

Background: Pain credibility in clinical encounters is often shaped by language, gendered expectations, and diagnostic uncertainty, making unequal recognition of suffering a communicative as well as biomedical problem. **Objective:** This study examines how Indonesian public clinical communication frames pain as credible, doubtful, ordinary, urgent, or diagnostically actionable. **Method:** Using a corpus-assisted discourse-pragmatic design, this study analyses 25 deduplicated public documents from national health institutions, hospital sources, public campaigns, and media texts through linguistic credibility analysis, a gendered pain legitimacy matrix, and a clinical communication and language-justice audit. **Results:** Pain was most frequently legitimised through communication contexts, symptom recognition, treatment pathways, service access, and warning-sign language. Gendered pain gained seriousness mainly when attached to reproductive, menstrual, pelvic, sexual, fertility, or screening-related categories, indicating that women's pain was recognised through specific biomedical thresholds rather than through gender-neutral suffering. **Implication:** Language access, plain explanation, informed consent, patient rights, listening, and diagnostic safety emerged as conditions through which pain testimony became clinically intelligible and actionable. **Novelty:** This study contributes by repositioning diagnostic inequality in pain care as an epistemic and linguistic process in which credibility, gendered expression, and communicative access jointly shape whose pain is taken seriously within Indonesian healthcare communication and patient-safety discourse contexts.

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1. INTRODUCTION

Globally, pain is not only a biomedical complaint but also a patient-safety problem because diagnosis often depends on how suffering is narrated, heard, and translated into clinical action. The World Health Organization estimates that around one in ten patients is harmed during health care and that unsafe care contributes to more than three million deaths annually; diagnostic errors account for nearly 16% of preventable harm. These figures matter because pain is frequently invisible to tests, variable across bodies, and dependent on patient testimony. Gender is not incidental to credibility: women and girls are more likely to experience chronic pain conditions and often report more severe pain and greater functional limitation than men and boys [1]. In Indonesian clinical encounters, patients may express pain through regional languages, indirect speech, metaphors, affective intensifiers, religious idioms, or restrained complaint. The issue, therefore, is not simply whether pain exists, but whose pain becomes clinically believable.

Existing scholarship has established that pain assessment is shaped by gender, race, language, and diagnostic uncertainty, yet these strands have rarely been integrated in Indonesian clinical communication research. Studies show that observers may underestimate women's pain according to patient sex and gender stereotypes [2], [3], [4]. Qualitative research shows that patients manage how they present themselves as "good" pain patients to avoid being judged as exaggerated, demanding, or psychologically unstable [5], [6]. Work on testimonial injustice demonstrates that credibility bias can be embedded in medical records and clinical language [7], [8], while studies of language justice and linguistic minoritization show that communication barriers can affect pain recognition and care equity [9], [10]. However, less is known about how gendered pain expression, linguistic credibility, and diagnostic inequality interact within Indonesian clinical discourse.

This study examines how pain is linguistically framed as credible, doubtful, ordinary, urgent, or diagnostically meaningful in Indonesian clinical encounters and public clinical communication. It asks three connected questions. First, how do Indonesian health texts and clinical communication materials describe pain in ways that invite recognition, escalation, normalization, or delay? Second, how are gendered forms of pain—especially menstrual, pelvic, sexual, reproductive, and chronic pain—positioned within thresholds of seriousness? Third, how do language access, patient comprehension, informed consent, diagnostic uncertainty, and clinician–patient interaction shape the conditions under which pain testimony becomes clinically usable? To answer these questions, this study brings together discourse-pragmatic analysis, a gendered pain legitimacy matrix, and a clinical communication and language-justice audit. This design is necessary because diagnostic inequality is not reducible to individual prejudice or clinical error; it also emerges through routine forms of wording, listening, documenting, and classifying pain.

This study advances a central argument: diagnostic inequality in pain care is partly produced through a credibility filter that converts some expressions of suffering into legitimate symptoms while rendering others vague, excessive, emotional, or insufficiently biomedical. This argument does not presume intentional discrimination, nor does it claim causality beyond what qualitative corpus evidence can support. Rather, it treats clinical communication as an institutional site where uncertainty, gendered expectations, and linguistic norms organize whose account is taken seriously. Research on diagnostic uncertainty confirms that uncertainty can shape patient experience when it is poorly communicated [24], [11], while Indonesian-oriented work on language barriers and pain-clinic communication indicates that comprehension and pragmatic accommodation remain practical concerns in care delivery [12], [13]. By linking these concerns, this study reframes pain assessment as an epistemic and communicative problem, with implications for more equitable documentation, listening practices, and diagnostic safety.

2. LITERATURE REVIEW

2.1. Linguistic credibility

Linguistic credibility refers to the degree to which a patient's account is treated as reliable, medically relevant, and worthy of clinical uptake. In pain care, credibility is fragile because pain is often unverifiable through immediate visual or laboratory evidence and must be mediated through narrative, gesture, scale, metaphor, and affect. Philosophical and clinical scholarship frames this problem as testimonial injustice: patients may be discounted not because their symptoms are absent, but because their speech is interpreted through prejudicial assumptions about rationality, exaggeration, emotionality, or communicative competence [8], [14]. Medical communication studies extend this concern by showing that clinical language can encode credibility judgments in subtle ways [7], [15]. Thus, credibility is not merely personal trust; it is an institutional interpretation of patient speech.

The main indicators of linguistic credibility include coherence, biomedical specificity, emotional restraint, consistency across retellings, alignment with expected symptom categories, and perceived patient cooperation. These indicators are not neutral, because they privilege patients who can translate embodied suffering into institutionally preferred language. Beach et al. (2021) [7] show that linguistic bias appears in medical records, while later evidence links clinician credibility assessments to racialized patterns in documentation [16]. Studies of "good pain patients" similarly show that patients learn to perform credibility by balancing distress with compliance, detail with restraint, and urgency with deference [5], [17]. In this sense, pain testimony becomes credible when it conforms to clinical expectations of narratable suffering.

2.2. Gendered pain

Gendered pain refers to the ways pain perception, expression, interpretation, and treatment are shaped by gender norms and stereotypes. Contemporary research consistently shows that pain is not assessed in a social vacuum: women's pain may be read as emotional, psychosomatic, excessive, or less urgent, while masculine restraint may be interpreted as severity or resilience [2], [3]. The concept is not limited to biological sex differences in pain sensitivity; it also includes social expectations governing how patients should speak about pain and how clinicians should interpret that speech. Reviews on gender bias and

diagnostic delay show that young women's symptoms are particularly vulnerable to dismissal when they are chronic, ambiguous, reproductive, or difficult to objectify [18], [4].

Gendered pain can be observed through several indicators: differential pain intensity judgments, delayed diagnostic escalation, psychologization of symptoms, normalization of reproductive pain, and unequal legitimacy attached to emotional expression. Text-mining and clinical studies indicate that chronic pain among women is often framed through socioeconomic and gendered vulnerability, while provider judgments may be influenced by sexism, gender ontological beliefs, and assumptions about pain tolerance [19], [20], [21]. Experimental and intervention-oriented studies also suggest that race and gender interact in pain assessment, making bias multidimensional rather than singular [22], [23]. This literature implies that gendered expression is not a background variable but an analytic pathway through which pain becomes either clinically serious or dismissible.

2.3. Diagnostic inequality

Diagnostic inequality concerns unequal access to accurate, timely, and respectful diagnosis across social groups, especially when clinical uncertainty is managed through biased interpretation. Diagnostic uncertainty is unavoidable in medicine, but it becomes inequitable when uncertainty is resolved by downgrading some patients' testimony more quickly than others. Dahm et al. (2022) [24] show that communication of uncertainty affects patient experience, while Scott et al. (2023) [11] argue that clinicians must learn to cope with uncertainty without converting it into premature closure. Emergency and pain-care research further shows that cognitive bias can shape decision-making and patient outcomes, particularly in high-pressure settings where symptoms are incomplete or ambiguous [25], [26]. Diagnostic inequality therefore emerges when uncertainty, credibility, and institutional routine converge.

Its indicators include diagnostic delay, failure to escalate symptoms, inadequate explanation of uncertainty, limited language accommodation, poor informed consent, and documentation that minimizes patient concern. Language justice scholarship adds that patients who speak in non-dominant languages, dialects, culturally specific idioms, or low-literacy forms may face additional barriers in making pain intelligible [9], [10], [27]. Indonesian-oriented studies on clinical communication, language barriers, informed consent, empathy, and rural consultations suggest that this problem requires attention to pragmatic interaction, not only biomedical procedure [12], [28], [29], [13], [30]. This study therefore positions diagnostic inequality as a communicative and epistemic process: pain becomes unequal when some linguistic forms are more easily transformed into diagnosis than others.

3. METHOD

This study uses Indonesian public clinical communication as its material object, with the unit of analysis defined as a document-level text unit in which pain, credibility, gendered expression, diagnostic communication, patient comprehension, or clinical safety is explicitly addressed. This unit is appropriate because this study does not observe private consultations directly; instead, it examines how official and public-facing clinical texts construct conditions under which pain becomes recognisable, serious, doubtful, or actionable. The corpus contains 25 deduplicated documents published or accessed between 2021 and 2026, consisting of 14 primary pain-related texts, two secondary media or campaign texts, and nine contextual governance or communication texts. This study adopts a qualitative corpus-assisted discourse-pragmatic design. The design is interpretive rather than experimental, so it does not claim causal effects between gender, language, and diagnostic outcomes. It examines how public clinical discourse organises credibility, seriousness, and uncertainty through wording, categorisation, warning signs, and patient-facing explanation. This approach is informed by work on testimonial injustice, gendered pain, language justice, diagnostic uncertainty, and bias in clinical communication [7], [8], [24], [9], [3]. The design enables this study to connect linguistic form with clinical legitimacy without overstating evidentiary reach.

Information sources were selected from public and legally accessible institutional, hospital, campaign, and media channels. National health communication texts were drawn from Kementerian Kesehatan RI, Direktorat Jenderal Kesehatan Lanjutan, and Ayo Sehat Kemenkes. Hospital-level material was included from Rumah Sakit Universitas Indonesia and RSUD Meuraxa to broaden institutional perspective beyond national policy communication. Secondary sources were limited to public campaign and news materials that directly addressed pain recognition, diagnostic delay, or patient trust. Contextual sources were included only when they clarified communication norms, patient rights, informed consent, language access, diagnostic safety, or patient-safety standards relevant to pain assessment.

Table 1. Composition of dataset

Code	Data Type	Source	Location	Period	Number	Characteristics	Status
IDCLI-PR-001–004	Primary	Kemenkes Keslan	Indonesia, national	2022–2024	4	General pain management, pharmacological and non-pharmacological care	Retained
IDCLI-PR-005–011	Primary	Kemenkes Keslan; Ayo Sehat	Indonesia, national	2022–2024	7	Menstrual pain, endometriosis, adenomyosis, dyspareunia, cervical screening	Retained
IDCLI-PR-012–013	Primary	Rumah Sakit Universitas Indonesia	Depok, West Java	Not stated on captured page	2	Pain clinic service and women's health education	Retained
IDCLI-PR-014	Primary	RSUD Meuraxa / Banda Aceh Government	Banda Aceh, Aceh	Not stated on captured page	1	General pain education from regional hospital source	Retained
IDCLI-SE-001	Secondary	Bayer Indonesia	Jakarta / Indonesia	2021	1	Public campaign on endometriosis awareness and diagnostic delay	Retained
IDCLI-SE-002	Secondary	Media Indonesia	Indonesia, national media	2026	1	Health news on pain management and patient trust	Retained
IDCLI-CT-001–006	Context	Kemenkes; Kemenkes Keslan	Indonesia, national	2022–2024	6	Guidelines, patient rights, communication, safety, informed consent	Retained
IDCLI-CT-007–009	Context	Kemenkes; Kemenkes Keslan	Indonesia / Indonesian patients abroad	2022–2025	3	Language barriers, trust, diagnostic safety, patient safety standards	Retained

Data collection followed a structured documentary protocol. Keywords included "manajemen nyeri," "nyeri haid," "endometriosis," "dispareunia," "diagnosis tepat waktu," "komunikasi efektif pasien," "hambatan bahasa pasien," "hak pasien," "informed consent," and "keselamatan pasien." Each item was recorded with document code, title, date, source, URL, source category, region, clinical scope, data type, inclusion basis, exclusion screen, and deduplication status. Text excerpts were stored with paraphrased context, speaker or institutional voice, pain-expression context, credibility context, gender context, diagnostic context, and link context. Visual and video fields were retained for consistency, although webpage images were not treated as analytic evidence.

Analysis proceeded in three linked stages. First, linguistic credibility and pain narration analysis identified how pain was named, intensified, scaled, localised, normalised, or made actionable. Second, gendered pain legitimacy analysis examined how menstrual, pelvic, sexual, reproductive, and chronic pain were positioned within thresholds of seriousness, warning, delay, or clinical legitimacy. Third, clinical communication and language-justice audit examined whether texts foregrounded plain language, listening, informed consent, comprehension, language access, patient rights, and diagnostic safety. Coding remained provisional and document-based; interpretive claims were therefore limited to discursive patterns in public clinical communication rather than direct evidence of clinician behaviour.

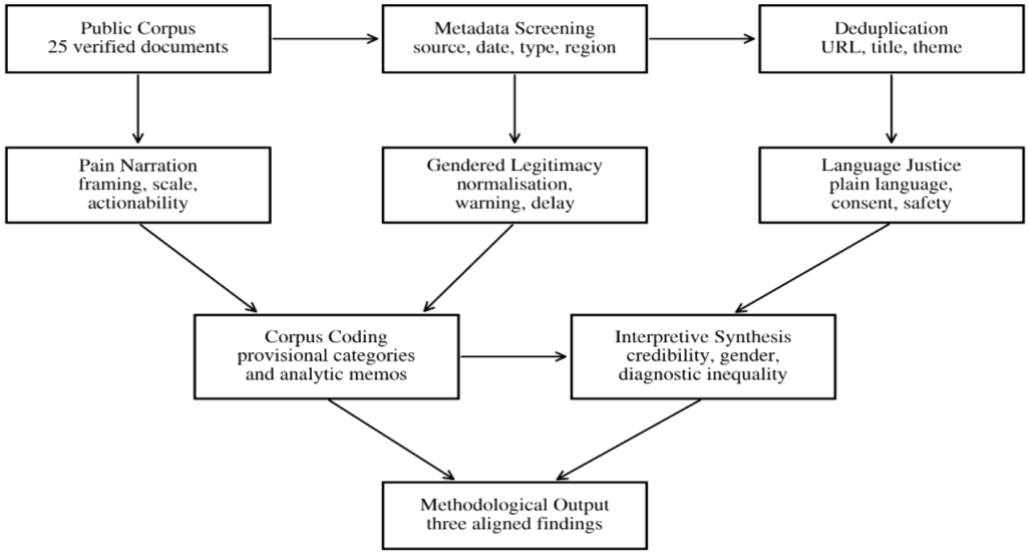

Figure 1. Operational analysis matrix

4. RESULTS

4.1. Linguistic pathways of pain credibility in Indonesian clinical communication

Pain credibility in Indonesian public clinical communication is organised through five recurring frames: communication context, symptom legitimation, treatment action, service access, and warning signs. The most important pattern is that pain is not made clinically meaningful only by describing intensity; it becomes credible when institutional discourse provides a route from complaint to interpretation. This route may involve listening, informed explanation, patient rights, diagnostic timeliness, specialist services, or warning thresholds. The distribution suggests that credibility is relational: patient speech needs communicative infrastructure before it can be converted into diagnostic relevance. This finding is consistent with scholarship on testimonial injustice and medical documentation, which argues that credibility is shaped by clinical language and institutional expectations rather than by patient testimony alone [7], [8], [15].

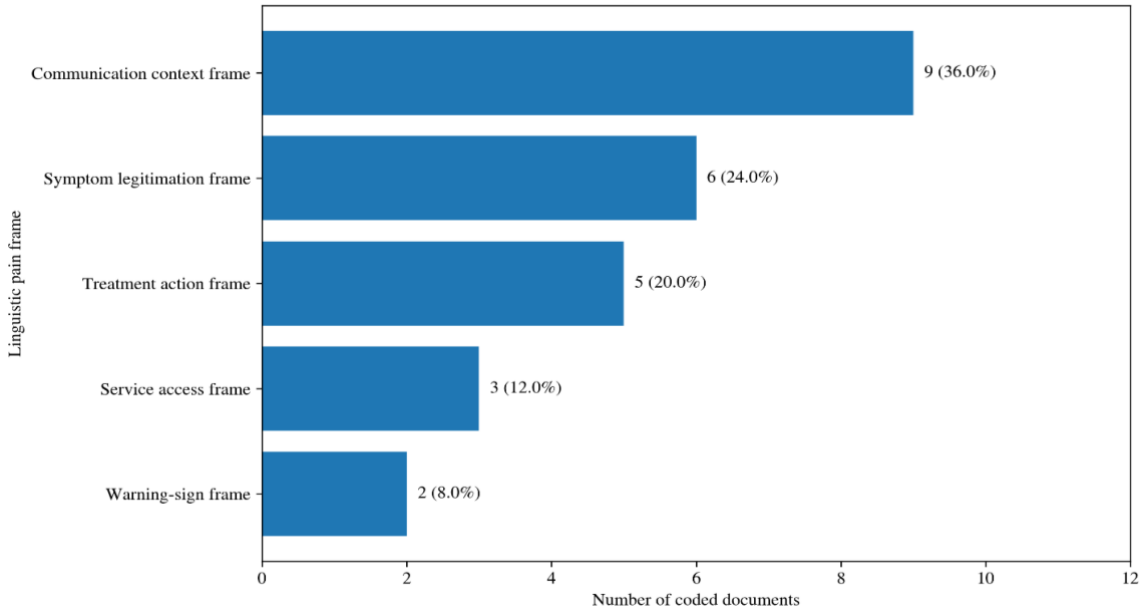

Figure 2. Distribution of linguistic pain frames in the corpus (n = 25)

Table 2. Linguistic credibility and pain narration in Indonesian public clinical communication

Main Category	Subcategory	Operational Indicator	Frequency	Percentage	Data Variation	Example / Short Excerpt	Data Code	Interpretation
Communication context frame	Patient voice, listening, informed explanation, diagnostic safety	Pain becomes credible when communication allows patients to describe complaints clearly and clinicians to interpret them safely	9	36.0%	Patient rights, informed consent, effective communication, language barriers, diagnostic timeliness, patient safety	"memberikan ruang kepada pasien untuk menyampaikan semua keluhan"	IDCLI-CT-003; IDCLI-CT-005; IDCLI-CT-007	Credibility is constructed less through pain vocabulary alone than through institutional conditions that enable complaint, clarification, and diagnostic translation.
Symptom legitimation frame	Recognition of pain as a clinically meaningful symptom	Pain is framed as serious when persistent, excessive, disruptive, unpredictable, or condition-specific	6	24.0%	Menstrual pain, endometriosis, adenomyosis, dyspareunia, reproductive pain, diagnostic delay	"Gejala endometriosis bervariasi dan tidak bisa diprediksi"	IDCLI-PR-005; IDCLI-PR-007; IDCLI-SE-001	Pain gains legitimacy when public clinical language provides thresholds that distinguish ordinary discomfort from symptoms requiring medical attention.
Treatment action frame	Pain as object of medication, intervention, or management	Pain is credible when it can be linked to treatment escalation, multimodal care, or clinical management	5	20.0%	General pain management, interventional pain management, analgesic use, regional hospital pain education, patient trust	"Manajemen nyeri bertujuan untuk mengurangi rasa nyeri"	IDCLI-PR-001; IDCLI-PR-004; IDCLI-SE-002	Clinical actionability functions as a credibility device: pain is taken seriously when it can be organised into a treatment pathway.
Service access frame	Pain as reason for entering specialist or hospital service	Pain is legitimised through institutional availability, specialist care, or named service pathways	3	12.0%	Pain clinic, non-pharmacological care, women's health education, fertility-related pain	"solusi terpadu untuk mengatasi berbagai jenis nyeri"	IDCLI-PR-003; IDCLI-PR-012; IDCLI-PR-013	Institutional service labels transform pain from private suffering into a recognised object of care, referral, and specialised management.
Warning-sign frame	Pain as danger signal	Pain is made urgent through warning vocabulary, non-resolution, functional disruption, or need for examination	2	8.0%	Dangerous menstrual pain, cervical cancer screening, pelvic pain, pain that does not resolve	"Nyeri yang Tidak Mereda"	IDCLI-PR-006; IDCLI-PR-011	Warning signs create a narrow but powerful credibility route: pain is serious when it crosses explicit danger thresholds.

The dominant pattern is the communication context frame, appearing in 9 of 25 coded documents, followed by symptom legitimation in 6 documents and treatment action in 5 documents. Service access and warning-sign frames occur less frequently, with 3 and 2 documents respectively. Objectively, this distribution shows that public clinical texts more often address the conditions for understanding complaints than explicit danger thresholds. Pain is frequently embedded in broader communication themes: giving patients space to express complaints, reducing misunderstanding, explaining consent, overcoming language barriers, and supporting diagnostic safety. By contrast, warning-sign language is concentrated in more specific reproductive or screening-related texts. The corpus therefore shows a layered pattern: general documents build communicative legitimacy, while condition-specific documents sharpen clinical seriousness.

Theoretically, this pattern supports the argument that pain credibility is produced through linguistic and institutional filtering. A patient's pain is more likely to become clinically actionable when it fits recognised frames: persistent disruption, named condition, treatment pathway, specialist service, or explicit warning sign. This does not imply that other pain is absent or less real; rather, it shows how public clinical discourse privileges certain routes of intelligibility. Studies on pain reporting show that patients often adjust expression because they anticipate disbelief, judgement, or dismissal [17], [5]. Work on gendered and linguistic disparities similarly demonstrates that pain recognition is shaped by social expectations and communication barriers [9], [10]. This study therefore positions credibility as an interaction between patient narration and institutional grammar.

4.2. Gendered thresholds of seriousness: normalisation, warning, and diagnostic delay

Gendered seriousness is organised through selective visibility: women's pain becomes most legible when it is named through reproductive, menstrual, pelvic, sexual, or screening-related categories. This pattern matters because gender is not distributed evenly across the corpus. General pain texts often remain gender-unmarked, while condition-specific texts explicitly mark women's pain through dysmenorrhea, endometriosis, adenomyosis, dyspareunia, cervical cancer, and fertility concerns. The analytical point is not that Indonesian public clinical discourse ignores women's pain, but that it recognises gendered pain most clearly when pain can be attached to a named reproductive condition or a specific diagnostic pathway. This supports studies showing that gendered pain is shaped by clinical expectations about what counts as serious, measurable, and medically actionable [2], [3], [4].

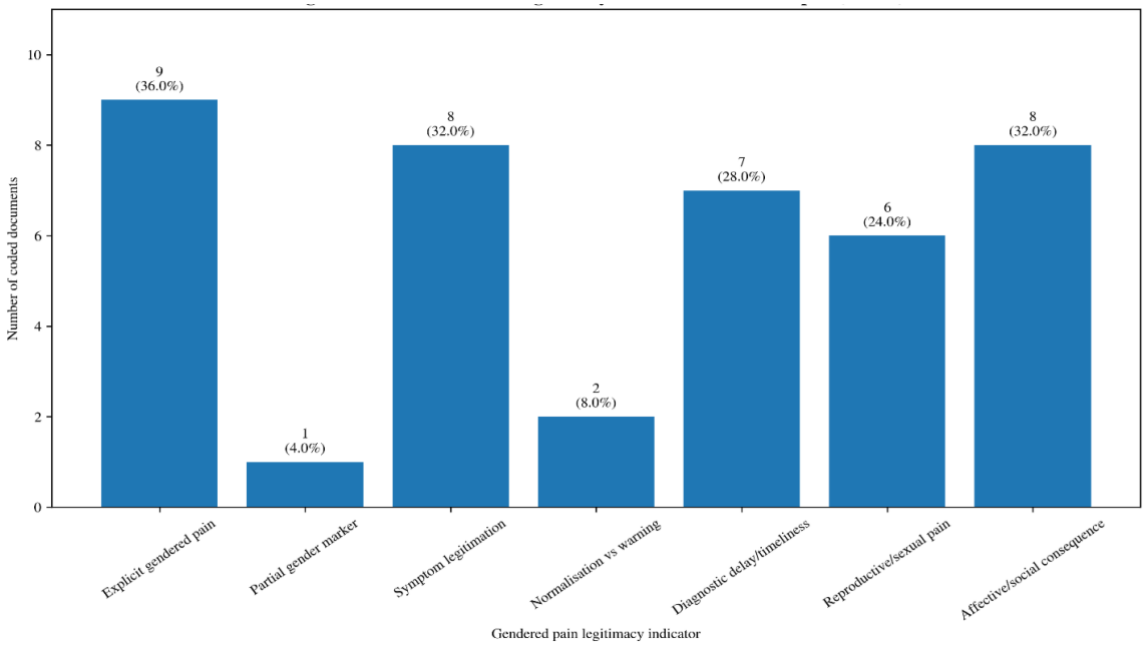

Figure 3. Gendered pain legitimacy indicators in the corpus (n = 25)

Table 3. Gendered pain legitimacy in Indonesian public clinical communication

Main Category	Subcategory	Operational Indicator	Frequency	Percentage	Data Variation	Example / Short Excerpt	Data Code	Interpretation
Gendered pain marking	Explicit gendered pain	Pain is directly linked to women, menstruation, reproductive organs, sexual pain, fertility, or cervical screening	9	36.0%	Dysmenorrhea, endometriosis, adenomyosis, dyspareunia, cervical cancer, fertility-related pain	"Beberapa perempuan merasakan sakit yang tidak tertahankan"	IDCLI-PR-005; IDCLI-PR-007; IDCLI-PR-009; IDCLI-SE-001	Gender becomes clinically visible when pain is attached to reproductive or sexual health, but less visible in general pain communication.
Gendered pain marking	Partial gender marker	Gender appears indirectly, without becoming the central organising frame of pain	1	4.0%	Anti-pain medication text mentioning menstrual pain among broader indications	"Menstrual pain is listed among common pain indications"	IDCLI-PR-004	Gendered pain is acknowledged but absorbed into general pain management, reducing its analytic specificity.
Clinical seriousness threshold	Gendered symptom legitimation	Pain is framed as a legitimate symptom when excessive, persistent, disruptive, unpredictable, or condition-specific	8	32.0%	Menstrual pain, endometriosis, adenomyosis, dyspareunia, cervical cancer screening	"Gejala endometriosis bervariasi dan tidak bisa diprediksi"	IDCLI-PR-005; IDCLI-PR-007; IDCLI-PR-008; IDCLI-PR-011	Seriousness is produced by transforming gendered discomfort into medically recognisable symptom language.
Clinical seriousness threshold	Normalisation versus warning	Pain is positioned between common bodily experience and danger signal requiring attention	2	8.0%	Dangerous menstrual pain, general pain that disrupts quality of life or indicates illness	"Ada nyeri haid yang perlu perhatian khusus"	IDCLI-PR-006; IDCLI-PR-014	Public discourse does not simply normalise pain; it creates thresholds where ordinary pain becomes clinically concerning.
Diagnostic temporality	Diagnostic delay or timeliness marker	Pain is linked to delayed recognition, earlier diagnosis, timely handling, or diagnostic safety	7	28.0%	Endometriosis campaign, pain clinic access, correct diagnosis, language barriers, safety communication	"Mempercepat diagnosa dan meningkatkan kualitas hidup pasien"	IDCLI-PR-007; IDCLI-PR-010; IDCLI-SE-001; IDCLI-CT-005	Gendered pain becomes diagnostically important when delay, uncertainty, or timely care is explicitly named.
Reproductive and sexual pain	Reproductive or sexual pain marker	Pain is located in menstrual, pelvic, sexual, cervical, fertility, or reproductive contexts	6	24.0%	Dyspareunia, endometriosis, adenomyosis, cervical cancer, fertility-related menstrual pain	"Dispareunia lebih sering terjadi pada wanita"	IDCLI-PR-006; IDCLI-PR-009; IDCLI-PR-013; IDCLI-SE-001	Intimate pain gains clinical legitimacy when it is named as a medical condition rather than treated as private discomfort.
Affective and social consequence	Affective or social consequence	Pain is connected to daily activity, quality of life, emotional burden, trust, or social disruption	8	32.0%	Activity-limiting dysmenorrhea, chronic pain, sexual pain, patient trust, quality of life	"Pain receives credibility when it is unbearable or activity-limiting"	IDCLI-PR-005; IDCLI-PR-010; IDCLI-SE-002	Pain becomes more credible when it is linked to functional and social consequences, not merely bodily sensation.

The dominant coded indicator is explicit gendered pain, appearing in 9 of 25 documents, while gendered symptom legitimation and affective or social consequence each appear in 8 documents. Diagnostic delay or timeliness appears in 7 documents, and reproductive or sexual pain appears in 6 documents. Normalisation versus warning is less frequent, appearing in only 2 documents, but it is analytically important because it marks a threshold between pain as ordinary bodily experience and pain as a warning sign. Descriptively, women's pain is most often legitimised through excess, persistence, disruption, unpredictability, or links to reproductive pathology. Sexual and intimate pain are also named explicitly, especially in dyspareunia-related documents, making private suffering available for clinical interpretation.

This pattern can be read through literature on testimonial injustice and gendered pain bias. Pain credibility depends not only on patient expression but also on available interpretive categories through which clinicians and institutions hear suffering. When public clinical discourse names endometriosis, dyspareunia, adenomyosis, or cervical screening, it provides an interpretive vocabulary that may protect patients from dismissal. Yet this same structure also reveals a limitation: pain becomes most legitimate when it can be translated into recognised biomedical categories. Research on women's chronic and overlapping pain conditions shows that patients often encounter disenfranchising talk when symptoms remain ambiguous, diffuse, or emotionally expressed [6], [5], [18]. This study therefore positions gendered diagnostic inequality as a problem of thresholds: pain is heard seriously when language, gender, and diagnostic category align.

4.3. From language access to diagnostic safety: communication conditions for credible pain

Clinical recognition of pain is shaped by communicative access before it becomes a matter of diagnostic classification. Across the corpus, language access and comprehension appear as the most frequent indicator, showing that public clinical texts repeatedly connect safe care with the ability to understand, explain, ask, and report. This pattern aligns with language-justice research arguing that healthcare inequity is reproduced when patients' linguistic repertoires are not institutionally accommodated [9], [10]. In this corpus, pain credibility is therefore not only a question of whether a patient reports pain convincingly, but whether clinical communication provides conditions for pain to become understandable, documentable, and actionable. The central implication is that credibility begins before diagnosis, at the point where language either enables or weakens clinical uptake.

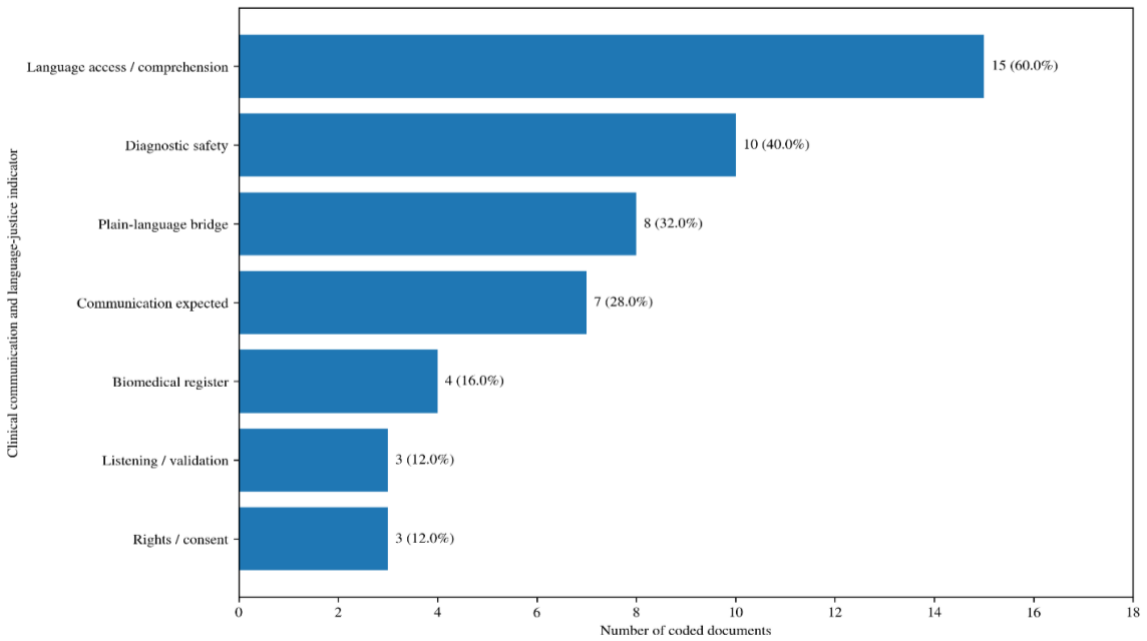

Figure 4. Clinical communication and language-justice indicators in the corpus (n = 25)

Table 4. Clinical communication and language-justice indicators in Indonesian public clinical communication

Main Category	Subcategory	Operational Indicator	Frequency	Percentage	Data Variation	Example / Short Excerpt	Data Code	Interpretation
Language access and comprehension	Patient understanding as clinical condition	Pain becomes clinically usable when patients can understand explanations, ask questions, and express complaints in accessible language	15	60.0%	Language barriers, patient education, clinical explanation, public health guidance, pain service access	"hambatan bahasa dapat menjadi kendala dalam menyampaikan keluhan"	IDCLI-PR-002; IDCLI-CT-004; IDCLI-CT-007	Credibility depends on communicative access; pain that cannot be explained, translated, or understood risks becoming diagnostically weak.
Diagnostic safety	Timeliness, accuracy, and safe interpretation	Pain is linked to correct diagnosis, timely recognition, patient safety, or prevention of diagnostic delay	10	40.0%	Diagnosis tepat waktu, patient safety, endometriosis delay, pain clinic access, communication failure	"diagnosis yang tepat dan cepat"	IDCLI-PR-007; IDCLI-SE-001; IDCLI-CT-005; IDCLI-CT-009	Diagnostic safety is framed as a communication-sensitive process, not only as technical clinical accuracy.
Plain-language bridge	Translation of biomedical knowledge into patient-facing explanation	Texts use accessible explanation to connect symptoms, risks, and care pathways	8	32.0%	Pain management education, menstrual pain information, informed consent, patient rights	"agar pasien memahami tindakan medis yang akan dilakukan"	IDCLI-PR-001; IDCLI-PR-005; IDCLI-CT-002	Plain language functions as an institutional bridge between subjective pain and medical decision-making.
Communication expectation	Communication as required clinical practice	Documents expect clinicians or health systems to provide explanation, education, listening, and clarification	7	28.0%	Effective communication, patient rights, informed consent, trust, diagnostic safety	"komunikasi efektif antara tenaga kesehatan dan pasien"	IDCLI-CT-003; IDCLI-CT-004; IDCLI-SE-002	Communication is treated as an expected condition of safe care, but not always linked explicitly to pain credibility.
Biomedical register	Technical language and clinical categorisation	Pain is explained through biomedical terms, procedures, service labels, or diagnostic categories	4	16.0%	Interventional pain management, adenomyosis, dyspareunia, cervical screening	"interventional pain management"	IDCLI-PR-002; IDCLI-PR-008; IDCLI-PR-009	Biomedical vocabulary can legitimise pain, yet may also narrow patient comprehension when not accompanied by explanatory support.
Listening and validation	Patient complaint as information source	Texts explicitly recognise patient narration, complaint, or dialogue as part of clinical interpretation	3	12.0%	Patient rights, communication ethics, diagnostic clarification	"pasien berhak menyampaikan keluhan"	IDCLI-CT-002; IDCLI-CT-003; IDCLI-CT-005	Listening appears as a crucial but less frequently explicit mechanism of credibility formation.
Rights and consent	Legal-ethical recognition of patient voice	Patient consent, rights, and participation are linked to explanation and decision-making	3	12.0%	Informed consent, patient rights, safety standards	"persetujuan tindakan kedokteran"	IDCLI-CT-001; IDCLI-CT-002; IDCLI-CT-006	Rights-based language strengthens patient voice, but appears more as procedural ethics than as pain-specific recognition.

Descriptively, language access or comprehension appears in 15 of 25 documents, followed by diagnostic safety in 10 documents and plain-language bridging in 8 documents. Communication as an expected clinical practice appears in 7 documents, while biomedical register appears in 4 documents. Listening and validation, together with rights or consent, appear in only 3 documents each. This distribution shows a layered communication pattern: broad institutional texts emphasise comprehension and safety, whereas more specific ethical texts address patient rights and consent. Pain-related service and disease documents often rely on biomedical vocabulary to legitimise symptoms, but explicit listening remains less visible. The corpus therefore shows that communication is widely recognised as necessary, yet patient voice is not always foregrounded as an epistemic source in pain interpretation.

Theoretically, this pattern strengthens the claim that diagnostic inequality is partly produced through communicative filtering. When pain is mediated through jargon, limited explanation, or weak listening, patients must do more work to make suffering clinically credible. Conversely, plain language, patient rights, consent, and diagnostic-safety discourse can reduce credibility loss by making patient testimony more intelligible within clinical systems. Studies on diagnostic uncertainty show that unclear communication can affect patient experience and clinical trust, especially when symptoms remain ambiguous [24], [11]. Work on distress communication and epistemic justice similarly cautions that suffering may be ethically misread when language, culture, and institutional expectations are misaligned [27], [14]. This study therefore interprets language justice as a diagnostic condition, not merely a communication preference.

5. DISCUSSION

The first implication of this study is that pain credibility is not produced only by the patient's capacity to describe pain, but by the institutional availability of frames that make pain clinically interpretable. The corpus shows that pain becomes more legible when linked to communication, symptom legitimation, treatment action, service access, or warning signs. This matters because pain is often invisible, fluctuating, and dependent on testimony; therefore, clinical systems need linguistic pathways that prevent subjective suffering from being dismissed as vague or exaggerated. This finding extends testimonial injustice scholarship by showing that credibility loss is not always explicit disbelief, but may occur when patient speech lacks a recognised institutional route into diagnosis or care [8], [7]. It also nuances patient-safety discussions by suggesting that diagnostic recognition begins before testing, at the level of listening, wording, and categorising. Pain credibility is therefore a communicative achievement, not merely a clinical judgement.

The underlying structure behind this pattern lies in how biomedical institutions transform embodied experience into actionable information. Pain narratives are clinically useful when they can be stabilised as intensity, duration, location, functional limitation, warning sign, or treatment target. Yet this conversion is uneven because patients do not all command the same linguistic resources, health literacy, or confidence to narrate suffering in institutionally preferred forms. Boring et al. (2021) [17] show that patients' concerns influence how pain is reported, while Dudley et al. (2024) [5] demonstrate that patients often manage self-presentation to appear credible in pain clinics. This study supports those insights but shifts attention to public clinical discourse: credibility work is anticipated before face-to-face consultation through educational texts, service descriptions, and safety communication. The relationship is not causal in a statistical sense; rather, the corpus suggests a structural correlation between recognised pain frames and the possibility of diagnostic uptake.

The second implication is that gendered pain becomes clinically serious through thresholds rather than through simple recognition or dismissal. The corpus does not show a total absence of women's pain; instead, it shows that women's pain is most visible when attached to reproductive, menstrual, sexual, pelvic, fertility, or screening-related categories. This has a double function. On one hand, naming endometriosis, dysmenorrhea, dyspareunia, adenomyosis, or cervical symptoms can protect patients from the idea that pain is merely ordinary or private. On the other hand, it may leave less categorised pain vulnerable to normalisation. This pattern resonates with studies showing that women's pain is frequently underestimated, psychologised, or delayed when symptoms are ambiguous or difficult to objectify [2], [6], [3]. This study therefore reframes gendered pain inequality as a problem of seriousness thresholds: pain is heard when it crosses an institutionally authorised boundary.

The reason this threshold structure matters is that gender norms shape what kinds of pain are expected, tolerated, or escalated. Menstrual pain, pelvic pain, and sexual pain occupy a culturally sensitive zone: they are common enough to be normalised, intimate enough to be underreported, and clinically significant enough to require careful interpretation. Literature on gender bias in pain shows that clinician and observer judgments may be influenced by assumptions about emotionality, endurance, exaggeration, and biological difference [4], [20], [18]. This study does not claim that Indonesian public clinical texts cause

gendered diagnostic delay, but it indicates how communicative structures can either challenge or reproduce it. When discourse provides clear warning thresholds, it can legitimise help-seeking. When it frames gendered pain mainly through specific reproductive conditions, however, pain that is diffuse, chronic, affective, or non-standard may remain harder to translate into clinical urgency.

The third implication is that language justice should be treated as part of diagnostic safety rather than as an auxiliary communication concern. The corpus shows that comprehension, plain-language explanation, informed consent, rights, listening, and diagnostic timeliness form the communicative environment in which pain testimony becomes usable. This is significant because pain assessment depends on reciprocal intelligibility: patients must understand what counts as clinically relevant, and clinicians must understand how patients encode suffering. Bigger et al. (2024) [9] and Lim et al. (2024) [10] argue that linguistic minoritisation can deepen pain disparities, especially when healthcare systems assume dominant-language proficiency or standardised symptom narration. Indonesian-oriented studies on language barriers, informed consent, rural directives, and empathic communication similarly suggest that clinical communication is shaped by pragmatic access, not only by information transfer [12], [28], [29], [13], [30]. This study therefore positions language access as a condition for equitable diagnosis.

The underlying structure here is a tension between biomedical precision and communicative accessibility. Technical vocabulary can legitimise pain by linking it to recognised diagnoses, procedures, and treatment pathways; however, the same vocabulary can weaken patient participation when not accompanied by explanation, translation, or dialogic repair. Studies on diagnostic uncertainty show that uncertainty becomes harmful when poorly communicated, especially when patients do not understand why diagnosis is delayed or why further monitoring is needed [24], [11]. White et al. (2022) [27] and Ritunnano (2022) [14] further remind us that distress is ethically misread when patients' interpretive resources are ignored. This study aligns with that position but grounds it in Indonesian public clinical discourse: diagnostic inequality is not only a matter of biased decisions after consultation, but also of communicative conditions that determine whether pain can enter clinical reasoning as credible evidence.

6. CONCLUSION

This study shows that diagnostic inequality in pain care is produced through communicative thresholds that determine which suffering becomes credible, urgent, and clinically actionable. Its central lesson is that pain is not merely reported by patients and assessed by clinicians; it is institutionally translated through frames of narration, gendered seriousness, and language access. By combining corpus-assisted discourse-pragmatic analysis, a gendered pain legitimacy matrix, and a clinical communication audit, this study renews inquiry into pain inequality beyond individual bias or biomedical uncertainty. Its contribution lies in positioning linguistic credibility as an analytic bridge between patient testimony, gendered expression, and diagnostic safety.

This study is limited by its reliance on public clinical communication rather than direct observation of consultations, patient interviews, or confidential medical records. Consequently, its claims concern discursive patterns and institutional framing, not actual clinician intention or patient outcomes. Further research should examine audio-recorded encounters, multilingual consultations, clinical notes, and patient narratives across urban, rural, public, and private healthcare settings in Indonesia. Comparative work should also test how gender, language background, age, class, and diagnostic uncertainty intersect in pain assessment. Such research would strengthen evidence on how equitable listening, plain language, and credibility-sensitive documentation can reduce diagnostic inequality in everyday clinical practice.

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Sri Astutik Andayani: conceptualization, methodology, formal analysis, investigation, data curation, writing – original draft, writing – review and editing.

CONFLICT OF INTEREST STATEMENT

Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Not applicable – this study did not involve direct human participants. Data consisted solely of publicly available Indonesian clinical communication materials.

ETHICAL APPROVAL

This research did not involve human or animal subjects; it analyzed publicly accessible Indonesian clinical communication materials, and therefore no institutional review board approval was required. Where research does involve human subjects, the author affirms that such research would be conducted in full compliance with all relevant national regulations and institutional policies, in accordance with the tenets of the Declaration of Helsinki, and would be approved by the author's institutional review board or equivalent committee.

DATA AVAILABILITY

The data (publicly available Indonesian clinical communication materials and coding materials) analyzed in this study are available from the corresponding author upon reasonable request.

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