Episteme (2025), **22**, 797–817
doi:10.1017/epi.2024.19

episteme

ARTICLE

Testimonial Compression

Elisa C. Reverman

Department of Philosophy, Georgetown University, Washington, DC 20001, USA
Email: ecr73@georgetown.edu

(Received 10 July 2023; revised 19 March 2024; accepted 26 April 2024; first published online 12 September 2024)

Abstract

This paper introduces the idea of testimonial compression, which I introduce as the audience enforcement of how testifiers may engage in testimonial exchange. More specifically, testimonial compression occurs when an audience requires the speaker to engage in the limited format of *simple testimony*. Using examples of dialogue from healthcare settings and scholarship on health communication, I illustrate the concept further. Dimensions of testimonial compression include its directness, the roles of audience enforcement and testifier resistance, the fuzziness surrounding structural and agential aspects, and ways in which compression can be negotiated between interlocutors. I further detail some rippling effects of testimonial compression, including impacts of patient-provider communication and the potential for epistemic harms (specifically informational and participatory prejudices). While testimonial compression is not unique to healthcare contexts, many contextual factors specific to medical discourse make testimonial compression especially useful.

Keywords: Testimonial knowledge; clinical communication; narrative testimony; social epistemology; epistemology of testimony

1. Introduction

Consider the following example, where a woman fills out a medical form in a waiting room while her husband observes.

> Survey
> "It starts with Theo in a waiting room reading over my shoulder.
> 1. Since my baby was born, I have been able to laugh and see the funny side of things.
> a. As much as I ever did.
> b. Not quite as much now.
> c. Not so much now.
> d. Not at all.
> 2. I have looked forward with enjoyment to things.
> a. As much as I ever did.

© The Author(s), 2024. Published by Cambridge University Press. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

> b. Not quite as much now.
> c. Not so much now.
> d. Not at all.
> "That's kind of evasive," Theo says. "'as much as I ever did.'"
> "Do you think I'm being dishonest?"
> "No, but…"
> "But what, Theo?"
> The baby squawks. I rock the car seat with my foot.
> "I'm just saying a diagnostic like this shouldn't be multiple choice," Theo says. "It should be short answer. Or essay. Don't you think?"
> "a. As much as I ever did." (Watkins 2021: 2–3)

In this passage, the fictional character Claire struggles to answer the questions with accuracy given the options available. None of them seem to *quite* map on to whether or not she has been able to see the funny side of things since giving birth. Her husband Theo indicates that the offered multiple choice format of this survey ought to be short answer or essay, suggesting that at the very least, the offered responses are lacking.

I find Theo's suspicion compelling, and find that this passage maps well onto a phenomenon that I introduce here. The phenomenon is *testimonial compression*, which I identify as a kind of audience enforcement of how it is that testifiers may engage in a testimonial exchange. More specifically, testimonial compression occurs when an audience requires the speaker to engage in the limited format of *simple testimony*, which I will define. Testimonial compression can happen in different ways, with varied effects.

In this paper, I first introduce testimonial compression as involving testimonial exchange. I then discuss the characteristics of testimonial compression, which are best demonstrated through a series of examples. Following this account, I then introduce a more specific subtype of testimonial compression: narrative compression. I define this subtype as the compression of narrative testimony into simple testimony. This subtype has its own ripple of epistemic dynamics, which I detail.

While all the examples I use are from healthcare settings, I do not find testimonial compression to be healthcare specific. Instances of compression can be identified in any setting, but healthcare seems to be particularly disposed to it. Further, conversations within healthcare are highly structured, contextually unique, and make frequent use of testimonial compression, enabling me to source sampled dialogs that best demonstrate the phenomenon.

2. Testimonial compression

To start, I identify cases of testimonial compression as cases involving testimonial exchange. I take up a broad definition of testimonial exchange, defining it as cases where interlocutors exchange testimonial knowledge. Testimonial knowledge is simply knowledge that an audience gains on the basis of a testifier's say-so.

2.1. Simple and narrative testimony

Testimonial compression occurs when the audience of a testimonial exchange enforces the format of the testifier's engagement, specifically enforcing the format of simple testimony. As defined by Rachel Fraser, simple testimony can be understood as "cases in which a speaker assertorically utters a single – most often, very simple – sentence" such

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

as "Elvis Presley is alive" or "the President is in New York" (Fraser 2021: 4025–26). Simple testimony is perhaps best understood and further defined in contrast to narrative testimony, a category of testimony also introduced and defined by Fraser.

Narrative testimony primarily differs from simple testimony in that it takes on the paradigmatic features of a story (2021: 4027). Paradigmatic stories are those that describe the doings of humans or human-like characters, taking place over a period of time, encoding some goal structure, and recounting some obstacle to the achievement of aims (2021: 4027). Not every instance of narrative testimony will include *all* of these paradigmatic features, as they are not a list of necessary and sufficient conditions, but these are the features that demarcate what Fraser means by a story.

Narrative testimony is also characterized by being a *structured and interlocking* set of claims, irreducible to its individual parts. To assume that narratives are simply strings of simple testimony, or are reducible to a string of individual sentences is to mistake both the nature of a narrative and the process of making sense of one. On understanding narrative testimony, Fraser writes, "discourse interpretation cannot be thought of simply as 'scaled up' sentence-interpretation. Rather, it involves distinctive dynamic processes" (2021: 4031). This interlocking nature of narrative testimony is notably absent from simple testimony, which instead takes the form of standalone, assertorical sentences.

Further, a key trait of narrative testimony is that it embeds a perspective, which Fraser breaks down into three dispositions: attentive, inquisitive, and interpretive. In terms of the attentive, this disposition asks, what will strike one as interesting or noteworthy? What details will draw them in, and what details will fade into the background or be irrelevant? In terms of the inquisitive, this disposition asks, what kinds of inquiry will be worthwhile? What sorts of investigative methods will one be include to use, and which kinds of explanations will close the inquiry at hand? Finally, in terms of the interpretive disposition, the following questions will emerge: what inferences should one draw, and what evaluations will one be inclined toward? (2021: 4028). Collectively, these dispositions interlock to form a perspective, and that perspective is *embedded* in narrative testimony, which then enables testimony to be used as a tool for achieving perspectival coordination.

When interlocutors achieve perspectival coordination, they are able to *share a way of looking at the world* (4028). Fraser describes this coordination as the audience not just adopting the opinions expressed by the narrative, but structuring and organizing information as the narrative suggests. In this way, perspectival coordination begets perspectival dependence. When the audience structures and organizes information as cued by the narrative, they become "thickly dependent on the testifier" (4047). Fraser argues that the epistemic dependence that emerges through the uptake of narrative testimony is not present with simple testimony.

These perspectival features are hallmarks of narrative testimony, and also help to further map out simple testimony as lacking these features. The simple, assertorical sentences that constitute simple testimony will not embed a perspective, nor will they require perspectival coordination in the way that narrative testimony does. Simple testimony may convey information, and perform other functions of testimonial exchange, but it will not have the rich and complex features that define narrative testimony.

A final feature of narrative testimony is its strong capacity to trigger affective responses. Because narrative testimony embeds a perspective, it encourages the audience to engage first-personally with an experientially rich simulation. Fraser cashes this out in terms of representational formats and argues that narratives can determine what kind of reactive stance ought to be adopted given the interpretive, inquisitive, and attentive dispositions of said testimony (4036–37).

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

Fraser's rich account of narrative testimony then serves as a foil to simple testimony. The key features of narrative testimony – the interlocking nature, the embedded perspective, perspectival coordination and dependence, the triggering of affective responses – are not present in simple testimony. A simple phrase like "Elvis Presley is dead" doesn't meet the criteria for narrative testimony and so lacks the corresponding epistemic features. I identify testimonial compression, then, as cases where an audience enforces the format of simple testimony upon a testifier.

Consider the following toy example of testimonial compression, an example that I suspect many individuals have experienced. Suppose you have been asked a question that, in your eyes, requires some explanation to answer. Your response is complex, and one that you believe requires contextual details to fully understand. You try to explain and describe the situation, including a timeline of events, motives and reasons behind various actions. To your frustration, your audience interrupts you repeatedly, and insists that you just answer their question with a simple "yes" or "no." It becomes clear that any other kind of answer will not be accepted. This is an instance of testimonial compression. Through this discourse, the testifier is limited to the response format of simple testimony: "yes" or "no." Further, this response format is enforced by the audience, who clearly indicates that they will not listen to, or give uptake to, narrative testimony response types – audience uptake is predicated on your testimony's lack of narrative features.

In the following sections, I analyze several examples of testimonial compression that all display different dimensions of testimonial compression. Further, my examples are all from healthcare settings as there is a rich literature on patient-provider communication and medical discourse that helpfully offers many examples, but I don't take testimonial compression to be limited to healthcare or medical contexts. As demonstrated in my toy example, testimonial compression is a common phenomenon, though perhaps frequently utilized in healthcare settings.

2.2. Examples of testimonial compression

In SURVEY, we see an instance of testimonial compression enacted through a medical form – an audience requests testimonial knowledge from the testifier and patient, Claire. What's more, the possible ways in which Claire can respond to the prompt answers are pre-determined for her: "as much as I ever did; not quite as much now; not so much now; not at all." In addition to her response options being limited to these options, the enforced format is *simple*. They are single, assertorical phrases, as Fraser describes, and Claire cannot expand on these options, nor can she wander from them. The audience, through the medical form, has enforced both a format of simple testimony and the available response options. Given this enforcement, and Claire's inability to negotiate these options or respond otherwise, SURVEY is an instance of testimonial compression.

Note that some prompts or inquiries have format norms that are deeply internalized and socially expected. For instance, if a medical form were to ask for an adult patient's age, it would go against standard norms for the patient to respond in any unit other than years. It would be deeply inappropriate, and frankly annoying without some strong justification, for a patient to give a narrative response to the question of age. Some questions or prompts are particularly well-suited to simple answers, and enforcing a response format (i.e. years, in number form) would not necessarily be compressive because any other way of answering the question would go against firmly established

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

norms. Given this, some kinds of information solicitation have a deeply embedded norm for response formats, and to stray from those norms would be strange. In the instance of asking for age, there are infinite ways in which a person might accurately respond, but the norm is so deeply accepted that anything other than the unit of years and the format of whole numbers would be inappropriate, and options for responses outside this set standard would likely have little value. However, I suspect that such strongly established norms around response formats for the infinite range of inquiries that one could make are in fact quite rare. In SURVEY, the prompts have no such expectations in terms of response format – "I have looked forward with enjoyment to things" could responded to in myriad ways, from a "yes/no" to a long, winding narrative. This particular inquiry has no obviously appropriate response format, unlike an inquiry about age.

Testimonial compression can be done by way of forms, as demonstrated in SURVEY, or through a verbal exchange between speakers. Here, I give an instance of spoken testimonial compression used in a medical setting. The following dialogue is from the 2020 film *Never Rarely Sometimes Always*, written and directed by Eliza Hittman (2020). To contextualize this exchange, the dialog takes place in an abortion center, where the patient is a young teen from Pennsylvania who has traveled to New York City for an abortion that would be illegal in her home state. She speaks with a counselor at the center, who screens her for intimate partner violence.

PREGNANCY

"DOCTOR: I wanna spend a few minutes talking with you about your relationship, okay, because they can affect your health. Did you know that?
PATIENT: *shakes head*
DOCTOR: No? Alright. So I'm gonna ask you some questions, they can be really personal, and all you have to do is answer either "never", "rarely", "sometimes", or "always". It's kinda like multiple choice, but its not a test.
PATIENT: okay
DOCTOR: okay? In the past year, your partner has refused to wear a condom. "Never", "rarely", "sometimes", "always"?
PATIENT: Um…sometimes?
DOCTOR: Okay. And your partner messes with your birth control or tries to get you pregnant when you don't wanna be. "Never", "rarely", "sometimes", "always"?
PATIENT: Nn…never?
DOCTOR: Okay. Your partner has threatened or frightened you. "Never", "rarely", "sometimes", "always"?
PATIENT: Why are you asking me this?
DOCTOR: I wanna make sure that you're safe. Your partner has threatened or frightened you. "Never", "rarely", "sometimes", "always"?
PATIENT: Um…Rarely?"

Here, the patient's testimony is compressed in real-time, during the conversation that she has with her doctor. The physician, or audience, has set the response options for the testifier, limiting her responses and their simple format. Note that in this verbal exchange, testimonial compression is more softly enforced than the compression in SURVEY. In the process of filling out forms, a testifier is quite literally unable to negotiate the format of responses, and in some cases the response options themselves. Further,

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

the enforcement of compression is more rigid with digital forms than with paper forms. While a testifier could be more of an anarchist with a paper form, and scribble in margins or respond in ways that go against the form's suggestion, digital forms not negotiable in format.

In PREGNANCY, testimonial compression is directed from the audience to the speaker, but its enforcement is significantly less strong than the enforcement found in digital forms. The patient has more space to stray from the proposed response format, and in fact she questions the prompts themselves. She maintains the freedom to deviate slightly from the set responses, but generally chooses to accept the format of questioning. Given this, PREGNANCY can be seen as an instance of more negotiable testimonial compression, where a digital form is an instance of less negotiable compression.

2.3. Enforcement and resistance

The strength or rigidity of the enforcement of testimonial compression will vary across contexts and be sensitive to the goals of the exchange, the dispositions and personalities of the interlocutors, further contextual norms, etc. However, if there is no enforcement whatsoever of the testifier's response format, the exchange will cease to involve testimonial compression. The simple response format must be enforced in order to be an instance of testimonial compression.

Relatedly, while I require enforcement of simple response formats, I do not require resistance for testimonial compression to emerge. This is in part simply because a testifier will not always have reason to resist compression. As I noted earlier, some inquiries are well-suited for simple responses, like asking what a person's age is. I suspect that testimonial compression will generally be present but not perceived when the inquiry and enforced response format are well coordinated, similarly to how good design is often not noticed. When things work well, the mechanics and choices that ground good functioning are often not perceived as they create a frictionless experience. Similarly with testimonial compression, there will not always be a reason to resist an enforced simple response format. However, as Theo points out in SURVEY, I suspect that compression becomes more visible when there is more dissonance, or room for different options, between an inquiry and the enforced response format. When Theo suggests that an inquiry about whether or not a post-partum patient still finds joy in their day-to-day life should be short-answer rather than multiple choice, part of what he is pointing to is a mismatch between the inquiry and the enforced response format. So while the enforcement of testimonial compression *may* be resisted by the testifier, resistance is not necessary. So long as a simple response format is enforced, testimonial compression occurs.

2.4. Discrete compression

While SURVEY and PREGNANCY are examples of testimonial compression where the compression itself is visible to the testifier, it can also be enacted more discretely, without testifier knowledge or engagement. For example, consider the following transcript of a conversation.[1]

[1]This video is inspired by physicians' experiences with both how patients sometimes answer questions, how these answers are expected to be documented, and intends to poke humor at the differences between the two. https://www.instagram.com/reel/CnuqNwZPmP4/?utm_source=ig_web_copy_link&igshid=MzRlODBiNWFlZA==

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

DOCUMENTATION

> Doctor: And then have you been experiencing any shortness of breath recently?
> Patient: So it's funny that you say that because I've been thinking about it a lot because when I'm exercising, of course I get out of breath, I know that everybody does and it's no different for me, but whenever I take *really* deep breaths and I *exhale* I get this weird twinge in my back, maybe every fifth breath or so.
> Doctor: …Okay.
> Doctor (to self, typing on laptop): Patient denies shortness of breath. (@docschmidtig, January 22, 2023).

The compression in DOCUMENTATION differs from SURVEY in its relation and visibility to the testifier. In being asked a question with no limitations on response format, the patient isn't restricted in how they answer and they offer a detailed response. Unlike SURVEY, where the compression is enforced prior to any particular patient filling out a form, or PREGNANCY, where the compression happens during a conversation, compression here occurs between the doctor's uptake of testimony and his documentation of what the patient said. Further, this kind of compression is done for an audience external to the two interlocutors. The audience of this medical documentation isn't the patient or testifier, but rather other clinicians that may be involved in the patient's care and need specific pieces of information presented clearly and concisely.[2]

This case may, at first glance, appear to challenge the criteria for enforcement and negates the possibility of resistance. The presence of enforcement is less transparent to the testifier in that the compression is occurring between the physician's uptake of the patient's testimony and its documentation, rather than the compression occurring during the interlocutors' discourse. Unlike other examples, the audience here compresses the testifier's testimony for a different audience of the patient's testimony: other readers of the patient's medical chart. However, whether or not a testifier is aware of the enforcement of simple response formats doesn't determine whether or not they are in fact enforced. So long as this is the case, the example matches the description of testimonial compression. In terms of resistance, the testifier is unable to resist compression if they aren't aware that it is happening. However, enforcement is a necessary criteria for compression, where resistance isn't. So while compression may be more or less evident to the testifier, testifier knowledge of compression isn't necessary for a case to count.

3. Narrative compression

I have illustrated the concept of testimonial compression and offered some examples to illustrate various dimensions of the concept. Here, I outline a sub-type of testimonial compression: *narrative compression*. In cases of narrative compression, narrative testimony is compressed into simple testimony.

Recall that Fraser describes narrative testimony as being defined by its structured and interlocking nature, that it embeds a perspective, that it is particularly suited for triggering affective responses, and generates a relation of epistemic dependence between

[2]A comment on the post states, "As the documenting physician, a HUGE part of my job is to distill the heaps of raw information I get from patients into concise, logically organized, problem-focused narratives that are easy to follow by future readers. Sometimes that means collapsing down a 1 minute monologue into 'Patient denies shortness of breath.'" (@nyospasm)

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

testifier and audience (2021). Fraser's simple/narrative distinction allows me to identify narrative compression as the compression of specifically narrative testimony into simple testimony.

An example of this can be found in the following conversation, which is sampled from a book written by emergency medicine physician Thomas Fisher. In this text, Fisher details the struggles of working as an emergency physician in a low-income area during the beginning of the COVID-19 pandemic.

> Emergency
> "I walk to my next patient in Room 27…I find the patient fully dressed on the gurney in gray leggings and a striped brown sweater….when I ask what's going on, she begins her story over a year ago, when she began coughing and having trouble breathing.
> "I was visiting family in Birmingham last Easter when I first started coughing."
> While she rambles on, I stand close to the door and listen with my arms crossed over my yellow gown…
> Her story, punctuated by coughs and throat clearing, continues with expressive eye and arm movements. With every cough I can almost see the droplets spraying through the room – a mild panic starts to rise in me, and I want to let her finish her story, but the story keeps going. When she pauses, I try to focus her attention.
> "If this started last year, what made today the day to come see about it?"
> "I'm trying to tell you, just give me a second."
> Another five minutes of coughing, throat-clearing, and rambling pass, and she has yet to get to the point of her current visit. When she pauses again, I jump in, trying to control my tone.
> "I'm sorry that you've been ill so long, but did something change this week that made you come in?"
> She restarts her story, this time beginning two years ago. "I'm trying to get to the past few days," she says. "Just let me talk."
> …I interrupt again when she takes a pause and ask specific questions: "Were you feeling better at all in the last two weeks? When did this cough start? Do you have a fever? Who is sick at home?"
> "I was feeling fine until a week ago when my family had a barbecue. My brother and son were coughing. Two days later I began coughing, and then two days after that I had a fever." She lets me know she's sure it's not coronavirus because, "as I've been trying to tell you, I've been sick for a very long time. Just on and off." (Fisher 2022: 21–22)

Here, the patient is clearly attempting to give narrative testimony. There is a beginning, middle, and end to her story, and an insistence on starting over from the beginning when interrupted. She insists that her testimony be heard as a whole and resists fragmentation, suggesting that the story consists of interlocking claims rather than sewn-together fragments. Further, the narrative indicates her perspective, in the Fraserian sense, in that it reveals what she takes to be attentional, inquisitive, and interpretive aspects. For the patient, going back two years before this visit is relevant to the arc of her testimony, and influences her interpretation of her experience and shapes what she perceives relevant inquiries to be. In other words, the patient's perspective is embedded in her narrative testimony.

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

The contrasting perspective here, that of the Fisher, who hears her "rambling" testimony with a different perspective. According to Fisher, the patient wastes time providing irrelevant information at the expense of the information that he really needs – their attentive, inquisitive, and interpretive dispositions share little overlap. In order to get the information that he finds relevant and needs, Fisher attempts to compress her testimony. What's more, he compresses from narrative to simple. The questions he asks solicit simple, straightforward responses: were you feeling better at all in the last two weeks? When did this cough start? Do you have a fever? In doing this, he seeks answers to these close-ended questions in the form of simple testimony, and *enforces* the response format of simple testimony through his repeated interruptions. Consequently, the key traits that define narrative testimony and enable the achievement of perspectival coordination are smothered.

Narrative compression is then a distinct subtype where the testimony that is compressed is specifically narrative testimony in the Fraserian sense. In contrast, SURVEY involves testimonial compression that doesn't begin with a narrative. Rather than compress a narrative, the prompts in SURVEY enforce simple testimony from the beginning, preventing the possibility of a narrative response being given at all. PREGNANCY is also an instance of testimonial compression, but not an instance of narrative compression, because the testifier doesn't begin with a narrative – her response options are pre-emptively chosen for her, and those response options do not take the form of narrative testimony.

4. Effects of testimonial compression

The effects of compression will vary as widely as the kinds of testimonial exchange that a person can have. Testimonial exchange can be a means to achieve several different ends, such as the exchange and circulation of knowledge (Greco 2020) or the expression of agency (Lindemann 2001). In healthcare settings, testimonial exchange can serve the purpose of sharing diagnostically relevant information, giving informed consent to procedures and treatments, asking for more information, and making medical decisions. It can also, by itself, be a form of caring for patients. In the pursuit of these various testimonial aims, the effects of compression can range from assistive to disruptive.

4.1. Testimonial compression and information extraction

Sometimes, the goal of testimonial exchange is primarily information extraction or knowledge gathering. People are asked to fill out surveys all the time, for a variety of purposes. Surveys are useful tools for the exchange of testimonial knowledge in that they are efficient, pre-emptively organize the knowledge being solicited, and as a result make the information collected reusable for later purposes. For example, in medical contexts, testimonial compression via medical forms may make patient responses useful for future analysis and research, or easier to process into external databases.

The streamlining that compression enables can also be extremely useful for reducing informational lag, or the time that it takes to transfer information from one place to another. It can also be instrumental in making information more digestible, or more useful for a particular audience. For instance, the specific format and structure of medical notes medical charting enhances the utility of that information. Medical charts are a keystone in hospital communication, and by enforcing a specific set of expectations for how medical information is documented, the audience can more easily find the information they need (Hobbs 2007: 41).

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

Testimonial compression for the purposes of information extraction can also be useful for triggering further inquiry. In SURVEY, Theo ruminates on how post-partum depression can't be accurately captured in the offered response options. While he may be correct, it is possible that the survey is intended merely to flag patients as potentially experiencing post-partum depression rather than as fully supplanting the diagnostic process. If Claire were to respond in a way that indicated in no way that she was struggling, her doctor may not feel the need to follow up on the subject. However, were Claire to respond with only "d. Not at all," her physician may then have reason to ask her more about it. So while Theo is skeptical of the form's diagnostic capabilities, it may in fact serve a lesser purpose than that.

Testimonial compression, when used for efficient information extraction, can also vary in its impact on the emotional valence of an interaction. In many cases, information extraction can feel cold and impersonal (Armstrong *et al.* 2012; Dichter *et al.* 2020; Lorimer *et al.* 2012; Skinner *et al.* 1985). When information extraction *is* cold and extractive feeling, patients report the downstream effect of feeling reduced to their illness, or their illness experience as broken into fragments of information (Akther *et al.* 2019; Todres *et al.* 2014).

A further downstream effect of information extraction done in ways that are cold, impersonal, or brusque can include leaving patients feeling uncared for. The provision of care has many different aspects, and getting good information and medical histories from patients is undoubtedly important (Hassan 2018; Ratna 2019). However, communication that conveys care for the patient can be equally important (Jangland *et al.* 2009; Markides 2011; Vermeir *et al.* 2015; Warnecke 2014). Testimonial compression, then, can run the risk of being used in a way the optimizes information extraction at the expense of caring communication.

Testimonial compression, if used in a way that disrupts quality communication, can also inhibit some of the benefits that patients experience from being listened to in medical contexts. There is growing evidence that physicians listening to their patients has, at minimum, instrumental value in clinical settings. Fisher, from EMERGENCY, acknowledges this himself – "they all want to tell their story…people queue as though they're waiting to meet an oracle" (Fisher 2022: 68–69). Meghan O'Rourke, author of *The Invisible Kingdom: Reimagining Chronic Illness*, discusses this in further detail. In chronicling her years-long struggle with chronic illnesses, she writes,

> "Being heard by your doctor isn't just an emotional need but a physical one: patients benefit clinically from feeling cared for. The emotional and the physical, science is learning, are more intertwined than we once understood. Many studies have suggested that emotional care – interpersonal warmth – has a measurable effect on patients' outcomes. For example, the incidence of severe diabetes complications in patients of doctors who rate high on a standard empathy scale is a remarkable 40 percent lower than in patients whose doctors do poorly on the empathy scale." (2022: 67)

O'Rourke points out a similar effect in a study on patients with irritable bowel syndrome (IBS). These patients were told that they were participating in a study examining the benefits of acupuncture. One group was assigned practitioners who only had "perfunctory" and "brusque" interactions with patients. The second group was treated by a researcher who "warmly asked questions about them and expressed empathy for their suffering." Both groups were given identical sham treatments, and the symptom

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

reduction in the second group was higher than the first. What's more, the percentage of patients in the "empathetic" group that reported adequate relief in symptoms was as high as those who reported symptom relief in clinical trials of drugs prescribed for IBS (O'Rourke 2022: 67–68). Other studies have been done that document similar effects, indicating that more empathetic and high-quality communication alone can benefit patients (Egbert *et al.* 1964; Fuentes *et al.* 2014; Hojat *et al.* 2002, 2011; Kaptchuk *et al.* 2010; Ofri 2017: 69–75; Rakel *et al.* 2011; Rao *et al.* 2007; Street Jr. *et al.* 2009).

As demonstrated in EMERGENCY, testimonial compression can be used in a way that paints an interaction as "perfunctory" and "brusque," rather than empathetic or caring. By definition, narrative compression reduces patient narratives, and the patient's own perspective is often lost or washed away in this process. Cases where patients experience and resist narrative compression, then, seem likely to miss the mark in terms of producing the benefits that high-quality communication can have.

Testimonial compression may also interfere with patients disclosing medically relevant information. Because testimonial compression (as I have introduced it) is a novel concept, there is no data to support this hypothesis. However, there is significant data that poor communication can increase the risk for misdiagnosis (Muhrer 2021) and medical errors (Frydenberg and Brekke 2012; Lazris *et al.* 2021; Murphy and Dunn 2010; Risser *et al.* 1999; Shitu *et al.* 2018). There is also significant evidence, in the opposite direction, that effective communication improves clinical decision-making and quality of care (Drossman 2013; Drossman and Ruddy 2020; Gaddis 2019; Patak *et al.* 2009). By extension, these studies support the hypothesis that when compression disrupts patient-provider communication, or lowers its quality and effectiveness, it can also increase the risk for misdiagnosis or medical errors. Cases of testimonial compression that pre-emptively decide for the patient what is medically relevant and what isn't could lead to missed information that wasn't solicited from the patient.

However, information extraction by way of testimonial compression need not have these negative effects. Compression is a tool, and it can be used to benefit patients, as evidenced in PREGNANCY. This case demonstrates an instance where testimonial compression is used as a strategy to solicit highly sensitive, health-related information from a distressed patient without requiring them to disclose any more than they need to. The nuances of this interaction aren't well-captured in the transcript, but the scene in the film depicted a nuanced and careful use of testimonial compression. For one, the clinician posing questions and directing the patient to answer them with the limited "never/rarely/sometimes/always" response options isn't depicted as cold and extractive. In fact, her soliciting of information from the patient in this way reads as a form of care – it allows the patient to provide the information needed, but *only* the information needed, in recognition that providing this kind of deeply personal information to a stranger can be distressing, unusual, and challenging.[3] Further, in limiting the patient's response options to her questions, the clinician also helps the patient maintain some privacy.

4.2. Testimonial compression and epistemic harms

As I have discussed, the use of testimonial compression need not be harmful. However, testimonial compression can be used to enact the specific epistemic harms of participatory and informational prejudice toward patients.

[3]For more on the sensitive nature of screening for intimate partner violence, see Dichter *et al.* 2020; Paterno and Draughon 2016; Alvarez *et al.* 2017; Swailes *et al.* 2016).

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

Ian Kidd and Havi Carel have extensively discussed epistemic harms within healthcare (Carel and Kidd 2014, 2017; Kidd and Carel 2017, 2018, 2019). They argue that some of the kinds of epistemic injustices that patients experience result what Gail Polhaus Jr. calls *truncated subjectivity* (Pohlhaus Jr. 2014). Polhaus, Jr. writes that in cases of truncated subjectivity, the testifier's "epistemic labor contributes to the community via which epistemic interests are pursued, but she is not permitted to contribute in ways that would redirect epistemic practices toward those parts of her experienced world" (2014: 107).

Kidd and Carel argue further that ill persons and patients often experience participatory and informational prejudices. Participatory prejudice occurs "when a person or group is prejudicially judged to lack capacities required for having a *sense of relevance*, and hence as not being suitable participants for collective epistemic activity" (Kidd and Carel 2017: 180, emphasis original). Ill persons are particularly vulnerable to participatory prejudice because first, they are assumed to "lack the training and experience needed for the possession of a robust sense of relevance…to make meaningful contributions to the epistemic practices of medicine" and second, because ill persons are "typically regarded as the objects of the epistemic practices of medicine rather than as participants in them" (180–81).

Informational prejudice "occurs when a person or group is prejudicially judged to lack the ability to provide information relevant in a given context and hence as being an unsuitable participant in collective epistemic activity" (2017: 181; Hookway 2010). This prejudice can manifest as a refusal to concede the relevance or significance of the information being offered by a testifier, or as a refusal to consider presuppositions about the significance and types of information that are legitimate and admissible in the epistemic project (Kidd and Carel 2017: 180–81). When ill persons experience informational prejudice, they are subject to these two refusals.

Kidd and Carel's account relates to testimonial compression in that testimonial compression, and more specifically narrative compression, can be a way of enacting these same kinds of epistemic harms. For example, in Emergency the patient's testimonial knowledge is solicited, and she isn't disbelieved about her symptoms despite the doctor's belief that the patient is mistaken about not having Covid. Rather, the patient's testimonial contributions are *truncated* such that she is only permitted to testify within an assigned format, in response to the doctor's close-ended questions, and her testimony outside of these constraints is ignored. She is able to contribute in the provision of factual information (simple testimony), but not able to describe her distinctive experiences (narrative testimony). In terms of informational and participatory prejudices, the patient's own perspective on her illness is dismissed as irrelevant for the epistemic activity of determining her diagnosis. While testimonial compression is not always harmful, it can be a way of enacting informational and participatory prejudices in the ways the Kidd and Carel articulate.

5. Structural and agential dimensions

Testimonial compression can be both agential and structural. Paradigmatic cases of agential compression would be those where a testifier attempts to give narrative testimony and their audience will only respond to simple testimony, as demonstrated in Emergency. In these cases, the compression is enacted by the audience as an individual agent. In contrast, structural compression will be cases where the compression is preordained by an institutional policy, protocol, intake process, or the like. For example, in Survey, the screening form for post-partum depression may be part of a system-wide

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

intake process. These cases can show a clear difference between compression actively enforced by an audience, and compression enforced by an institutional policy, but many cases of compression will have both agential and structural aspects.

In returning to EMERGENCY, we can also see how practical and institutional constraints can blur the distinction between agential compression and structural compression. Fisher is an individual person who compresses his patient's testimony. However, he describes at length the structural constraints he works within that limit his ability to listen to patients. Multiple structural aspects of emergency medicine force Fisher to forsake unrushed, empathic communication, and by extension limits his ability to make time for a patient's narrative testimony. Fisher directly identifies these structural influences on his interpersonal behavior – "All of these things happen within a system. The question is: why is the system designed like this?" (2022: 80). Others have described the impact of inadequate time on quality communication with patients (Crawford and Brown 2011; Keshavarzi *et al.* 2022; Prasad *et al.* 2020).

The blurring of the structural/agential dimensions of testimonial compression is also displayed in DOCUMENTATION, where the patient's narrative response to a question gets documented in a tightly compressed way that follows the conventions of medical charting. Pamela Hobbs details how medical charting follows a strictly ordered set of conventions "designed to ensure that the intended meaning is conveyed," which has the effect of allowing physicians unfamiliar with a patient to accurately interpret information about them (Hobbs 2007: 43). Medical charts also make use of "an extensive and highly developed system of abbreviations," which shape the form and meaning of patient care notes (2007: 44). Given these firmly established conventions, those contributing to a patient chart are limited by these expectations and instances of compression for the purpose of medical charting will not be entirely agential or structural. While an individual person does the documenting, the way in which information is documented is established and enforced by standards set by a discipline more broadly. Further, adherence to these standards is crucial in that medical charts are ultimately a key part of a broader web of communication and information, and established norms and standards enable the efficient functioning of that communicative web.

6. Negotiating compression

Negotiations are commonplace in patient-provider communication (Ainsworth-Vaughn 1994, 2005; Drass 1982; Fisher and Groce 1985; Keeling *et al.* 2015), and have been widely explored in the health communication literature. The concept of testimonial compression allows me to introduce and identify a new kind of negotiation: the negotiation of compression. I have pointed out that some instances of compression are more negotiable than others – the enforcement of compression with digital forms is often non-negotiable, while compression enacted in spoken conversations is often more negotiable. Here, I detail some further aspects of negotiations and testimonial compression.

Many have already noted that negotiations and conflict resolution are a common feature of medical discourse. Aaron Lazare offers a definition of negotiation, and discusses conflicts that can emerge between clinician and patient, influences on the negotiating process, and negotiation strategies that can be necessary during the medical interview. He writes that negotiation is a "process fundamental to the clinician/patient relationship" (Lazare and Putnam 1995: 50), and can be defined as "a coming together or a conferring over a source of conflict with the purpose of achieving some agreement"

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

(53). Further, typical negotiating relationships are describe as having the following features: (1) at least two interlocutors involved; (2) the parties have a conflict with respect to at least one issue, (3) the parties are engaged in a voluntary relationship; (4) the relationship is concerned with an exchange of resources or the resolution of intangible issues; and (5) the activity involves a sequential presentation of demands or proposals followed by concessions and counterproposals" (53).

Lazare points out that the medical encounter is distinct from other kinds of negotiating situations (particularly commercial ones) in at least two ways. First, the medical encounter is not necessarily conflicted, and thus does not always require negotiation for resolutions. Second, economic negotiating involves both distributive and integrative bargaining. In distributive bargaining, there is a competition for resources that one party can win or use to improve their position, with the other party losing or assuming an unfavorable position. In integrative bargaining, both parties have a common motive, and there is no competition for resources. Further, the relationship is cooperative and the focus is on joint problem-solving (54). Lazare argues that negotiations in the medical interview more often take the form of integrative bargaining – the patient and physician are not necessarily negotiating for one limited and finite resource, and there are no "winners" or "losers" of the negotiation. Rather, there is a conflict that needs to be negotiated by both parties in order for said parties to achieve a shared goal or solve a problem (54).

In addition to this, Lazare lists a series of points from which conflicts are generated. Conflict tends to be over the medical problem itself, the goals for the patient, the methods with which the problem will be solved or treated, the conditions of diagnosis and treatment (in other words, the location of treatment, the providers of treatment, payment methods, etc.), and the clinician-patient relationship and the roles of each party (55–56).

I suspect that Lazare is too quick to write off the significance of epistemic and social authority within patient-provider negotiations. While Lazare may be correct in that negotiations in medical discourse ought not orbit around winning and losing, and that there is presumably a shared goal between negotiators, many aspects of medical discourse already position the interlocutors favorably and unfavorably. Physicians, as I have discussed, are already presumed to have medical expertise which grounds their epistemic authority. They are further advantaged in that medical expertise is easily and frequently conflated to be general expertise (Veatch 1973). Thus, physicians tend to be advantaged in the currency of epistemic credibility, and may even be afforded a credibility excess (Medina 2011). Further, physicians begin in a more favorable negotiating position than patients in that they are not medically vulnerable to them and hold practical gatekeeping power over diagnoses and access to treatments and care.

Patients are not reliably afforded the same epistemic presumptions, even when they themselves are healthcare practitioners (Fielding-Singh and Dmowska 2022). They are also dependent on their practitioners for accurate diagnoses and access to treatment and care. Given this imbalance, Lazare may be overly quick to assume that negotiations in medical discourse more closely resemble integrative bargaining. While material resources may not be the determinant of favorable positioning, there is certainly an imbalance in terms of where interlocutors stand if negotiations begin. Thus, it may be the case that these negotiations can in fact resemble distributive bargaining, where the distributed resource is credibility or epistemic authority. Lazare additionally leaves out time as a relevant resource in negotiations, but it is undeniably relevant in contemporary medical practices. A recent study found that physicians would need to work 27

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

hours a day to follow all recommended medical guidelines – a clearly impossible expectation (Kolata 2023). Further, different practices can have different time constraints, and time constraints in, for example, emergency medicine or intensive care may make compassionate and empathetic discourse impossible.

6.1. Aspects of negotiation

Negotiations of testimonial compression entail the testifier negotiating the enforcement of simple response formats. The identification of this kind of negotiation is compatible with Lazare's claim that sometimes the negotiations are not about the medical problem itself, but about *how* the medical problem is made known.

Consider again EMERGENCY. Not only is this conversation an example of verbal narrative compression, it is also an example of a *negotiation* of the patient's testimony's narrative form. Fisher, the physician, attempts to enforce both the kinds of questions answered and the patient's response format (simple), but the patient repeatedly resists. Her insistence on starting over when interrupted transforms the exchange into a negotiation of compression, unlike PREGNANCY where the patient doesn't resist the imposed formatting. EMERGENCY resembles many aspects of integrative bargaining and Lazare's mapping of potential sources of conflict – it involves interlocutors having a shared goal, the care of the patient. However, conflict emerges over the nature of the patient's problem. The concept of testimonial compression enables me to identify more specifically a negotiation over how the patient is able to convey knowledge about her problem, which shapes Fisher's identification and understanding of it.

EMERGENCY also resembles some aspects of distributive bargaining. Fisher and his patient do not start with equal levels of presumed epistemic authority – Fisher obviously holds an advantage. Further, Fisher is beholden to many more patients and potential negotiations, while the patient has no such ties to other patients. This leaves the patient not only vulnerable in that she needs medical care, disadvantaged in that Fisher serves as a gatekeeper to further care, but also in that she must compete for her physician's extremely limited time. Both epistemic authority and time are negotiated resources in this case. All of these aspects have a cumulative effect on the patient's ability to resist Fisher's compression of her testimony from narrative to simple.

6.2. Negotiating medical relevance

Testimonial compression can also be negotiated in the way that it is used to draw the parameters of relevance. As W. A. Rogers describes, the physician is tasked with "filtering" patient testimony through a "medical sieve" (2002: 79), which by extension enforces parameters of medical relevance.[4] This is further presumed to be necessary because "the patient cannot be trusted to know the relevant details from the insignificant" (79). Rogers's reasoning is undoubtedly true at least some of the time. But as Popowicz argues, patients' medical information and corresponding medical decisions are rarely **merely** medical (Popowicz 2021: 10). Further, being overly dismissive of

[4]Hobbs also uses this metaphor, writing that "clinical medicine is an investigative process in which information is assembled and analyzed. But sifting the evidence gleaned from the patient's report of symptoms, the physical examination and laboratory test results, and by measuring them against competing possibilities and probing to discover missing information, the physician creates a recognizable clinical picture that matches the patient's condition to a known disease" (2007: 43).

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

the relevance of information that patients provide can have a negative effect on both the patient-provider relationship and the overall negotiation.

An instance of this can be found in Susan Greenhalgh's autoethnography on her experience with a fibromyalgia diagnosis. Greenhalgh's physician was (allegedly) a fibromyalgia specialist, albeit a controversial one, and treated her for nearly a year. His prescribed treatment was extremely aggressive, requiring her to eventually refrain from all physical activity or exercise, take up an extremely restrictive diet, and cease work as an academic. After months of suffering and personally documenting her decline, Greenhalgh confronted her doctor and accused him of both falsely diagnosing her and of dismissing her documented evidence that her symptoms were not improving. She writes,

> "Dr D.'s first reaction was to ask what on earth [Greenhalgh] was talking about. Waving the most recent lab reports in the air, he cried out animatedly, 'Look! The numbers are great!' He went on to read them out, exclaiming in all earnestness at how good the white blood cell count was, how low the sedimentation rate had fallen. And it was not only the blood work that was good. His numbers from the spring showed that the arthritis and fibromyalgia had been greatly alleviated… [Greenhalgh] found these comments hilarious. She was reproaching him for reducing her to a body and ignoring the emotional and cognitive aspects of the disease. Even as she complained about his discourses of objectification and quantification, he continued to deploy them, missing her point entirely. She was also protesting his silencing of her views of her own well-being. Yet he persisted in ignoring her account and insisting that his was the only knowledge that counted." (Greenhalgh 2001: 266–67)

This exchange helps demonstrate two key things. First, that in her physician's eyes, Greenhalgh's *whole illness experience* was compressed into physiological measurements, not just her testimony about it. Second, the conversation demonstrates a negotiation of relevance. Dr D doesn't necessarily indicate that he disbelieves Greenhalgh's detailed documentation of her steady decline. The conflict isn't a matter of her trustworthiness as a testifier.[5] Rather, he demonstrates that her testimony, regardless of its truth, is simply *irrelevant*. The scope of medical relevance is narrowly defined as quantitative, and as detached from Greenhalgh's daily experience of illness.[6]

[5]This aspect contrasts Greenhalgh's case from EMERGENCY. We might be sympathetic to Fisher in EMERGENCY because not only is his patient using a lot of time to tell her narrative, but she also turns out to simply be wrong about not having covid. But note that in Greenhalgh's case, the negotiation isn't centered around whether or not her testimony is believe to be true – its presumed irrelevance supersedes this.

[6]Greenhalgh, understandably, finds this to be adequate reason seek medical care elsewhere. The dynamic in this exchange is also captured by what Elliot Mishler calls the "voice of medicine" and the "voice of the lifeworld" (1984). The voice of medicine reflects a technical interest and expresses a scientific attitude. The meaning of events is provided through abstract rules that serve to decontextualize them, and to remove them from the individual patient's personal and social contexts (104). The voice of medicine is also characterized by its goal of describing the patient in terms of "objective, physical features" (114). Such questions might draw "subjective" answers from the patient, but in a medical interview, "an appropriate answer is one that refers to objective physical signs or indicators of the problem. If an answer is not objective in these terms, the physician will ask the question again" (114). In contrast, the voice of the lifeworld "refers to the patient's contextually-grounded experiences of events and problems in her life. These are reports and descriptions of the world of everyday life, with the timing of events and their significance being

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

This negotiation also fails in an important way. Borrowing from the integrative bargaining model, there is no achievement of a shared goal. Further, neither party leaves the interaction giving much epistemic weight to the other's opinion or beliefs – they more or less end where they began, epistemically speaking. The core issue, Greenhalgh's medical situation, is unresolved and Greenhalgh feels disempowered as a patient.

While the identification and discussion of negotiations in medical discourse is nothing new, testimonial compression is a kind of negotiation that I add to the existing taxonomy. When negotiating compression, patients negotiate how it is that their medical problems are made known, the relevance of their perspective or narratives, or some combination of these. Further, different types of testimonial compression will be more or less amenable to these kinds of negotiations.

7. Testimonial compression and narrative medicine

The role and significance of narratives in medicine has been most prominently discussed by Rita Charon and her model of narrative medicine. Charon introduces narrative medicine as a model for medical practice that emphasizes humane and effective care by adopting methods from literary studies, the biopsychosocial model of medicine, and patient-centered medicine (2001, 2008). Within the model of narrative medicine is the concept of narrative competence, which Charon describes as "the ability to acknowledge, absorb, interpret, and act on the stories and plights of others" (Charon 2001: 1897).

Narratives are used in narrative medicine to better illuminate several key relationships: the connection between patient and physician, the meaning of medical practice for an individual physician, physicians' collective profession of their ideals, and the role of medicine within society. Further, narrative medicine is said to collectively enable physicians to improve the effectiveness of their work with patients, themselves, their colleagues, and the public (2001: 1898).

A key point of overlap between narrative medicine and this project is the recognition of narrative testimony's distinctness, or what Charon calls narrative knowledge. Charon writes, "narrative knowledge is what one uses to understand the meaning and significance of stories through cognitive, symbolic, and affective means. This kind of knowledge provides a rich, resonant comprehension of a singular person's situation as it unfolds in time" (2001: 1898). While this description of narrative knowledge is slightly different from Fraser's account of narrative testimony, they share many similarities. Fraser's account of the ways in which narrative testimony creates a mental simulation for audiences and the affective power that narrative testimony can have are similarly captured by Charon. However, Charon uses the concept of narrative knowledge and the methods of literature to prescribe a way of practicing medicine. She writes,

> "Not unlike acts of reading literature, acts of diagnostic listening enlist the listener's interior resources…to identify meaning. Only then can the physician hear – and then attempt to face, if not to answer fully – the patient's narrative questions: 'What is wrong with me?' 'Why did this happen to me?' and 'What will become of me?' Listening to stories of illness and recognizing that there are often no clear answers to patients' narrative questions demand the courage and generosity to

dependent on the patient's biographical situation and position in the social world (104). Mishler argues that the voice of the lifeworld reveals a different structure of meaning, one that is contingent on events in the patient's world of experience, is self-centered, and is coherent.

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

> tolerate and bear witness to unfair losses and random tragedies. Accomplishing such acts of witnessing allows the physician to proceed to his or her more recognizably clinical narrative tasks" (2001: 1899).

In endorsing literary methods of "diagnostic listening," Charon's proposal is central to medicine and engaging in effective care for patients. In contrast, Fraser's scope is much wider and less prescriptive – she identifies narrative testimony as epistemically distinct, but the context of narrative testimony is not bound to any particular context. Further, while my discussion of testimonial compression (specifically narrative compression) draws on similar dynamics present with narrative knowledge, I am not proposing a medical model to physicians. My project is much narrower in scope, aiming instead to identify the presence of testimonial compression and the effects of compressing and negotiating narrative response formats. While I have discussed various practical, clinical, and epistemic effects that testimonial compression can have on the patient-provider relationship, the phenomenon is not central to medicine.

8. Conclusion

I have argued that compression is something that we can do with testimony. While testimonial compression is not exclusive to healthcare contexts, the uniqueness of medical discourse and its particular aims and constraints provide both rich examples and elegant uses of testimonial compression. I have used several examples to illustrate the key dimensions of testimonial compression – its epistemic and practical effects, assistive and disruptive uses, structural and agential dimensions, and negotiation. This project is primarily descriptive, though I do include some epistemic caution with how compression can be disruptive or harmful to the patient-provider interaction. At root, compression is a multi-purpose tool, with as many different uses and effects and testimonial exchange itself.[7]

References

Ainsworth-Vaughn N. (1994). 'Negotiating Genre and Power: Questions in Medical Discourse'. In B.-L. Gunnarson, P. Linell and B. Nordberg (eds), *Text and Talk in Professional Contexts*, pp. 149–66. Uppsala, Sweden: Association Suédoise de Linguistique Appliquée.

Ainsworth-Vaughn N. (2005). 'The Discourse of Medical Encounters.' *The Handbook of Discourse Analysis*, 453–69.

Akther S.F., Molyneaux E., Stuart R., Johnson S., Simpson A. and Oram S. (2019). 'Patients' Experiences of Assessment and Detention under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis.' *BJPsych Open* **5**(3), e37.

Alvarez C., Fedock G., Grace K.T. and Campbell J. (2017). 'Provider Screening and Counseling for Intimate Partner Violence: A Systematic Review of Practices and Influencing Factors.' *Trauma, Violence, & Abuse* **18**(5), 479–95.

Armstrong N., James V. and Dixon-Woods M. (2012). 'The Role of Primary Care Professionals in Women's Experiences of Cervical Cancer Screening: A Qualitative Study.' *Family Practice* **29**(4), 462–66.

Carel H. and Kidd I.J. (2014). 'Epistemic Injustice in Healthcare: A Philosophical Analysis.' *Medicine, Health Care and Philosophy* **17**, 529–40.

[7]I would like to thank John Greco, Quill R. Kukla, Joel Michael Reynolds, Marissa Fond, Paddy McShane, Rachel Fraser, Nikki Ernst and the members of the Words Workshop, Ari Watson, Megan Ritz, and Philipp Kremers for their invaluable commentary on this project.

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

Carel H. and Kidd I.J. (2017). 'Epistemic Injustice in Medicine and Healthcare.' In I. J. Kidd, J. Medina, G. Pohlhaus, Jr. (eds), *The Routledge Handbook of Epistemic Injustice*, pp. 336–46. New York: Routledge.

Charon R. (2001). 'Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust.' *JAMA* **286**(15), 1897–902.

Charon R. (2008). *Narrative Medicine: Honoring the Stories of Illness*. New York: Oxford University Press.

Crawford P. and Brown B. (2011). 'Fast Healthcare: Brief Communication, Traps and Opportunities.' *Patient Education and Counseling* **82**(1), 3–10.

Dichter M.E., Makaroun L., Tuepker A., True G., Montgomery A.E. and Iverson K. (2020). 'Middle-Aged Women's Experiences of Intimate Partner Violence Screening and Disclosure: "It's a Private Matter. It's an Embarrassing Situation".' *Journal of General Internal Medicine* **35**, 2655–61.

Drass K.A. (1982). 'Negotiation and the Structure of Discourse in Medical Consultation.' *Sociology of Health & Illness* **4**(3), 320–41.

Drossman D.A. (2013). '2012 David Sun Lecture: Helping Your Patient by Helping Yourself – How to Improve the Patient–Physician Relationship by Optimizing Communication Skills.' *Official Journal of the American College of Gastroenterology* **108**(4), 521–28.

Drossman D.A. and Ruddy J. (2020). 'Improving Patient-Provider Relationships to Improve Health Care.' *Clinical Gastroenterology and Hepatology* **18**(7), 1417–26.

Egbert L.D., Battit G.E., Welch C.E. and Bartlett M.K. (1964). 'Reduction of Postoperative Pain by Encouragement and Instruction of Patients: A Study of Doctor-Patient Rapport.' *New England Journal of Medicine* **270**(16), 825–27.

Fielding-Singh P. and Dmowska A. (2022). 'Obstetric Gaslighting and the Denial of Mothers' Realities.' *Social Science & Medicine* **301**, 114938.

Fisher T. (2022). *The Emergency: A Year of Healing and Heartbreak in a Chicago ER*. New York: One World.

Fisher S. and Groce S.B. (1985). 'Doctor-Patient Negotiation of Cultural Assumptions.' *Sociology of Health & Illness* **7**(3), 342–74.

Fraser R. (2021). 'Narrative Testimony.' *Philosophical Studies* **178**, 4025–52.

Frydenberg K. and Brekke M. (2012). 'Poor Communication on Patients' Medication across Health Care Levels Leads to Potentially Harmful Medication Errors.' *Scandinavian Journal of Primary Health Care* **30** (4), 234–40.

Fuentes J., Armijo-Olivo S., Funabashi M., Miciak M., Dick B., Warren S., Rashiq S., Magee D.J. and Gross D.P. (2014). 'Enhanced Therapeutic Alliance Modulates Pain Intensity and Muscle Pain Sensitivity in Patients with Chronic Low Back Pain: An Experimental Controlled Study.' *Physical Therapy* **94**(4), 477–89.

Gaddis L. (2019). 'Patient-Provider Communication.' *Portable Health Records in a Mobile Society*, 103–18.

Greco J. (2020). *The Transmission of Knowledge*. New York: Cambridge University Press.

Greenhalgh S. (2001). *Under the Medical Gaze: Facts and Fictions of Chronic Pain*. Berkeley and Los Angeles: University of California Press.

Hassan I. (2018). 'Avoiding Medication Errors through Effective Communication in Healthcare Environment.' *Movement, Health & Exercise* **7**(1), 113–26.

Hittman E., dir. (2020). *Never Rarely Sometimes Always*. New York City, NY and Shamokin, PA: BBC Films.

Hobbs P. (2007). 'The Communicative Functions of the Hospital Medical Chart.' In R. Iedema (ed), *The Discourse of Hospital Communication*, pp. 39–66. New York: Palgrave Macmillan.

Hojat M., Gonnella J.S., Nasca T.J., Mangione S., Vergare M. and Magee M. (2002). 'Physician Empathy: Definition, Components, Measurement, and Relationship to Gender and Specialty.' *American Journal of Psychiatry* **159**(9), 1563–69.

Hojat M., Louis D.Z., Markham F.W., Wender R., Rabinowitz C. and Gonnella J.S. (2011). 'Physicians' Empathy and Clinical Outcomes for Diabetic Patients.' *Academic Medicine* **86**(3), 359–64.

Hookway C. (2010). 'Some Varieties of Epistemic Injustice: Reflection on Fricker.' *Episteme* **7**(2), 151–63.

Jangland E., Gunningberg L. and Carlsson M. (2009). 'Patients' and Relatives' Complaints about Encounters and Communication in Health Care: Evidence for Quality Improvement.' *Patient Education and Counseling* **75**(2), 199–204.

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

Kaptchuk T.J., Friedlander E., Kelley J.M., Sanchez M.N., Kokkotou E., Singer J.P., Kowalczykowski M., Miller F.G., Kirsch I. and Lembo A.J. (2010). 'Placebos without Deception: A Randomized Controlled Trial in Irritable Bowel Syndrome.' *PLoS One* **5**(12), e15591.

Keeling D.I., Laing A. and Newholm T. (2015). 'Health Communities as Permissible Space: Supporting Negotiation to Balance Asymmetries.' *Psychology & Marketing* **32**(3), 303–18.

Keshavarzi M.H., Safaie S., Faghihi S.A.A. and Zare S. (2022). 'Barriers of Physician-Patient Relationships in Professionalism: A Qualitative Study.' *Journal of Advances in Medical Education & Professionalism* **10**(3), 199.

Kidd I.J. and Carel H. (2017). 'Epistemic Injustice and Illness.' *Journal of Applied Philosophy* **34**(2), 172–90.

Kidd I.J. and Carel H. (2018). 'Healthcare Practice, Epistemic Injustice, and Naturalism.' In S. Barker, C. Crerar and T.S. Goetze (eds), *Harms and Wrongs in Epistemic Practice*, pp. 1–23. Cambridge, UK: Cambridge University Press.

Kidd I.J. and Carel H. (2019). 'Pathocentric Epistemic Injustice and Conceptions of Health.' *Overcoming Epistemic Injustice: Social and Psychological Perspectives*, 153–62.

Kolata G. (2023). 'According to Medical Guidelines, Your Doctor Needs a 27-Hour Workday.' The New York Times, February 14. https://www.nytimes.com/2023/02/14/health/doctors-medical-guidelines.html.

Lazare A. and Putnam S. (1995). *The Medical Interview*. New York: Springer.

Lazris A., Roth A.R., Haskell H. and James J. (2021). 'Poor Physician-Patient Communication and Medical Error.' *American Family Physician* **103**(12), 757–59.

Lindemann H. (2001). *Damaged Identities, Narrative Repair*. Ithaca and London: Cornell University Press.

Lorimer S., Cox A. and Langford N.J. (2012). 'A Patient's Perspective: The Impact of Adverse Drug Reactions on Patients and Their Views on Reporting.' *Journal of Clinical Pharmacy and Therapeutics* **37**(2), 148–52.

Markides M. (2011). 'The Importance of Good Communication between Patient and Health Professionals.' *Journal of Pediatric Hematology/Oncology* **33**, S123–25.

Medina J. (2011). 'The Relevance of Credibility Excess in a Proportional View of Epistemic Injustice: Differential Epistemic Authority and the Social Imaginary.' *Social Epistemology* **25**(1), 15–35.

Mishler E.G. (1984). *The Discourse of Medicine: The Dialectics of Medical Interviews*. Norwood, NJ: Ablex.

Muhrer J.C. (2021). 'Risk of Misdiagnosis and Delayed Diagnosis with COVID-19: A Syndemic Approach.' *The Nurse Practitioner* **46**(2), 44.

Murphy J.G. and Dunn W.F. (2010). 'Medical Errors and Poor Communication.' *Chest* **138**(6), 1292–93.

Ofri D. (2017). *What Patients Say, What Doctors Hear*. Boston: Beacon Press.

O'Rourke M. (2022). *The Invisible Kingdom: Reimagining Chronic Illness*. New York: Riverhead Books.

Patak L., Wilson-Stronks A., Costello J., Kleinpell R.M., Henneman E.A., Person C. and Happ M.B. (2009). 'Improving Patient-Provider Communication: A Call to Action.' *The Journal of Nursing Administration* **39**(9), 372.

Paterno M.T. and Draughon J.E. (2016). 'Screening for Intimate Partner Violence.' *Journal of Midwifery & Women's Health* **61**(3), 370–75.

Pohlhaus Jr. G. (2014). 'Discerning the Primary Epistemic Harm in Cases of Testimonial Injustice.' *Social Epistemology* **28**(2), 99–114.

Popowicz D.M. (2021). '"Doctor Knows Best": On the Epistemic Authority of the Medical Practitioner.' *Philosophy of Medicine* **2**(2), 1–23.

Prasad K., Poplau S., Brown R., Yale S., Grossman E., Varkey A.B.,Williams E., Neprash H., Linzer M. and The Healthy Workplace (HWP) Investigators. (2020). 'Time Pressure During Primary Care Office Visits: A Prospective Evaluation of Data from the Healthy Work Place Study.' *Journal of General Internal Medicine* **35**, 465–72.

Rakel D., Barrett B., Zhang Z., Hoeft T., Chewning B., Marchand L. and Scheder J. (2011). 'Perception of Empathy in the Therapeutic Encounter: Effects on the Common Cold.' *Patient Education and Counseling* **85**(3), 390–97.

Rao J.K., Anderson L.A., Inui T.S. and Frankel R.M. (2007). 'Communication Interventions Make a Difference in Conversations Between Physicians and Patients: A Systematic Review of the Evidence.' *Medical Care* **45**(4), 340–49.

Ratna H. (2019). 'The Importance of Effective Communication in Healthcare Practice.' *Harvard Public Health Review* **23**, 1–6.

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press

Risser D.T., Rice M.M., Salisbury M.L., Simon R., Jay G.D., Berns S.D. and MedTeams Research Consortium. (1999). 'The Potential for Improved Teamwork to Reduce Medical Errors in the Emergency Department.' *Annals of Emergency Medicine* **34**(3), 373–83.

Rogers W.A. (2002). 'Is There a Moral Duty for Doctors to Trust Patients?' *Journal of Medical Ethics* **28**(2), 77–80.

Shitu Z., Hassan I., Aung M.M.T., Kamaruzaman T.H.T. and Musa R.M. (2018). 'Avoiding Medication Errors through Effective Communication in a Healthcare Environment.' *Malaysian Journal of Movement, Health & Exercise* **7**(1), 115–28.

Skinner H.A., Allen B.A., McIntosh M.C. and Palmer W.H. (1985). 'Lifestyle Assessment: Applying Microcomputers in Family Practice.' *British Medical Journal (Clinical Research Ed.)* **290**(6463), 212–14.

Street Jr. R.L., Makoul G., Arora N.K. and Epstein R.M. (2009). 'How Does Communication Heal? Pathways Linking Clinician–Patient Communication to Health Outcomes.' *Patient Education and Counseling* **74**(3), 295–301.

Swailes A.L., Lehman E.B., Perry A.N. and McCall-Hosenfeld J.S. (2016). 'Intimate Partner Violence Screening and Counseling in the Health Care Setting: Perception of Provider-Based Discussions as a Strategic Response to IPV.' *Health Care for Women International* **37**(7), 790–801.

Todres L., Galvin K.T. and Dahlberg K. (2014). '"Caring for Insiderness": Phenomenologically Informed Insights that can Guide Practice.' *International Journal of Qualitative Studies on Health and Well-being* **9** (1), 21421.

Veatch R.M. (1973). 'Generalization of Expertise.' *Hastings Center Studies* **1**(2), 29–40.

Vermeir P., Vandijck D., Degroote S., Peleman R., Verhaeghe R., Mortier E., Hallaert G., Van Daele S., Buylaert W. and Vogelaers D. (2015). 'Communication in Healthcare: A Narrative Review of the Literature and Practical Recommendations.' *International Journal of Clinical Practice* **69**(11), 1257–67.

Warnecke E. (2014). 'The Art of Communication.' *Australian Family Physician* **43**(3), 156–58.

Watkins C. (2021). *I Love You but I've Chosen Darkness*. New York: Riverhead Books.

Elisa Reverman earned her doctorate from the Georgetown University Department of Philosophy and is a Clinical Ethics fellow at Cleveland Clinic. She received her bachelor's degree in Biology from the University of Portland, and worked briefly in biomedical engineering before redirecting her focus to bioethics and philosophy. Her research interests include social epistemology, bioethics, research ethics, and the ethics of science communication. Email: ecr73@georgetown.edu

Cite this article: Reverman EC. (2025). "Testimonial Compression." *Episteme* **22**, 797–817. https://doi.org/10.1017/ epi.2024.19

https://doi.org/10.1017/epi.2024.19 Published online by Cambridge University Press