

Diversifying Syllabi 2017 Text Summary and Teaching Tips

Article/Essay Title: Epistemic Injustice and Illness

Authors: Ian James Kidd & Havi Carel

Readability: Easy to Moderate

Thesis:

Negative stereotypes and structural features of modern healthcare practices make ill people especially vulnerable to testimonial and hermeneutical injustice.

Key Definitions:

epistemic injustice – one is wronged in one’s capacity as a knower. This concept explores the *ethical* fallout of certain kinds of *epistemic* dysfunction.

testimonial injustice – a form of epistemic injustice in which a speaker’s testimony is rated less credible by a hearer due to prejudice on the hearer’s part. The speaker is thus wronged specifically in their capacity as a giver of knowledge.

EX: disbelieving eye-witness testimony given in court due to the color of the person’s skin

participatory prejudice – a person or group is prejudicially judged to lack a *sense of relevance* (capacity to determine which ideas/objections are worth taking seriously) and is thus regarded as unsuitable for collective epistemic activity

informational prejudice – a person or group is prejudicially judged to lack the ability to provide relevant information and is thus regarded as unsuitable for collective epistemic activity

1. *refusal to concede* the relevance of the information being offered (especially likely where the type of information in question is not recognized by the experience of the dominant social group)
2. *refusal to consider* presuppositions about the types of information that are legitimate and admissible (often a refusal to reassess even in the face of vigorous and sustained calls to do so)

hermeneutical injustice – a form of epistemic injustice in which someone is unable to make sense of their social experience due to a conceptual gap in collective interpretive resources. This gap is often the result of the marginalization or oppression of a social group to which the person belongs and reveals structural prejudice in the collective interpretive resources. The speaker is wronged because they are put at an epistemic disadvantage when trying to make their experiences intelligible to themselves and to others.

EX: a woman trying to make sense of her experience of unwanted touching/comments of a sexual nature prior to the emergence of the concept “sexual harassment”

- global lack – the conceptual resources do not exist and no person or group has access to them
- non-dominant – a social group has adequate interpretive resources, but they are not recognized by the dominant social group
- epistemic isolation – a person or group lacks access to important interpretive resources, though the resources exist

Brief Summary:

Although there are persistent complaints (from both patients and physicians) regarding the quality of doctor-patient communication, attempts to address these complaints often focus on superficial modifications (practicing “open body language” and making eye contact) without addressing the deeper epistemic dysfunction at work (the loss of medically important patient-provided information and the epistemic harm done to patients). This article provides an epistemic analysis of patient-physician communicative dysfunction with an eye to reform.

Two claims:

- I. Chronically ill people are a socially vulnerable group and Fricker’s account of epistemic injustice is thus applicable.
 - a) Subject to negative stereotypes and prejudices
 - The rationally experienced anxiety and insecurity that results from illness are often taken up as diminished agency, bodily failure, and/or psychological fragility.
 - Illness in general is often seen in terms of moral or social failure, or a shortcoming of the will.
 - b) These stereotypes and prejudices are structurally reinforced
 - An emphasis on the biological minimizes attention paid the subjective experience of illness.
 - An emphasis on efficiency and financial profit promotes the needs of health specialists rather than patients.
 - Time pressure, short consultations, and use of standardized protocols leave little room for person-specific needs and values.
 - Task-based rather than patient-focused work minimizes opportunities for rich and sustained provider-patient contact and communication.

- II. The concept of epistemic injustice accurately explains and identifies the source of patient complaints
 - a) **Testimonial Injustice** – pervasive negative stereotypes of ill-people emphasize the non-rational; patient testimonies are as a result accorded lower degrees of epistemic credibility
 - **Participatory prejudice** – an implicit co-definition of *sense of relevance* with medical expertise means that ill people are presumed to lack the training and experience needed to meaningfully contribute to the epistemic practices of medicine
 - **Informational prejudice** – there is a persistent refusal to reconsider the significance of the information ill people are in a position to provide (ex: their sense of bodily estrangement or social isolation). “Efforts to design medical interventions without appropriate consultation with patients may result in health care systems that are not only epistemically unjust but also practically inefficient because a rich range of forms of information required for the genuine improvement of services is structurally excluded.” (182)

 - b) **Hermeneutical Injustice** – ill people have *non-dominant hermeneutical resources*; they can make sense of their experience but the concepts they use to do so lack social recognition and epistemic respect. Patient are:
 - Subject to *strategies of exclusion* (excluded from the practices and places where medical concepts and meanings are made and legitimated); they are forced to adopt an epistemically marginal role in consultative exercises.
 - Subject to *strategies of expression* (their expressive style is not recognized as rational and contextually appropriate); they are required to employ the language

and conventions which require professional training and experience; their preferred expressive styles are implicitly and derogatively interpreted as irrational.

Possible Applications:

Bioethics
Epistemology
Agency Subsections or Classes
Action Theory
Metaphysics (section on personal identity)
Authenticity Subsections or Classes

Complementary Texts/Resources:

- Miranda Fricker, Epistemic injustice: Power and the ethics of knowing, Fricker, *"Epistemic justice and a role for virtue in the politics of knowing"*
- Kristie Dotson, *"Tracking epistemic violence, tracking practices of silencing"*
- Jose Medina, *"Hermeneutical injustice and polyphonic contextualism: Social silences and shared hermeneutical responsibilities"*
- Selections of Michel Foucault's and others' work on Biopower
- Literature on Micro-Aggression in Medical Contexts
- Selections from Michel Foucault's work on the clinic
- Shelley Tremain's work on Disability (e.g. *"On the subject of impairment"*)
- Terrence Ackerman, *"Why doctors should intervene"*
- JP Sartre, selections on the Tripartite Dialectic on the Body in Being and Nothingness

Possible Class Activities:

- How to Survive a Plague
 - Patients have become active in medical discourse and study on illness. Good example of goal of the article.
- Come up with stereotypes about ill folks and think about how that might undermine ill folks agency.
- Review Case Studies Looking At....
 - Vaccine
 - Public debate around this and how different folks reports get taken up as evidence or not.
- Rebecca Kukla's video lecture on Autonomy
- Other Georgetown Mooc Videos on Autonomy
 - (e.g. Madison Powers' video)