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Social Structure and Epistemic Injustice in Healthcare

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Abstract Deutsch

In dieser Masterarbeit argumentiere ich, dass das Verständnis von Patientenrollen als soziale Position unsere Wahrnehmung der emotionalen und epistemischen Verletzbarkeit (vulnerability) von Patient*innen vertieft. Im ersten Teil zeige ich, dass Patienten nicht nur medizinisch, sondern auch emotional und epistemisch von Ärzt*innen abhängig sind, was zu einem Machtgefälle führt, das moralisch-epistemische Ungerechtigkeit verursachen kann. Im zweiten Teil diskutiere ich aktuelle Konzepte epistemischer Ungerechtigkeit und deren mögliche Unzulänglichkeiten bei der Erfassung struktureller Probleme im Gesundheitswesen. Um diese besser zu verstehen, greife ich auf Iris Marion Youngs Konzept der strukturellen Ungerechtigkeit (structural injustice) zurück, um zu erklären, wie dieses Machtgefälle durch verschiedene politische Maßnahmen, Verhaltensweisen und soziale Normen entsteht, und betone die Notwendigkeit, strukturelle Prozesse, anstatt bloß isolierte Fälle zu untersuchen, um die Verletzbarkeit von Patient*innen besser zu begreifen.

Abstract English

In this thesis, I argue that understanding patienthood as a social role deepens our awareness of patients' vulnerability to emotional and epistemic harm. In Part I, I demonstrate that patients depend on doctors not only medically but also emotionally and epistemically, leading to a power differential that can cause moral-epistemic harm. In Part II, I discuss current concepts of epistemic injustice and how they might fall short of capturing structural problems in healthcare. I thus draw on Iris Marion Young's concept of structural injustice to explain how this power differential arises from various policies, behaviors, and social norms, emphasizing the need to examine structural processes rather than isolated cases to better address patient vulnerability.

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Contents

Introduction to the thesis

When going to the doctor, patients, who may be extremely vulnerable as is, are in a position to seek help and support. However, many patients recount instances in which they felt unheard, or worse, belittled, dismissed, or ridiculed. Consider the following report by Daniel, who had a series of still unexplained symptoms such as pain, feelings of being touched when he wasn't, numbness in body parts, and sight impairment. During a hospital stay in the neurology department, none of the various examinations indicated any links to illnesses the clinicians suspected such as multiple sclerosis or neuropathy. They thus started considering that the symptoms be psychosomatic, something Daniel was not unfamiliar with and open to investigating. Two psychiatrists came to the ward to examine Daniel, who recounts:

> "One of the first things one [of the psychiatrists] said to me was: "Well sometimes life just is a little bit shit. Maybe a young person like you doesn't understand that." Then she asked me whether I had some kind of history with mental stuff and I replied yes. Before I could say much more, she pointed out that maybe I was still young, and my life was just never properly shit so far and maybe that was that. […] she finally suggested that I might go for walks and do breathing exercises which is maybe helpful, I don't know. But as a person who was still honestly quite afraid that he might have a very serious disease, that was the opposite of helpful. Like I said, I'm open to the idea that this is psychological […] but at this moment I would have needed someone to take me seriously and slowly explain to me how such strong symptoms could come about psychologically, what could be done about them long term. I definitely didn't need someone who, without knowing anything about me, assumed about me that my life had never been properly shit so far and that I apparently can't deal with that."[1]

Several things went wrong in this situation. Daniel was already in a very tough situation before meeting the psychiatrists. He had symptoms that scared him, and the results of his medical tests were all inconspicuous, which may lead to ambivalent emotional reactions. While Daniel felt relief, he also grew more anxious due to the lack of clarity about what may cause his symptoms and what could be done about them without a diagnosis. The psychiatrist seems extremely dismissive of this difficult emotional state. She made wrong assumptions about Daniel's life based on his age, and the advice she gave him may not have been bad per se, but it seems inadequate and insufficient in light of Daniel's level of suffering, which she seemed to drastically underestimate. This left Daniel more discouraged, scared and dismissed (and I think it is unlikely that it made him want to do breathing exercises). Different problems may have led to this less-than-ideal interaction. Maybe the psychiatrist simply wasn't listening. Maybe she didn't take the time to inform herself through Daniel's chart or his neurologist. Maybe she did listen but didn't

[1] Source: Personal communication. In this thesis, I use cases taken from autobiographical books and personal communication as well as fictitious examples. All real cases are marked by their sources (normal citations or note of "personal communication") and anonymized.

believe him due to false assumptions she made about him. The roots of the problem too could be manyfold: maybe the psychiatrist was overworked or stressed, maybe she was out of her depth and preferred to distrust Daniel rather than to admit to that, or maybe she is a generally insensitive person. In any case, the dismissiveness of the encounter was problematic because as Daniel's psychiatrist, at this moment, she had a responsibility for his wellbeing. She could have reassured him, expressed empathy, given him better and more tailored advice, and, as Daniel states himself, explained in an understandable way how his symptoms could come about psychologically and what could be done about it. Or, in case she was overburdened, she could have been honest and referred Daniel to another psychiatrist. Cleary, the psychiatrist harmed Daniel emotionally and potentially medically as there was no further psychological testing done in the hospital after her visit. And importantly, she also harmed him *epistemically* in at least two ways:

(1) She didn't do any explaining, leaving Daniel without any further information or understanding of his situation or potential next steps. This is especially damaging because Daniel was epistemically reliant on specialists such as her. His symptoms were complex and couldn't just be googled or diagnosed by someone asking him a few questions. He was in a position of dependency on the psychiatrists to help him both medically manage his symptoms and understand his situation as an important step to accept and cope with it, and he was left to his own devices with both. In the worst case, Daniel could have left the hospital thinking he was a hopeless case and stopped looking for medical support.

(2) She didn't ask questions to understand his past and instead assumed things about Daniel that were false. She didn't seem to take him seriously as an interlocutor and was closed off to receiving potentially viable information that Daniel had about himself and his experiences. Daniel wasn't treated as someone with relevant knowledge and understanding, or as someone who could do a proper job of presenting this knowledge.

It is my aim in this thesis to provide conceptual tools with which to understand what is going on in cases such as Daniel's by relating the harms just stated to the patient's and the doctor's social role and corresponding dependencies and vulnerabilities. In Part I of my thesis, I will start with concrete cases of doctor-patient interactions where, intuitively, something has gone wrong such that the patient is harmed by the doctor's actions, behavior, or words. I will present an overview of important dependencies and vulnerabilities patients are subjected to and from there map out the potential harms against them. I will argue that many of these issues can be traced back to the fact that patienthood is a social role and position. I will therefore, and first of

all, elaborate on and support this claim. More precisely, I will argue that it is a social role that is based on several dependencies on doctors. Then, I will show how these dependencies are a manifestation of a power differential between doctor and patient, thereby putting the patient in a socially situated position of vulnerability.

Part II of my thesis will be more conceptual. I will draw on the current concepts of epistemic injustice – in general, and specifically concerning the medical realm – to show that patients are vulnerable to testimonial and hermeneutical injustice. Drawing on Iris Marion Young's account of structural injustice, I will argue that a deeper understanding of patients' vulnerability requires us to look into the social-structural processes that place patients in a position of vulnerability. Also, actual cases are often too complex to fit concepts well, and, importantly, looking at cases in isolation doesn't do justice to the issue. Young's account of structure as an object of justice can help here. I will show that looking both at the interpersonal level and the structural level and their connectedness helps to perform normative judgments of individual cases and locate the manyfold sources of the problem of patient vulnerability.

PART I: PATIENT DEPENDENT

1. From doctor to patient: social roles, the "sick role", and the patient role

In his memoir *And Finally. Matters of Life and Death* (2022), Henry Marsh, a retired brain surgeon in the UK, recounts his experience of getting diagnosed and living with advanced prostate cancer. Throughout the book, he reflects on changes not only concerning the physical changes he underwent and his emotional journey facing a potentially fatal illness but also shifts in how he is treated and spoken to by clinical staff, and how he himself views patienthood and the doctor-patient relationship. Consider, for example, the following passage, in which Marsh writes about a medical appointment he had as a patient at the Royal Marsden Hospital, in which he had previously worked as a neurosurgeon and delivered an annual memorial lecture:

> I struggled with being both a doctor and an anxious patient at the same time and found it very hard to ask [the oncologist] about my future – reluctant to hear news but hoping for hope.
> 'Please talk to me as a doctor,' I said to him. 'I used to have to tell my patients about their cancers and try to cheer them up at the same time.'
> 'That's not how we do things here,' he replied cryptically. In retrospect I realized I had given him conflicting messages – that I wanted to be told the truth but also hope. (Marsh, 2022, pp. 94–95)

After seeing the doctor, Marsh had understood that he would meet "the team":

> I must have misunderstood the oncologist about meeting the team, because when the nurse returned to say that I could go, I said that I thought I was going to meet the team. The nurse looked dubiously at me and reluctantly went into the next room. Through the open door I could see the oncologist sitting in front of a computer monitor, laughing and talking with a couple of colleagues. The nurse returned.
> 'You can go,' was all she said.
> Ah, I thought, I have crossed to the other side. I have become just another patient, another old man with prostate cancer, and I knew I had no right to claim that I deserved otherwise. (Marsh, 2022, p. 100)

Marsh had decades of experience in medical encounters and had even worked a prestigious job in that same hospital. But going there as a patient was a very different experience in many ways. He was, this time around, the *object* of the medical encounter. It was *his* body, *his* test results, and *his* life, that he discussed with an expert, who both of them expected to know more about the medical and technical side of the illness, while Marsh was experiencing the distress and anxiety of being faced with deep uncertainties about his life. His oncologist didn't want to give in to his request to be spoken to "as a doctor". What exactly this means, Marsh doesn't say (and

maybe didn't know). Possibly, it meant the wish to be talked to at eye level, to be given "the facts", and not "cheerful white lies" of the kind that Marsh himself had given as a doctor to patients in order not to demoralize them (Marsh, 2022, p. 7). In any case, the request shows that there were two incompatible ways Marsh expected to be viewed and treated: as a doctor – a trusted and respected expert with knowledge and objective distance – and as a patient – vulnerable, seeking to be given "hope", and susceptible to fears and overthinking. Clearly, Marsh doesn't understand these two ways of being seen as equal. He describes feeling like he has "crossed to the other side". This crossing, I suggest, is best understood as Marsh undergoing a role switch, going from the social role of a doctor to that of a patient, where he is dismissed as "another old man with prostate cancer".[2] To better understand what happens to Marsh, and what such a "crossing" implies, I suggest we look closer at patienthood as a social role.

According to role theory, individuals occupy different social positions that involve rights, duties, and expected or typical behaviors (Hindin, 2007, p. 3956). People occupy more than one position. For example, someone can be a sibling, parent, teacher, friend, and more. How someone acts, which rights, privileges, and duties they have, depends on the role they perform at that moment. The roles someone takes on may be more or less compatible. For instance, the experience of many women who struggle with the double burden of wage working and parenting may be understood as two competing roles with very time-consuming and demanding duties and responsibilities. Furthermore, certain roles are more demanding on one's time than others. Someone who is the primary caretaker of their elderly parent, for instance, might be on standby even when they aren't physically with their parent, while the role of grandfather may demand only irregular and temporary attention to the grandchildren, such as when they come to visit for the weekend.

The specific social position, or role, that I want to bring into focus is that of the *patient*, and more concretely, the patient's role in the interaction with their doctor. Of course, this relationship is not taking place in a vacuum. There are social structures (legal and institutional structures, social norms, etc.) that position doctors and patients in this role relation with unique responsibilities, expected behaviors, and vulnerabilities. The so-called "sick role" came into sociological focus in the second half of the 20th century. The term was coined by Talcott Parsons in 1951. According to Parsons, when people feel ill or have an injury, they take on a new role:

[2] Being not just a patient but a retired "old" man with prostate cancer may involve more specific stereotyping, including but not limited to ageist discrimination. For more on the stereotypes of older people, see for example (Levy et al., 2013; Kwong See & Nicoladis, 2010).

the "sick role". This role is "deviant" in the sense that people who take it on are neither able nor expected to function in their other social roles, such as worker, or parent. The sick role is legitimated by others, who don't hold the person occupying it responsible for being unable to function in their other roles. They are thus excused from (certain) duties and expectations. However, the sick person has other responsibilities. They are expected to do their best to get healthy, or well enough to resume their other roles. They are also expected to cooperate with caregivers and physicians for that goal (Parsons, 1951, p. 437; Burnham, 2014, p. 71). Note that what Parsons refers to as "cooperation" is nowadays commonly called "treatment adherence", or "treatment compliance", although the latter is more linked to paternalistic abidance by the doctor's orders, and the term "adherence" is described as implying more of an interactive and collaborative doctor-patient-relationship (Martin, 2014, p. 9). The "sick role" is particular insofar as it exempts the individual from certain, or even all, other obligations while confronting them with the responsibility to take the necessary steps to get out of the sick state (and to want to do so) as soon as possible and to cooperate with health specialists to do so. It is thus considered by Parsons as an irregular or dysfunctional role, which starts with the physician's diagnosis (Cheshire et al., 2021, p. 299). Notably, in places with a functioning healthcare system, people can go on sick leave. They will need a doctor's note and are thereby exempt from responsibilities related to their work but also legally required to refrain from behavior that may delay the recovery (with possible exceptions, such as going outside to get groceries even if one has the flue and was ordered to stay in bed by their physician). It is not necessary to agree with Parsons in detail to go along with the idea of there being a certain role taken on by people requiring medical attention which comes with certain rights and duties, and which has an influence on the rights and duties one may have in other parts of one's life. While Parson's „sick role" focuses on how the individual's behavior, rights, and duties diverge from societal norms because of their illness, he did also note the asymmetric dimension of the patient-doctor interaction, which is where my main interest lies.

While Parson's remarks on patienthood are (partially) helpful in framing patienthood as a social role, his primary focus remains on sickness as deviance. What makes sickness a social role, then, is how it relates to "normal", i.e. "healthy", functioning.[3] I, however, am interested in the

[3] The concept almost disappeared from research in the 1990s. According to John C. Burnhman, the concept became irrelevant to medical sociologists due to "the negative politicization of the concept and the shift of medical sociologists to a focus on applied health behavior" (Burnham, 2014, p. 70). The sick role, according to Parsons, has the function of discouraging so-called secondary gains of illness, meaning that sick people should not act in ways that prevent healing in order to profit from the advantage of being exempt from duties, and to prevent deviant subcultures of sick people (Parsons, 1951, pp. 437–438). This can be criticized as an inadequate concept of sickness which doesn't do justice to the complex lived experience of illness.

patient role (and not primarily sickness) as a *position* in the structure of social relations. In virtue of being a patient, in the most basic sense of seeking support from healthcare professionals, individuals are socially situated in a position of dependence, first and foremost on their doctors. There are social images associated with doctors, that is to say, certain culturally formed ideas, many of them stereotypical, of what a doctor "is like". This entails how we expect them to look, act, speak, etc. Although these images evolve over time, they are somewhat persistent, such as the image of a male, white, able-bodied doctor in a white coat, who is composed and knowledgeable. The patient is viewed as someone who seeks help, while the doctor counts as the expert, having acquired expertise through medical studies, training, and professional experience, and having sovereignty over the course and outcome of the interaction. In many contexts, these social images of doctors and patients, along with principles and values of paternalism, are questioned and criticized, and many patients are empowered through patient activism, support groups, and more autonomous understandings of patienthood. However, asymmetric dependency is still a constitutive element of the relationship. I believe that to understand the patient role, we need to look into the various dependencies at play in the doctor-patient interaction, which is what I will do in the following section.

2. The doctor-patient-relationship: dependencies

2.1. Patienthood: preliminary remarks

Before getting into the different dependencies that are obtained between patients and doctors, I have two preliminary remarks. Firstly, patienthood looks different for everyone, and individuals belonging to marginalized groups often experience particularly harmful medical encounters. Structural discrimination against women*, BIPOC, or queer people does not stop at the doctor's office. Quite to the contrary, there is a large and hugely important body of research going into problems such as the hysterization of women*, the pathologizing of male Black slaves in the 1800s (e.g. Sebring, 2021), and biased research methods and unfair access to medical care (e.g. Ruíz, 2020; Berenstain, 2020). Various identity markers and occupied social roles can thus play

Much of the criticism against Parsons has been noted by Williams (2005): Parsons was criticized for neglecting the illness iceberg (whereby most cases and parts of illness aren't clinically apparent, for example due to being undiagnosed), limited applicability to chronic illness and other medicalized conditions such as old age and pregnancy, and his failure to address social factors such as gender or ethnicity in health care practices. Further criticism includes the framing of the sick role as deviance rather than conformity (Williams, 2005, pp. 124–125). Recently, there has been renewed use of the concept, both critical and affirmative, see for example Heidarnia & Heidarnia, 2016, Schipke, 2021, and (Cheshire et al., 2021). I will not get into the details of the criticism against Parsons here as I am only leaning on some general ideas and observations.

into the quality of medical care and the relationship to one's doctor, for some in complex intersectional ways. This is not only a sad reality but also a methodological hurdle. In cases of bad medical practice, it is often near impossible to filter out what exactly elicits the bad practice, especially since there are usually hidden or unconscious prejudices at play. However, there are strikingly similar experiences that all kinds of patients recount, including cisgender, white, able-bodied men (Daniel, for instance, fits that description), and it is this common experience that I am interested in this thesis.

Secondly, as briefly mentioned before, patienthood comes in any number of intensities and durations. Virtually everyone knows the patient role in Western societies. For many, these are a few fleeting moments in their life, while for others, patienthood can feel like a part of their identity. Accordingly, different people are more or less vulnerable to difficult experiences in the medical realm, depending on factors such as how long their medicalized condition lasts, how intense and regular their check-ups or treatments are, how well they cope with them, etc. For people who require frequent doctors' visits, hospital stays, regular medication intake, or other treatments such as physiotherapy, and medical testing, the vital necessity of, and dependency on, medical care we are all subject to is profoundly present. For the obvious part, they spend a lot of time in the medical realm, i.e. doctors' offices, hospitals, and other medical institutions. It might not be so obvious to people who aren't affected, however, just *how much* time people will spend there due to long waiting periods and high frequency of visits, not to mention travel time. It was only once I was hospitalized for the second time that I realized that one of the main reasons I was in the hospital was not because I needed constant medical supervision (I was perfectly able to take my regular medication and evaluate the amount of pain medication I needed by myself) but because it made me constantly available for testing procedures and doctors' visits. (Note that I wasn't in a private hospital and that the ward was full, giving me good reason to believe that the hospital didn't keep me there for economic purposes.[4]) I lay around for the vast majority of a week but when a slot for a certain test, such as an X-ray, was free, the staff could just fetch me. Incidentally, I was also perfectly able to walk but I was pushed around in a wheelchair. Although I didn't mind it, that unnecessary way of being transported made me feel like it reinforced and visualized my role in the hospital, one which I knew I would have to

[4] This may be connected to Austria's inefficiency when it comes to inpatient care. As noted in the Health system summary 2022 for Austria, which is published by the European Observatory on Health Systems and Policies, a partner organization of the World Health Organization: „In terms of efficiency, the Austrian health system is costly and characterized by high utilization of inpatient care, with a high number of hospital beds and hospitalization rates per inhabitant, which are among the highest in the EU. […] In terms of technical efficiency, despite a decline in values for the indicators of average length-of-stay and bed-to-population ratio, Austria records some of the highest rates in the OECD." (Bachner et al., 2022, p. 17) I will come back to this in part II of the thesis.

get used to. Furthermore, for chronically ill people, people with medicalized disabilities, and pregnant people, the medical realm enters patients' lives in various ways. Just to mention one material way this happens: medication as well as medical equipment and utensils are often a part of patients' homes and of the essential items they carry with them. The patient role can thus become all-encompassing, and the experiential expertise of patients comprises both the experience of the condition itself and its medicalization. This makes it all the more important to look into the ways in which patients may be harmed in the space where they ought to receive care.

2.2. Overview of the dependencies in the doctor-patient-relationship

There are social relations that are, under the right circumstances, presumed to be symmetrical, such as the relation between participants of an economic exchange, or between friends. When it comes to the relationship between doctor and patient, the question of symmetry is not so clear. While patients are in many ways dependent on their doctors, there has been a shift towards a more equal understanding of their relationship. Most importantly, paternalistic models of the relationship (Emanuel & Emanuel, 1992, p. 2221) are nowadays considered outdated and there have been profound movements of change toward patient empowerment in the last decades (see, for instance, Epstein, 1995; Rabeharisoa et al., 2014).

But even in instances where the patient is empowered, i.e. when they are well-informed about their condition and treatment options, have well-founded opinions about them, and are treated with respect and at eye level by their doctor (and indeed, even if both parties see the relationship as a mere rendition of service), the relationship still comprises unequal dependencies. The doctor is first and foremost *financially dependent* on her patients. The existence of illness and other medicalized conditions such as pregnancy and disability creates a demand for the profession of doctors, who, in turn, need patients to practice that profession, whether they are paid via a public health care system or directly by patients. But given many factors such as the academic and technical difficulty, time intensity, and usually the high expense of medical education, as well as the aging of the population, doctors do not have to worry about competition currently. On the contrary, Europe for example has a concerning and growing shortage of doctors (OECD, 2015). This financial dependency of the doctor on the patient is therefore relatively unlikely to strongly factor into the relationship.

Patients, on the other hand, are dependent on their doctors in multiple ways which I propose to break down into practical, emotional, and epistemic dependencies. These factors are not mutually exclusive and are rather usually interwoven in complex ways. My drawing of this distinction is an effort to structure them for the sake of clarity and, subsequently, to carve out the vulnerabilities patients may be subjected to.

Note that doctors usually have an interest in the patient getting better too. I could thus frame the patient's well-being as a common goal, making both parties equally dependent on the other. However, the doctor's role is most commonly a professional (sometimes honorary) role that the individual has chosen (and actively pursued for years) while the patient role may be characterized as a sort of encroachment onto the individual's life. I don't mean to say that it is necessarily a bad thing to be a patient or to have a medicalized condition but rather that it often turns one's life upside down in scary and difficult ways, and in ways that people might not expect or be prepared for. And most saliently, it is not a voluntarily chosen role. The patient's stakes are thus much higher than the doctor's and I therefore understand the patient's well-being as being primarily in the patient's interest, making them especially dependent on the doctor in the ways I will elaborate on.

2.2.1. Practical dependencies

First, patients are dependent on their doctors for practical necessities. As Parsons states, in the social structure of doctor and patient, the first is hierarchically superior because it is inherent to her role (Parson, writing this in the 1970s, would of course write '*his* role') that she is endowed with responsibility for the health of her patients. Through specific education and training, she is institutionally certified to take on this responsibility (Parsons, 1975, pp. 166–167). To satisfy this responsibility, she has specific exclusive *legal* rights: handing out sick notes, establishing diagnoses,[5] prescribing treatments and medication, performing certain treatments, performing surgery, preparing medico-legal reports, and, in certain healthcare systems, referring to therapists such as psychotherapists or physiotherapists such that their costs are (partially) covered by patients' health insurance. As there is no other social role in the Global North that is vested with these rights, patients are *legally dependent* on their doctors in many ways.

[5] There are exception to the exclusivity of the right to performe diagnoses. For example, in Austria, psychotherapists also have the authority to establish certain diagnoses, specifically for mental health conditions (BMSGPK & Psychotherapiebeirat, 2020)

Note that some of the legal rights just mentioned also entail *technical dependencies*. Doctors, more specifically surgeons, are not simply the only ones *allowed* to perform surgery, they are also the only ones who *can* because they are trained for it. The doctor can thus, both legally and technically, be understood as a gatekeeper to medical care who has a duty of care towards the patient. This duty of care reflects the patient's dependencies, for the patient relies on the doctor to fulfill that duty.

Additionally, I want to mention specific *social dependencies* involving the recognition of third parties. While she can release the patient from wage labor in a legally regulated way (although *paid* sick leave is not a matter of course even then, depending on the insurance system[6]), she may also release the patient from expectations of others outside of salaried or paid work, which has also been noted by Parsons (Parsons, 1975, p. 262). Consider, for instance, the case of an orthopedist who diagnoses Osgood–Schlatter disease, a kind of inflammation in the knee that may be very painful but not visible, in her athletic adolescent patient. For Osgood–Schlatter disease, it is usually recommended that the patient avoid strain on the knee when the self-assessment of pain on a 0-10 scale exceeds 2 (Rathleff et al., 2020). As it is not a visible injury, the patient may be expected to function as usual by their coach, parents, teammates, etc. But by issuing a diagnosis and a treatment plan, the orthopedist will release them from obligations to participate in athletic activities (of course, this release may not be something the teenager wants, but neither is sick leave for many patients).

2.2.2. Emotional dependencies

Second, patients stand in emotional dependence on their doctors. Illness, old age, pregnancy, and other medicalized conditions are often the source of great emotional turmoil. As noted by Parsons, the issues concerning patients may be urgent and/or severe. They may include great suffering, risks of death, and feelings of helplessness. Interactions between patients and doctors can be highly intimate due to bodily contact and exposure, as well as the sharing of confidential information about the patient's life. Patients may need to make hard decisions, and legally carry risks via consent forms. They may experience emotional shock, especially when getting newly diagnosed, as well as anxiety about the future (Williams, 2005, pp. 125–129; Parsons, 1951, pp.

[6] And in fact, I should mention a special case of legal dependency which I won't be able to dive in deeper, namely that of public health officers whose main interest is not the wellbeing of the patient but the inspection of the patients' legal and financial claims against their employers, health insurances, or the state. Such public health officers usually work as independent third parties or appointed experts to inspect whether the condition of the patients is ground enough for specific claims, e.g. in cases of longer-lasting sick leaves.

440–453) In these vulnerable phases, doctors are usually expected to act compassionately, comfortingly, and encouragingly – or at the very least to not act harshly and apathetically. Emotional support may not strictly speaking be in the purview of doctors, but they are often the ones who are with the patient in some of the most vulnerable moments and the effects of strong emotions have to be accounted for to ensure functional communication with patients. For example, there a several reports of doctors who recount the importance of careful communication when they are first giving a serious diagnosis to a patient. For instance, Marsh, as well as Danielle Ofri, an internist and associate professor of medicine in New York who writes about her experience with the realities of health care and doctor-patient-relation, write about how, as doctors, they never expect patients to remember any important details when receiving bad news such a cancer diagnosis due to the state of shock they may be in (Ofri, 2017, p. 33).

I thus suggest seeing the responsibility of doctors to act following the patient's emotional needs as a rule of the biomedical principle of non-maleficence, or the "do no harm principle". This is one of the four principles of biomedical ethics (along with respect for autonomy, beneficence, and justice). Note that these principles can, and often do, conflict with each other, in which case the risks and benefits need to be weighed (Beauchamp & Childress, 1994, pp. 291–305). But even if there may be incidents in which the responsibility to meet the patient's emotional needs is outweighed by other factors (e.g. urgency), I still retain that the patient is dependent on the doctor to at least not hurt them emotionally, or not to hinder them in dealing with a difficult situation. When practitioners are not responsive to the patient's emotional state (e.g. by meeting them with respect and compassion), patients risk emotional harm, aversion against seeking medical care, and not being in the right frame of mind when being confronted with important information.

2.2.3. Epistemic dependencies

Informational and explanatory dependencies

Closely related to the aforementioned factors, patients are epistemically dependent on their doctors in various ways. Most evidently, doctors give patients important, even vital, information about their health status and their treatment. They ought to provide the right kind and the right amount of expertise, and do so in the right way, meaning that they ought to make technical and potentially complex knowledge understandable and digestible for the patient, who, ideally, should neither feel belittled nor overwhelmed. So, this first kind of epistemic dependency is *informational and explanatory*. To illustrate the close tie to emotional dependency, consider a gynecologist who gives a patient whose biggest wish is to become a mother a diagnosis of

polycystic ovary syndrome, a condition which prevents ovulation and thereby decreases the chances of getting pregnant (Cunha & Póvoa, 2021, p. 1). The practicing doctor needs to explain the situation and be open to questions, take their time to explain problems, risks, and potential solutions, and be as present as possible to make sure that the patient understands and retains important information. Of course, many patients are very well informed on their condition and treatment through other sources, such as personal research or patient associations, and even come to their doctor's office with specific requests. However, doctors are, for most people, an extremely important source of information when it comes to their health. The patient is thus dependent on the doctor to receive, in a suitable and understandable way, crucial, potentially vital, *knowledge of* the (possible) diagnosis, i.e. an answer to the question "What is going on with me?", and *knowledge about* the diagnosis and its ramifications, i.e. information on how it will affect the patient's life through risks, treatments, and prognosis.

Meaning-making dependencies

However, the epistemic exchange between patient and doctor is not a mere trade of experiential knowledge against medical information. Medicalized conditions are deeply personal and often affect patients' lives in a myriad of ways. They may go hand in hand with difficult experiences such as shock, anxiety, feelings of loss or being lost, challenging pain management, unwanted changes in life plans and social habits, changes in physical, emotional, or cognitive abilities, etc. Receiving relevant information is thus only one of many steps in the navigation of a condition. Making sense of the experience of medicalized conditions is about more than knowing of and about a condition. It is about bringing together disparate suffering and experiences and finding individually suitable ways of acceptance and orientation. In this endeavor, patients often rely on doctors to help them comprehend and make sense of the complex experience of illness, pregnancy, or of simply getting older. As Marsh puts it, we want the truth from our doctors but also hope. In other words, what I am arguing here is that when it comes to medicalized conditions because they hit so close to home, it is not enough to do some explaining. Patients may also need to process information, cognitively and emotionally, and make it make sense for themselves, which can mean different things for everyone. What they may thus need from their doctor is not just "the" best available treatment but one that fits that person's life and needs. Sometimes, this may also mean waiting a bit because the patient needs time to digest everything before being ready for treatment, in other cases, it might mean accepting that the patient refuses treatment. When a treatment is urgent, such as chemotherapy in many cases, a patient may need

to be guided in understanding and emotionally grasping the risks of (not) undergoing a treatment. I consider such factors to be part of the dimension of *meaning-making*. This dimension isn't quite captured either by the explanatory or by the emotional dependencies mentioned already. When we ask our doctor whether a certain treatment will work, we don't just ask whether it will alleviate symptoms. We also ask whether it will help us in living (or, indeed, dying) meaningfully. Consider the case of Crohn's disease and ulcerative colitis, both chronic inflammatory bowel diseases (IBD) that come along with taboos as they relate to the digestive tract and symptoms such as diarrhea, blood in the stool, and flatulence. Some patients require a colostomy, or stoma, which is a surgical opening in the large intestine through which feces can leave the body into an attached colostomy bag. Such visible changes to the body which relate to private bodily functions may be hard to accept for some patients (Stavropoulou et al., 2021, p. 1). But it is far from impossible to find meaning in a life with a colostomy bag. On the contrary, there are many patient activists, individuals, and groups, working to remove taboos around IBD.[7] As in the case of meeting the patient's emotional needs, it is not strictly in the doctors' area of responsibility to support their patients in their meaning-making process. However, good or bad guidance from doctors can make or break a person's relation to their own condition and their own body (e.g. ridiculing or blaming a patient for worries they have may add shame or guilt on top of the worries). I suggest understanding the doctor's responsibility to do nothing to constrict the patient's meaning-making as a rule of the *principle of nonmaleficence*. Ideally, of course, a doctor wouldn't just refrain from constricting but assist the patient in this process. The right guidance through the medical maze can relieve feelings of shame, and empower patients to understand, accept, or even appreciate[8] their condition. This could happen, for example, by telling the patient of past experiences with other patients who went through similar hardship, by referring the patient to self-help groups, or, quite simply, by communicating with and examining, the patient in a non-judgmental and respectful manner such that the patient is not reduced to being an object of medical intervention but a person with dignity.

[7]For example, in 2022 the campaign "#makeitvisible" from the Austrian Crohn's Colitis Association, aimed to raise awareness about chronic bowel diseases and to destigmatize the topic. Trams in Vienna were adorned with images of affected and cheerful looking individuals with scars or colostomy bags, with the first name of the individuals, their illness and slogans such as "Your bowel is not a taboo!" [my translation] (Gmeinder, 2022)

[8] For most people, appreciation of illness is difficult to understand. Some psychiatrists see this as problematic cases of "secondary gains of illness" (Davidhizar, 1994). But to give an example that might not be so hard to grasp, people with chronic illness, not unlike many people with disabilities, can appreciate that the experience of illness prompts them to (re)consider their priorities and to adjust their life accordingly.

Conversational dependencies

For now, the epistemic dependencies I mentioned are based on things the patient receives from their doctor: relevant medical-technical information and explanations, as well as support in meaning-making. But there are also epistemic transferals in the other direction. First and foremost, patients give doctors testimony. Medical appointments usually start with the doctor's question along the lines of "What brings you here today?". This is followed by an initial statement by the patient, to which the doctor will react with follow-up questions on the medically relevant issues. However, for this exchange to take place productively, the doctor needs to conduct the medical interview sensibly. This is important mainly for two reasons. Firstly, so that the doctor captures what the patient's concern is and *what matters* to the patient. Indeed, what is important to a patient is not necessarily what they mention first. For example, I once told an internal specialist that my bowels hurt in the prone position. He interrupted by saying: "Then don't lie on your stomach." No problem was solved that day because the problem wasn't properly identified. I didn't care about avoiding the pain for the sake of not being in pain, I was worried about *why* it hurt, and whether something serious might cause the pain. This identification of what matters to the patient is also called *soliciting* or *eliciting the patient's agenda*. In a 2019 study conducted in the United States, Singh Ospina et al. found that physicians more often than not interrupted the patient's first statement, after a median of 11 seconds, thereby failing to properly elicit the patient's agenda (Singh Ospina et al., 2019). Secondly, giving patients the room to speak is important so that all the relevant information is brought to the table. This information can include symptoms that lead to a diagnosis, or that are relevant for treatment, or to enable the realization of the patient's wishes.

One might ask why patients don't simply insist on telling the doctor what matters to them and everything that may be relevant. There are at least three reasons patients may, in many instances, not be able to do this if the doctor doesn't lead the interview properly. Firstly, and most obviously, patients may not know what information is relevant and what isn't. Secondly, they also don't necessarily know from the get-go what matters to them. Their agenda might be blurred, for example, due to anxiety, and it might change in the course of the meeting due to new information, or new ways of looking at the situation. For example, a pregnant woman might not know at the beginning of the medical encounter whether she wants to carry the pregnancy to term or undergo an abortion. Medical information may be relevant to that decision. Thirdly, the medical interview follows a script in which the roles of patient and doctor are delimited by social norms of what, how, and when each is supposed to speak, behave, to act. Doctors are the

ones who lead the medical interview: they have the upper hand in the script, and they are the ones asking questions, and choosing what should be focused on, and what is irrelevant. Not following the script may lead to social or even medical repercussions for the patient, who may be branded as cheeky or annoying, leading the doctor to not listen anymore. The patient is thus *conversationally dependent* on the doctor, meaning that they are dependent on the doctor to lead the medical interview in a way that enables both of them to find out what matters to the patient, and what the patient has to say that may be relevant to help them.

Interpretive/ uptake dependencies

Giving the patient the room to speak, and asking the right questions, so that as much relevant information as possible is communicated to the doctor, is closely related to, but distinct, from a further dependency, that I call *interpretive* or *uptake dependency*. As a next communicatory step, the doctor needs to believe and understand the patient's testimony. Of course, this doesn't mean that the doctor should believe everything a patient says. Patients can have difficulties articulating certain experiences. For instance, pain description and assessment can be challenging due to a lack of vocabulary to describe certain unfamiliar sensations. Danielle Ofri, for example, lays out an experience in which differences in mannerisms and time constraints have negatively impacted the communication with one of her patients such that she missed important information and misjudged the medical urgency of the situation (Ofri, 2017, pp. 1–5). Patients may also say medically irrelevant things, making it hard for the doctor to recognize what is important and how disparate experiences of an individual might be linked. Ofri writes about the worry of being overwhelmed by patients' initial accounts of why they came, as they often introduce a wide array of themes and anxieties that are not necessarily clinically relevant (Ofri, 2017, pp. 22–27). Moreover, patients can also exaggerate or lie for different reasons, for example, to obtain medication they don't need, or to avoid incarceration. They may also "malinger", which signifies that a patient consciously simulates symptoms for secondary gains, such as avoiding work (Palmieri & Stern, 2009). Also, a patient might have false beliefs, for example, if they make a wrong guess about what causes a symptom. In short, doctors may have trouble correctly understanding and interpreting the patient's testimony as well as be wary of believing it. This is important to mention because it entails that the right uptake and interpretation of the patient testimony is not a matter of course, which makes patients dependent on doctors to understand and trust them where it is due (unless specifically mentioned, I will assume that patients are being honest in this thesis). This is what I mean when I use the terms *interpretive,* or *uptake, dependency*.

Epistemic validation dependencies

The last dependency I want to mention is, again, closely related to but distinct from the previous point. In addition to ideally understanding and believing the patient's testimony, patients often also need to be acknowledged, confirmed, or validated, resulting in an *epistemic validation dependency* (I emphasize that these dependencies are epistemic because validation also plays a role within the framework of emotional dependencies). Consider Daniel's report again. The psychiatrist may well have believed Daniel, at least she didn't state otherwise. However, she failed to be responsive in a way that made Daniel feel validated. On the contrary, he states: "I would have needed someone to take me seriously and slowly explain to me how such strong symptoms could come about psychologically, what could be done about them long term." What is important here, I believe, is that Daniel's desire to be "taken seriously" is not solely aimed at getting treatment. It is also about receiving confirmation that his symptoms are real. What I mean here is not necessarily that Daniel needed to be told that the symptoms are somatic but rather that they in fact exist, that he didn't make them up. Experiences can be either validated or dismissed, and this determines whether they are something to be *tracked* or not, i.e. whether they will be made a subject of conversation and whether they are seen as an actual problem one will try to solve. According to recognition theory, we all depend on others to have a good relationship with ourselves. We rely on acts of recognition from other people and institutions that express acknowledgment of our worth (Congdon, 2018). I would add that we especially need recognition from authorities. Who counts as an authority depends on the specific subject. Subjective experiences such as pain, itching, numbness, but also anxiety, depression, etc. cannot be evaluated by other people than the person experiencing it. Yet, medical experts hold the power to validate or dismiss them to a certain degree. If I say: "I am in pain", I will expect my physician to react in a way that implies validation, i.e. to track that pain. She might explicitly say: "I believe you", or "This sounds very straining", or she might implicitly express validation by asking follow-up questions and performing examinations to find the source of the pain. If she for instance ignores my statement or responds dismissively, then not only will the pain not be tracked (which indicates clinical negligence), but her response, or lack thereof, might leave my need for validation unfilled. Consider the following case. Vesper has lichen sclerosus, an inflammatory mucocutaneous condition affecting the skin of the vulva, the perianal and/ or the

penile regions,[9] and ulcerative colitis, a chronic inflammatory gastrointestinal disease.[10] At a regular colonoscopy, her IBD specialist found hemorrhoids and thus sent her to a proctologist. Vesper did as she was told, looked up a proctologist who had a trust-inspiring online presence, and made an appointment. When entering the office after spending an hour in the waiting room, the proctologist didn't look at her or ask her to sit down. He asked Vesper a few questions while she was standing, feeling awkward. Although she felt rushed, she told him that she had always thought the itching was caused by the lichen sclerosus and asked his opinion. The proctologist did not look up from his computer and didn't respond. The rest of this doctor's visit and examination were so unpleasant, and Vesper felt so rushed, that she forgot to bring it up again. Vesper was sent home with a prescription for hemorrhoid medication which did not end up alleviating the itching. She hasn't done anything about the symptoms since because she felt deflated. What is more, she felt like her situation of comorbidity (the presence of more than one chronic condition which can complicate diagnosis and treatment) didn't "fit" in the proctologist's script.[11] Instead of either telling Vesper his assumption on what caused the itching or telling her he wasn't sure about the cause, Vesper was left hanging in her need to be seen and heard and left feeling like a hopeless case.

The exploration of these various dependencies illustrates crucial aspects of the patient-doctor dynamic that go beyond the basics of medical care but are nonetheless an everyday part of interactions in the health care system. Building on this foundation, let me round up this list with four remarks that further explore the nature and implications of these dependencies.

Firstly, I don't presume that the list of dependencies I have just provided is exhaustive. However, I hope to have shown that patients are dependent on doctors in various, and unequally apparent, ways. Secondly, the way in which I have categorized the dependencies is not the only way to divide them. I focused on the epistemic dependencies for this thesis but in other contexts, other emphases might make more sense. Thirdly, all the mentioned aspects are closely related.

[9] For lichen sclerosus, „[t]he typical clinical picture includes chronic whitish atrophic patches along with itching and soreness in the vulvar, perianal and penile regions. In addition to genital scarring, and sexual and urinary dysfunction, LS may also lead to squamous cell carcinoma." (Luca et al., 2023, p. 1)

[10] More precisely, "[u]lcerative colitis is a lifelong inflammatory bowel disease, usually characterised by a relapsing and remitting course (appendix pp 3–4). Ulcerative colitis commonly presents with rectal bleeding in more than 90% of patients.38 Associated symptoms generally reflect the severity of mucosal disease and can differ according to disease extent. Increased stool frequency and decreased stool consistency are frequent, notably when the disease extends beyond the rectum. […] Patients might also report rectal urgency, tenesmus, faecal incontinence, mucus discharge, nocturnal defecations, and cramp-like abdominal pain, often localised to the left lower quadrant, particularly before, and relieved by, a bowel movement." (Berre et al., 2023, pp. 573–574)

[11] Source: personal communication.

For instance, the validation of experience is connected to the emotional dependencies. It is difficult (but possible) to imagine a doctor who harms a patient emotionally, for example by acting without compassion towards a frightened patient, but at the same time validates that patient's experience, making them feel seen and acknowledged. Also, to take a more material example, consider the connection between meaning-making and practical dependencies. In order to make sense of the experience of certain life-changing illnesses in a world that is catered towards able-bodied people fit for work, patients depend on doctors to enable them to go on sick leave if necessary or to get access to certain benefits, such as job protection. The advantage of taking the dependencies apart is precisely to identify such interconnections and to pinpoint related problems when indicated. And lastly, I understand dependencies in the doctor-patient interaction to be the basis for many vulnerabilities. For instance, Daniel was vulnerable to being harmed by the psychiatrist precisely because he was dependent on her in many ways. I will return to this point in Part II of the thesis when discussing the social structure of patient vulnerability.

I will now move on to the asymmetric relationship between doctor and patient by proposing that we view these dependencies as an expression of the social power of doctors over patients.

3. Dependencies and social power

My goal in this section is to further the understanding of where the dependencies discussed in the previous section stem from. I will argue that they are not only connected to expertise but also to social power and norms to which both parties – patient as well as doctor – adhere to.

3.1. Annotations on dependency

I have for now primarily described several ways in which patients are, or may be, dependent on their doctors. What I haven't yet explicitly stated is that while many of these dependencies relate directly to doctors' medical and technical knowledge and skills, other dependencies seem to go beyond that. Take Vesper's case again. She was sent to the proctologist for specific medical care. By then, she was already aware of having hemorrhoids, but the proctologist was supposed to examine her further and propose a treatment plan. She was thus informationally or explanatorily dependent on the proctologist based on his medical and technical knowledge and skill (specific skills are required for proctological examinations). In this sense, he had legitimate authority in this situation. But as we saw earlier, by ignoring Vesper's question about the source

of her symptom, he made her feel discouraged. This suggests that there was, inter alia, an emotional dependency at play here. Whether either of them realized it or not, and whether the proctologist meant well or not, this interaction harmed Vesper emotionally. By virtue of being her doctor, the proctologist made her feel like a hopeless case (a friend, for instance, could have equally ignored Vesper without the same effect). Yet, Vesper being informationally dependent on the proctologist is, in some way, very different than her being emotionally dependent on him. In this section, I aim to explain this difference. I will do so by first making some theoretical remarks on dependency as well as dependency's relation to power. From this, I will conclude that certain aspects of doctors' social power over their patients relate to social norms rather than to their medical expertise and skills alone.

Let's start by looking into a theoretical account of the correlation between dependency and power, starting with a definition of dependency by Richard M. Emerson (1962):

> A depends upon B if he aspires to goals or gratifications whose achievement is facilitated by appropriate actions on B's part. […] The dependence of actor A upon actor B is (1) directly proportional to A's *motivational investment* in goals mediated by B, and (2) inversely proportional to the *availability* of those goals to A outside of the A-B relation. (Emerson, 1962, p. 32)

Let's say Aaron wants to buy a beautiful house by the lake. The other day, he saw the perfect house and found out that it belonged to Baron who was considering selling it. Aaron is thus dependent on Baron to attain his goal of having his dream house. The extent of the dependency decreases if Aaron's motivational investment decreases, for example, if his vision of a dream house changes and he also considers buying a house in the city center (1). A few days after seeing Baron's house, Aaron finds Caryn's house on an online real estate site. Caryn's house fits Aaron's criteria perfectly and she is willing to sell the house to Aaron. Aaron's dependency on Baron thus decreases (2).

A few annotations are in order here. *Firstly*, the motivational investment doesn't have to be a conscious one. Neither A nor B have to be aware of A having the goal in question (if you don't agree with the term "goal" in that case, replace it with *aim*, *objective*, *desire*, or *need*) and *secondly*, neither A nor B needs to be aware that A's goal is, or can be, mediated by B. Take an example: Ada can have the goal (or desire) to feel confident about how she looks. She only feels confident when others compliment her on her appearance. Let's say Ada is not aware of having this goal because it is an unconscious desire. This doesn't change that she is dependent on others for it to be satisfied. Now let's say that she is aware of the goal, but she doesn't realize that she only feels confident when others compliment her. Again, this doesn't change that she

is dependent on others for it to be satisfied. *Thirdly*, it is not merely relevant whether there *exists* availability of the goals to A outside of A's relation to B, but also whether A is aware of this availability, and whether there are hurdles for A to get to them. These hurdles can be inter alia material, financial, social, or emotional, and A does not need to be aware of these hurdles. Let's assume that Ada is aware of her goal of feeling confident about her looks and her need to be complimented. The only person who compliments her is her partner, Bob. Bob is extremely jealous. Everyone in Bob's and Ada's social circle knows this and therefore, no one dares to compliment Ada. Ada could be complimented by others if she broke up with Bob. However, Ada is held back because she loves Bob and fears hurting his feelings. Thus, even though the fact that Ada *could* get complimented by other people reduces her dependency on Bob, the fact that there are things blocking her from doing what would be necessary to satisfy her goal by other means increases, or maintains, her dependency on Bob. *Fourth*, it is not necessarily the case that B mediates, or is able to mediate, A's goals by actively doing something. The satisfaction of A's goal can also require that B *refrains from* certain actions. For instance, a child has the (unconscious) goal of feeling safe at school. If the child's teacher excessively yells and threatens the pupils, the child won't feel safe. The child is thus dependent on the teacher refraining from yelling and threatening to feel safe. Lastly, in this view, dependencies are not binary in the sense that they are either on or off but rather gradual, meaning that A can be more or less dependent on B. However, if we want to track our intuitions of what counts as dependencies, I believe that there needs to be minimum requirements not only of *motivational investment* on A's part, and *availability* of goals outside of the A-B-relation but also of *B's ability* to facilitate the goal. Let's take Arianna, who is thinking about going to the cinema with a friend. One of her closest friends is Brianna. If Arianna doesn't really want to go to the cinema, we wouldn't think of saying that she is dependent on Brianna to go to the cinema. Also, we wouldn't say that Arianna is dependent on Brianna to go to the cinema if Arianna has many other friends who would join her (although she might be a little dependent on her if there was only one other friend who might be able to join). It would also be counter-intuitive to say that Arianna is dependent on Brianna to go to the cinema if Brianna is currently out of town and thus unavailable to hang out.

So, what does this mean for the patient-doctor dependencies I have listed above? In the following, I will address how the mentioned theoretical aspects of dependency relate to the doctor-patient relationship.

- *High motivational investment*: Many of the dependencies are based on very profound desires and needs which are deeply entangled with the goal of leading a good life. For example, many patients may wish for their suffering to be alleviated, such as pain, itching, nausea, and discomfort, but also emotional suffering such as anxiety or despair. Other goals may be the wish to have a safe pregnancy and labor, to prolong life, or to end it. Patients' "motivational investment" may thus be very high, making the dependency proportionally stronger.
- *Unconscious goals*: Patients aren't necessarily aware of having certain desires or needs (and neither are their doctors) for there to be a dependence. For instance, this may apply to meaning-making, validation, or emotional support. Let's take patient P who was just told they may have melanoma (a form of skin cancer). P is generally very rational and pragmatic and in an automated way asks Dr. D about the further procedure. But P is actually in shock and has the unconscious wish to be comforted and given hope. Even though he isn't aware of this need, P is, at this moment, dependent on D to mediate its gratification. Relatedly, neither P nor D are necessarily aware of D having the ability/ being in the position to comfort P.
- *Factors affecting availability*: How great the dependency on a specific individual doctor is depends on many factors. For instance, free access to doctors may be limited. But even when there technically is free or affordable access to other doctors, P needs to have the necessary resources and motivation to find them, and there mustn't be hurdles that keep P from finding them. For instance, if P is suffering from migraines such that he can only lie in dark, quiet rooms, it may be too irksome to look up doctors. Or if P has had many disappointing encounters with several doctors and after a long search found D whom he trusts, his dependency on D may increase as he fears more disappointments from other doctors.
- *Dependencies on omissions*: In many ways, P is dependent on D to refrain from harmful actions. Clearly, D could give P bad advice, harmful medications, or wrong diagnoses, and P is dependent on D not to do these things to receive helpful medical care. But what is more, P may have needs and desires that don't require direct mediation by D but do require D to not frustrate them. For instance, imagine Anna complaining about terrible period cramps to Dr. Bana who responds dismissively, telling Anna that period cramps are normal and that she can just take some ibuprofen and lie down with a hot water bottle. Dr. Bana adds: "You'll be fine, period cramps aren't that serious. You just have to stop overreacting." Anna goes home confused, wondering if the problem is that she is just overly sensitive. Anna may not have needed active validation from Dr. Bana. If Dr. Bana hadn't said these things, Anna

would have been fine. However, they had the effect of invalidating her experience, and thereby confusing her.

- *Ability to mediate goals*: Lastly, I want to mention doctors' ability to mediate various goals. Doctors may indeed *not* be the best suited to satisfy many of the needs and desires of patients. However, I believe their social role, as well as that of patients, positions them in a dyadic structure in which doctors are often allocated power over patients that goes beyond their legitimate medical authority. I shall come back to this in the next section where I discus social power.

These annotations to the dependency relation between patients and doctors aren't meant to be an exhaustive list but an exemplification of the complexity of the dependencies. They demonstrate that patients may be more dependent, or dependent in more ways than can be explained merely by doctors' medical expertise. Think of Vesper's case again. We don't know too much about the intensity of Vesper's motivational investment, but as she is doing her best to manage her chronic illnesses well, every doctor's appointment related to her chronic illness is likely quite important to her. Something that reinforced Vesper's dependency on the proctologist is that she had a hard time finding one in the first place and highly dreads going to new doctors due to an array of unpleasant experiences she has had. Furthermore, Vesper being disheartened after the visit indicates that she had the unconscious goal of being validated, at least to the minimum degree of having the doctor display attentiveness and answer her questions. It is very questionable whether the proctologist was well suited to gratify Vesper's need for validation. Two likely reasons he didn't reply to Vesper's question are: (1) As he rushed Vesper and neither asked her to sit down for the interview nor looked at her, it is possible that he simply didn't hear the question. (2) Or maybe he wasn't sure and preferred to say nothing at all, which would be unfortunate because, as a patient, Vesper would have needed an answer, even if it had been "I don't know", to be able to relay the information to her other doctors, to make well-informed decisions on the matter, and to feel validated and seen. Either way, the communicative failure doesn't tell us anything about the proctologist's medical capabilities. Rather, it tells us something about the script a doctor's visit usually follows and the seeming mistakes that were made in this case. The doctor, according to the script, should have asked Vesper to sit down. He should have conducted the interview slowly enough for Vesper to fully participate. Evidently, *he* was the one in the position to change the script. He was the one deciding who speaks, what is relevant, where everyone is positioned in the room, when the encounter starts, and when it ends. This has more to do with social norms than with the doctor's medical expertise. I will thus get into the role of social power and norms in the following section.

3.2. Social power and moral-epistemic harms to patients

In this section, I will argue that the dependencies sketched above entail the following differential between doctor and patient:

(1) *There is a social power differential between doctor and patient in the sense that one of the agents, namely the doctor, has the capacity to influence and control the other agent's, the patient's, actions and attitudes*.

I will proceed to argue that

(2) *certain breaches of duty of care may lead to moral-epistemic harm to patients* and that
(3) *the social power of doctors is connected to and strengthened by their high social status.*

3.2.1. Social power

Dependencies, according to Emerson, are the basis for power. This is quite intuitive: When P is dependent on D to get X, then D has power over P. If P's dependency decreases, for example, because someone else can give X to P, then D's power over D decreases equally (Emerson, 1962).[12] Uncontroversially, I believe that doctors are in a position of power over patients. But I argue that their power goes beyond their medical technical dependencies and that commonly, individuals involved aren't aware of this. Put plainly, we all know that we need to go to a dermatologist to get our birthmarks examined but we are probably less aware that we may have the need to be validated and to receive emotional care when visiting the dermatologist. I will use Miranda Fricker's notion of social power to elaborate on this.

Miranda Fricker defines *social power* as follows: "a practically socially situated capacity to control others' actions, where this capacity may be exercised (actively or passively) by particular social agents, or alternatively, it may operate purely structurally." (Fricker, 2007, p. 13)[13] I will come back to the point about social power being socially situated. For now, let's just note that a doctor's social power is agential in the minimal sense that it is not purely structural and that there are particular agents (i.e. doctors) exercising it. In contrast, to illustrate purely structural forms of power, Fricker references Foucault's elaborations on institutionalized discursive customs, such as categorizing certain criminals as "delinquents" as part of the medical-legal

[12] However, D's power over P will often manifest only if D, for whatever reason, will not give X to P.
[13] There are many disagreements on the definition of "power". I am working with Miranda Fricker's definition here for three reasons. (1) It tracks an intuitive understanding of what power does, (2) it indicates why we should be critical of who has power and who hasn't, and (3) it allows for both views of power as *power-over* someone, and *power-to*, i.e. a capacity to do something (Allen, 2022).

discourse (Fricker, 2007, p. 11, Foucault, 1975). Furthermore, for capacities being exercised *passively*, it suffices that a person *has* them. For example, general practitioners have the capacity to write sick notes, whether they actually do it or not. A capacity is exercised *actively* when the agent acts on it, for example when a doctor actually writes – or refuses to write – a sick note.

Note that doctors, with exceptions, do not have the ability to control patients' actions in the strict sense of coercing or forcing them to do, or not do, something. However, I don't think that this is necessary to agree with Fricker's definition (and I don't think that Fricker herself understood social power in this restrictive sense). Rather, these rights amount to social powers insofar as they delimit the scope of options for patients' actions, enable certain actions, and make others impossible. If someone wants to go on sick leave, they need a doctor's note. It is thus in the doctor's power to control whether they will go on sick leave. The same goes for someone who wants to take certain medications or undergo surgery. But I want to slightly amend Fricker's definition for another reason. In many ways, doctors may not *control*, but merely (strongly) *influence* what people want, and thus how they will act. Due to trust in their doctor's expertise, one might for example change their mind about getting a certain treatment, taking medication, or staying in bed. This too is a way of exercising power.

Relatedly, I also want to amend Fricker's definition concerning the capacity to control *actions*. Social agents, I believe, can also have the capacity to control or influence people's thoughts, beliefs, and feelings, all of which I subsume under *attitudes*. For instance, a university professor may have the power to influence how her students assess their own academic prowess through acts of grading papers, giving feedback, or showing interest in their contributions in class. Similarly, doctors often have the power to influence how their patients view a situation. For example, a doctor may influence which treatments the patient will consider and which ones they will exclude from consideration, or how the patient assesses their own pain.

Much of doctors' social power stems from legitimate and justified legal and medical authority. The rights to hand out sick notes, make diagnoses, prescribe certain medication, perform surgery, etc. are strictly regulated by law, and (specific) doctors having them is justified by their rigid medical studies and technical training (and vice versa, non-doctors not having these rights is justified by them not having undergone the relevant studies and training, or not having re-

ceived required certifications). Such dependencies are desirable, or at least reasonable. However, when the duties related to these rights are breached, they may cause severe medical, emotional, as well as moral-epistemic harm to patients, which I will get to next.

3.2.2. Moral-epistemic harms caused by breaches of duty of care

This leads me to my second claim: (2) *certain breaches of duty of care may lead to moral-epistemic harm to patients*. Patients have good prima facie reason to trust their doctors in their professional skills and opinions. However, being an expert is not equivalent to being infallible, and being a medical practitioner doesn't entail being a moral hero. Yet, patients may react to interactions with their doctors as if the doctors were more infallible and morally heroic than can realistically be expected. Patients may wrongly doubt their own judgment as a direct upshot of a doctor's breach of duty of care.

Let me illustrate with another example from Vesper.[14] As mentioned, Vesper has lichen sclerosus. She was diagnosed at the age of 26, seven years after the beginning of her symptoms. Her first gynecologist misdiagnosed her with yeast infection several times within a period of five years. As is the case with many autoimmune diseases, Vesper's symptoms came in waves (so-called "flares"). At the age of 25, her symptoms got quite strong and the medications for yeast infections, again, wouldn't alleviate them (medication against yeast infections usually alleviates symptoms within a few days (Sobel, 2005, pp. 255–256)). Vesper felt crestfallen and anxious and decided to go to another gynecologist. This second gynecologist told Vesper that her skin was raw from scratching due to the supposed past infection and that other than that, she was fine. As the itching persisted, Vesper revisited her after a few weeks. The gynecologist stuck with her view that Vesper was fine and bid her farewell with the words: "Say goodbye to the yeast infection". Vesper felt confused but tried hard to ignore her symptoms. She started to feel desperate. A year later, still itching, Vesper decided to go to a private gynecologist even though the mental hurdle to seek yet another opinion had grown, given the unpleasant experiences Vesper had had with doctors. This third doctor had a hunch that it might be lichen sclerosus after a few seconds of examining Vesper. Within two weeks, Vesper underwent a biopsy, was diagnosed with lichen sclerosus, and received a long-term medical plan of high-potency topical corticosteroids.

[14] This example is also taken from personal communication.

Vesper's first two doctors did not do due diligence. For instance, the first two gynecologists ignored the white spots on the skin of the vulva which the third gynecologist immediately recognized as an indication of lichen sclerosus. They also failed to ask Vesper any questions which may have opened their search for a source of the problem to other illnesses besides a yeast infection. These mistakes were medical in kind, but I also consider them moral-epistemic because the first two gynecologists met Vesper with an attitude of mistrust. It is understandable that from their perspective, at first encounter, Vesper's symptoms may have been psychosomatic. But rather than thoroughly ruling out all possible physical diagnoses (this process is called diagnosis of exclusion) they focused on a single one (yeast infection). Once that was ruled out, they could have looked for other possible physical issues causing the itching. Instead, their reaction was to locate the source of the itching in Vesper's head. These breaches of duty of care caused Vesper physical, emotional, and epistemic harm, for her trust in her doctors' expertise and morality led her to believe that she was overreacting and that she ought to just get used to the itching.

3.2.3. Social hierarchy

Let me now get to my third claim: (3) the social power of doctors is connected to and strengthened by their social status.

The fact that patients such as Vesper can be so deeply affected by their doctors' actions, or lack thereof, may stem from the doctor's medical expertise, but it is also related to the high social power doctors hold. Let's revisit Daniel's case. The psychiatrist's actions and words had an intense negative effect on Daniel. She fell short of professional communication and thereby breached her duty of care. But this itself, I believe, is not enough to explain why Daniel was so hurt. After all, he could have stood up and said something like: "Excuse me, doctor, who are you to tell me that I haven't known hardship before? And why are you not properly examining me?" I don't see how the doctor having social power, in the mere sense of her having the ability to influence Daniel's behavior and attitudes, is enough to explain the effect the doctor's actions had on him, or why he didn't respond defensively. I believe the reason Daniel was affected in these ways and didn't defend himself has to do with expectations of behaviors and attitudes that Daniel adhered to by virtue of being in the social position of patient, i.e. in a position of vulnerability and dependency on the doctor and the medical system at large. Social positions are commonly sustained by the enactment of social norms. To help understand why patients such as Daniel may conform to expected behaviors and attitudes, I will briefly turn to Han van

Wietmarschen's (2021) insightful account of social hierarchy. Van Wietmaschen understands social norms to be

> rules of *behavior*, and of *attitudes*, such as dispositions, emotions, and feelings, to which individuals prefer to conform "on condition that they believe (a) most people in their reference network conform to it (empirical expectation), and (b) that most people in their reference network believe they ought to conform to it (normative expectation)" (Wietmarschen, 2022, p. 923).[15]

When it comes to social status, there are sets of social norms that express more or less *valence* towards individuals, thereby *hierarchically ranking them*. In other words, a social position A is hierarchically above another social position B if A's occupants are valued more than B's (Wietmarschen, 2022, pp. 923–925). Let me illustrate this with a professor's example again and take the university where she is employed as the reference framework. The professor – let's call her Prof. Smard – is viewed as an academic leader in her research field by the faculty members, her seminars are regularly over-booked, and dozens of graduate students apply for her to be their PhD supervisor each year. Prof. Smard's colleague, Prof. Lessmart, is less praised by the faculty who view his research as slightly uninspired. His classes are well booked but mostly because he is known to give out easy As. He receives an average of ten PhD applications per year. By virtue of displaying more behaviors and affections that express value towards Prof. Smard, she is ranked higher in the university's social hierarchy than Prof. Lessmart. What is more, both Prof. Smard and Prof. Lessmart are ranked higher than all the students in the university, even though a few members of the faculty value a couple of academically outstanding students more than they value Prof. Lessmart. Similarly, I would argue that within a large societal reference framework, doctors, even if they perform their jobs in a mediocre fashion, are generally ranked above their patients in the social hierarchy.

What does this tell us about Daniel? Being a patient is more than going to the doctor. It is a social position that goes hand in hand with a way of doing things. As a patient, one acts a certain way, addresses the doctor a certain way, but also views the doctor in a certain way. The same goes for the social position of doctors, who are also expected to behave in specific ways and demonstrate specific behaviors. We expect doctors, in a medical encounter with a patient, to act professionally, which includes behaving calmly, being focused, showing interest, and exuding confidence in their medical abilities. Even though patients are not in a professional role, there

[15] This is a slightly amended version of Cristina Bicchieri's (2017) account of social norms (Bicchieri, 2017). Van Wietmarschen added that social norms are not only made up of rules of behavior but also of attitudes (which is quite important for my purposes). He illustrated this with the social expectation of *grieving* when a loved one dies (Wietmarschen, 2022, p. 924).

still are many behaviors that we expect from them, as they have become part of an implicit social script of the patient-doctor interaction. For instance, we expect patients to wait to be called in by the doctor, listen to her advice, cooperate with her suggestions, and let her lead the interaction (both in the interview and by following instructions on when to sit, to un- and redress, to lie down, to leave, etc.). What is more, we also expect certain attitudes towards doctors, such as trust, attention, gratitude, respect, intention to follow, or even admiration. All of these express *valence*. And they are not incidental. Patients don't test out the waters to see if they should indeed trust the doctor before they are expected to follow instructions or divulge personal information. Rather, these rules of behaviors and attitudes are valence-demonstrating *social norms*. Indeed, they fulfill the conditions for social norms mentioned above: Patients conform to these rules because of empirical and normative expectations:

(i) *Empirical expectations*: We generally assume that other people also conform to these rules when they take on the patient role (these expectations are not explicitly verbalized, in contrast to, for example, children in school who are told how to behave). Going to the doctor is something we know from childhood, and we are taught that doctors can do certain things that other people aren't allowed to (like instructing us to undress and asking intimate questions).

(ii) *Normative expectations*: We usually also believe that we *ought to* conform to these patterns. We can of course question whether we should trust a doctor, or follow a specific instruction, but this is usually triggered by something that leads us to deviate from expectations we otherwise think we ought to conform to (e.g. if a gynecologist seems creepy, I might break the rules of behavior and leave their office). What is more, we expect others to conform to these rules as well. This could for example be expressed by asking a sick friend questions or making remarks towards them, which express trust towards the doctor, and possibly mistrust towards the sick friend, such as: "Well, what did your doctor say?", or "You can go to school if your doctor said it's fine."

In Daniel's case, I believe that the psychiatrist had the power to influence him in the way that she did because Daniel was expected to, and expected himself to, act in specific ways, but also show specific attitudes towards the psychiatrist in virtue of being in the social position of patient. As part of the rules of *behavior* in place, he let her say things he might not have let a friend tell him, and as part of the rules of *attitude*, he trusted her (or at least went into the encounter with the intention to trust her), listened, paid attention, and took her words seriously and, therefore, was hurt by her dismissive statement. Any behavior or attitude on his part that

would have defied the psychiatrist would have been a deviation from the expected way of doing things. The relationship of dependency in itself makes Daniel and other patients vulnerable to being harmed but the fact that the dependencies are strengthened by the discrepancy of social status further enhances the vulnerabilities of the patient role.

With that in mind, let me add a remark on the idea of there being rules of *attitude*. Not only do I agree with van Wietmarschen that social norms include rules of attitude, but I would also add that when it comes to many of the dependencies I have sketched, it is precisely these expectations of attitude that, at least partially, explain the vulnerability of patients vis-à-vis their doctors. Why do I want validation from my doctors? Why do they have the power, under certain circumstances, to pronounce that the pain Vesper feels is not real? Why is the psychiatrist's remark so hurtful to Daniel? Such mental states and reactions, I believe, have to do with patients having certain attitudes in virtue of being in that social position, and in virtue of the other person being in the social role of doctor.

The claim that doctors take up a higher position in the social hierarchy than patients is neither new nor controversial. However, I think it is often unsatisfactorily attributed solely to doctors' legitimate medical authority.[16] Take Parsons again. He notes that health care is socially organized in hierarchical terms, that the role of the "sick person" is the lowest, independent of the individual's social status in their other roles, and that the role of the physician is the highest, as it is obtained through the highest grade of expert certification in health care. The superiority of the physician's role, according to Parsons, rests in the fact that the physician is endowed with the responsibility for the health of patients (Parsons, 1975, pp. 266–267). But people being endowed with great responsibility is far from sufficient to explain their social status. Take child-care workers for instance. They are endowed with the responsibility to care for young, vulnerable, and impressionable children, yet aren't highly valued socially. I will not aim to explain why we value doctors to the extent that we do. But I hope to have made it clear that some aspects of doctors' social power cannot sufficiently be explained by them having medical expertise, but rather by them having a particularly high position in the social context of the doctor-patient encounter.

[16] Interestingly, one might argue that legitimate practical authority (for example expertise due to specialized studies) is the *source* of a high social status, whereas van Wietmarschen describes the ascription of legitimate practical authority as a way of *displaying* valence and admiration (Wietmarschen, 2022, p. 928).

4. Conclusion of Part I

In this part of the thesis, I have argued that there is a power differential between doctor and patient which cannot be solely explained by the overt skills, rights, and duties of doctors but rather also through social norms. I have first argued that people take on specific social roles when being doctors and patients. Then, I have shown that patients depend on doctors in complex and interrelated ways. Lastly, I argued that these dependencies amount to a social power differential between doctors and patients such that doctors may deeply epistemically harm patients. This power differential, I concluded, is connected to and strengthened by doctors' high social status, which enhances the vulnerability of the position patients are in.

To deepen our understanding of where this power differential comes from and how it manifests within the doctor-patient interaction, it is necessary to consider the social-structural processes that lead to patient vulnerability which I shall do in the second part of this thesis.

PART II: THE SOCIAL STRUCTURE OF THE PATIENT-DOCTOR RELATIONSHIP

The accounts of epistemic injustice, in general and concerning the medical realm specifically, are quite piecemeal and it is often unclear which account would be the most fitting. I believe this is caused by the fact that example cases are often specifically chosen or constructed to fit a specific concept in order to illustrate that concept as clearly as possible. This makes perfect sense for single conceptual endeavors, but it also leaves us with a multitude of accounts that are not always easy to match with real cases and stories. In this second part of my thesis, I propose that to understand what is going on in individual cases, we need to assess them with a double perspective on interactions and structure. I will start by elaborating on the difficulty of applying epistemic injustice concepts to cases in health care with the example of the concepts of *testimonial injustice*, *hermeneutical injustice*, and *gaslighting,*[17] and I will show that problems of understanding arise when we look at cases in isolation. Then I will use Iris Marion Young's approach of structure as the subject of justice to show that patients' position of vulnerability stems from social-structural processes. Only by viewing the doctor-patient interaction as a locus of social structure can we deepen our understanding of individual cases and find out what to do to reduce patient vulnerability.

1. Concepts of epistemic injustice and the doctor-patient-relation

1.1. Testimonial injustice, hermeneutical injustice, and gaslighting: differences and difficulties of application to health care

In this section, I aim to give an overview of some of the main concepts and terminology used in the epistemic injustice discourse with a focus on the application of these concepts to the medical realm. Focusing on the terms *testimonial injustice*, *hermeneutical injustice,* and *(medical) gaslighting*, I want to show how these terms are used as well as some ways in which I disagree with the conceptual distinctions and categorizations.

[17] Other, more specific, concepts include "willful hermeneutical ignorance" (Pohlhaus, 2012) and "hermeneutical death" (Medina, 2017, p. 42)

1.1.1. Testimonial injustice

Testimonial injustice, according to Fricker, occurs when "a speaker receives an unfair deficit of credibility from a hearer owing to prejudice on the hearer's part." (Fricker, 2007, p. 9). When it comes to the medical realm, as noted by Jennifer C.H. Sebring (2021), the doctor is the one conducting the interview, giving directions (e.g. to lie down or to undress), and holding the power to pronounce what is real and what is not. The patient on the other hand has little to no room to deviate from that script (Sebring, 2021, p. 1956).

Ideally, the patient and the doctor work collaboratively. Patients have, first and foremost, experiential knowledge,[18] meaning that they know how their condition feels as well as how it impacts their lives in often deep and complex ways (Carel, 2016). Clinicians have credentialed scientific and medical knowledge which they use to analyze and interpret the patient's testimony (Carel & Kidd, 2014, p. 535; Rabeharisoa et al., 2014). The patient's testimony is thus an indispensable part of the clinical interaction. However, it is not a matter of course that the patient is taken at their word. Carel and Kidd (2017) note that clinicians often complain about patients being unclear and giving irrelevant or unimportant information (Carel & Kidd, 2017, p. 338). In a time of time management and shortage of skilled labor in the medical field, it seems understandable why scouring testimony after testimony for pertinent information can be taxing and stressful. On the other hand, patients keep reporting that clinicians are dismissing critical information the patients are uttering, even when the information is given outright, or that their clinician prevents them from speaking of relevant symptoms by cutting them off, being dismissive or overtly distrustful, or making them otherwise uncomfortable.

More precisely, Carel and Kidd identify various ways in which patient testimonies may be dismissed due to a credibility deficit. Patients' testimonies may be simply ignored or be heard but remain unacknowledged, the clinician might exclude relevant parts of the testimony from her considerations, judging them as irrelevant or uninformative. In addition to the content of the testimony being judged epistemically unusable, the expressive style of the patient may also be deemed unfit for epistemic contribution. Patients are often perceived as lacking abilities necessary to properly give testimony, such as articulate and calm speech, chronological or logical narration, abstraction from blurring emotions, etc. Their testimony may be acknowledged but seen as less important, valuable, or authoritative as the clinician's view, making the patient a useful informant but not an active participant in the understanding of their condition (Carel &

[18] The so-called "patient expert" (Epstein, 1995) may of course acquire medical knowledge and a more profound understanding of their condition.

Kidd, 2014, pp. 531–532).[19] The credibility deficit of patients is, at least partially, caused by the fact that patients often suffer from ableist stereotypes against ill people, including their epistemic abilities. As Carel and Kidd (2017) note: "The ill are often stereotyped as, *inter alia*, cognitively impaired, overwrought, unable to 'think straight', existentially unstable, anxious, morbid, and so on, due either to their condition or their psychological response to it." (Carel & Kidd, 2017, p. 338) Patients, in short, may receive an unfair deficit of credibility from their doctors who may view them as bad informants who are unclear in their testimonies and say a lot of irrelevant things, and, in this sense, they may suffer from testimonial injustice.

1.1.2. Hermeneutical injustice

According to Fricker, hermeneutical injustice is "the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource." (Fricker, 2007, p. 155). For patients, such injustice may manifest itself when they struggle to articulate and make sense of their experience of their medicalized condition.

Broadly, Fricker has identified two kinds of *hermeneutical gaps* that may cause *hermeneutical marginalization*. i.e. the experience of being excluded from a significant social meaning-making practice (Fricker, 2007, pp. 152–155). The first gap concerns the *content* of what is tried to be made intelligible. Let's take an example from Fricker which incidentally happens to concern an illness, namely postpartum depression. She cites Susan Brownmiller's memoir of the US women's liberation movement. Brownmiller tells of a woman named Wendy Sanford who had had postpartum depression but had never heard of it during the time, meaning that she lacked an important *hermeneutical resource* she would have needed to understand what she was going through. She had blamed herself for failing and had been blamed by her husband. Upon hearing of the illness for the first time in a university workshop on women's medical and sexual issues in the late 1960s, she had a moment of realization that fully changed her interpretation of her experience and made it suddenly intelligible and effable (Fricker, 2007, pp. 148-149; Brown-

[19] More precisely, Carel & Kidd differentiate between participatory and informational prejudice. Both have to do with the assumption that patients lack a sense of relevance in the medical interview (Carel & Kidd, 2017, pp. 340–341).

miller, 1990, p. 182). The hermeneutical gap prevented Sanford from making sense of a substantial experience in her life, and from communicating it to others, and it thus deeply and negatively impacted her self-image (Ritunnano, 2022, p. 4).[20]

The second kind of hermeneutical gap concerns the form of what is said, i.e. the expressive style (Fricker, 2007, p. 160). As noted by Kidd & Carel, illness (but this also goes for other medicalized conditions such as pregnancy) usually has an extreme impact on people's lives which may dispose them to an emotive expressive style, comprising socially objectionable emotions such as envy and fear, nonlinear, repetitive and confusing narration, and uncomfortable themes such as mortality and isolation (Carel & Kidd, 2017, p. 342). Arguably, this kind of hermeneutical gap is the one that is more prevalent in the clinical realm.

I want to point out here that *hermeneutical injustice* seems hardly separable from the kind of *testimonial injustice* I discussed above. This is relevant because when we want to understand specific (potential) cases of epistemic injustice we may be tempted to put a single label on it and thereby miss the complexity of the layers of the injustice's modes of operation. Indeed, in many cases, it might be unclear whether hermeneutical or testimonial injustice is at play. A doctor deeming a patient's testimony irrelevant clearly has to do with the patient's expressive style being judged inadequate. A doctor disbelieving her patient because postpartum depression is not yet established as a medical condition is clearly caused by the lack of a hermeneutical resource (one they *both* lack). The doctor's distrust of the patient's testimony is directly linked to the patient having "experiences obscured from collective understanding". In fact, cases of 'pure' testimonial injustice would require that a speaker uses a perfectly acceptable and appropriate expressive style and has all the hermeneutical resources at hand to convey their knowledge. This is of course possible, but it isn't the case in Fricker's examples, and it certainly isn't the case in many instances of epistemic injustice in the medical sphere. Usually, even the 'ideal' patient who testifies in the purest form, giving all and only essential information without emotions deemed inappropriate, is seen as mostly an epistemic object and will lack the terminology and credentialed expertise necessary to be regarded as an equal participant in the epistemic project. Patients are still the ones whose testimony ought to be filtered, analyzed, and interpreted by the main epistemic authority, the clinician. The *testimonial injustice* to which patients are vulnerable thus relies on their subjection to *hermeneutical injustice*, i.e. the fact that

[20] Notably, Fricker focusses on the harm to Sanford *qua* being a woman. I believe Sanford was also harmed *qua* being an ill person. She wasn't only unable to execute the societal expectancy of womanhood and motherhood but also of healthy functioning.

the way that patients express their predicament is marked as insufficient, overly emotional , and, in short, as a hindrance rather than a contribution to the epistemic endeavor.

The potential difficulty of understanding whether testimonial or hermeneutical injustice is occurring is due to the fact that in cases of hermeneutical injustice, according to Fricker, there is no culprit because she sees it as a purely structural, i.e. non-agential, problem but hermeneutical injustice still *manifests itself* in interactions with others. Put briefly, someone struggling to articulate themselves due to an unjust hermeneutical lacuna is also more likely to, unjustly, be deemed an unreliable testifier by another person, like their doctor (Fricker, 2007, p. 159). Indeed, Fricker's own main example cases of testimonial injustice go hand in hand with hermeneutical injustice, for they are based on sexist and racist stereotypes that hinder the protagonists, Marge Sherwood and Tom Robinson, from making themselves believed.[21] The culprits themselves are hermeneutically disadvantaged because they are shaped by the prejudices of their times. Likewise, the classification of hermeneutical injustice as never having a culprit is denied by philosophers such as José Medina (2017) and Gaile Pohlhaus Jr. (2012), who argue that members of socially privileged groups will close their minds to the experience of marginalized groups, thereby cultivating hermeneutical shortcomings which prevent them to be receptive to marginalized knowers' testimonies (Medina, 2017, p. 44; Pohlhaus, 2012, p. 715).

The interwovenness of structural and interpersonal problems also goes to show that (most) clinicians who may subject their patients to testimonial injustice are not epistemic villains but rather hermeneutically disadvantaged themselves. They might not be the ones suffering the harm of epistemic injustice, but they are also embedded in societal imaginations of a clear division of epistemic labor in the clinical encounter, in which patients are stereotyped as overly emotional and unfit to judge which information is relevant. In cases like Sanford's, in which an illness is not recognized as a medical condition, the doctor too lacks the hermeneutical resources necessary to understand and diagnose it. One might now argue that this situation releases clini-

[21] *Marge Sherwood example*: In Anthony Minghella's screenplay of "The Talented Mr. Ripley", Dickie Greenleaf goes missing and his girlfriend, Marge Sherwood, expresses the suspicion that Tom Ripley, a supposed friend, had murdered Dickie. Dickie's father, Herbert Greenleaf, who had been buttered up by Tom, invokes gender stereotypes when he answers her: "Marge, there's female intuition, and then there are facts." And thereby silences her concerns. Marge's suspicion later turns out to have been right (see Fricker, 2007, pp. 14-15)
Tom Robinson example: In Harper Lee's novel "To Kill a Mockingbird," set in 1935 in Maycomb County, Alabama, a young Black man named Tom Robinson is falsely accused of raping a white girl, Mayella Ewell. Despite clear evidence of Robinson's innocence, including his disabled left arm which could not have caused the girl's injuries, the all-white jury's decision is swayed by racial prejudice. His honesty about helping Ewell leads to further bias against him, as sympathy from a Black man towards a white person is seen as taboo. The jury's prejudiced perceptions ultimately lead to Robinson's wrongful conviction, despite efforts by his defense attorney, Atticus Finch, to challenge their biases (see Fricker, 2007, pp. 23-29).

cians from blameworthiness, and thus from being perpetrators of testimonial injustice. However, if one rejects all cases of patients being dismissed by their clinicians as being instances of testimonial injustice due to the (alleged) perpetrator also being hermeneutically disadvantaged, then one must also reject Tom Robinson's and Marge's cases as instances of testimonial injustice, since the prejudices held by the respective perpetrators where also products of their times.

1.1.3. Medical gaslighting

To *gaslight* someone means to wrongfully make them doubt the veracity of their own well-justified beliefs. Originally, the term stems from the 1938 thriller play *Gas Light* by Patrick Hamilton, brought to a wider audience by George Cukor's 1944 film *Gaslight*. It tells the story of Bella (Paula in the film) who is made to believe she is insane by her Husband Jack (Gregory in the film). Most notably, Jack dims the gas light in the house and keeps assuring Bella that she is imagining the dimming.

The philosophical and sociological literature on gaslighting at large and medical gaslighting in specific can be divided into two categories: individual, or interpersonal, gaslighting (e.g. Abramson, 2014; McKinnon, 2017; Sebring, 2021) and structural gaslighting (Pohlhaus, 2020). Concerning medical gaslighting specifically, interpersonal gaslighting puts the focus on the doctor-patient-relationship (Sebring, 2021), and structural gaslighting on the marginalization of groups in the medical realm via biased research methods, unfair access to medical care, etc. (e.g. Ruíz, 2020; Berenstain, 2020).[22] The term *medical gaslighting* has also become prevalent in the disabled and chronically ill community, where it is often used more broadly than in the philosophical and sociological literature to describe the frequent experiences of not receiving adequate medical care due to doctors' invalidation and dismissal of the patients' statements regarding their symptoms. This can include shaming the patient for researching their symptoms, refusing to order lab work, or blaming symptoms on mental illness.

All in all, these accounts seem to me quite piecemeal and often become murky when it comes to the question of whether these kinds of epistemic harms are individual moral wrongs or structural problems. I do deeply appreciate these concepts and the general importance of categorization and generalization within philosophy. But precisely because I believe these categories to

[22] The latter category looks at people who are marginalized in other ways (e.g. due to racism) and dissects how this marginalization works within the medical realm, as only one of many spaces where these individuals experience discrimination.

be so useful, I think it is paramount that we relate them to individual, and real, cases in a cautious and sensible manner not just for the sake of clarity but ultimately to be able to describe and counteract experienced wrongs.

1.2. Social position and identity markers

I need to mention a caveat when it comes to using Fricker's account in the project of this thesis. Fricker's example cases in *Epistemic Injustice* (2007) have been the stepping stone for much epistemic injustice literature and have become highly influential. I thus think it's important that I go into a few points that may seem or are indeed, dissenting from Fricker in order to counter potential critical points, as well as draw a clearer picture of my claims.

Namely, according to Fricker, epistemic injustice is based on identity (Fricker, 2007, pp. 153-154, or "social type", p. 155). More precisely, all of her main example cases (such as the cases of Brownmiller, Tom Robinson, and Marge Sherwood) are based on the identity markers of *race* or *gender*. Such "tracker" identity prejudices, Fricker notes, pursue the affected subject through different branches of their life and thus make them susceptible to various injustices, including epistemic ones (Fricker, 2007, p. 27).

The role of patienthood can and often does, do just that, i.e. track the subject throughout life, especially in cases of certain chronic illnesses and medicalized disabilities but it doesn't necessarily do so. Unlike race or gender, patienthood can be, firstly, of short duration and, secondly, it can often be the case – such as with invisible illnesses – that it *doesn't* track the subject everywhere they go. A third possible objection to my application of concepts of epistemic injustice to patients is that many aspects of the doctor-patient hierarchy are warranted or desirable, which is *not* the case when it comes to race or gender. Tom Robinson, for instance, was accused of murder, and placed in front of a jury with the power to decide over his life, merely because of racial prejudice. That is never warranted.[23] A patient going to see their doctor, who has duties and powers the patient doesn't, is caused by the patient's physical or mental condition – that is warranted.

However, there are important salient commonalities between Fricker's examples and cases of what I consider to be epistemic injustice to patients. Firstly, patients, like people affected by

[23] It is warranted of course for jury members to be suspicious of the defendant's testimony, but in Tom Robinson's case, they were clearly motivated by racist beliefs and, as Shelley Tremain (2016) has rightfully noted, Tom Robinson was not only the victim of racism but also of ableism. More precisely, he was met with contempt when he expressed that he felt sorry for Mayella Ewell, a poor, white, young woman, specifically because of being a black, disabled man (Tremain, 2017, p. 181).

racism and sexism, may be highly dependent on people around them who have more social, and often economic, power than they have. In the case of patients, these people are doctors and other health care professionals, relatives they may be economically and/or physically dependent on, employers, etc. If anything, the fact that the dependencies are partially warranted enhances the vulnerabilities caused by them. Secondly, all mentioned groups are dependent on their community to countervail the disadvantages they suffer – for patients this means, first and foremost, access to a functioning health care system, which is never guaranteed (for instance, following the 2007-2008 financial crisis, the British government made drastic budget cuts to the National Health Service, see Edwards, 2023). Thirdly, for all mentioned groups, the position of dependency and vulnerability is not a chosen one.

Note, also, that occupying the patient role can make one particularly vulnerable to tracker prejudices based on other identities. A pregnant woman who is socioeconomically disadvantaged, for instance, may suffer more when experiencing complications because she cannot choose any doctor she wants and probably cannot afford a midwife. And blatantly, women and other people able to get pregnant face risks based on misogyny cis men don't, such as abuse during childbirth (WHO, 2015). What is more, patients can be targeted both by identity-based prejudices and via their vulnerable social position. For instance, Daniel's psychiatrist implied that he was a hypochondriac, which targeted him as a person, and he also suffered from the vulnerability of his social position, because, as I argued above, social norms don't allow for patients to defy one's doctor.

In short, I believe that there are salient commonalities between Fricker's cases and cases affecting patients that give good reason to apply Fricker's framework of epistemic injustice to patienthood.

1.3. Example cases

In this section, I will return to Daniel and Vesper's cases to demonstrate how epistemic injustice may function in different cases, and how individual cases are affected by broader processes and policies.

Both Daniel and Vesper have suffered epistemic injustice in their encounters with doctors. In their patient interviews, they provided testimony of their experiential knowledge but were not believed. Daniel's psychiatrist, without knowing him for more than a few minutes, dismissed his perceptions and, rudely and condescendingly, implied that he wasn't experiencing anything

unusual and didn't have the necessary life experience to realize that. His testimony was thus judged medically irrelevant. What is more, the psychiatrist heavily implied that Daniel was incapable of correctly matching the level of intensity of his symptoms to the level of seriousness of the root of the symptoms. In other words, she implied that he was making a mountain out of a molehill. The issue here is not that the psychiatrist had a different view of how bad Daniel's medical state was. There surely are many cases where doctors are right to assess that the patient's worries exceed their medical condition. Rather, the issue was that Daniel's suffering was put into question and that the psychiatrist made assumptions about him (his life not having been "shit" yet) which are, at the very least, questionable when coming from a psychiatrist. Daniel thus suffered from testimonial injustice owing to a credibility deficit in an important moment which continued to affect him later on. As mentioned earlier, testimonial and hermeneutical injustice usually go hand in hand. I believe this is the case here as well. Daniel likely articulated himself in an emotive way, as he was scared and looking for reassurance. A psychiatrist should be able to go about such patient interviews in a sensitive manner, leaving room for emotions, fears, and possibly confusing narrations, since these come with the territory. She didn't do that, thereby repressing any chance Daniel had of making himself heard. On top of that, Daniel and the psychiatrist followed the social norms of the doctor-patient script, giving Daniel no room to deviate from the doctor's pronouncement.

Vesper's experience was one of being misdiagnosed by two gynecologists. When Vesper's patient testimony didn't match the typical diagnosis and course of treatment, both doctors omitted further investigation and rather assumed, and let Vesper know, that her bodily perception was off. Vesper's doctors faced a patient testimony that stumped them (Vesper told them each several times that her symptoms persisted after using the anti-yeast medication). This in itself is not a moral-epistemic issue. Rather, like in Daniel's case, the doctors both didn't look any further for a potential medical issue they may have overlooked, and they didn't say "I don't know what's going on" either. Rather, they left Vesper hanging without any indication of where to go from there other than to "say goodbye" to an illness she had been misdiagnosed with in the first place. But unlike Daniel's case, Vesper was demoralized bit by bit over several years. Whenever she mustered up the strength to give the search for treatment another go, she was let down. So, while she suffered testimonial injustice several times, the effects on her only got worse due to the accumulation of her experiences with doctors. Both Daniel and Vesper were medically gaslighted in the broad sense of the term used by patient activists. Vesper, at least, was also affected

by gaslighting in the stricter sense, as she started to doubt her perceptions and to believe she was overreacting.

There were medical and moral-epistemic wrongs being done to Daniel and Vesper. However, and this is a central point of this thesis, the snippets of Daniel and Vesper's experiences depicted in this thesis are not enough to fully explain the moral-epistemic wrongs occurring. Indeed, Daniel and Vesper most likely don't know enough themselves to fully account for what went wrong. Above all, they (and I) don't know two things: firstly, why the doctors behaved this way (was it out of character or not?) and whether there might be some mitigating factors to excuse their behavior (e.g. extreme stress), and secondly, what structural factors played a role in the doctors' choices and behavior (this overlaps with the mitigating factors, e.g. if there is a doctors' shortage and individual practitioners, therefore, need to work more efficiently). When it comes to public health care, patients are not simply dependent on the medical and moral quality of the practitioner they are seeing but on a whole array of social, economic, and political processes and operating modes of health care institutions which are largely out of the patient's control and/or knowledge. The medical encounter is simply the place where the effects of these processes crop up. The World Health Organization has identified many deeply rooted problems in healthcare systems in the last few years. In a 2022 report on the healthcare workforce in Europe, the WHO noted that the employment and working conditions of healthcare workers are often unattractive, and demotivating, and fail to protect the physical and mental health of healthcare workers. Gender- and ethnic-based discrimination thus flourish and women are clustered in lower-status jobs as well as underrepresented in decision-making positions (WHO, 2022, p. 2). Such working conditions are of course deplorable in and of themselves, but they also fall back on patient care. Doctors (and other health professionals) may be overworked and strained, and therefore less likely to be able to provide the care they would provide under better working conditions. Much of biomedical ethics is concerned with the moral decision-making of doctors because the complexity of medical practice often leads to ethical uncertainties and dilemmas (e.g. Beauchamp & Childress, 1994). Moreover, far from idealized thought experiments, the day-to-day circumstances of health care are taxing, and the realities of organizational structures, stress, liabilities, and strains have strong influences on personal ethical choices and behaviors (see, e.g., Herzog, 2018). For instance, a British comprehensive systematic review and meta-analysis by Alexander Hotkinson et al. (2022) has assessed the association of physician burnout with career engagement and the quality of patient care and found that burnout in physicians reduces the quality of patient care. Physicians with burnout were found twice as likely to be

involved in patient safety accidents and over twice as likely to receive low satisfaction ratings from their patients (Hodkinson et al., 2022).

Structural issues also manifest more locally. Take Daniel and Vesper's cases: they are both from and were treated in, Austria.[24] For context, Austria's health care system is complex and responsibilities are divided between the federal level and the regional level (i.e. the level of the nine federal states) (Bachner et al., 2022, p. 3). All things considered, Austria has an effective health care system for EU standards, which are already high. It also has one of the most cost-intensive healthcare systems in the EU. The levels of unmet medical care needs based on financial reasons, waiting time, or travel distance are low due to the available benefits package provided via social health insurance (SHI) (Bachner et al., 2022, pp. 13, 18). However, there are factors that further enhance the vulnerability of patients, and which may help to explain Daniel and Vesper's cases. Let me point out some of them:

- In Austria, out-of-pocket health payments are higher than the EU average (18% vs. the EU average of 15%). According to a 2017 survey, the reduction of co-payments is the most important aspect patients are dissatisfied with (GfK, 2017).[25] There are exemptions for co-payments (i.e. payments split between our-of-pocket and SHI) for vulnerable groups such as asylum seekers under federal care, pensioners entitled to compensatory allowances, and children, meaning these groups don't have to pay out-of-pocket for certain services (Bachner et al., 2022, pp. 5, 14). The high percentage of out-of-pocket payments for health services points to a larger issue that is not Austria-specific, namely the difference between public, or social, health insurance, and private means of paying for health care services (private, or voluntary, insurance, or out-of-pocket payments). Whether one relies on SHI or has the means of paying more for health services often affects the quality of doctors' visits, for instance concerning the amount of time a doctor has for her patients. This likely affected both Daniel and Vesper, as their doctors had no incentive to spend more time and resources on their cases. As mentioned, Vesper's third gynecologist was indeed privately paid and ended up diagnosing her correctly. When it comes to non-contracted physician's fees, Austrian SHI providers reimburse 80% of the amount a contracted physician would have received for the same service. Non-contracted physicians can however freely determine their

[24] My source for numbers and policies concerning Austria is the *Health system summary, 2022.* The Health system summaries are published by the European Observatory on Health Systems and Policies, a partner organization of the World Health Organization (WHO), and they are updated every two years, starting 2022, for countries of the WHO European Region and some additional OECD countries.
[25] This survey was commissioned by the main association of the Austrian social insurance providers.

fees, they are not bound to any rates. Whether one relies on SHI also affects whether they can easily change doctors. In Austria, SHI usually allows one to change doctors within a medical specialty once per quartal. When a patient feels unsatisfactorily treated, they might thus have to wait three months to change doctors, unless they can afford to pay out-of-pocket. As is often the case in structural injustice, this policy by itself is sensible because it enables control of potentially unnecessary spending. But for individuals such as Vesper, it meant a restriction on the possibility of finding a new doctor during a time of physical suffering.

- Even though Austria has low levels of unmet needs for medical care, there are increasing differences when it comes to accessibility to health care:

> waiting times for treatments in hospitals differ significantly between patients. Moreover, waiting times for, and opening times of, ambulatory (extramural) specialists affect many patients in Austria, especially for radiological examination. In addition, the sharply increasing share of non-contracted physicians and decreasing number of contracted physicians mainly, particularly among GPs but also certain specialists such as paediatricians, is a major cause for concern in the Austrian health system. The situation jeopardizes the principles of equity of access to ambulatory care, because fees of GPs and specialists without a SHI contract are largely unregulated and only partly covered by SHI. While the number of contracted physicians decreased by about 4% between 2012 and 2021 (from 10 555 to 10 182), the number of non-contracted physicians increased by nearly 31% in the same period (from 9177 to 12 002). (Bachner et al., 2022, p. 13)

The decrease in contracted physicians puts a further strain on patients dependent on SHI, as it means that waiting times become longer, durations of doctor visits become shorter and many contracted GPs and specialists don't take on new patients at all, pushing patients towards non-contracted doctors whose fees aren't regulated. This coincides with a shortage of healthcare workers in Europe, which is largely caused by the growing need for healthcare workers due to aging populations as well as increased multimorbidity and chronic conditions (WHO, 2022, pp. 12, 67)

- According to the *Health system summary*, the Austrian population largely approves of the health care system, with satisfaction being very high for independently practicing physicians (95% of 3478 respondents in a survey in 2016[26] indicated being satisfied or very satisfied), and lowest with outpatient care in hospitals (10% indicated being dissatisfied or

[26] This survey was also commissioned by the main association of the Austrian social insurance providers (TQS & HVSVT, 2016). This main associate no longer exists in this form. In 2018, so shortly after the two mentioned surveys were conducted, there was a reform of the social insurance organization to streamline the health care system and increase efficiency. Instead of numerous insurance providers (there were 21), there are now five main providers which are summarized in an umbrella organization of the social insurance.

very dissatisfied) (TQS & HVSVT, 2016; Bachner et al., 2022, p. 14) But interestingly, the degree of satisfaction with the doctor-patient-communication was comparatively low:

> patients were less satisfied with collaborations between GPs and specialists and the quality of doctor–patient communication. Only 68% and 63% of respondents, respectively, evaluated collaboration and doctor–patient communication as good or very good, pointing to scope for improvement […]. (Bachner et al., 2022, p. 14)

This dissatisfaction with collaboration between doctors and the doctor-patient-communication coincides with Daniel's and Vesper's experience. They have been condescended to and disbelieved, and, when not finding the source of their symptoms, their doctors refrained from getting in contact with other specialists who may have had more insight on the issue. Such lack of professional collaboration increases individuals' dependence on being lucky enough to fall into the right hands, especially when being in hospital care, as there is usually no option of choosing one's doctor there.

- All hitherto mentioned points are related to lack of resources. Austria may be a very affluent country, but it is not known for its efficiency. Too much of a focus on efficiency is of course counter-productive in all fields that require close personal care but at the moment, much-needed resources may be wasted on inefficiency. For instance, there is a high utilization of inpatient care in Austria compared with other EU and OECD countries, contributing to high costs relative to health outcomes achieved. One thing that contributes to this inefficacy is the separation of financing between inpatient and ambulatory divisions (Bachner et al., 2022, p. 17). Another example of ineffective financial management is the high per capita spending on pharmaceuticals without a focus on cost-effectiveness. Most notably, generic medication, which is cheaper than name-brand medication, is not promoted and thus doesn't end up on the market as much as, for instance, in Germany or the Netherlands. Practitioner's prescribing behaviors are also relatively unassessed, hindering transparency, accountability, and the monitoring of medication use and expenditure (Bachner et al., 2022, p. 14).

These structural issues take medical and economic tolls on patients. But they also influence healthcare workers, especially SHI-contracted ones, who are bound to tight schedules and difficult working conditions. Whether these factors mitigate the culpability of Daniel and Vesper's doctors specifically, we don't know. But they do show that they weren't acting in a vacuum and may very well have been exposed to processes, policies, and economic restraints that made it harder for them to provide high-quality patient care. Such structural constraints on the doctor-

patient interaction make patients more vulnerable within the dependency relation to their doctors. For instance, the restraints on changing specialists made Vesper more dependent on receiving care from someone who clearly couldn't or wouldn't provide it. She was thus more vulnerable to medical harm since her symptoms went untreated, as well as more vulnerable to epistemic harm such as gaslighting because she couldn't easily find a better and more acknowledging source of information.

When looking at the structures in which Daniel and Vesper's cases took place, it becomes clearer that their experiences weren't isolated or fleeting. Patients may be harmed by institutions, structural practices, social norms, and individuals. And doctors can do morally better or worse with the tools they have. There is of course a moral difference between, for example, a doctor who misses something important in the patient statement because she is in a rush to see all her other patients in the little time she has, and a doctor who plainly says to her patient in pain to not make such a fuss and just learn that life is difficult sometimes. However, these two cases have something important in common: they are only as harmful as they are due to the structure in which they happen. They are harmful because of the strong dependencies, and because of the severity of the dependencies caused by factors such as lack of alternatives and social norms deterring patients from disagreeing with doctors who breach their duty of care.

To further elaborate on the effect of the social-structural process on patients' vulnerability, I will draw on Iris Marion Young's account of structure as the object of justice. I will argue that our normative judgments of cases are more informed when we consider the social-structural processes that, cumulatively, put patients in a vulnerable position.

2. The structure of epistemic injustice in healthcare

2.1. Social positions of vulnerability

In *Responsibility for Justice* (2011), Iris Marion Young uses the story of a single mother of two called Sandy who falls victim to the lack of affordable housing to illustrate *structural injustice*, which, according to Young, is a specific kind of moral wrong distinct from wrongs traceable to individual people, actions or policies: "Structural injustice occurs as a consequence of many individuals and institutions acting to pursue their particular goals and interests, for the most part within the limits of accepted rules and norms." (Young, 2011, p. 52)

Here is Sandy's story put briefly: Sandy decides to move out of her deteriorating apartment building when it is about to be converted into condominiums (units that are separately owned). As Sandy's daily commute to the mall, where she works as a clerk, is three hours in total, she searches for an apartment closer to her work. However rental prices are high and limited in options; more affordable ones are far away from her job or in unsafe neighborhoods. The waiting list for the housing subsidy program she is applying for is two years. After two months of searching amidst an eviction deadline, Sandy finds a one-bedroom apartment that is a 45-minute drive from her job, although it lacks amenities and requires her children to share a bedroom while she sleeps on a foldout bed in the living room. However, Sandy used her savings for a downpayment on her car and ends up being unable to afford the three months' rent deposit required by the landlord. Being unable to rent the apartment, Sandy is at high risk of homelessness. (Young, 2011, pp. 43–44)

Sandy, according to Young, is a victim of structural injustice because she is neither to blame herself nor has anyone else harmed her in individual interactions. Young goes into more detail on the case, highlighting that everyone Sandy interacted with was decent and respectful towards her, some people even going beyond what can be expected of them morally. Interactions that harm Sandy, such as the landlord asking for a downpayment, are perfectly within the law and social norms. Sandy also doesn't suffer from pure bad luck. Indeed, her situation was predictable and explainable. As Young notes:

> The sources of the generalized circumstance of being vulnerable to homelessness are multiple, large scale, and relatively long term. Many policies, both public and private, and the actions of thousands of individuals acting according to normal rules and accepted practices contribute to producing these circumstances. (Young, 2011, pp. 47–48)

Analogously to Sandy's story, consider the fictitious case of Wendy, which I base on Vesper's case. Wendy had been suffering from vulvar itching for a few weeks. She bought over-the-counter yeast infection ointments in her pharmacy. When that didn't work, she was too ashamed to seek out further help for a while because of social stigma related to medical issues concerning the genital area. However, her partner was very supportive and encouraged her to mention the itching at her next routine gynecological examination. Feeling supported, Wendy overcame her nervousness and told her gynecologist about the symptoms. The gynecologist examined her thoroughly. She had recently had several patients who had quite persistent yeast infections and Vesper's symptoms seemed very similar, so she prescribed her stronger yeast infection treatment, including oral medication. Wendy was relieved about not being severely ill and took the

medication. When it didn't work, she revisited her gynecologist. The doctor could not find anything else that was wrong. Being a contracted physician, she had a lot of patients that day and didn't have more than 15 minutes to spare for Wendy. Seeing how anxious Wendy was, the doctor got worried about the stress causing her to overfocus on the itching. She told Wendy to work on reducing her stress levels. She had seen many patients before getting overly scared after googling their symptoms so, just to be sure, she also gave Wendy the advice to not look up her symptoms online. Wendy got frustrated and her partner encouraged her to seek out a second opinion. Being in Austria and not having the money to go to a private gynecologist, Wendy had to wait for the next quartal to change doctors. She could barely sleep because of the itching, and she grew ever more worried. Going into the appointment of her new gynecologist, she was emotionally exhausted. Therefore, her patient interview was disorganized. She had a hard time remembering the timelines of her symptoms and the exact medication she had previously taken. The second gynecologist tried to gather all the relevant information but didn't grasp the degree to which Wendy's life quality was deteriorating because of the symptoms. She didn't notice anything out of the norm when examining Wendy physically. Ideally, she would have spotted the white spots on the vulva skin which are an indication of lichen sclerosus but she had never seen that illness in a woman younger than 40 and therefore didn't think anything of it. Wendy seemed so anxious and stressed that the doctor figured whatever it was that caused her symptoms, it must be getting worse with all those intense negative emotions. In order not to cause even more anxiety, she told Wendy that everything looked good physically and that she should take care of her mental health and come back for a check-up a year later. Wendy remained undiagnosed and started to think that she must be exaggerating and that the itching probably really was caused by stress. Wendy decided to look for remedies online. She quickly found someone in a Facebook group who sent her links to an alternative treatment. The person sending her these links was truly convinced about the effectiveness of the treatment, which, however, had not undergone scientific testing and was quite expensive relative to Wendy's budget. Unbeknownst to that person on Facebook, she too had lichen sclerosus but had gone into remission (which is common for autoimmune diseases, as they appear in so-called "flares") at the same time as starting that treatment. Wendy spent hundreds of euros on alternative medicine in the next months. She remained undiagnosed for years until she decided to spend the money to go see a private gynecologist. Finally, she was diagnosed and received the correct treatment.

Like Sandy, Wendy wasn't to blame herself. Her partner acted highly morally, supporting Wendy throughout the difficult journey. The first two doctors acted within the law as well as the rules and social norms of their profession. They were respectful towards Wendy and truly wanted to help her. Any shortcomings on their part can be explained and mitigated by a lack of resources, including a lack of further professional training. Wendy also didn't simply suffer from bad luck. It was the actions of several people, accepted practices, and policies that per se are quite sensible (e.g. restrictions on how often one may change a certain medical specialist) that led to circumstances that made Wendy vulnerable to believe that her symptoms were stress-based. Had Wendy not had the resources to seek out the third gynecologist, she may very well have stayed un- or misdiagnosed for years to come. One of many issues was that Wendy was discouraged from doing research. Her first doctor had very good reason to give her that advice, but it also discouraged Wendy from learning to do proper research and to learn to read scientific papers, which she would very much have been able to with the right guidance. In addition, the person on Facebook was very uninformed about autoimmune diseases commonly going into partial or total remission and was unknowingly spreading wrong information. What is more, Wendy was only as overly emotional when seeing the second gynecologist because she was already frustrated from her previous experiences and worn down from the symptoms and their effects on her sleep and well-being. All this indicates that Wendy, like Sandy, suffers from injustice due to the social position that her patient role places her in.

Young notes that Sandy's vulnerability is not merely an individual's story but rather something that happens to her by virtue of her *social-structural position*:

> For the judgment that Sandy suffers injustice refers not to her particular life history, but rather to the *position* she is in. Sandy's situation is similar to that of many others. She and they stand in a position of being *vulnerable to homelessness or housing deprived*. This position, being vulnerable to homelessness, is a social-structural position. Persons in this position differ from persons differently situated in the range of options available to them and in the nature of the constraints on their action. Whether persons occupying the social-structural position of being vulnerable to homelessness actually become homeless will depend partly on their own actions, partly on luck, and partly on the actions of others. Those in a different structural position might act in similar ways, however, and not risk becoming homeless. The issue of social justice raised by this story is whether it is right that *anyone* should be in a *position* of housing insecurity, especially in an affluent society." (Young, 2011, p. 45)

One important common feature of this passage and Wendy's case is that being in a position of a specific vulnerability (of homelessness, or harm from doctors) doesn't necessarily entail actually suffering the harm one is vulnerable to. Wendy, for instance, did suffer for a while but ended up paying out-of-pocket to see a doctor who diagnosed her and with whom she feels

comfortable. Wendy could very well have stayed undiagnosed or misdiagnosed for years, even decades, as is frequently the case with lichen sclerosus (Schlosser & Mirowski, 2015, p. 126). The question we should ask, analogously to Young, is whether it is right that anyone should be in a social-structural position of vulnerability to deep emotional and epistemic harm in medical care. If the answer is no, as I argue it is, then we ought to work on assessing where exactly that vulnerability stems from (as the exact reasons may vary from place to place) and work against it on all possible fronts, in a solidary way.

Here, the dependency factors I discussed above come into play. The more dependent one is on doctors or a concrete doctor, the more one is in a position of vulnerability. And it comes as no surprise that people with chronic illness, medicalized disabilities, periods, pregnant people, elderly people, trans people, overweight people, and people of low socio-economic status are especially vulnerable. The more intense, time-extensive, and frequent an individual's utilization of health care, the more they are in such a position of social-structural vulnerability.

To be clear, let me note that Wendy's case, like Sandy's, is clean of individual moral wrongs for the purpose of analytic clarity. But cases such as Vesper's and Daniel's which do (at least arguably) include individual moral wrongs are no less cases of social-structural injustice in Young's sense than Sandy's and Wendy's case. Structural injustice is not about the absence of individual moral wrongs. It is about vulnerability that occurs not through single individual interactions but as a consequence of an accumulation of several actors (people and/or institutions, who may for example act via policies and laws) who each pursue their particular goals, mostly conforming to widely socially accepted norms. When such an accumulation of factors leads to generalized circumstances of vulnerability, as is the case with emotional and epistemic vulnerability in health care, we ought to consider it as a case of structural injustice.

2.2. Practices and processes that engender harm to patients

Young goes on to elaborate on what exactly the practices and processes that result in housing insecurity are (Young, 2011, p. 48ff). Analogously, there are practices and processes that, in accumulation, result in patient vulnerability to medical, epistemic, and emotional harm. I have discussed patients' dependency-laden relationships to doctors in Part I of this thesis. These dependencies, in and of themselves, are justified. It makes sense that a patient relies on their doctor to explain their diagnosis to them, to assess whether a certain pain has a medically relevant source, or to lead the patient interview such as to navigate through the patient's testimony. In virtue of being in a relation of dependency, the patients are vulnerable to being harmed in all

mentioned areas: they are vulnerable to receiving the wrong diagnosis, being dismissed and overheard, etc. However, patients do not face these risks solely because there are bad doctors out there but because certain practices and processes make it more likely for them to be harmed (by good *and* bad doctors). For instance, as I have previously elaborated with the example of Austria, such processes and practices include high out-of-pocket payments, differences in quality between social and private health care services, different levels of accessibility to health care, decreasing number of contracted physicians, shortages of health care workers, problems in the doctor-patient-communication, and difficult working conditions for health care workers.

Furthermore, patients are vulnerable outside of the medical care system. There are non-social vulnerabilities such as the difficulty of experiencing pain or other burdensome symptoms, and there are vulnerabilities that I consider social, in the sense that we can imagine a social environment in which people are ill but don't go through these difficulties because of a better social imaginary and solidarity. These social vulnerabilities include being scared of becoming "different" (like Marsh, who felt like he "crossed to the other side") or being forced to restructure one's private and professional life after becoming ill. Also, being a patient is often a deeply isolating experience, especially at the beginning of an illness journey, when one has not yet had the chance to establish support systems. These vulnerabilities further contribute to the difficulties in patient-doctor interactions, for example when it comes to communication issues. I have already discussed how patients may suffer from hermeneutic injustice when they are judged to lack a sense of relevance or when their expressive style is deemed overly emotional or confusing. When, on top of that, one is scared and goes through difficult life changes related to these symptoms, their ability to express "what's wrong" may suffer even more.

This goes hand in hand with the way patients are often perceived or treated within their social environment, who will often be mistrustful of ill people's judgment. Patients will frequently be asked by friends, family, and acquaintances: "What did your doctor say?" without follow-up questions such as "And is this feasible for you?", "What do think about that suggestion?", or "And did the doctor listen to you properly?". Also, the social surroundings of patients tend to speak of upcoming doctor's visits in a way that frames these appointments as fix-all salvation moments, when in fact, they are often burdensome endeavors ("Oh, you're still sick? Well, have you gone to the doctor yet?"). Indeed, the social imaginary of doctors as all-knowing and always-caring puts doctors on a pedestal of medical ingenuity and moral heroism, which may harm patients because it makes it harder to question the quality of their care.

Patients being vulnerable in their interactions with doctors is thus due to their social-structural position. Their interactions with doctors are related to policies, beliefs, and actions of numerous groups and individual people in their lives or influencing their lives. Many of these policies, beliefs, and actions operate within the scope of accepted rules and norms, but this may actually reinforce vulnerability because it means that these policies, beliefs, and actions, are difficult to denunciate. The mentioned aspects may be scattered, and it can be difficult to see how they interact with each other. But that is precisely what makes structural relations so inconspicuous. To elucidate that these varying influences on patients' experiences with doctors are indeed the object of structure, I will now follow Young's elaboration of social-structural processes, employing four related aspects. Social-structural processes, according to Young, can be described in the following ways:

> (1) as objective social facts experienced by individuals as constraining and enabling; (2) as a macro social space in which positions are related to one another; (3) as existing, however, only in actions; and (4) as commonly involving the unintended consequences of the combination of the actions of many people. (Young, 2011, p. 53)

Each of these aspects is applicable to patient vulnerabilities, which I will briefly demonstrate.

(1) Objective social constraint

Young mentions two kinds of objective social facts that individuals experience as constraining or enabling. First, there are what she calls "material" constraints. People, often long ago, made decisions, and we live with the material consequences of these decisions. For instance, the way cities are constructed. When it comes to patients, one of these material constraints concerns which illnesses have (not) been studied in the past, and therefore, what diagnostical measures, medical apparatus, and treatments exist. Secondly, there are institutional and social rules, such as legal rules, formal and informal rules, and social norms. Such institutional or social constraints are often followed through habit, but also because they are enforced and because people may feel obligated to follow them, or because they lead to an advantage. As discussed previously, the doctor-patient relationship is constituted by an array of social norms which are not bad in themselves but play a part in establishing status hierarchization of the social positions.

What becomes apparent here is that social structures "appear as objective, given, and constraining. [They] do not constrain in the form of the direct coercion of some individuals over others; they constrain more indirectly and cumulatively as blocking possibilities." (Young, 2011, p. 55) Individuals thus often experience social structures as giving them no choice about (not) doing

something (Young, 2011, p. 56). Not getting medical appointments when one is in pain, not having the time to properly discuss one's symptoms, or facing hurdles when wanting to change doctors are examples of constraints that individuals often have no way of overcoming and that play a crucial role in placing them in a vulnerable position.

(2) Social position

From a sociological perspective, the relationship between a patient and his doctor is, to a large degree, defined before their interaction. In virtue of their social positions, there are expectations and possibilities which condition their interaction. As Young notes, when we look at social positions and relations between them, it is important not to focus solely on individual actions, etc. because that puts us at risk of missing the significance and potential consequences of these actions. (Young, 2011, p. 57) For instance, a doctor disbelieving my symptoms has important significance and potentially bad consequences for me precisely because she is my doctor.

(3) Structures produced in action

As Young notes, structures work because individuals produce them. As with other institutions, within the medical system, people know the rules[27] and play by them for the most part. Both health professionals and patients have certain expectations concerning the way things are done, how others will behave, how much respect is shown to one another, etc. Importantly, depending on one's social position, different rules will apply. And people may be sanctioned if they violate implicit or explicit rules. Conforming to such rules is oftentimes more a matter of habit than of conscious decisions (Young, 2011, pp. 60–61). This production of structures via rules corresponds with what I have remarked on social norms in Part I of the thesis, namely that social norms play a crucial role in establishing the hierarchical dynamics of the doctor-patient interaction. As patients are expected to show trust, respect, and valence towards their doctors, these norms produce the social power doctors hold.

[27] It should be noted that it is not always the case that everyone involved in an interaction knows all the rules for these rules to come into praxis. Indeed, it is often the case that individuals are disadvantaged precisely because they don't know about certain rules or resources and will therefore not be able to take advantage of them. For example, take a student in a prestigious British university who comes from an economically disadvantaged home and who hasn't learned status-related rules of behavior, and therefore has a hard time "fitting in" with the other students, making their academic journey more difficult.

(4) Unintended consequences

As mentioned, the effects of social structure refer not to single cases but to the accumulation of policies and individual actions that are performed through habit or to further individual goals. In other words, structure *doesn't* refer to a coordinated project. Thereby, the outcomes of such accumulations are very often unintended, or even unwanted, by participating agents (Young, 2011, pp. 62–63). This of course also goes for harm to patients. Doctors, nor other participating agents, need to have bad intentions for there to be bad outcomes for patients. Adding to that, it is likely that they are unaware of participating in actions leading to harm to patients.

The doctor-patient interaction, in short, is a specific social locus produced by and reenacting social structure. I therefore believe that the reason for the social power of doctors within the doctor-patient-relationship, and, respectively, the patients' vulnerability, can be much better understood by using the lens of social structure rather than by looking at it as a mere dyadic structure. Being able to take both perspectives is significant for the kinds of normative judgments we make. We should do both: we should strive to create social spaces of doctor-patient-interactions in which patients are less vulnerable, and we should also hold individual doctors accountable to do as good as can be expected of them with the tools they have (This can only be assessed case by case, and needs to take into account how the concrete case is affected by the social-structural processes). In Young's words: "It is important to evaluate both whether people treat one another with respect in their direct interactions with one another, and whether the socially caused positions they are in afford them fair opportunities, especially when compared with the positions of others." (Young, 2011, p. 72) Differentiating between the two points of view is not to isolate them from one another. Rather, this double view enables us to ask if and how we and others contribute to producing vulnerable positionings, and to make informed judgments on individual cases.

Finally, the complexity of injustices caused by social-structural practices calls for solutions that tackle all possible levels, and will thus include the levels of policy (e.g. working against the decline of contracted doctors, better the working conditions of health care staff), scientific research (e.g. gathering qualitative data on patient satisfaction with doctor-patient-communication), patient activism (e.g. furthering patient empowerment through spreading of information on epistemic harm in the health care system and new social images of what it means to be "healthy" and "sick"), the interactional level (e.g. establishing and expanding platforms for the

exchange between doctors and patients, or patient representatives[28]), and the individual level (e.g. doctors reflecting on the social power they hold).

So, while it is possible to examine cases such as Daniel's and Vesper's in isolation, I hope to have shown that a deeper understanding requires us to look at them in terms of Daniel's and Vesper's social positioning as patients interacting with people in the social position of doctors. Only then can we understand why, and to what degree, Daniel and Vesper were harmed, formulate informed judgments (or recognize that we lack the relevant information to do so), and begin to understand what knobs need to be turned to decrease patients' vulnerabilities vis-à-vis their doctors.

3. Conclusion of Part II

In Part II, I have drawn on the current concepts of epistemic injustice to show that patients are vulnerable to testimonial and hermeneutical injustice, as well as medical gaslighting. Drawing on Iris Marion Young's account of structural injustice, I have then argued that a deeper understanding of patients' vulnerability requires us to look into the social-structural processes that place patients in a position of vulnerability. This enables us to better understand actual cases which we ought to assess from the perspective of the interpersonal *and* the structural level as well as their connectedness in order to detect the sources of the problem of patient vulnerability.

[28] An example of such a platform is the "Trialog" in Vienna, which is focussed on mental health disorders. Twice a month, people affected by mental illness, relatives of people who are mentally ill, and professionals in the field of mental health share thoughts and perspectives on psychological crises and illnesses in a semi-structured conversation round (VereinFreiräume, 2021)

Conclusion

In this thesis, I have shown that understanding patienthood as a social role and position deepens our understanding of the ways in which patients are vulnerable to emotional and epistemic harm. In Part I of the thesis, I argued that patients are often dependent on their doctors not just in practical medical ways but also in different emotional and epistemic ways, which include *informational and explanatory dependencies, meaning-making dependencies, conversational dependencies, interpretive/ uptake dependencies, and epistemic validation dependencies*. These dependencies are linked to doctors' social power which exceeds power based directly on their medical expertise and is rather connected to their social position, which leads to a power differential between doctor and patient and the possibility of moral-epistemic harm to patients. Due to social norms and hierarchies, patients will usually conform to rules of behaviors and attitudes, especially attitudes of valence towards their doctors.

In Part II, I used Iris Marion Young's account of structural injustice to argue that the power differential discussed in Part I is caused by a myriad of policies, behaviors, attitudes, and actions brought into praxis by varying institutions, groups, and individual people. I began by showing that while being extremely helpful in understanding epistemic harm to patients, current concepts of epistemic injustice are also hard to apply because they have become so fragmented, which is why we ought to take a step back and look and patients' and doctors' social positions more broadly. Relatedly, the examination of individual cases in isolation is not apt to capture the social positioning of patients and doctors. Instead, we should look at interpersonal problems with a focus on the structural processes that position patients in a way to be vulnerable to emotional and epistemic harm. This, I argue, helps us to make informed normative judgments and detect the buttons that can be pushed to reduce patient vulnerability.

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