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Epistemic Injustice and Clinician Mental Health: The Ethical Implications of Clinician Disclosure

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Abstract

What ethical considerations are at play when healthcare providers disclose, either advertently or inadvertently, their experience with mental ill health to their patients? With the increasing prevalence of mental illness among healthcare providers, questions of ethics and justice surrounding disclosure are paramount to explore. This paper uses narrative analysis to explore the ethics of health care providers disclosing mental ill health to their patients through the lens of Miranda Fricker's (2007) concept of epistemic injustice. I argue that the negative stereotypes attributed to those who experience mental ill health results in an undermining of perceived competence, experiences of epistemic injustice, and the potential for practical harm. Drawing on narratives of an ethical dilemma faced by healthcare providers who have experienced mental ill health, the experience of testimonial and hermeneutic injustice in this context is explored.

Key words: Epistemic injustice, stereotypes, disclosure

Introduction

Our six-member team sat around a table discussing the transcripts and coding of our newly-collected interview data. As part of a large project looking at the experiences of marginalization among healthcare providers who were racialized, ethnic minorities, LGBTQ+, from working class backgrounds, and/or disabled, we had interviewed physicians, occupational therapists, nurses, and social workers from across Canada. One item for which we had been coding was experiences of

ethical tensions that arose as a result of their personal experience with mental illness. This is a quote from that data:

> *Interviewer: Do you find that having a mental illness has raised any particular ethical issues for you, in working?*
>
> *Participant 1: And then, so this is a less kind of one, but just when, I'm just trying to think of having, like, been attending a, seeing a psychologist weekly, for the first year, I just thought, like, there's the potential, I'm a mental health clinician and seeing a mental health clinician myself, I could have bumped into potential patients, and different things in that area. So that didn't happen, but those are potential ethical conflicts. Like, what would I have done with that?*

After reviewing this quote, in which a participant describes a potential accidental disclosure of mental illness as an ethical dilemma, our team was divided on whether this was truly a matter of professional ethics with ethical implications in the clinical encounter. Those of us on the team who held professional designations and had worked in clinical environments unquestioningly accepted that it was, while our colleagues who did not, met our assertion with confusion, agreeing that disclosure would have significant implications, but that it was not a matter of specifically *ethical* tension.

A pattern emerged, however, in healthcare providers continually referencing ethical tensions surrounding the disclosure of mental illness, yet struggling to find the words to explain how or why this was an ethical issue.

> *Participant 2: "so I actually in professional practice, like what am I supposed to do, like how am I supposed to um, choose to answer questions or not about [it]. I don't want to disclose [it], I don't want that to become– 'cause sometimes people, when people get sick they can get really angry, right?"*
>
> *Participant 3: "But then I got into a bit of a jam again, of discomfort…Like, I, a client is going to know that I've, I'm in their shoes. Like, it's just, it's not going to be avoided, at some point. So, I, I did feel a little bit nerve wracked by that."*
>
> *Participant 4: "It means, my identity, if my identity is at a halfway mark, I'm okay to just kind of come clean. If most of my identity is more professional, as far as being in [my*

> *profession], then I have to suck it up a little and fake it a little bit more. Just so that I'm, maybe, let's see, maybe, for the sake of clients, so that they have, you know, confidence that their [healthcare provider] – knows what they're doing."*

In discussing the ethics of disclosure of mental illness to clients, articulate, well-spoken, highly educated professionals struggled to express their experience.

This paper takes as its starting point the participants' stance that disclosure of mental illness creates ethical conflict in clinical practice. It explores the ethical tension involved in healthcare professionals disclosing experience with mental ill health to their patients through the lens of Miranda Fricker's (2007) account of epistemic injustice. Beginning with an exploration of how hermeneutical injustice obscures this experience from being classified as an ethical issue, I argue that the stereotype of those who have experienced mental ill health results in a negative identity prejudice which undermines healthcare providers' credibility and, therefore, capacity, as knowers. This testimonial injustice has ethical implications not only for the most obvious reason that it is an intrinsic injustice to healthcare providers, but also because the prejudice attached to those who experience mental ill health undermines healthcare providers' credibility, which affects perceptions of their competence, which in turn can lead to practical harm in the clinical encounter. The practical harm may not only affect healthcare providers, but also the care received by patients.

Methods/Process

This paper takes a narrative approach to explore the epistemic injustice captured in the above quotes. Using what Gubrium and Holstein (2008) describe as analytic bracketing, analysis shifts between analyzing form, content, and circumstance to explore how testimonial and hermeneutical injustice are at play when healthcare providers disclose mental illness. Although only four anecdotes are used as the primary example from which this analysis draws, they are interpreted in the context of instances of epistemic injustice and ethical tension described by other healthcare providers who experience marginalization in their profession. All participants gave informed consent to participate in the study.

Definitions and key terms

Epistemic injustice, according to Miranda Fricker (2007), takes on two forms: testimonial injustice and hermeneutical injustice. Testimonial injustice occurs when the hearer – in this case the

patient – does not give due credit to the teller's account – in this case the healthcare provider – because of negative prejudicial stereotypes the hearer holds about the identity group to which the teller belongs. Mental illness "is often seen as a mark of moral, social and epistemic failure" (Crichton et al., 2017, p. 68). As such, when the hearer is a patient who holds a prejudice towards those with mental illness, and the healthcare provider discloses they are part of that identity group, an undermining of competence occurs. As competence is a key component of the healthcare provider role and is what grants healthcare professionals the privilege they need to do their job (Parsons, 1939), the prejudice held by the patient that results in testimonial injustice may have ethical relevance in the clinical encounter.

Fricker (2007) describes hermeneutical injustice as another key component of epistemic injustice. Hermeneutical injustice occurs when the concept required to understand one's experience does not exist in the collective conscious – a collective consciousness dominated by more powerful social groups – so members of oppressed groups lack the resources to understand or explain their experience. I argue that hermeneutical injustice occurs in the discussion of ethics in mental health disclosure due to the lack of a concept in the collective consciousness for both experiencing mental ill health and being competent, and the lack of ethical concepts available to understand this experience.

In both cases, of hermeneutical injustice and testimonial injustice, the healthcare provider is wronged in their capacity as a knower either because their account is not given due credit (testimonial injustice) or because the concepts to understand and articulate their experience do not exist because of systemic inequity (hermeneutical injustice). However, the implications of this injustice occurring within the healthcare system have the potential to also cause harm to the patient.

Results and Analysis

The quotes above were voiced by mental healthcare providers while being interviewed by a researcher who was also a healthcare provider. Participants 1 and 4 experienced their first episodes of mental ill health partway through their careers, while participants 2 and 3 experienced mental ill health before and during their professional careers. Throughout the interviews, participants described the ways in which their experiences enhanced the visibility of ethical tensions in the mental healthcare field, including the distribution of clinical resources, but also tensions regarding their position relative to their patients.

Hermeneutical Injustice

The struggle to find words to conceptualize and describe the ethical tension experienced in disclosure was evidenced by the way in which the response was approached. For example, Participant 1 began to answer the question with: "*And then, so this is a less kind of one, but just when, I'm just trying to think of having, like….*" The lack of a concept-at-hand to describe this experience of ethical tension (as, by comparison, would have been readily available had the provider been describing conflict of interest or breach of confidentiality) was apparent. This absence of concept is reflective of the experience of hermeneutical injustice, where a significant part of someone's experience, in this case their experience of ethical tension, does not have a place in the collective understanding (Fricker, 2007). The lacuna of concept for this experience becomes obvious in the participant's attempt to overcome it (Crichton et al., 2017; Hookway, 2010), for example by talking around it and using examples to bring out the nature of the experience. The quotes above suggest participants 2, 3, and 4 tumbled into similar lacunae when grasping for the same absent concept.

Hermeneutical injustice occurs when marginalized groups are excluded from institutions which produce collective knowledge (Carel & Kidd, 2017; Fricker, 2007). A plethora of evidence exists to suggest that healthcare providers have indeed been active contributors, and often gatekeepers, to the production of collective knowledge around clinical ethics and mental health (Carel & Kidd, 2017; Laing, 1967; Szasz, 1960). However, historically excluded from the group of healthcare providers who produced this dominant collective knowledge on professional ethics have been those from marginalized groups, including those who are women, racialized, Indigenous, working class, LGBTQ+, and people who have experienced mental ill health, resulting in epistemic oppression (Martimianakis et al., 2009). As Pohlhaus (2017) describes, "epistemic oppression occurs when particular knowers are precluded from making an impact, not just with shared epistemic resources, but also on shared epistemic resources" (p. 14). The knowledge that exists in the collective understanding of ethical tensions in clinical encounters exists because of the epistemic dominance of groups who find themselves at the centre of the health professions. Concepts surrounding ethical tensions in the context of mental illness disclosure are, therefore, lacking.

Some professions are beginning to acknowledge the bias this epistemic oppression has produced in the production of disciplinary knowledge (Grenier, 2020). I argue that the gap in collective available knowledge extends beyond practice competencies and treatment protocols to also include

ethical issues encountered in clinical practice. Indeed, this was echoed by numerous participants in the study who struggled to find ways to name and explain their ethical experiences using the concepts collectively available. The words are not there to name these ethical dilemmas.

Testimonial Injustice

The second component of epistemic injustice, testimonial injustice, is also evident in the quote from Participant 1. The healthcare provider describes how, "*I'm a mental health clinician and seeing a mental health clinician myself, I could have bumped into potential patients, and different things in that area."* Similarly, Participant 2 describes being stuck with how to respond to questions from clients, and Participant 3 describes the fear that disclosure will decrease patients' confidence in them as a healthcare provider. What this implies is that exposing a mental health issue, as a mental health clinician leaves the clinician open to experiencing testimonial injustice by diminishing their credibility.

Credibility is diminished as a result of the stereotypes associated with mental illness becoming attached to the healthcare provider. A mentally ill person "may be regarded as cognitively unreliable, emotionally compromised, existentially unstable or otherwise epistemically unreliable in a way that renders their testimonies and interpretations suspect simply by virtue of their status as an ill person with little sensitivity to their factual condition and state of mind" (Carel & Kidd, 2014, p. 5-6). This is in direct conflict with the accepted stereotype of the healthcare provider who is impartial, technically competent, and scientifically rational (Parsons, 1939). This accepted stereotype of the healthcare provider is what justifies healthcare provider-patient trust, justifies the clinician's privileged access to information that would otherwise cross social boundaries, and that justifies the ascription of the healthcare provider's wisdom as trustworthy (Parsons, 1939); this forms the foundation of what is commonly taken to be ethical clinical practice. As such, the stereotypes associated with mental illness mean that disclosure of mental illness, either intentionally or out of circumstance, undermines the credibility with which the hearer interprets the clinician's wisdom. This affront is particularly salient given the direct opposition of the stereotypes attributed to someone with mental illness and those attributed to healthcare providers results in testimonial injustice for the healthcare provider.

This injustice can harm the clinician in that it undermines their credibility as a knower, but can also result in practical harm to the patient if the fracturing of clinician credibility leads their knowledge to be disregarded, not based on the value of the knowledge, but on the basis of prejudice towards the

clinician. As Carel and Kidd (2017) describe, those identified as mentally ill may "suffer prejudicial credibility deflations and hermeneutical marginalisation at the hands of medical staff, strangers, colleagues, friends and family, and, perhaps more surprisingly, other ill persons" (p. 338). As such, the clinician is in a place where the stereotype of mental illness leaves them discreditable (Goffman, 1986), meaning at risk of a credibility deflation (Carel & Kidd, 2017) which, if it occurs, can lead to testimonial injustice. This testimonial injustice may result in practical harm to the patient if, due to this lack of credibility, the healthcare provider can no longer access the privileges afforded by their role that may be needed to fulfill their responsibilities in communication with clients.

The majority of literature exploring epistemic injustice in clinical encounters discusses how the patient experiences injustice at the hands of the healthcare provider or the medical system due to their lower status in the power hierarchy (Carel & Kidd, 2014, 2017; Carver et al., 2017; Crichton et al., 2017; Young et al., 2019). This form of injustice is arguably much more common, as the system of power in place in the medical system privileges healthcare providers over patients, typically resulting in patients having a credibility deficit when interacting with and within the healthcare system (Carel & Kidd, 2017). Within this power structure, however, it is not only that patients may be conferred a credibility deficit, but also that healthcare providers may be granted a credibility excess, meaning their testimony is unduly inflated beyond their epistemic capacity (Medina, 2011). It may be argued, therefore, that the diminished credibility that occurs with disclosure of mental illness levels the platform by reducing undue credibility excess, creating the possibility for more equitable and just communication.

This is entirely possible, and was reported by participants 3 and 4 as having occurred in practice. These participants discussed being able to have open and frank conversations with clients after disclosure and the positive impact this had on patient care. It is potentially the case, therefore, that what healthcare providers experience as an injustice is simply a diminishment from their position of inflated credibility to one that reflects their actual epistemic capacity, and is, therefore, actually reducing epistemic injustice, rather than causing it.

Based on the above quotes, however, this seems unlikely to occur in *all* instances of disclosure. The fear of anger, mistrust, discrimination, and discomfort that is captured in these participants' descriptions is rooted in their previous experiences of disclosure within the profession that they either faced themselves or that they have witnessed among others who also experience marginalization that

has resulted in personal, professional, and patient harm. It is particularly this unpredictability of response, the potential for disclosure to cause harm or benefit, that creates ethical tension. There is the possibility for credibility to be diminished to reflect actual epistemic capacity and enhance the quality of communication within the clinical encounter. It is equally possible, however, that credibility will be diminished below actual epistemic capacity, wronging healthcare providers in their capacity as knowers and impacting patient care. Moreover, inequity remains in that the diminishment of epistemic credibility – whether harmful or beneficial – would accrue only to a specific group of clinicians (those disclosing mental illness), and only based on false stereotypes of mental illness.

A diminishment of credibility below their actual epistemic capacity as a healthcare provider, due to stereotypes associated with mental illness, threatens the privileges associated with the actual capacity and typically attributed epistemic capacity to act as a health professional and adequately fulfill their role responsibilities. Importantly, I am not arguing that mental ill health diminishes epistemic capacity to below the level that would be required to adequately fulfill the healthcare provider role. Rather, I am arguing that if the stereotypes associated with mental illness diminish one's credibility to below actual epistemic capacity as a healthcare provider, resulting in testimonial injustice, this testimonial injustice may prevent healthcare providers from adequately fulfilling their role responsibilities due to impaired reception of testimony by patients, which may negatively impact their care. The unpredictability of the level to which credibility will be diminished with disclosure creates ethical tension for the healthcare provider. This ethical tension emerges relating to healthcare providers' responsibility to avoid harm as testimonial injustice directed towards the healthcare provider not only harms the healthcare provider in their capacity as a knower, but also may increase the risk of harm to the patient.

Conclusion

Through a narrative analysis of interviews with healthcare providers who have experienced mental ill health, I explore how themes of epistemic injustice are implicated in disclosure of mental illness to clients. The four quotes provided, in which healthcare providers struggle to put into words the type of ethical dilemma they face in disclosure, form the basis of further analysis of testimonial injustice and hermeneutical injustice. The lack of a ready-at-hand concept available for these healthcare providers to draw on to capture their experience navigating disclosure demonstrates the lack of hermeneutical resources available due to historical exclusion from the professions, resulting in

hermeneutical injustice. It also suggests perceived hermeneutical incommensurability of 'mental illness' and 'competent professional'. Testimonial injustice is also involved, as avoiding disclosure is used to prevent the possibility of testimonial injustice from occurring. Due to the stereotypes associated with mental illness that directly conflict with the role expectations of a healthcare provider, disclosure puts healthcare providers at risk of an undue credibility deficit. The testimonial injustice that arises because of this undue deficit not only wrongs the healthcare provider in their capacity as knower, but puts patients at risk of harm when provider expertise is undermined.

While the majority of literature on epistemic injustice in healthcare focuses on the epistemic injustice done to patients as a result of healthcare provider actions and the broader healthcare system, I argue that healthcare providers also face the threat of epistemic injustice from their patients. This may be particularly salient for healthcare providers with experience of mental ill health, where the stereotypes of mental illness so starkly contrast with those attributed to healthcare providers. However, other marginalized groups who have similarly been excluded from knowledge generation surrounding professional ethics are likely to face similar experiences of hermeneutical and testimonial injustice. As such, Fricker's (2007) theory of epistemic injustice and the contributions by others in its wake may be useful tools to further unearth hermeneutical lacunae in professional ethics and explore how injustice creates harm in the healthcare context.

References

Carel, H., & Kidd, I. J. (2014). Epistemic injustice in healthcare: A philosophical analysis. *Medicine, Health Care and Philosophy*, *17*(4), 529-540. https://doi.org/10.1007/s11019-014-9560-2

Carel, H., & Kidd, I. J. (2017). Epistemic injustice in medicine and healthcare. In I. J. Kidd, J. Medina, & G. Pohlhaus, Jr. (Eds.), *The Routledge handbook of epistemic injustice* (1st ed., pp. 336-346). Routledge. https://doi.org/10.4324/9781315212043-33

Carver, L., Morley, S., & Taylor, P. (2017). Voices of deficit: Mental health, criminal victimization, and epistemic injustice. *Illness, Crisis & Loss*, *25*(1), 43-62. https://doi.org/10.1177/1054137316675715

Crichton, P., Carel, H., & Kidd, I. J. (2017). Epistemic injustice in psychiatry. *BJPsych Bulletin*, *41*(2), 65-70. https://doi.org/10.1192/pb.bp.115.050682

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford Scholarship Online. 10.1093/acprof:oso/9780198237907.001.0001

Gubrium, J. F., & Holstein, J. A. (2008). Narrative ethnography. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of emergent methods* (1st ed., pp. 241-265). Guilford Press.

Hookway, C. (2010). Some varieties of epistemic injustice. *Episteme 7*, 151-163.

Laing, R. D. (1967). *The politics of experience and the bird of paradise*. Penguin Books.

Martimianakis, M. A., Maniate, J. M., & Hodges, B. D. (2009). Sociological interpretations of professionalism. *Medical Education*, *43*(9), 829-837.

Medina, J. (2011). The relevance of credibility excess in a proportional view of epistemic injustice: Differential epistemic authority and the social imaginary. *Social Epistemology*, *25*(1), 15-35. https://doi.org/10.1080/02691728.2010.534568

Parsons, T. (1939). The professions and social structure. *Social Forces*, *17*(4), 457-467.

Pohlhaus, G., Jr. (2017). Varieties of epistemic injustice. In I. J. Kidd, J. Medina, & G. Pohlhaus, Jr. (Eds.), *The Routledge handbook of epistemic injustice* (1st ed.). Routledge.

Szasz, T. S. (1960). The myth of mental illness. *American Psychologist*, *5*(1), 146. https://doi.org/10.1227/00006123-197907010-00080

Young, J. A., Lind, C., Orange, J. B., & Savundranayagam, M. Y. (2019). Expanding current understandings of epistemic injustice and dementia: Learning from stigma theory. *Journal of Aging Studies*, *48*, 76-84. https://doi.org/10.1016/j.jaging.2019.01.003

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