Healthcare Inequalities and Social Justice Blog Series: Epistemological relevance in social justice: a justified belief or pinion? By Dr. Nagina Khan and Professor Kam Bhui

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Miranda Fricker is a critical philosopher, who identified a particular form of social injustice which she named epistemic injustice which occurs when a person is wronged as a knower.[1] Fricker explained that the harm this can do and identified there is instant injury when not believed and to be rejected or discredited on a deeper level – "to be wronged as a knower, or speaker' is to be wronged in a capacity essential to human value" (p. 44). Sadly, epistemic injustice has become a popular concept in healthcare. In healthcare and psychiatric practice, epistemic injustice is concerned with the negative socio-epistemic experiences constantly described by individuals with psychiatric conditions and correspondingly there is a parallel with the preoccupation of scholars within healthcare studies who endorse discourses of equality, diversity, and inclusion (EDI) on the one hand, yet ignore racism and the epistemic injustice suffered by Black and ethnic minority populations and scholars alike? See table. 1 below for the snapshot of evidence related to this.

Table. 1 Existing evidence of inequality in healthcare

Study	Finding
Mental health care for Asian, black and white patients with non-affective psychoses: Pathways to the psychiatric hospital, in-patient and after-care.	Evidence exists that Black patients had more-complex pathways to specialist services.
The first contact of patients with schizophrenia with psychiatric services: Social factors and pathways to care in a multi-ethnic population.	Compared with White and South Asian patients who visited their general practitioner (GP), Black people were less likely to be referred to specialist services.

Mental health care for Asian, black and white patients with non-affective psychoses: Pathways to the psychiatric hospital, in-patient and after-care. The first contact of patients with schizophrenia with psychiatric services: Social factors and pathways to care in a multi-ethnic population.	Police were more likely to be involved in admissions or readmissions of Black people.
Early manifestations, personality traits and pathways into care for Asian and white first-onset cases of schizophrenia. The first contact of patients with schizophrenia with psychiatric services: Social factors and pathways to care in a multi-ethnic population.	In West London, specialist referral following primary care assessments appeared to be equally common among White and South Asian patients, but hospital admission was more likely among South Asians following a domiciliary visit.
Access to mental health care in an inner-city health district. I: Pathways into and within specialist psychiatric services.	In Birmingham South Asians had the highest community rates of mental disorder, were the most frequent consulters in primary care and were less likely than White people to have their mental disorder recognised.

Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses.	The risk for a diagnosis of non-affective and affective psychoses is particularly elevated for Black ethnic groups and is higher for all ethnic minority groups. Including those previously not assessed through meta-analyses (White Other, Mixed Ethnicity).
Department of Health. The independent review of the Mental Health Act.	Final report sets out recommendations covering 4 principles that the review believes should underpin the reformed Act: • choice and autonomy – ensuring service users' views and choices are respected • least restriction – ensuring the Act's powers are used in the least restrictive way • therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act • people as individuals – ensuring patients are viewed and treated as rounded individuals.
Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography.	Found that the delivery of safe and equitable person-centred care requires a model of mental health that is responsive to the lived experiences of people in ethnic minority groups. Highlighting that this requires better alignment of mental health services with social and anti-racist models of care.

Power and the Ethics of Knowing. Epistemic Injustice: Power and the Ethics of Knowing The Emperor Has No Clothes: Rewriting "Race in Organizations." Epistemic injustice and hegemonic ordeal in management and organization studies: Advancing Black scholarship.	Penelope Muzanenhamo writes, that, rather than deter me, I believe my socially powerless identity has inspired my participation in the struggle for epistemic justice with other Black (female) scholars with the goal to advance Black scholarship. By Black scholarship, I denote epistemological approaches grounded in the social realities of Black (and Brown) individuals and communities, that are adopted by non-White bodies such as myself.

Fricker stated, "*in contexts of oppression the powerful will be sure to undermine the powerless in just that capacity, for it provides a direct route to undermining them in their very humanity*" (p. 44).[1] Furthermore, Muzanenhamo, P., suggested, this is because the capacity to reason and to give knowledge to others is fundamental to being human and so to be insulted or ignored in this capacity is deeply wounding.[2] Hence, perhaps why we can identify with Capponi (2003) who identifies as Mad and a service user of the Canadian Mental health system, she has written numerous prevailing autobiographies authenticating her personal knowledge and the experiences of others. She says, every individual is different, despite comparable circumstances and diagnoses, in terms of potential, character, awareness, welfares and capabilities. "These differences might be obscured by labels and behaviours, by homelessness and poverty, but they are there. And they need to be expressed for us to find out what makes us special, what makes us unique. The failure to see us as people, not as pathologies, continues to wear us down" (p. 150).[3] This picture of her involvement in the mental health system and experience of epistemic injustice reverberates with Fricker's account of the deep wounding and harm through, weakening personal testimony or failure to provide a respectful platform. This oversight can destabilise independence, autonomy and an individual's route to civilisation, humanity, and mortality.

Scholars have identified two main co-operating notions for epistemic injustice:

1. *Testimonial injustice occurs when a speaker is denied credibility and is degraded, ignored, or dismissed as a reliable knower.*[1]
   And
2. *Hermeneutic injustice is an injustice of meaning-making where a particular experience is not only not part of the collective knowledge*

resource but has perhaps not even been named and conceptualised.

Not being heard – not feeling heard

- *Why is it tough for healthcare to listen?*
  and
- *Why is hard for the knower to be heard in healthcare?*

An assurance to epistemic justice in institutions should not be seen as a down grading of evidence-based reasoning. Problems of testimonial injustice do not ascend from constraining evidence, rather they emerge from constraining particular forms and sources of knowledge and differing levels of evidence. Mistakes arise from disbelieving connected evidence and exclusion of some sources, as unreliable without believing them true despite good reason. Importantly, testimonial injustice is typically not committed intentionally.[4] In this sense and in institutions, it may be qualified as 'just a mistake' unless it is and becomes systematic and an deceptive ethical wrong along with being a dangerous epistemological destruction.

This is mainly common in relation to dominated voices, as they are subject to testimonial injustice and so are deprived of chances, not only to join in and be 'heard' but also to be the voice to their own experiences and talk in ways that may increase their own understanding of their experience. The consequence of this is that their experiences are excluded from collective knowledge and are not part of learning, or resource, there is difficulty in communicating, acknowledging and understanding.[1] This mechanism then allows for social order to be maintained by domination and power, rather than by consensus and conformity. The example of sexual harassment is cited by Fricker, M., to show that in the past before the joint female realisation-raising in the 1970s, sexual harassment was an unnamed phenomenon, was not discussed, and was not thought about in the community spheres even though it was a common incidence in the workplace.[1]

The above problem illustrates, how mechanisms, systems and cultures in institutions can prevent the voices, the naming of experiences, that fundamentally prevent them from becoming part of the collective knowledge. Hence, resulting in those with resource and power holding on to it by any means possible, primarily by suppressing the underprivileged and powerless, often these processes are invisible and difficult to identify. Therefore, no resource rules ever become established or are put in place so that consequences can be enforced. This would allow minority populations to communicate incidents of social injustice, so that they can also increase their own self-understanding of why they experienced feelings of ruin and assault

when incidents of social injustice occurred. Fricker calls the absence of conceptualisation of an experiential phenomenon a hermeneutic gap.[1] This gap can occur in interdisciplinary teams and research, as well as with different identities in terms of lived experience, and more complex identities. Epistemic injustice influences whose knowledge, ideas and contributions become public and whose don't, leading to large gaps in our understanding of certain experiences.[5]

We have all read, witnessed and perhaps tried to speak up about social injustice, safety, racism, equality, in our own leadership trajectory, and recently there have been high profile cases (I will not attempt to list here as they will be discussed in the later blogs in this series), with elements of epistemic injustice playing out in front of our very eyes, with grave mistakes and errors that in hindsight, should never have occurred. This is indeed a sombre time for leadership and its reflection, as some of the cases do not highlight honest mistakes, which can occasionally result from following the correct procedures and forming a clinical judgement based on the evidence available at a particular moment in time and not listening to the 'apprehender' and 'knower.' As later on, this evidence might be archaic, accordingly and with hindsight, giving reason for a very different clinical judgement. Yet, the arguments for not listening to the 'knower' with experience, or understanding – is often verbalised as 'is no basis for forsaking evidence-based reasoning in future clinical practice, which institutions erroneously accept is the only method to protect themselves (faultily) from testimonial justice.[6]

This is what makes epistemic injustice enormously problematic to address without any critical apparatuses precisely created for this issue that draws on both proficiency by experience and a wide range of disciplines, including but not limited to epistemology, ethics, law, economics and sociology. However, co-production, on the other hand, makes sure voices that aren't typically heard or judged to be credible are listened to. And different models of resolving, PPI and EDI are proposed, yet they too have had their limitations and so more progressive models are proposed by NIHR which tackles epistemic injustice.

Furthermore, Kidd and Carel, suggest the following as mechanism for cultural and institutional change:

- Epistemic complaints can be in the form of two basic types of epistemic injustice a) testimonial and b) hermeneutical injustice, where the former can manifest in the specific forms of participatory and informational prejudice.
- These injustices are produced and are held though negative stereotypes of individuals aided by structural features of current healthcare practice.

- There is a methodical ignorance of the knowers/speakers' testimonies however the interpretations do have epistemic authority in the lived experience.

To conclude, leaders and institutions can – as first steps – resolve and eliminate epistemic injustice through recognising and acknowledging its existence in their everyday practices. And as suggested by Kidd and Carel, leaders must undertake critical analysis of the range of stereotypes and distinctive stereotypes which engender epistemic injustice. And perhaps institutions that are grappling with such issues can study implicit processes of exclusion, strategies by which the expression of their beliefs is established. They must question the structures and functions and practices and policies of institutions and propose how contemporary healthcare be reformed in order to minimise dispositions towards epistemic injustice.

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Declaration of interests

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