Bioethical Inquiry
https://doi.org/10.1007/s11673-023-10314-y

CRITICAL RESPONSE

Putting "Epistemic Injustice" to Work in Bioethics: Beyond Nonmaleficence

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Received: 29 July 2023 / Accepted: 11 September 2023

Abstract We expand on Della Croce's ambition to interpret "epistemic injustice" as a specification of non-maleficence in the use of the influential four-principle framework. This is an alluring line of thought for conceptual, moral, and heuristic reasons. Although it is commendable, Della Croce's attempt remains tentative. So does our critique of it. Yet, we take on the challenge to critically address two interrelated points. First, we broaden the analysis to include deliberations about hermeneutical injustice. We argue that, if due consideration of epistemic injustice is to require more than negative ethical obligations in medicine, dimensions of hermeneutical injustice should be explored as an avenue to arrive at such positive duties. Second, and relatedly, we argue that this may encompass moral responsibilities beyond the individual level, that is: positive obligations to take action on a structural level. Building on Dotson's concept of "contributory injustice" and Scheman's concept of "perceptual autonomy," we suggest that the virtues of testimonial and hermeneutical justice may provide additional content not only to negative prohibitions of action (i.e. non-maleficence) but also to positive requirements of action, like respecting patient autonomy.

Keywords Epistemic Injustice · Autonomy · Contributory injustice · Bioethics

Introduction

In aiming to bring more attention to the ways in which "epistemic injustice" (Fricker 2007) relates to the bioethical principles (Beauchamp and Childress 2019), Yoann Della Croce (2023) specifies that the sub-concept of testimonial injustice conflicts with the principle of nonmaleficence and that it should therefore actively be prevented in healthcare. Della Croce's aim to incorporate epistemic injustice into a well-entrenched framework of biomedical ethics is relevant for at least two reasons. First, it contributes to an argument to demonstrate the moral relevance of epistemic injustice in medical contexts. Second, it illuminates possible connections between "principlist" bioethical methodology and the conceptual set that is commonly denominated as "epistemic injustice." In that regard, it challenges (bio)ethicists to both add content to abstract principles and to think through the utility of the varied shades of epistemic injustice in moral contexts.

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Published online: 13 November 2023

That said, there will be theoretical and normative difficulties that require further unravelling. For instance, if one accepts with Della Croce that the ethical principle of nonmaleficence requires avoiding unwarranted epistemic exclusions, then depending on how pessimistic one is about the difficulty or even impossibility to avoid such unwarranted epistemic exclusion, the demands of that fundamental principle may become unattainable. We just mention this here at the outset without further consideration and will leave it to other occasions or perhaps other authors to toss this around.

For this article, we set to critically address, in a somewhat tentative way, two interrelated points in response to Della Croce's analysis. We appreciate the author's focus on testimonial injustice but see the ethical relevance of expanding the analysis to include considerations in terms of hermeneutical injustice. This elaboration allows us to respond to the author's stated challenge to formulate positive duties of physicians to address epistemic injustices, an obligation which—we believe—bleeds into more structural levels than the restricted agential position. Our argument includes reflections on Kristie Dotson's concept of "contributory injustice" (Dotson 2012, 2014) and Naomi Scheman's concept of "perceptual autonomy" (Scheman 2009). The latter also serves as a linchpin to bolster our argument that epistemic injustice can equally be specified as a violation of the principle of respect for autonomy.

Pathocentric Hermeneutical and Contributory Injustice

Della Croce (2023) starts with Miranda Fricker's conceptualization of epistemic injustice as "a wrong done to someone specifically in their capacity as a knower" (Fricker 2007, 1). Fricker outlines two sub-concepts: "testimonial injustice" which "occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker's word" and "hermeneutical injustice" which "occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker 2007, 1). Della Croce focuses on testimonial injustice (Della Croce 2023). We add hermeneutical injustice to the conversation for the reasons that we indicated above and which we will develop throughout this commentary.

First, Della Croce states that physicians are susceptible to committing testimonial injustice in doctor–patient relationships, assuming that they are "as prone to reasoning through stereotypes and possessing negative identity-prejudicial stereotypes as non-physicians" (Della Croce 2023, 3). Some of these testimonial injustices fall under the umbrella of what Kidd and Carel call "pathocentric epistemic injustice" (Kidd and Carel 2018). Kidd and Carel's analysis, however, illuminates that this is not limited to testimonial injustice, showing that ill persons are especially vulnerable to various forms of hermeneutical injustices (Kidd and Carel 2018, 219). Arguably, physicians' social situatedness "outside of the hospital or medical school grounds" can—as Della Croce points out—lead to the stereotyping involved in testimonial injustice, but it can also lead to a specific type of pathocentric hermeneutical injustice (Della Croce 2023, 3). These hermeneutical injustices map on difficulties that patients experience in making sense of their own experiences and in sharing these experiences with others (e.g. physicians). While it may be true that physicians obtain specific hermeneutical tools through their medical training—which patients typically lack—the reverse is also true: patients have the epistemic advantage of situatedness and lived experience. These are hermeneutical tools that physicians typically lack. Kidd and Carel have argued that those lived experiences may be situated in a hermeneutical lacuna. That is, they might be insufficiently grasped by the existing dominant hermeneutical tools, which are skewed by societal power relations and imbalances to favour the experiences of those with more social power, and therefore disadvantage marginalized groups such as (chronically) ill people. As an aside: this does not exclude that some healthcare professionals themselves will inevitably experience "from within" what it means to be ill. Yet, it would be rather quaint—for more than one moral reason—to define the ideal for good medical help in reference to those professionals who do have such experiences.

More to our point, it should not be overlooked that patients may build particular, non-dominant hermeneutical tools within their minority groups to make sense of experiences of illness on their own terms (Dotson 2012, 2014). Yet, patients—like other epistemic agents—may be susceptible to what

Dotson calls "contributory injustice." In a medical context, this may transpire when healthcare professionals use their own set of hermeneutical resources to interpret a patient's situation while remaining wilfully ignorant of that patient's own hermeneutical resources, even though these might be better suited to explain their situation (Dotson 2012). This notion of "wilful" ignorance and its magnitude require further ethical scrutiny and empirical insights in medical contexts, as the reproach here is not merely about ignorance due to physicians' situatedness (which, with habitual practice can—or should—be dialectically calibrated in relation to patients' experiences) (Pohlhaus Jr. 2012). It is more deeply accusatorial than that because it pertains to an assumed willed refusal to acknowledge patients' non-dominant epistemic resources. Where such claims are made, standards of evidence must go up. Yet, taking a cue from feminist epistemology's credo "start thought from marginalized lives" (Harding 1991), this again underscores the importance for physicians to actively work towards awareness of patients' own hermeneutical tools and structures, and of the particular epistemic agency these tools afford them.

Structural Action and Positive Obligation

Second, Della Croce (2023) focuses on what Fricker calls the agential level, but both testimonial and hermeneutical injustice can happen on a structural level too. In the case of testimonial injustice, this happens because identity power (meaning the power one has due to factors of their social identity, such as gender, race, class …) can operate both on an agential and a structural level. Hermeneutical injustice is always a consequence of structural identity prejudice—societally embedded stereotypes which skew credibility judgements (Fricker 2007). Della Croce focuses on the agential level because that is where individual physicians can effect change. It is also where Fricker largely situates the virtues of testimonial and hermeneutical justice. She incites individual agents to actively correct for identity prejudice in their credibility judgements (testimonial justice) and to correct their credibility judgements to where they would be in a fair hermeneutical climate without structural identity prejudice skewing them (hermeneutical justice) (Fricker 2007). Individual agents are encouraged to strive towards being virtuous hearers.

In response to Della Croce's aim to specify the principles of bio-medical ethics and align them with considerations of epistemic injustices, it seems reasonable to investigate how the virtues of testimonial and hermeneutical justice can be regarded as providing additional content not only to negative prohibitions of action (i.e. nonmaleficence) but also to positive requirements of action. We follow Dotson (2012, 2014) in encouraging a broader picture of (positive) responsibility for change on three levels. Testimonial injustice requires first-order change: changing the stereotypes one employs to make credibility judgements. Hermeneutical injustice requires second-order change: changing our shared hermeneutical resources. Contributory injustice, Dotson's own contribution, requires third-order change: adopting a completely new set of hermeneutical resources (Dotson 2012). Della Croce discusses how physicians can i) combat epistemic injustice and ii) promote epistemic justice (Della Croce 2023), but in effect both types of change are situated on Dotson's first level. We suggest that in order to inclusively promote epistemic justice in healthcare it is necessary to commit to changes on all three levels. Physicians need to work on correcting for their own prejudice, but they also need to be prepared to critically examine their shared hermeneutical resources, and, on a third level, to be open to adopting new hermeneutical resources, such as the ones marginalized patient groups might have built already.

We here merely broach the consideration that opening up to hermeneutical injustice and relevant structural dimensions, may support putting epistemic injustice "to work" in a medical context as a specification of bioethical principles unlimited to nonmaleficence. For one thing, if physicians not only have a negative but also a positive obligation to respect patient autonomy, then a healthcare professional has a responsibility to learn from patients' contextual and idiosyncratic knowledge and resources (Scheman 2009). Naomi Scheman insightfully labels this "perceptual autonomy," which requires patients' capability of communicating a "nonperiscopic point of view" that has not been refracted to fit a dominant perspective. Respect for autonomy thus generates a positive obligation on physicians to recognize patients' articulations of how the world appears from their particular position. This presumes a view of autonomy

that considers "identities other than dominant ones" tethered by an inclusive range of agents' experiences (Walker 2007). We recognize that this may place high demands on healthcare professionals in an already tumultuous context, though this only seems to buttress the societal duty to provide the structural resources that allow them to live up to those expectations. Finally, critics might grumble that this analysis will only culminate in the finding that the notion of "epistemic injustice" does not add anything that cannot be addressed by reference to already well-established bioethical principles. While this may be true, this need not imply that its adaption leads to undue conceptual expansion and obfuscation. In fact, enthusiasts may wish to reason along with "principlist" methodology that the concept of "epistemic injustice" may be usefully employed in the continuous process of reducing the indeterminacy of broad principles like beneficence, nonmaleficence, justice, and respect for autonomy, which are, in themselves, too slender to tackle substantive moral questions.

Conclusion

We have responded to Della Croce's arguments on epistemic injustice and nonmaleficence on two main levels. First, in addition to Della Croce's analysis of testimonial injustice, we added hermeneutical and contributory pathocentric injustice to specify physicians' duty towards epistemic justice. Second, we suggested that epistemic justice in healthcare necessitates change on more levels than the agential one discussed by Della Croce. Using Scheman's concept of perceptual autonomy, we consider the possibility that epistemic injustice may be "put to work" as a specification of more bioethical principles than only the negative responsibility of nonmaleficence. We have ventured the invitation to formulate positive duties of physicians to address epistemic injustices and suggest that the virtues of testimonial and hermeneutical justice may provide additional content to the principle of respect for autonomy.

Funding No funding was received for writing this manuscript

Declarations

Competing Interests The authors declare no conflicts of interest

Disclosure No study-specific approval for research involving humans and/or animals was required for this work.

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