**Pathocentric Epistemic Injustice and Conceptions of Health**

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**1. Introduction**

Over the last few years, a flourishing literature has emerged that uses the concept of epistemic injustice to articulate and understand the negative social experiences of ill persons within healthcare environments and in the broader social world (Blease et al. 2016; Crichton et al. 2016; Kidd and Carel 2016; Carel and Kidd 2014; Carel and Gyorffy 2013). We label these *pathocentric epistemic injustices*, ones that arise from the epistemic prejudices and hermeneutical difficulties associated with experiences of illness (Kidd and Carel 2017). The experiences are consistently of unfair and injurious epistemic exclusion and marginalisation: of ill persons being ignored, silenced, or dismissed; of not being listened to or taken seriously, and of being treated as mere sources of information, only able to answer within the defined terms of clinical-epistemic practice, and locked into what one critic has dubbed a ‘stance of silence’ (Hinshaw 2008, 8-9).

 Such reports are common within a large literature produced by healthcare researchers, patient activists, and pathographers who document and describe the lived experience of illness, most obviously in the range of writings that fit under the capacious category of ‘illness narratives’ (Carel 2016 and 2018a, Cutter 2018, Sontag 1978, Toombs 1988 and 1993). Many of these narratives document patient needs, requests, dignity and testimony being ignored and sometimes silenced. For example, psychiatric patients’ views and utterances can be dismissed by psychiatric staff to the extent that there is, since 2009, a legal duty to provide Independent Mental Health Advocacy (IMHA) to patients who qualify under the Mental Health Act 1983.[[1]](#footnote-1) There is compelling evidence that psychiatric patients can be treated harshly and inconsiderately, with their views ignored, leading to unnecessary suffering (Crichton et al. 2016). Those suffering from somatic illness find their requests for basic care and assistance routinely ignored, as seen in the case of the Mid-Staffordshire Inquiry, published in 2013, detailing the horrific neglect, leading to increased mortality rates, of elderly patients that was systematic, continuous and pervasive.[[2]](#footnote-2) Individual patients provide countless, and ongoing, examples of being ignored.

Paul Kalanithi, a neurosurgeon diagnosed with lung cancer at the age of 35, for example, recalls how Brad, a resident physician, refuses to re-order a medication for him, without which he would be in excruciating pain within hours. After repeated requests from Kalanithi to receive the drug, and explanations of why he needs it, Brad dismisses Kalanithi’s claims and finishes his shift without re-ordering the medication. Kalanithi understands this as Brad’s way of getting out of an unpalatable situation. In order to order the drug, he needs to ring up a more senior clinician, disturbing them at home. He doesn’t want to do that so simply does nothing, passing the problem on to the next physician on shift. Kalanithi says: ‘I could see that in Brad’s eyes I was not a patient, I was a problem: a box to be checked off. “Look,”, [Brad] continued, “if you weren’t you [i.e. a medic] we wouldn’t be having this conversation. I’d just stop the drug and make you prove it causes all this pain”’ (Kalanithi 2016, 187).

The epistemic injustice affecting ill persons within and beyond healthcare environments is a central concern of patient activists, health professionals, and healthcare policymakers. This can be evidenced by the ‘patient-centred care’ movement, on the webpages of organisations such as the Patients Association, and by stable and high levels of dissatisfaction reported by patients.[[3]](#footnote-3)

 Building on our previous work on epistemic injustice in illness (Kidd and Carel 2016; Carel and Kidd 2014; Kidd and Carel 2018), in this chapter we broaden our understanding of what can cause epistemic injustice to ill persons. Until now we examined individuals (e.g. health care professionals) and institutional structures and processes as causing epistemic injustice (ibid.). Here we argue that certain theoretical conceptions of health, particularly those described as ‘biomedical’ or ‘naturalistic’, contingently but powerfully support epistemically unjust conduct and attitudes of health professionals. However, our claim that abstract, non-agential objects can be bearers of virtues and vices sounds counterintuitive, at best, and a category mistake, at worse.

We therefore draw on recent work in vice epistemology to identity three ways that abstract objects – such as theoretical conceptions – can be legitimately described as epistemically vicious. Although only two of these apply to theoretical conceptions of health, this is enough for our claim that amelioration of pathocentric epistemic injustice must go ‘all the way down’ to the conceptions of health that shape how people talk and think about illness and ill persons. If this is right, then robust reform of individuals, social systems, and institutions would not be enough to secure epistemic justice. Also needed are substantive changes in the underlying conceptions of the nature of health that undergird medical education and training, including health professionals’ education, training, attitudes and ethos.

Before we move on to the main claim of the paper, we would like to highlight three features of pathocentric epistemic injustice. First, the social experiences of ill persons are diverse and dynamic, since there are so many different forms of illness, which are experienced according to the values, needs, social situations, and intersectional identities of particular ill persons (Carel 2016). This diversity should not be collapsed by an epistemic analysis.

Second, there are many different practices and experiences of disregarding, ignoring and dismissing patient utterances, wishes and needs. These admit of local variations, shaped by particular, and changing power relations, social and practical arrangements, and different social contexts (Dotson 2011; Medina 2013). We must remain aware of this diversity too. In particular, we note the stereotypes and stigma surrounding mental illness, which makes those suffering from it particularly vulnerable to epistemic (and other kinds of) injustice (Crichton et al 2016; **Kurs and Grinshpoon forthcoming; Kyratsous and Sanati 2015;** LeBlanc and Kinsella 2016).

Finally, there are different vocabularies and conceptual resources available for making sense of epistemically-toned concerns, as reported by ill persons and those that care for them. Epistemic injustice is only one of these, albeit a powerful one, that can play roles within and beyond philosophy.[[4]](#footnote-4) We would like to leave the door open to other forms of concern—for example, inclusion and exclusion practices—to be studied in the future. We do not suggest that epistemic injustice captures all such concerns, only that it is a powerful tool for such an analysis.

**2. Pathocentric Hermeneutical Injustice**

In previous work we analyse pathocentric epistemic injustices, ones that that target and track ill persons, generally. In this section, we turn our attention specifically to *pathocentric hermeneutical injustice* experienced by chronically ill persons, preparing the ground for the claims in the following sections about concepts of illness and their role in such injustice. Hermeneutical injustice is only one dimension of a subject’s complex vulnerability to a variety of forms of epistemic injustice, but insofar as chronic illness can be, and usually is, a dominant component of a subject’s social identity, it will be one of the main loci for those injustices. Indeed, one of the most common laments in illness pathography is “I became my illness”.

 At their most general, the varieties of hermeneutical injustice all involve interactive and/or institutional constraints that limit the capacity of a person or group to create or share the meanings of some of their social experiences in appropriately intelligible ways. Following José Medina, in this section we discuss the source, dynamics, breadth, and depth of pathocentric hermeneutical injustice (Medina 2017, 45-48).

Starting with sources, hermeneutical injustices can be produced *semantically* or *performatively*. The former is more familiar, arising from an absence of appropriate labels, categories, terms, or concepts for recognising, understanding, and appreciating forms of social meaning. But hermeneutical injustice can also be generated when a subject fails to *perform*, epistemically and socially, in legitimated ways. Perhaps the styles of expression or forms of communicative performance are unfairly regarded as unintelligible, or, at the least, as less intelligible than others, as when chronically ill persons use highly subjective, narrative, autobiographical, or anecdotal styles in their efforts to describe their lived experiences. Pathographic testimonies are often derogated as imprecise, vague, irrelevant, lacking relevant detail, or communicatively and epistemically deficient in other ways (Burley 2011; Kidd 2017). Such derogations ignore the fact that chronically ill persons determine that content or those styles to best suit their expressive capacities and hermeneutical needs: to speak in *those* ways with *those* words about *those* experiences is an exercise of hermeneutical agency. Impugning or thwarting that agency prevents the person from performing hermeneutically—obstructing their efforts to make or share a sense of one’s bodily, social, and existential experiences as a chronically ill person—making them especially vulnerable to hermeneutical injustice.

 The dynamics of hermeneutical injustice are the ways that access to and use of different resources and styles can be impaired or constrained by *structural* (or institutional) conditions and *interpersonal* interactions. Certain institutional designs, for instance, favour certain hermeneutical resources or make it difficult to use certain expressive styles, while certain ways of interacting with other subjects can be more or less receptive to mutually productive hermeneutical agency. *Structurally*, an obvious feature of multiple areas of the social world are pervasive constraints on the task of creating and sharing understanding of the lived experience of chronic illness, of many sorts. Chronic illness might not be talked about at all; or only spoken of in banal ways insensitive to the subjective and situational particularities of a particular ill person; or only discussed within specific contexts, such as healthcare practice or end-of-life care, whose norms and practices may not allow for appropriately sensitive discussion of the various dimensions of the lived experience of illness, or only allow discussion of certain ‘acceptable’ aspects of those experiences.

 When patients are asked ‘how they are’, for instance, they're typically expected to limit their answer to providing factual information about somatic sensations, functionality, response to medication, or the appearance and severity of symptoms. Such a piecemeal approach yields a partial view of the full phenomenon: it recognises and privileges the physiological dysfunction (disease), while hiding the experience of this dysfunction (illness). In effect, this approach glosses over and marginalises the holistic, existential nature of the illness experience, reducing the patient’s ability to see the wide-ranging impact of illness on their life. Since this sense-making is largely absent from medical discourse, ill persons are often left to their own devices to make sense of the dramatic, holistic, overwhelming experience of falling ill and being ill. Those ill persons can then be trapped between the Scylla of medical jargon rooted in natural science and the Charybdis of confining social scripts and stereotypes – of ‘combatting’ cancer, being brave and stoical, ‘not making a nuisance of oneself’.

*Interpersonally*, chronic illness is typically difficult for people to discuss, and many pathographies attest to the various forms of interpersonal obstacles they encounter in their efforts to initiate and sustain meaningful conversations about the lived experience of illness. Initially, ill persons may encounter aversive behaviour that has the effect, whether intended or not, of discouraging social interaction: think of the awkwardness or discomfort that healthy persons often display when they encounter ill persons, especially those with visible or stigmatised conditions. In such encounters, interactions might be resolutely banal, reliant on ritualised exchange of trite assurances, superficial counsels, and prosaic commentary of the sort that proliferate on social media, posters, and postcards – the worst being ‘What doesn’t kill me makes me stronger’ (a statement Nietzsche intended to critique, not condone, in *Twilight of the Idols*).

There are important social roles for banalities, of course, most obviously as a means of escape for ill persons who may wish, at times, to avoid the task of recounting their experiences. But when such banalities are the norm, prospects for appropriately complex, sustained hermeneutical agency will become increasingly remote. After all, people often resort to banality as a means of signalling to an interlocutor their lack of desire to engage seriously with others’ experiences. Banality therefore functions symbolically and communicatively as the rejection of the invitation to engage in shared hermeneutical activity.

An example is Barbara Ehrenreich’s experience of breast cancer, especially when she sought support and wisdom from fellow sufferers of the disease. Struck by the culture of zealous optimism, she posted a negative post on an online breast cancer forum, entitled ‘Angry’. It immediately met a hostile reception: anything other than ‘gratefulness’ for the ‘gift’ or ‘journey’ she has been ‘invited’ to go on, was considered blasphemy and policed accordingly (Ehrenreich 2009, 55). Other cultures frown on testimonies that are too self-centred (e.g. ill persons describing in detail their symptoms or treatment), divulging information deemed personal or upsetting (e.g. describing the details of chemotherapy, talking about an ‘embarrassing’ illness), or ‘attention seeking’ behaviour that includes displays of pain, discomfort, or anguish. As Ehrenreich concludes:

[B]reast cancer did not make me prettier or stronger, more feminine or spiritual. What it gave me, if you want to call this a ‘gift’, was a very personal, agonising encounter with an ideological force in American culture I have not been aware of before – one that encourages us to deny reality, submit cheerfully to misfortune, and blame only ourselves for our fate. (2009, 44)

The breadth of pathocentric hermeneutical injustice concerns their reach across the social world, whether they are, in Fricker’s terms, *incidental* or *systematic* cases. Certain injustices may be confined to hermeneutical hotspots, generated by contextually-specific conditions, meaning that the subject still enjoys relatively unconstrained hermeneutical agency elsewhere in their social world. But injustice can also be systematic, tracking the subject across different domains of their social world. In later writings, Fricker refers to a ‘continuum of possibilities’, ranging from maximal to minimal cases of hermeneutical injustice, focusing mainly on what she calls ‘midway cases’, where there exist ‘sophisticated interpretive practices […] not shared with at least one out-group with whom communication is needed’, in which the injustice ‘does not involve any confused experiences whatever, but only frustratingly failed attempts to communicate them to members of an out-group’ (Fricker 2016, 167).

In pathocentric cases, many ill persons may initially lack the sorts of practices and resources needed to make sense of altered experience of their body, self, and the world.[[5]](#footnote-5) Considering the intensity and negativity of the process of falling ill, from symptom appearance to diagnosis, prognosis and adjustment, it’s not surprising that ill persons lack the resources required for sense making.[[6]](#footnote-6) Sometimes, these can be partially acquired from the social world—from patient support groups, online communities, blogs, pathographic literature, healthcare professionals. Unfortunately, the intellectual and emotional labour needed to create and share understanding of overwhelming and upsetting experiences cannot always be done solely by chatting to strangers online or reading blog posts. The hermeneutical labour intrinsic to chronic illness is all too often unrecognised, misunderstood, and underestimated.

In other cases, the resources are largely confined to members of specific communities, most obviously groups and communities of those with particular illnesses – a local breast cancer support group or the online community for a certain rare disease. These often function as hermeneutical communities, by virtue of the distinctive hermeneutical needs and interests of their members, even if accounts of the role of support groups tend to be articulated in terms of moral, emotional, and practical support.

Finally, the depth of hermeneutical injustice concerns Medina’s question,‘how deep the hermeneutical harm goes in undermining or destroying the meaning-making and meaning-sharing capacities of the victims of such harm’. If they become sufficiently pervasive, such experiences can come to destroy one’s very capacity to make sense of one’s experiences, a state that Medina calls *hermeneutical death* (Medina 2017, 47).[[7]](#footnote-7)

Although such cases are comparatively rare, they are more likely to occur within the lives of agents who are already hermeneutically vulnerable. This includes those suffering from acute destabilisation of their structures of meaning, amplified by the imposition of a disturbing new set of hermeneutical demands, as their bodily and social experiences are transformed, in ways that bring emotional and cognitive stress. Chronic illness offers precisely these sorts of cases, since its lived experience typically incorporates radical changes to the content and structure of experience (Carel 2013).

Many pathocentric forms of hermeneutical injustice arise from the structural features of contemporary social and healthcare environments, consistent with Fricker’s original characterisation of hermeneutical injustice as an exclusively structural phenomenon. Subsequent research, however, cogently demonstrates the existence of an important agential dimension, too. Medina, for one, notes that societies and cultures are typically heterogeneous, with different groups and publics bearing different degrees of responsibility for the adequacy and authority of available hermeneutical practices and resources. Some groups attempt to identify and repair gaps in those resources, or to reform those practices. Although some members of a society may be content with hermeneutical failure, other groups and publics will not be similarly content. Think, for instance, of social activist movements, who may be assisted, resisted or simply observed. If so, argues Medina, there is an essential, irreducible agential dimension to hermeneutical injustice, rooted in the ‘degrees of complicity in how individuals [and groups] respond to the lacunas and limitations in the hermeneutical resources they have inherited and in how they participate (or fail to participate) in expressive and interpretative dynamics’ (Medina 2017, 42-43).

With this account in place, we now want to suggest one possible source of such injustice. We locate this in the deeper epistemological structures that underlie the hermeneutical dynamics of communities. What’s epistemically unjust may, fundamentally, be certain conceptions of disease that overlook the experience of illness.

**3. Epistemically Unjust Conceptions of Disease**

We have pointed out that there can be epistemically unjust individual and collective agents, structures and institutions, perpetrating pathocentric forms of testimonial and hermeneutical injustice by unfairly subjecting ill persons to credibility deflations and constraints on their capacity to create or share intelligible accounts of their experiences. In the final section, we argue that hermeneutical injustice can be a vice manifested not only by individual and collective agents and institutions, but also by abstract non-agential objects, specifically certain *theoretical conceptions of health*. Our claim is that theoretical conceptions can be epistemically unjust, as well as persons and groups, such that the pursuit of epistemic justice for ill persons is going to need to go beyond reform of agents and institutions.

The typical claim within virtue ethics and epistemology is that the bearers of virtues and vices must be agents, with the individual moral or epistemic agent being the locus *par excellence*. Within virtue epistemology, there is a growing interest in the idea of collective epistemic virtues, where a virtue is possessed by the group, but not all (or any) of its members: imagine a group whose members individually lack the virtue of epistemic courage, but who, when acting together as a group, reliably act in epistemically courageous ways (Kidd 2019; Lahroodi 2019).

The best defence of a collective or structural virtue of epistemic justice is developed by Elizabeth Anderson. While retaining a role for individual virtue, there is an essential role for ‘reform of our social practices of enquiry’, so that agential virtue is accompanied by more systematic efforts to ‘scale up the virtue of epistemic justice to systemic size’ (Anderson 2012). Such epistemically virtuous social systems and practices can help to amplify and reinforce acts of epistemic justice of individual agents, while – in a stronger claim – there are acts and forms of epistemic justice that are only attainable at the social or structural level. Anderson explains:

in the face of massive structural injustice, individual epistemic virtue plays a comparable role to the practice of individual charity in the context of massive structural poverty. Just as it would be better and more effective to redesign economic institutions so as to prevent mass poverty in the first place, it would be better to reconfigure epistemic institutions so as to prevent epistemic injustice from arising. (Ibid, 171)

In the case of pathocentric epistemic injustice, we claim that the bearers of the virtue of epistemic justice can be *individual agents* (health professionals, carers, managers), *collective agents* (a multidisciplinary team, a hospital executive committee), and *institutions* (a hospital, a national health service).

We suggest that these three possibilities hold true in the pathocentric cases and so should be taken seriously by those committed to epistemic justice for ill persons. But there is a further possibility that we want to consider: that *stances*, *policies*, *doctrines*, or *theoretical conceptions* can also be epistemically vicious, such that the vice is not located in an individual, collective, or institution (see Battaly 2013, Kidd 2018). If this is right and applicable to epistemic injustice, then ameliorative efforts to achieve epistemic justice must target such abstracta, as well as agents, collectives, and institutions. In this section, we make a case for the existence of vicious abstracta; then, in the following, we argue that some theoretical conceptions of disease are epistemically unjust.

The idea of vicious theoretical conceptions finds support in recent work in vice epistemology by Heather Battaly, who proposes we shift ‘our focus from the vices of people to the vices of policies’, as a specific type of abstracta (2013, 264). In brief, she describes a vice of epistemic insensibility, a deficiency of epistemic appetite, marked by failures to desire, consume, or appreciate appropriate epistemic goods. Epistemically insensible people may, for instance, only value knowledge with obvious instrumental value, not what has intrinsic value—they lack the sense that some things are just ‘good to know’, for their own sake. Battaly then goes on to argue that we can reasonably extend talk of epistemic insensibility to higher educational policies, such as the Research Excellence Framework in the UK:

[A]n epistemically insensible *policy* promotes a failure to desire, consume, and enjoy some true beliefs that it is appropriate to desire, consume, and enjoy; and does so because it employs a false conception of the epistemic good—it wrongly assumes that such true beliefs are not, or are not sufficiently, epistemically good. (Ibid, 272)

In these cases, the policy *itself* is vicious – epistemically insensible – independently of the viciousness of the educators and others whose activities it shapes or dictates. One may object that this is a category mistake, since policies, as abstract objects, cannot be bearers of virtues and vices. In response, Battaly (2013, 276) notes, first, that we do talk naturally of policies, stances, practices, and institutions as vicious, whether cruel, unjust, or dogmatic, like the cruelty of slavery (cf. Kidd 2016). Second, a vicious policy need not possess *all* of the features of a vicious person, such as perceptual habits or affective dispositions, only those definitive of the vice. The REF, for instance, (i) promotes a failure to desire,consume, and enjoy some appropriate epistemic goods and (ii) does so because it has a false or deficient conception of the epistemic good. A vicious policy, then, *promotes* vicious actions, attitudes, or states of affairs.

We accept the ‘promotion’ account developed by Battaly and add two others: ‘exercise’ and ‘attraction’. First, a policy is vicious if its enactment or implementation requires the *exercise* of one or more vices: the institution of slavery, for instance, requires slave-owners to exercise the vices of cruelty and injustice, which are necessary to deprive human beings of their freedom and objectify them. Second, a policy will be vicious if one must be vicious, at least latently, in order to find it *attractive*. A person who regarded acts or institutions of enslavement as attractive – as exciting, or worth ‘having on the table’ as a tenable option – must be already disposed, to some degree, to cruelty, injustice, and other vices. Anyone who regards slavery as anything other than atrocious must be, to some degree, guilty of such failings as wilful ignorance, insensitivity, or conformism.

Gathering these points together, we propose that a theoretical conception will be epistemically vicious if it does one or more of the following:

*(a)* promotes epistemically vicious attitudes or actions;

*(b)* requires the exercise of one or more epistemic vices for its enactment in agential conduct, structures, or institutions;

*(c)* could only be regarded as attractive by agents with at least some disposition to one or more epistemic vices.

A few caveats are needed before we go on to consider epistemically unjust conceptions of health: first, a single vice can be borne by individual and collective agents as well as by the policies, theoretical conceptions, or other abstracta that make up a community. Second, careful work will be needed to identify the viciousness of a conception, since this will be expressed in and through the practices, social structures, and institutional arrangements that concretise and give form and force to the conception. In the final section of this chapter we argue that theoretical conceptions of health can also be epistemically unjust, if and when they become exclusively privileged within a social system.

**4. Naturalism about Health**

Modern healthcare practice and science are largely governed by a naturalistic or biomedical conception of health that privileges the concepts, theories, and terminology of natural science. The most influential account within philosophy of medicine is that of Christopher Boorse, who conceptualises health and disease in terms of biological functionality and dysfunctionality, respectively, defined relative to statistical norms within a reference class (see, for instance, Boorse 1977 and Rachel Cooper 2002). Ideally, health is defined from a value-free, third-person perspective, independently of subjective and contextual values and other ‘extra-biological’ factors, such as ‘intentional actions’, ‘goals’, and other aspects of human subjectivity (Nordenfelt 2014, 25). As a consequence, both the conceptualisation and treatment of health and illness become the primary, if not exclusive, responsibility of biomedical science. It is this epistemic and practical privileging of naturalistic resources that can, we argue, act as a source of pathocentric hermeneutical injustice.

By ‘naturalistic conception of health’ we mean one that privileges or presents as exclusively or primarily authoritative the concepts, categories, and vocabularies of biomedical science. Such conceptions involve certain attitudes towards biochemistry, physiology, and other sciences, rather than use of those sciences themselves. The use of scientific resources does not require adoption of a naturalistic conception of health. A person can view their cancer in the terms of oncology, without thinking those terms offer a complete, exhaustive account of the lived experience of cancer. Many ill persons, carers and health professionals accept the existence of dimensions of health and illness that are only articulable and intelligible using methods and resources taken from *outside* biomedical science, such as those offered by embodied existential phenomenology of illness (see Carel 2016, Toombs 1993, and Svenaeus 2000).

 The epistemic privileging of naturalistic conceptions of health can take many different forms, instantiated in interpersonal interactions, institutional structures, or background cultural convictions. At its most basic, privileging can consist of blunt rejection of alternative accounts of health and illness as alterations to one’s embodiment or structures of experience, as false, inchoate, or unintelligible. When cancer patients talk of feeling “betrayed” by their body and its “traitorous” tumours, or when ill persons report that the world feels “weird”, “unstable”, or “hostile”, their testimonies can be rejected as clinically irrelevant at best, confused or meaningless at worst.

Closely related is *acceptance* of non-naturalistic accounts of health and illness, coupled to the judgment that they are epistemically inferior to those of the biomedical sciences. An altered sense of embodiment, time, and space may be accepted as genuine, but nonetheless of only marginal relevance to medico-epistemic practices.

A further privileging practice is the insistence that only natural scientific methods and resources can disclose the *fundamental* features of health and illness, beyond superficial or subjective appearances. Phenomenological description of one’s altering experiences of self, body, and world is relegated to an epistemically second-order role, unable to tell us the *truth* about the nature of health and illness.[[8]](#footnote-8) Such criticisms of the privileging of naturalistic conceptions is a theme of Martin Heidegger’s defence of the primacy of engaged experience, and his complaint, in his later writings, that what is distorting modern thought is ‘the dominance and primacy of the *theoretical*’ (1987, 87). Heidegger was not impugning naturalistic science or theory *tout court*, since these have important roles in human life; the ‘danger’ only arises when their limits become forgotten and other, alternative ways of experiencing and engaging with the world are ‘driven out’ (1977, 26ff). Indeed, if taken to the extreme, the *very idea* that there are or could be any alternatives to natural scientific descriptions of phenomena comes to be excluded from individual or collective imagination—an obliviousness to possibilities that is a breeding ground for such vices as closed-mindedness and dogmatism, construed as an unwillingness or inability to engage seriously with relevant epistemic options (Battaly 2017).

 These are some general privileging practices that can help to sustain the naturalistic conceptions that prevail within contemporary Westernised societies, which are already predisposed to privilege the sciences. We now need to demonstrate that the privileging of naturalistic conceptions of health within healthcare systems tends to generate the pathocentric hermeneutical injustices described in section 2. We suggest they can do this in three mutually reinforcing ways:

1. Privileging of naturalistic conceptions can manifest as failure to acknowledge the existence of alternative accounts of health and illness, meaning the only available options are those from biomedical methods and resources.
2. Privileging can encourage epistemic derogation of those alternatives, perhaps as ‘subjective’, ‘unscientific’, or worse.
3. Privileging of naturalistic conceptions could allow limited roles for alternatives, albeit tempered by the conviction that only biomedical science can disclose the fundamental features of health and illness.

We suggest that the contemporary entrenchment of naturalistic conceptions of health in healthcare practice has epistemically privileged natural scientific ways of conceiving and responding to health and illness. As a consequence, alternative ways of conceptualising and understanding illness that fall outside the strictures of natural science tend to be excluded, marginalised, or derogated. An important consequence, with reference to epistemic injustice, is the generation of gaps in the range and type of hermeneutical resources and practices privileged within healthcare environments.

Such hermeneutical gaps arise because naturalistic medicine recognises only certain types of meaning and significance and certain kinds of experience, namely, those relevant to the biomedical sciences and their associated forms of clinical practice. This is entirely legitimate, since much can be achieved, medically, using biomedical theoretical and therapeutic modalities. Moreover, *any* conception of health can only serve certain types of hermeneutical needs, just as any tool can only serve a certain range of functions: partiality is the price one pays for specificity. But this is a problem if one lacks a sufficiently diverse set of tools, depriving one of the right tools for the job.

Our worry is that the privileging of naturalistic conceptions of health tends to deprive medical science and healthcare practice of a sufficiently diverse range of hermeneutical resources. It has also concealed this poverty by reducing sensitivity to the range of experiences and meanings that make clear the need for enrichment. As a consequence, the privileging of those naturalistic conceptions both promotes and requires the exercise of pathocentric hermeneutical injustice. If so, those conceptions are hermeneutically unjust.

 Recalling our account of vicious abstracta in the last section, we proposed that a naturalistic conception of health is hermeneutically unjust if it:

(*a*) promotes hermeneutically unjust attitudes or actions;

(*b*) requires the exercise of hermeneutical injustice for its enactment and in agential conduct, structures, or institutions.

*(c)* could only be regarded as attractive by agents with at least some disposition to cause or accept hermeneutical injustice.

Both of these features obtain in the case of naturalistic conceptions of healthcare as enacted within many, if not most, contemporary healthcare systems. But, crucially, the injustice only occurs with the *privileging* of those conceptions in ways that reject, derogate, or marginalise alternative hermeneutical resources and practices pertinent to experiences of illness. We can therefore pinpoint these privileging practices as an important, if not primary, cause of pathocentric hermeneutical injustices. If so, we can now ask about the aetiology of those injustices: what form do these privileging practices take? where do they take place? who performs them? how do they become legitimated and authoritative? how can they be resisted?

We offer these questions to guide future investigations of pathocentric epistemic injustice, hopefully in the direction of epistemic justice. Whatever the results, a role still exists for a virtue-theoretic framing of those injustices, including at the level of theoretical conceptions. It is not only individual and collective agents and institutions that can be viciously epistemically unjust, but also naturalistic conceptions of health, if privileged epistemically within a healthcare system and social culture. If privileged, a conception can start to promote and to require exercise of the vice of hermeneutical injustice.

Ben Sherman remarks that “harms can be caused through social structures,” and so could be “improved through structural change without anyone becoming more virtuous” (2015, 233). We have argued that insofar as theoretical structures cause the harms constitutive of hermeneutical injustice, those structures *are* hermeneutically unjust, just as the very concept and institution of slavery are cruel and unjust, over and above the cruelty and injustice of individual slave-owners, practices, and so on. Successfully improving vicious structures, in itself, can make for a more virtuous society, independently of any contemporaneous increase in incidences of agential virtue, even if that is something to strive for, too.

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1. https://www.seap.org.uk/services/independent-mental-health-advocacy/about-independent-mental-health-advocacy.html (accessed on 23 October 2018). [↑](#footnote-ref-1)
2. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013 Executive summary <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf> (accessed 23 Oct. 18). [↑](#footnote-ref-2)
3. See *BMJ* editorial ‘Satisfaction with NHS hits new low’. *BMJ* 2018;360:k943; see also emphasis on listening to patients in the Patient Association strategy document (https://www.patients-association.org.uk/Handlers/Download.ashx?IDMF=f4f5bfb8-e61a-49fa-8635-07a7af98d076), accessed on 1 June 2018. [↑](#footnote-ref-3)
4. A bibliography of work on epistemic injustice, illness, and healthcare is maintained at https://ianjameskidd.weebly.com/epistemic-injustice-and-illness.html. See also Kidd, Medina, and Pohlhaus 2017. [↑](#footnote-ref-4)
5. For an ameliorative toolkit, see Carel 2012. [↑](#footnote-ref-5)
6. For an account of that process, see Carel 2015 and 2018a. [↑](#footnote-ref-6)
7. For a cinematic exploration of this theme, see *Murder in the First* (1995, Director Marc Rocco, US). [↑](#footnote-ref-7)
8. This account of theoretical conceptions and of privileging practices is informed by David E. Cooper (2002, 341ff). [↑](#footnote-ref-8)