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Invited Letter Rejoinder

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'What does epistemic injustice add? A response to Grim and Aftab'

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What does epistemic injustice add? A response to Grim and Aftab

We are grateful to Dr Katarina Grim and Dr Awais Aftab for their thoughtful and detailed responses to our recent essay about epistemic injustice (EI) in psychiatry (Kious, Lewis, & Kim, 2023). While we agree with them on a number of things, especially about what constitutes good clinical care, many of their comments are unpersuasive.

Dr Grim's first criticism is that our original paper did not undertake a comprehensive review of the literature before evaluating the usefulness of the concept of EI for psychiatrists, and she recommends such a review. While that might be a worthwhile endeavor, this criticism reflects a misunderstanding of our project. Our limited sample of cases was dictated not by a selective or incomplete review of the literature, but rather by the nature of the philosophical arguments to which we responded, which themselves depended on such cases. Ours was primarily a conceptual, normative analysis, not a literature review of an empirical issue.

Having interpreted our paper as a 'review,' Grim introduces other literatures which, she believes, are related to EI. She notes that there is a robust literature about such topics as shared decision-making (SDM), including the work that she and colleagues have conducted. She reports that patients (service-users) often feel that their personal knowledge about recovery is ignored or rejected by psychiatrists and that some patients describe silencing themselves because they had previously been treated as unreliable or fear being labeled as 'difficult.' She describes providers as 'unduly pessimistic' about patients' decisional abilities. She notes that EI has, for her and her collaborators, been 'a valuable tool for exploring these interactions…' (Grim, 2023).

We see Grim's review of the literature about SDM, though interesting, as orthogonal to the claims of our paper. We did not consider SDM or related ideas, like the recovery movement or patient-centeredness, because such ideas are, despite Grim's own experience, distinct from EI. One can (as we do) think that SDM, patient-centeredness, and recovery are important for psychiatric practice without thinking that attention to EI is useful for psychiatrists. Even the timelines over which these concepts evolved illustrate this. As far as we can ascertain, SDM was first discussed in the English-language literature in the mid-1970s (Hirsch & Shulman, 1976), and in German even earlier (Kettner, 1970). Similarly, Pubmed reports 127 publications using the phrase 'shared decision-making' in 2006, one year *before* Fricker's highly influential book (Fricker, 2007) was published, and none of those 2006 publications appear to mention 'epistemic injustice.' Thus, interest in SDM is not conceptually dependent on a concern with EI. Other values, such as respect for patient autonomy and beneficence, support SDM, too (Elwyn et al., 2012).

Of course, this does not show that appeals to EI are *never* helpful. Grim asserts that thinking about EI has been helpful to *her*, and we can only accept this. Again, however, showing that EI is *never* helpful was not our project. Our goals were, instead, to demonstrate that philosophical arguments for psychiatric EI are not especially compelling, that psychiatry already has ample tools to identify and remedy the problems picked out by proponents of EI, and to raise the worrisome possibility that reliance on EI could damage the patient-physician relationship. Ultimately, then, Dr Grim's examples provide us, albeit indirectly and inadvertently, with an opportunity to reinforce our point: we do not need to think about EI, and the risks attendant to it, in order to realize other important goods – like patient-centeredness and SDM. These are supported by other aspects of good psychiatric practice and other moral theories.

Grim also criticizes our paper by bringing up the issue of hermeneutical injustice, but we would remind readers that we clearly distinguished hermeneutical injustice and testimonial injustice, and explicitly set concerns about hermeneutical injustice aside. We also doubt whether limitations on patient self-expression due to time constraints and inflexible clinical settings constitute hermeneutical injustice, as she suggests, as opposed to practical constraints on delivering care with limited resources. Dr Aftab also criticizes us for not addressing hermeneutical injustice, but does so by claiming that our emphasis on testimonial injustice 'conveys' an 'impression' that we are criticizing the idea of hermeneutical injustice without offering arguments. We note, however, that our attention to testimonial injustice was dictated by the

essays to which we were responding; these argued clearly that psychiatry inflicts testimonial injustice. Moreover, hermeneutical injustice, while potentially relevant to the design of systems of care or conceptual structures like the DSM, does not lend itself to an analysis of clinical practice; testimonial injustice does.

Dr Aftab's other comments are both puzzling and instructive. They are puzzling because they attribute to us claims which we did not make and which we were, in fact, very clear about not making. They are instructive because of the way they reveal what may really be animating those who wish to use the concept of EI to criticize psychiatry, as Aftab clearly does.

Consider Aftab's remark that '[t]his makes evident what Kious *et al.* appear to have difficulty understanding. Epistemic justice is not something that is outside of good clinical care. Good clinical care is inclusive of our best ethical practices…. We cannot appeal to good clinical care to justify ignoring epistemic justice because epistemic justice clarifies a vital aspect of what good clinical care ought to be' (Aftab, 2023). We find this remark puzzling because we explicitly stated that the requirements of epistemic justice, under any reasonable interpretation, would be subsumed by existing standards of good clinical practice, for instance when we wrote (in our abstract), 'The concept of epistemic injustice does not add significantly to existing standards of good clinical practice.' Again, our view is that simply by trying to practice good medicine, which requires good clinical reasoning, psychiatrists can avoid being epistemically unjust. Consider the example Aftab gives of a patient with a real physical complaint who is not taken seriously 'because of their status as a psychiatric patient.' We do not deny that this sort of error can occur, nor that it is wrong, nor that it is an instance of EI. Our point is simply: since it is already bad medicine, we do not need to appeal to EI to show that it is wrong. And, we would observe, while Aftab claims that attention to EI would add materially to existing standards of good clinical practice, he does not support that claim or deal directly with our attempts to show that good clinical practice already condemns behavior he would call epistemically unjust.

Aftab implies that being against using the framework of EI is inconsistent with being against racism, sexism, and the like: '[Kious *et al.*] recognize the relevance of racism and sexism but decline to extend the same attitude to epistemic discrimination against individuals with mental illness' (Aftab, 2023). Again, however, this misunderstands us. We agree that EI is, when truly present, wrong; we simply reject the idea that it is often useful to say so, because what is wrong in these scenarios already has a perfectly adequate label: bad clinical reasoning. And recall that in our original essay we observed that, while epistemic marginalization on the basis of race is virtually always wrong, since race is irrelevant to epistemic ability, the same is not true for having a psychiatric diagnosis; having a psychiatric diagnosis often is epistemically relevant. Aftab fails to distinguish all the different kinds of EI that might be perpetrated. We do not.

Perhaps most importantly, Aftab misconstrues our third claim, which was that clinical application of the concept of EI runs the risk of causing more harm than good. We do not think (and did not assert) that epistemic justice requires psychiatrists to believe everything patients tell us. We do think (and said) that emphasis on EI could lead psychiatrists (and patients) to *assume* that psychiatrists are obligated to believe nearly everything patients say, or at least believe much more than good clinical practice requires.

We suspect that Aftab's misinterpretation of us is probably due to the fact that he does not like the 'impression' (his term) we convey. He thinks our paper does not show a sufficient 'gesture of support for … individuals of marginalized classes…' (Aftab, 2023). But then it is not the logic of our paper with which he finds fault, only the fact that it seems irreverent. We simply are not showing enough solidarity with patients, in the right ways, in his view. Our response to this is that psychiatrists' commitment to respectful, effective, compassionate care for their patients is enough. It should not require any 'gesture' that involves allegiance to frequently erroneous and superfluous applications of a theory, whatever virtues that theory has in other domains.

Should we 'believe patients,' as Aftab suggests? Yes and no. 'Yes' in all the respects we already highlighted: psychiatrists generally do believe their patients, and must do in order to practice competently. But 'no' to the sense that Aftab prefers: we do not think that psychiatrists owe some special deference to patients as a 'corrective' for supposed mistreatment. This is one way in which we disagree substantively with Aftab: while we think that epistemic justice can be secured through good clinical practice and the good reasoning it requires, Aftab does not. He, along with other proponents of the framework of EI, believes that these standards should be altered by some extra deference to patients that functions as a moral 'gesture.'

That way peril lies. As we argued before, forsaking good clinical reasoning in favor of deference risks bad clinical reasoning; it risks, too, creating expectations that patients are never to be doubted; it risks portraying doubt as a betrayal rather than the exercise of a physician's duty; and, most of all, it recasts the patient-physician relationship as adversarial instead of supportive. The fact that appropriate concern for what patients know is already captured by standards of good clinical practice means that Aftab's 'gesture' is not worth those risks. Sticking with good medicine and good clinical reasoning – not signaling a correct 'impression' – should be the primary concern of psychiatrists.

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