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Diagnostic Overshadowing in Psychiatric-Somatic Comorbidity: A Case for Structural Testimonial Injustice

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Abstract

People with mental illnesses have higher prevalence and mortality rates with regard to common somatic diseases and causes of death, such as cardio-vascular conditions or cancer. One factor contributing to this excess morbidity and mortality is the sub-standard level of physical healthcare offered to the mentally ill. In particular, they are often subject to diagnostic overshadowing: a tendency to attribute physical symptoms to a pre-existing diagnosis of mental illness. This might be seen as an unfortunate instance of epistemic bad luck, where particular features of a group of patients make a timely and correct diagnosis unlikely. While this can explain some cases of diagnostic overshadowing, I argue that in other cases, epistemic injustice is involved. Analyzing the case of diagnostic overshadowing, I distinguish two kinds of testimonial injustice. For one, there are classic cases of transactional testimonial injustice resulting from prejudices against the mentally ill. In addition, there are cases of structural testimonial injustice resulting from features of health care systems. To overcome diagnostic overshadowing, remedies on the individual as well as structural level are thus needed.

"I wish sometimes they'd just actually listen to what I'm saying,
and they could see that it's not always a mental health problem." (Hamilton et al., 2016, 19)

1. Introduction

We are lucky to live in an age where concepts such as patient-orientation and shared-decision making are becoming increasingly prominent, and medical research and practice strive to overcome former paternalist, sexist, racist, or even ableist patterns. Yet, the reality of health care still often falls short of these ideals. Patients continue to report stories of not being listened to, having their treatment preferences disregarded, or feeling offended by medical professionals. The abundance of such patient complaints indicates that communication in health care encounters is often difficult in ethical as well as epistemic respects: patients feel mistreated and the transfer of knowledge is endangered.

In recent years, the concept of *epistemic injustice* (Fricker, 2007) has been applied to health care contexts in order to analyze such mixed ethical-epistemic problems. Epistemic injustice occurs, for example, when a hearer assigns a diminished degree of credibility to a speaker's testimony because of prejudices against the speaker's social group. An example would be to dismiss female medical complaints as exaggerated due to a prejudice of women being oversensitive. Of course, such prejudices, and thus epistemic injustice, are not independent from the general social structure of a society and its distribution of resources and power. What makes the perspective of epistemic injustice particularly fruitful is that it illuminates the epistemic dimension of social inequality and the consequences of undermining people in their capacity as knowers.

The work of Havi Carel and Ian Kidd (2014; 2017) has been seminal in both identifying and analyzing *pathocentric epistemic injustices* sustained by patients. Other scholars have followed in their footsteps and argued for the existence of epistemic injustice in relation to a variety of medical conditions (e.g., Blease et al., 2017; Buchman et al., 2017; Merrick, 2019). It has also been argued that psychiatric patients are particularly vulnerable in this regard (e.g., Crichton et al., 2017; Gosselin, 2018; Scrutton, 2017).

My aim in this article is two-fold. Firstly, I wish to add a focus on epistemic injustice in *diagnosis* to the existing literature on pathocentric epistemic injustice. In particular, I will argue that a certain type of diagnostic error – the phenomenon of *diagnostic overshadowing* – often involves epistemic injustice. Diagnostic overshadowing occurs when a pre-existing diagnosis of a mental disorder leads to delays in recognizing or a failure to recognize additional physical health problems. While the phenomenon of diagnostic overshadowing has received some attention in recent empirical research, it deserves more attention: as I will show, the notion of diagnostic overshadowing can help us understand the negative experiences of mentally ill people with physical health care, which have grave consequences for their health and well-being. Examining diagnostic overshadowing through the conceptual lens of epistemic injustice helps to further illuminate the issue in terms of its causes, potential remedies, and ethical and epistemic responsibilities. Sometimes, diagnostic overshadowing is just epistemic bad luck, resulting from inherent diagnostic difficulties in complex medical cases. However, it can also be the result of testimonial injustice, where the mentally ill experience an unfair discrediting of their report of somatic symptoms.

Secondly, I will use the case of diagnostic overshadowing to illustrate a systematic point: the need for a category of structural testimonial injustice. For Fricker, testimonial injustice requires a prejudiced hearer, such as a clinician disbelieving a patient's complaints based on prejudices against the mentally ill. While that does happen, there are also structural features of the health care system that result in diagnostic overshadowing, such as a lack of feedback mechanisms in cases of misdiagnosis or insufficient integration of mental and physical health care institutions. This accounts for cases of patients being unfairly disbelieved without a prejudiced clinician.

I will start by introducing the case of diagnostic overshadowing and draw on empirical research to illuminate its significance and causes. After reconstructing Fricker's concept of testimonial injustice, I will then argue that cases of diagnostic overshadowing fall into three main categories: epistemic bad luck, transactional testimonial injustice, and structural testimonial injustice. Distinguishing these is consequential as it relates to potential remedies for the issue of diagnostic overshadowing. In particular, establishing a category of structural testimonial injustice emphasizes a need for counter-measures on the level of health care systems, as I will conclude.

2. Physical Health and Mental Illness

2.1 Excess Morbidity and Mortality

People with severe mental illnesses exhibit a highly increased morbidity as well as mortality from common physical diseases. A review by De Hert et al. (2011) concludes that people with severe mental illnesses (SMI; e.g., major depressive disorder, schizophrenia, or bipolar disorder) have higher prevalence rates for nutritional and metabolic diseases, cardiovascular diseases, viral diseases such as hepatitis and HIV, respiratory tract diseases, musculoskeletal diseases, sexual dysfunctions, pregnancy complications, and stomatognathic diseases. They explain these differences in morbidity by lifestyle-related factors risk factors (e.g., smoking, poor diet, and obesity) on the one hand, and treatment-related factors on the other hand. Treatment-related factors include a lack of access to health care, side-effects of common psychiatric medications (such as weight gain), and deficiencies in the care

provided to people with SMIs. For example, people with SMIs are less likely to be screened for metabolic risk factors, to be diagnosed with and/or treated for diabetes mellitus, and to receive specialized interventions or medications for cardio-vascular diseases.

Regarding mortality, a number of nation-wide cohort studies from the Nordic countries have shown that, on average, people with mental disorders have a significantly lower life expectancy than those without mental disorders: approximately 15 years for women and 20 years for men (Gissler et al., 2011; Nordentoft et al., 2013; Wahlbeck et al., 2011). A meta-analysis of 203 English-language cohort studies has found a median reduction in life expectancy of 10.1 years in people with mental illnesses (Walker, McGee and Druss, 2015).[i] Importantly, this gap cannot be completely explained by elevated suicide rates – mentally ill people mostly die of the same typical somatic diseases as the rest of the industrialized west, only earlier. De Hert et al. (2011) estimate that about 60% of the excess mortality in people with SMI is due to physical illness (ibid., 52).

These studies, moreover, agree in painting a multi-factorial picture of the causes of this mortality gap. Wahlbeck et al. (2011) list as explanatory factors "an unhealthy life-style, inadequate access to good-quality physical health care, and a culture of not taking physical disease into consideration when treating psychiatric patients" (ibid., 455). Importantly, they emphasize that the "unhealthy life-style" of people with mental illness is related to socio-economic factors such as poverty, unemployment, and marginalization. Nordentoft et al. (2013) add iatrogenic morbidity to the list of potential causes (e.g., cardiovascular disease and diabetes relating to adverse effects of psychotropic medication), as well as shared genetic risk factors for psychiatric and somatic disorders. Important in the current context, they also point to under-diagnosis and under-treatment of physical disorders among the mentally ill (ibid., 6) – a phenomenon to which diagnostic overshadowing contributes.

2.2 Diagnostic Overshadowing

The term "diagnostic overshadowing" was introduced by Reiss, Levitan and Szysko (1982) and originally referred to a failure to diagnose concomitant mental disorders in people with intellectual disabilities.[ii] A review by Jopp and Keys (2001) confirmed diagnostic overshadowing as a robust effect in clinical practice. Once a patient is diagnosed as intellectually disabled, it becomes less likely that symptoms of concomitant mental disorders will be interpreted as such, rather than attributed to the patient's cognitive deficits. This is the case even though people with intellectual disabilities have a higher risk of mental disorders than their counterparts with average intelligence.[iii]

In recent years, the concept of diagnostic overshadowing has been applied to the problem of psychiatric-somatic comorbidities. As Jones, Howard and Thornicroft (2008) point out, diagnostic overshadowing in psychiatric-somatic comorbidity has a complex causal background: clinician bias and stereotypes may play a role, but so may systemic factors. Moreover, they stress that the sub-standard physical health care offered to the mentally ill resembles similar, well-established patterns with regard to other minorities (e.g., offering fewer diagnostic procedures for cardio-vascular diseases to women or African-Americans). As this means that patients are treated worse based on their membership in a certain group, they argue that it constitutes discrimination. Moreover, they rightly state that this is an important but under-studied issue. There is a lack of knowledge about diagnostic overshadowing in psychiatric-somatic comorbidity in the health professions. Part of the problem here seems to be that, while many professionals are aware that there is some kind of issue, they do not necessarily have a name for it and may discuss it in different terms. For instance, the issue of diagnostic overshadowing also appears in studies on the "continuity of (mental and physical) care" (cf., e.g., Folker et al., 2019).

While there is no exact quantitative data on the extent and impact of diagnostic overshadowing in psychiatric-somatic comorbidity, qualitative research on the experiences of psychiatric patients and physicians confirms the significance of this phenomenon. In a UK study on experiences of

discrimination by mental health service users, the five most common contexts of discrimination reported were welfare benefits, mental health care, family, friends, and physical health care. Within physical health care, the most prominent problems mental health service users reported were experiencing stereotyping, negative judgments of credibility, lack of support, and of not being heard. This related in particular to their physical symptoms being incorrectly interpreted as psychogenic and attributed to the pre-existing psychiatric diagnosis (Hamilton et al., 2016).

Another qualitative study with 31 mentally ill people on experiences in physical health care (Ewart et al., 2016) found that all of the participants reported primarily negative experiences.

> "While participants mentioned some success in access to physical health care, it was always a challenge to find and sustain. This was primarily due to the difficulty attached to escaping inappropriate health provider judgments once a "mental health" diagnosis was noted by a provider. This adversely affected how providers then related to consumers." (Ewart et al. 2016, 7)

The patients described these difficulties as highly consequential. They found them disempowering and damaging to their mental health, as well as generating negative feelings of frustration and anger towards physical health care providers. Unsurprisingly, diagnostic overshadowing also led to worse physical health among the participants, both because it meant their acute somatic problem was not diagnosed but also because they developed a long-term reluctance to visit their physician.

Brämberg et al. (2018) interviewed patients, relatives, and clinicians on barriers to physical health care for people with mental disor. They also found diagnostic overshadowing to be a major concern for both patients and their relatives. Moreover, they attest the occurrence of self-stigmatization and self-doubt.

> "All patients reported self-stigmatization as a barrier to accessing health care. They described previous experiences of not being believed and not being taken seriously. This, in combination with their own thoughts about psychiatric disease, sometimes made the patients doubt whether their somatic symptoms were 'for real'." (ibid., 5)

The clinicians interviewed in this study reported difficulties in assessing patients with mental ill-nesses, because of both a lack of psychiatric knowledge and difficulties in communication. They sometimes found it hard to understand patients' descriptions of symptoms and had difficulty in establishing their medical histories. Moreover, they pointed to barriers on the organizational level, such as the fragmentation of the health care system and a lack of cooperation between its various sections, especially between mental and physical health care.

Other studies have also focused on the experiences of clinicians, especially emergency de-partment staff (Shefer et al. 2014, 2015; van Niuewenhuizen et al. 2013). Van Nieuwenhuizen et al. (2013) found that the interviewed staff members commonly acknowledged diagnostic overshadowing as a significant phenomenon. They recalled some very serious (even fatal) cases:

> "She was discharged and then returned in less than 24 hours…and she actually didn't survive as a result of that…the decision was that her behavior seemed compatible with the pre-existing mental health problem and therefore there was no need to investigate". (ibid., 257)

In addition to such drastic examples, the clinicians suggested that many instances of diagnostic over-shadowing pass unnoticed, where self-limiting physical problems are causing the symptoms or patients simply change their provider. When asked about reasons for the occurrence of diagnostic overshadowing, clinicians pointed to frequent difficulties in communicating with mentally ill patients and difficulties in conducting exams. They also remarked that the stressful natureof emergency departments exacerbates communicative and behavioral challenges for the patients and presents additional time-pressure challenges for the staff. Moreover, they admitted a lack of knowledge about mental disorders that makes it harder for them to assess the symptoms, and they called for a better integration of physical and psychiatric services. Some staff members also reported deliberately avoiding mentally ill patients or to keeping the consultation as short as possible for fear the patients

may become violent; a factor that led to mentally ill patients being less informed about their care. Finally but importantly, the interviewed clinicians acknowledged effects of labeling and stigma:

> "Once you have been labelled as having a psychiatric illness, it's very difficult to put that label to one side and to try to deal with what you have in front of you." (ibid., 259)

> "I think sometimes we focus too much on the mental illness more than the physical…So if a patient comes in and they've got mental problems, like they come in with a broken leg […] then we probably focus more on the mental illness than the broken leg." (ibid, 259)

> "[W]e put it down to the person being a bit overly dramatic through his or her psychiatric problem." (ibid, 257)

Shefer et al. (2014) interviewed 39 clinicians working in emergency departments and came to similar conclusions. The majority of participants (77%) recalled at least one episode of diagnostic overshadowing. Again, many of the cases recalled were severe (four ended in the concerned patients' death). In other cases, delayed diagnosis (and thus treatment) led to irreversible long-term damage, such as a patient becoming paraplegic. Many episodes were near misses: cases that were medically cleared by physicians and later sent back by the psychiatric department. Among these were cases of liver failure, herpes encephalitis, delirium, overdoses of paracetamol, and renal impairment complications.

When asked for explanations, participants identified direct causes related to patients as well as background factors related to clinicians or organizational issues. Among the former were complex presentations with medically unexplained symptoms. When initial tests did not yield results, it was deemed easier to dismiss patient complaints as psychogenic if these patients already had a diagnosis of mental illness. Background factors included time pressure and stigmatizing attitudes among staff members, which became evident in disrespectful comments to or about patients. Moreover, it was often unclear whose responsibility it was to assess these patients, and staff lacked knowledge about mental illnesses and presentations of organic diseases that may look similar.

In summary, while the existing research on diagnostic overshadowing in psychiatric-somatic comorbidity thus has not established its exact prevalence or quantified its contribution to excess morbidity and mortality, it supports the claim that diagnostic overshadowing is an important problem in clinical practice: Literally all interviewed patients complained about it, and the vast majority of interviewed clinicians acknowledged it, too. Concerning the causes, a complex picture emerges in which factors related to mental illness stigma, training, physician's working conditions of physicians, and a lack of integration of physical and mental health care services play a role.

3. Epistemic Injustice

3.1 Miranda Fricker's original account

The concept of epistemic injustice was introduced by Fricker (2007) to characterize a mixed ethical-epistemic problem, which essentially consists in undermining someone in her capacity as a knower. Fricker distinguishes two basic forms of epistemic injustice*: testimonial* and *hermeneutical injustice*. *Testimonial injustice* refers to the speech act of testimony in which a speaker makes an assertion. This assertion can be believed or disbelieved by the hearer based on assumptions about the speaker's credibility in the respective subject matter. While there are some variations, the central case of testimonial injustice involves an *identity-prejudicial credibility deficit*: a hearer assigns a speaker's testimony less credibility than it deserves because of prejudices that concern the speaker's social identity (e.g., her gender, ethnic background, sexual orientation, or class) (ibid., 17-29).

In everyday exchanges, we often need to make credibility judgments quickly and rely on stereotypes to do so. This is not ethically or epistemically problematic per se, as using stereotypes as heuristics in such situations is often unavoidable, automatic, and not necessarily harmful (ibid., 30-41). Fricker defines stereotypes as "widely held associations between a given social group and

one or more attributes" (ibid., 30). Such stereotypes can be connected to positive or negative emotions and be more or less empirically adequate. Stereotypes become ethically and epistemically problematic when they turn into prejudice, which is defined as a stereotypical association, which "embodies a generalization that displays some (typically, epistemically culpable) resistance to counter-evidence owing to an ethically bad affective investment" (ibid., 35). An example would be holding on to beliefs about women being incapable of abstract thinking despite a large number of women being highly accomplished in this regard.

Testimonial injustice concerns individual communicative episodes. It can be *incidental,* i.e., arise from localized, context-specific prejudices. However, often it is *systemic*; i.e., it is connected to social structures and prejudices that affect respective group members in all aspects of their social life (ibid. 27 ff). Especially the harms involved in systemic testimonial injustice tend to be cumulative and pervasive. According to Fricker, the primary ethical harm in testimonial injustice is that the speaker is wronged in her capacity as a knower; a capacity so important to us that undermining it degrades the speaker's very humanity. It can, moreover, lead to secondary, follow-on harms, such as diminished career prospects or a lack of epistemic self-trust of the speaker whose credibility is continually questioned by others. Last but not least, testimonial injustice leads to epistemic losses on the public level, as it hinders the successful transfer of knowledge (ibid., 43 ff.).

The second type of epistemic injustice that Fricker identifies is *hermeneutical*. *Hermeneutical injustice* refers to a lack of conceptual resources that asymmetrically disadvantages certain social groups. Fricker's main example is the situation in which women found themselves before the concept of "sexual harassment" became available. Lacking such a concept, it was difficult for women to understand and precisely express the problems associated with behaviors commonly described as "flirting". This example shows that, while the conceptual gap pertains to all members of society, it is the harassed person, and not the harasser, who suffers most from this lack (in terms of both cognitive and more practical disadvantages).[iv] Moreover, the existence of such gaps is not random but connected to social structures and inequalities (ibid., 147-152). Emphasizing this, Fricker defines hermeneutical injustice as resulting from the hermeneutical marginalization of social groups; that is, the exclusion of these groups from practices that produce meaning and concepts, such as science, journalism, or politics. She thus describes hermeneutical injustice as "the injustice of having some significant area of one's social experience obscured from collective understanding owing to persistent and wide-ranging hermeneutical marginalization" (ibid., 154).

Since such conceptual gaps concern all members of a society – even the most privileged ones – hermeneutical injustice is a *structural* problem: there is no individual agent who can be blamed for the gap. By contrast, Fricker considers testimonial injustice to be *transactional* (even though it is connected to structural inequalities via identity-prejudices): it requires a hearer assigning a deflated degree of credibility to a speaker due to prejudice. For Fricker, this is important to distinguish epistemic injustice from innocent errors that are epistemically and, especially, ethically non-culpable (cf. ibid., 21ff). "The speaker sustains [...] a testimonial injustice if and only if she receives a credibility deficit owing to identity prejudice in the hearer" (ibid., 28). According to this, a credibility deficit that is not caused by a hearer's prejudice is not an instance of testimonial injustice. Consequently, Fricker distinguishes testimonial injustice from epistemic bad luck. She argues that there are situations in which speakers will be disbelieved based on stereotypical assessments of their epistemic trustworthiness but where these stereotypes present usually reliable generalizations. An example she gives is a speaker who avoids looking the hearer in the eye, leading to a negative evaluation of his trustworthiness due to stereotypes of eye contact as a marker of sincerity. Even if this marker usually presents a good rule of thumb, it may fail in particular situations; for instance, if the speaker displays this kind of behavior simply out of shyness (ibid., 41 ff). While the credibility judgment here is incorrect, it is an innocent,

non-culpable error. According to Fricker, such situations should be considered as instances of epistemic bad luck, not of epistemic injustice, to avoid overly blurring the lines of the latter concept (ibid., 42).

In addition, Fricker's approach is rooted in her virtue-ethical framework for epistemic injustice. This overall approach is decisive in her discussion of potential remedies for epistemic injustices: namely, the virtues of testimonial and hermeneutical justice, which describe an individual's willingness and ability to be aware of, and correct for, prejudices and related conceptual gaps. While Fricker identifies social structures and inequalities at the root of epistemic injustices, her virtue-ethical solution has been criticized for placing too much emphasis on individuals rather than social institutions (Alcoff, 2010; Anderson, 2012; cf. also Wanderer, 2016).

3.2 Elizabeth Anderson on structural testimonial injustice

The concept of epistemic injustice has proven to be very fruitful and has inspired a new field of philosophical research and discussion, both regarding applications of this concept and its exact formulation (see Kidd et al., 2017; McKinnon, 2016). Of particular importance to this article is Elizabeth Anderson's (2012) critique of Fricker's original characterization as lacking a category of structural testimonial injustice. Drawing on theories of distributive injustice, Anderson introduces a distinction between *transactional* theories of justice that provide criteria for just personal interactions, and *structural* theories that provide criteria for a just system of rules governing these interactions.

Based on this, Anderson argues that a transactional approach lacks the ability to account for structural epistemic (testimonial) injustice that does not arise from prejudiced hearers, but in which members of disadvantaged social groups nevertheless suffer from unfairly decreased credibility when testifying. She gives a number of examples. Firstly, this relates to cases of testimonial exclusion, or what Fricker calls pre-emptive testimonial injustice. Testimonial exclusion occurs when members of marginalized social groups are not even given the opportunity to testify (Fricker 2007). As Anderson argues, such an exclusion can be transactional, when it results from an identifiable agent's decision. However, in other cases, it is structural, "when institutions are set up to exclude people without anyone having to decide to do so" (Anderson 2012, 166). In the context of health care, an example of structural testimonial exclusion could be medical councils, which gather medical specialists to discuss patients but do not traditionally invite patients to participate. In this example, none of the specialists would actively decide to exclude the patient from the conversation; they would simply conform to normal practice in accordance with hospital regulations.

Secondly, Anderson explains how given testimony can be unfairly discredited without prejudice. For instance, this may happen due to an unprejudiced evaluation of certain markers of epistemic credibility, such as a low level of education. Even if someone's education is generally a good indicator of his epistemic competence, the speaker whose testimony is discredited due to a lack of education can suffer from an injustice in a society with unequal access to education (ibid., 169). Other examples Anderson gives are rooted in common cognitive biases (e.g., ethnocentrism and shared reality bias) that are, as such, morally innocent and even epistemically useful, but cause unfair credibility evaluations of members of disadvantaged groups in a society characterized by structural inequalities (ibid., 169 f.). In the following section (in particular in 4.3), I will further explore these different kinds of testimonial injustice in relation to mechanisms involved in diagnostic overshadowing.

4. Diagnostic Overshadowing as Epistemic Injustice

As described in section 2, patients with mental illnesses have higher prevalence and mortality rates with regard to common somatic diseases and causes of death, such as cardio-vascular disease or diabetes. As this seems to be well-established, the optimal reaction of health care professionals would

be to look out for concomitant physical diseases in the mentally ill and to offer them at least the standard level of diagnostic scrutiny. However, in reality, the exact opposite seems to happen. Even when complaining about physical symptoms to professionals in physical health care, mentally ill patients often suffer from diagnostic overshadowing; i.e., their physical symptoms are attributed to their pre-existing psychiatric diagnosis. Qualitative research shows that mental health service users, as well as their relatives and care givers, consistently report problems in accessing physical health care, experiences of not being listened to, and not being taken seriously. They often interpret these problems and experiences as their testimony about their own bodily experiences receiving an unfairly low degree of credibility because of their mental illness. This also coheres with results from research on clinician perspectives. Based on these empirical results, it seems prima facie plausible that what these patients experience are instances of testimonial injustice. However, the empirical research also shows that the causality behind diagnostic overshadowing is complex. When we look at this in more detail, three different categories emerge: cases of diagnostic overshadowing that correspond to Fricker's concept of transactional testimonial injustice (1), cases of epistemic bad luck (2), and cases of structural testimonial injustice (3).

4.1 Transactional testimonial injustice

For a case of diagnostic overshadowing to count as *transactional testimonial injustice* (1), the diagnostic error needs to be caused by the clinician's devaluation of the patient's credibility due to her prejudices against people with mental illnesses. These prejudices affect her assessment of the patient's report and thereby her diagnostic performance. Unfortunately, this is not as rare as we may wish, as negative stereotypes pertain to chronically ill or disabled people in general, and to the mentally ill in particular.

As mentioned above, Carel and Kidd have argued that ill people are vulnerable to epistemic injustices in health care encounters. Firstly, they identify common prejudices about patients being emotionally compromised and cognitively impaired as a result of being ill. As patients often (and understandably) react somewhat emotionally to their own suffering, and emotionality is often considered the opposite of rationality and epistemic reliability, their testimonies may be regarded as irrelevant or inadequate (e.g., as exaggerating their symptoms). Moreover, the typical health care encounter entails a significant epistemic asymmetry, since the physician represents the expert on medical matters. However, Carel and Kidd argue that this expertise is often unjustly privileged over the expertise that patients (especially patients with chronic illnesses) can have due to their lived experiences. Thus, patients often sustain unfair credibility reductions that are related to prejudices – that is, testimonial injustice. As Carel and Kidd point out, such tendencies to commit testimonial injustice can be amplified by structural features (such as putting the physician under extreme time pressure).

Secondly, experiences of illness are often accompanied by difficulties in articulating them and making oneself understood, which points at hermeneutical injustice. Such hermeneutical injustice can also occur in different ways, as they argue: by excluding patients from meaning-producing practices, by ignoring conceptual resources developed by patients, and by depicting certain styles of expression (e.g., not using specialist medical terminology) as epistemically untrustworthy (cf. Kidd and Carel, 2014, 2017; Carel and Kidd, 2017).

In addition to the problems highlighted by Kidd and Carel, patients with psychiatric diagnoses suffer from mental illness stigma. Stigma is commonly conceptualized as involving three different dimensions: problems of knowledge (ignorance), problems of attitudes (prejudice; i.e., stereotypes with a negative emotional valence), and problems of behavior (discrimination) (Thornicroft et al., 2007). Based on mental illness stigma research, Gosselin (2018) points out three main types of relevant prejudices. These depict people with mental illness as (1) dangerous and violent, (2) incompetent and needing to be taken care of, and (3) having a character flaw such as a lack of willpower.[v] These typical

prejudices against people with mental illnesses relate to epistemic credibility, as they characterize mentally ill individuals as, among other things, irrational, delusional, unable to care for or control themselves, and overly complaining. Such prejudices remain wide-spread and accompany a social marginalization of people with mental illnesses, leading to difficulties regarding access to proper housing, employment, or medical care (e.g., Corrigan and Bink, 2016; Roessler, 2016). Empirical research, moreover, shows that not only lay people but also medical professionals – even mental health care professionals – display negative attitudes towards the mentally ill (e.g., Lauber et al., 2006; Kopera et al., 2015).

The qualitative studies summarized in section 2.2 have also revealed prejudices against mentally ill patients. In particular, the interviewed clinicians reported disrespectful comments to or about patients with psychiatric diagnoses as well as fear of violent outbreaks. This fear of violence was repeatedly reported as a reason to either avoid such patients altogether or to at least minimize the consultation time as much as possible (cf. Shefer et al., 2014; van Nieuwenhizen et al., 2013). This avoidance can be understood as transactional pre-emptive testimonial injustice: the clinician does not even give the mentally ill patient the chance to properly describe his physical symptoms. Obviously, this makes the clinician less likely to reach a correct diagnosis. Moreover, it is intentional behavior that discriminates against a group of patients on the basis of negative stereotypes.[vi]

Patients with mental illnesses have, furthermore, been described as overly dramatic by the interviewed clinicians, who assume that these patients tend to exaggerate their symptoms and deserve less credibility in their physical self-assessment (ibid.). This also means that the clinicians do not trust the patient's own evaluation of her symptoms as physical and distinct from her mental symptoms. Distrusting such self-evaluations because of general beliefs about the incompetency of mentally ill people can be seen as discrediting the patients' expertise stemming from (often life-long) lived experience with a certain mental illness, as described in the work of Kidd and Carel (cf. also Scrutton, 2017).

These reports by clinicians are, moreover, supported by the abundance of patient complaints about not being taken seriously (cf., e.g., Brämberg et al., 2018; Ewart et al., 2016; Hamilton et al., 2016). Based on the empirical evidence, it seems plausible to infer that at least some health professionals tend to neglect physical symptoms and discredit self-reports of mentally ill patients out of prejudice. Some cases of diagnostic overshadowing can therefore be described as instances of classic transactional testimonial injustice.

4.2 Epistemic bad luck

It might be objected that explaining diagnostic overshadowing with testimonial injustice is unfair on physicians. After all, couldn't diagnostic overshadowing be due to inherent difficulties in psychiatric-somatic comorbidity that are independent of prejudice and for which physicians cannot be blamed? In all likelihood, some of the diagnostic errors and delays are just epistemic bad luck. In principle, such bad luck could ensue from two different sources: a complicated clinical presentation of psychiatric-somatic comorbidities, or the clinician's reliance on stereotypes that are generally reliable.

With regard to the first source, there are a number of potential difficulties that will make diagnosis more complicated than usual in cases of psychiatric-somatic comorbidity. For instance, the patient might have a neurological problem with symptoms that seem compatible with his psychiatric diagnosis; or the patient could be displaying symptoms related to his mental disorder and a somatic disease at the same time. In some of these cases, communication with the patient will be genuinely difficult, for example, because the patient is very agitated and/or unable to provide a coherent medical history and an intelligible description of his symptoms. This might make it impossible for even the most

open-minded and engaged clinician to work out what is going on, and it also puts the psychiatric diagnosis into the spotlight.

Concerning such issues in communication, it might be objected that this is not simply bad luck, but hermeneutic injustice unjustly discrediting a different style of expression. As Fricker puts it: "If one lives in a society or subculture in which the mere fact of an intuitive or an emotional expressive style means that one cannot be heard as fully rational, then one is thereby unjustly afflicted by a hermeneutical gap – one is subject to a hermeneutical injustice." (Fricker 2007, 161; see also above on Carel and Kidd 2017). However, this seems somewhat of a stretch and places a high epistemic and ethical burden on individual clinicians if the "style of expression" in question is just incoherent. For instance, a symptom of schizophrenia is "disorganized speech", which can be characterized by topics/sentences being only loosely associated or the use of made-up words. However, many cases will be less extreme than this and will fall somewhere on a continuum between perfectly clear and unintelligible. These cases will require the clinician to make an additional effort in order to make sense of the patient's testimony (to be sure, such cases can also occur among mentally healthy people, such as those experiencing an acute medical emergency, young children, non-native speakers, etc.). There will thus be cases of hermeneutical injustice due to expressive styles, but also cases of genuine bad luck.

With regard to the second source, as we saw above, Fricker does not condemn the use of stereotypes per se, since she holds that stereotypes can be more or less reliable. On her account, if a clinician dismisses patient complaints about somatic symptoms on grounds of a generally reliable stereotype of mentally ill patients, this would amount to epistemic bad luck, not injustice. Thus, the decisive question here is whether beliefs that lead to credibility decrease (e.g., about mentally ill patients being overly dramatic and bad at self-assessment), are generally reliable stereotypes, or whether they are prejudices connected to negative attitudes and resistant to counter-evidence.

A reason why one might suspect stereotypes rather than prejudices here is that mental disorders can in fact interfere with a person's mental capacities and epistemic abilities (e.g., another key symptom of schizophrenia spectrum disorders is delusions). It is not epistemically unjust to assign a speaker who is in the middle of a psychotic episode less credibility and to question his ability to make competent judgements, even regarding judgements that concern his own state of physical health.[vii] Thus, there will be individual cases where a clinician's error is excusable. For example, if a clinician is confronted with a patient who has a known history of hypochondria, which is consistent with his current complaints, she might justifiably but mistakenly discredit the patient's self-assessment of having a somatic disease.

However, this is very different from assuming that all patients with psychiatric diagnoses will be hypochondriacs or delusional, and it is also different from assuming that a patient who has experienced delusional episodes is always delusional and should never be believed. Such generalizations across different diagnoses, people, and timespans are clearly empirically incorrect (as health care professionals in particular can be expected to know), which is why relying on them will lead to prejudiced assessments of patient testimonies. As Gosselin (2018) argues, rather than just assuming that any mentally ill (or any schizophrenic, depressive, etc.) person is generally epistemically compromised, we should only discredit a (mentally ill) person's testimony if we have a good reason to do so in a specific situation:

> "We have a responsibility to treat their testimony and their participation in various practices of knowledge production and meaning-making as credible, assuming it comes from someone sufficiently rational and autonomous to be epistemically credible, unless we have good reason to believe otherwise." (Gosselin, 2018, 89)

In summary, a significant number of cases of diagnostic overshadowing will likely be instances of epistemic bad luck. These are cases where the mental and somatic symptoms are genuinely difficult to distinguish, the mental illness makes communication challenging to impossible, or the credibility

decrease is based on the local assessment of a particular patient's history and presentation in a way that is epistemically and ethically responsible, yet still happens to lead to a false diagnosis. This is important to stress, in order not to place exaggerated ethical and epistemic demands on clinicians. However, not all cases of diagnostic overshadowing can be seen as epistemic bad luck, as this would mistakenly presume a stereotype of the mentally ill as epistemically compromised to be generally reliable.[viii] In general, cases of genuine epistemic bad luck involve a credibility deflation that is not based on the patient's membership in a certain socially salient group (such as "the mentally ill") but on local features of the patient's particular presentation.

4.3 Structural testimonial injustice

So far, I have argued that some cases of diagnostic overshadowing fall into the category of epistemic bad luck, while others can be accounted for by Fricker's concept of transactional testimonial injustice. However, others are best understood as cases of a structural type of testimonial injustice. As described in 3.2, Anderson (2012) provides three kinds of examples for this category: (1) institutional structures prohibiting the testimony of certain people (structural pre-emptive testimonial injustice); (2) differential access to markers of epistemic credibility such as education; and (3) common cognitive biases such as ethnocentrism and shared reality bias, which produce testimonial injustice against members of socially disadvantaged groups in a society with structural inequality, but which are different from prejudice.

In response to discussions in the research field, Fricker's own account of epistemic injustice has evolved since she originally presented it. In particular, she partially concedes the option of structural testimonial injustice to Anderson. However, she restricts this category to the exclusionary form (1):

> "It is worth noting that any such structural testimonial injustice would have to be pre-emptive, for as soon as anyone actually said anything (perhaps they speak uninvited […]), it would become transactional as well as structural, since there would be a speaker whose word was prejudicially received by another party." (Fricker 2017, 56 f.)

Fricker thus allows for cases of structural testimonial injustice that are either pre-emptive or simultaneously transactional and structural.

In addition, she agrees with Coady (2010) that there can be a distributive kind of epistemic injustice that consists in an inequality in access to epistemic goods such as education or expert advice. Based on this, Fricker (2017) distinguishes *distributive* from *discriminatory epistemic injustice*. Given this distinction, Anderson's second example of a structural testimonial injustice, the differential access to markers of epistemic credibility (2), could be understood as a case of structural distributive epistemic injustice. Discrediting someone's testimony due to the speaker's lack of education may often correspond to the speaker's actual level of competence in the matter; the discrediting here is thus not unfair or discriminatory. Yet, there is an epistemic kind of injustice involved, which derives from structural inequalities in society that affect the opportunities of certain social groups to get a good education.

These developments in Fricker's account (allowing for structural pre-emptive testimonial injustice and distributive epistemic injustice) thus enable her to deal with the first two of Anderson's examples of structural testimonial injustice. At the same time, Fricker (2017) argues that it is important to keep the concept of discriminatory epistemic injustice as clearly defined as possible, and distinct from other wrongs, such as, e.g., intentional manipulation. In particular, she rejects the idea of a non-preemptive form of structural testimonial injustice. This rejection, however, lacks an argument that can refute the third of Anderson's examples, in which there is group-based credibility deflation that does not result from prejudice, but from common social biases in conjunction with structural inequality. Such cases are structural, not transactional: the speaker's testimony would be unfairly discredited due to his

social group membership; yet this discrediting does not stem from prejudice but ultimately from structural inequality.

The example of diagnostic overshadowing provides further support for the idea of structural testimonial injustice. Firstly, we might interpret cases of overshadowing in line with Anderson's example (3), where common cognitive biases create unfortunate synergies with structural social inequalities. One could argue that diagnostic overshadowing is caused by a human tendency to focus on certain salient features of medical cases that make it more difficult to see what else is going on (cf. Jopp and Keys 2001 on availability and representativeness bias as potential causes of diagnostic overshadowing). If these salient features (here, the presence of a psychiatric diagnosis) happen to characterize a certain group that is socially marginalized (here, people with mental illnesses), the result would be an unfair group-based credibility deflation not involving prejudice.

Secondly, the example of overshadowing presents a fourth type of structural testimonial injustice: instances of testimonial injustice resulting from structural background conditions that shape diagnostic (transactional) encounters but involve neither prejudices nor cognitive biases. This can occur in a variety of ways, as I will now elaborate in the following.

In the empirical research summarized in section 2.2, clinicians were asked to explain why they believe diagnostic overshadowing occurs. While they reported prejudices against the mentally ill (pointing to transactional epistemic injustice) as well as inherent difficulties in some cases (pointing to epistemic bad luck), many also stressed issues on the organizational and institutional level. For instance, many of them admitted to having a lack of knowledge about mental illnesses (such as their possible presentations and somatic comorbidities) and about possible organic causes of symptoms that may appear psychological (cf. Brämberg et al., 2018; Shefer et al., 2014; 2015; van Nieuwenhuizen et al., 2013). Such a lack of knowledge can lead to misinterpretations and obviously makes it much more difficult to adequately deal with cases of psychiatric-somatic comorbidity. So, here, the cause of diagnostic overshadowing would be ignorance rather than prejudice. This ignorance is at least in part a structural issue. While there is undoubtedly a point at which a clinician's ignorance of medical knowledge becomes morally and epistemically culpable, we can hardly expect every clinician to be familiar with every aspect of medical knowledge (considering its high degree of specialization and speed of proliferation). Minimally, we can require clinicians to know and apply what they have been taught in their medical training. If this training does not provide them with sufficient knowledge of mental illnesses, this lack of knowledge can make them prone to underestimate the credibility of mentally ill patients out of ignorance, not prejudice. This credibility decrease degrades the mentally ill patient as a knower based on membership in a socially salient group, but ultimately stems from the way medical training is organized and what its blind spots are.

Another structural problem the interviewees emphasized was a lack of integration of physical and mental health care services. Rather than having to assign patients to either physical or mental health care services, the clinicians proposed integrated models of teamwork between psychiatrists and physicians. Implementing such models would make it easier to consult a psychiatrist on a difficult case. The clinicians also repeatedly referred to the dominance of a "single disease paradigm" (or rather: single kind of disease paradigm), which expresses the view that patients either have somatic or mental health issues (cf. ibid.). While this is empirically plainly incorrect, the single kind of disease paradigm is deeply ingrained in and promoted by an institutional fragmentation of the health care system, which affects both medical training and the organization of clinical care. In a call for a better integration of mental and physical health care, Druss and Newcomer (2007) distinguish several inter-related dimensions of their fragmentation: geographic, financial (e.g., funding of services or reimbursement of patients), organizational (making it difficult to share information and knowledge across sectors of the system) and cultural (focusing on particular disorders rather than the patient as a whole). This tendency

to keep mental and physical health care distinct constitutes a structural cause of a credibility-deflation of mentally ill patients even in the absence of prejudice. It sets physicians up for failure; yet this is not just bad luck, as it is by no means random but systematically promoted by the organization of the health care system. This organization disadvantages members of socially marginalized and stigmatized group.

Unsurprisingly, clinicians also identified the pressurized working conditions of many health care professionals, such as too restrictive time spans and overly high patient loads, as causal factors in diagnostic overshadowing. While the fragmentation of mental and physical health care presents special difficulties for the mentally ill, these factors likely contribute to diagnostic errors among all patients. Pressured working conditions will be particularly consequential in all sorts of cases that are more complicated and/or require a longer timespan for communication; for instance, patients with physical comorbidities, cognitive disabilities, or young kids. Among these particularly affected groups of patients are those with psychiatric-somatic comorbidities, as these patients will often require more time for a successful diagnosis – in order to give clinicians the opportunity to listen and patients the opportunity to explain not only their current symptoms but also their previous experiences with their respective mental illness, as well as their assessment of the similarities and differences of these experiences.[ix]

Moreover, there seems to be a need for better feedback mechanisms to allow clinicians to recalibrate their diagnostic assessments after errors. As mentioned above, many of the identified cases of diagnostic overshadowing were either highly consequential in terms of harm done to the patient or they were near misses sent back by a psychiatric unit (cf. Shefer et al., 2014; van Nieuwenhuizen et al., 2013). It was suggested that many more cases remain undetected because the patient changes the health care provider, waits for the problem to solve itself, or decides to live with the problem after repeated negative experiences with physical health care. In cases where the patient changes the health care provider, it seems important that, once a correct diagnosis is established, the previous doctor is informed. The point of this is not to blame the previous doctor but rather to provide opportunities for learning. If there is no such feedback mechanism, it might seem to a physician that his stereotype of the mentally ill drama queen is actually empirically supported. He simply never gets to see these patients again and never hears about what the correct diagnosis was. In consequence, he might continue to discredit the testimony of mentally ill patients based on an apparently reliable stereotype, and not on prejudice. Prejudice would involve a culpable resistance to counter-evidence; but the problem here is rather the physician's lack of access to the relevant counter-evidence, which stems from structural features of the health care system.

These different explanations given by clinicians thus point to cases of diagnostic overshadowing in which the patients experience an unfair reduction of their credibility not because their doctors have prejudices about the mentally ill, but because their doctors work in a system that does not provide them with the necessary resources (in terms of time, training, cross-sectoral integration, and feedback mechanisms) to avoid such mistakes. As such, these are instances of structural testimonial injustice. The case of diagnostic overshadowing thus supports Anderson's argument in favor of this category of epistemic injustice by means of an additional kind of example.

5. Conclusion

Approaching diagnostic overshadowing from the perspective of pathocentric epistemic injustice, I have argued that this phenomenon can have different kinds of causes that correspond to different categories. Firstly, there are instances of classic *transactional testimonial injustice*, in which a mentally ill patient's report of physical symptoms is dismissed based on prejudice by an individual physician. Secondly, physicians can also make innocent errors in scenarios where diagnosis is particularly

challenging due to difficulties inherent in some cases of psychiatric-somatic comorbidity, such as a lack of an intelligible description of symptoms or of a coherent medical history. The overshadowing here results from local characteristics of particular cases rather than from a group-based credibility deflation. These are therefore cases of *epistemic bad luck.* Thirdly, there are cases that do not result from prejudice but nevertheless involve an unfair group-based credibility deflation. Here, the credibility deflation is systematically promoted by structural features of the health care system, such as lacunae in medical training, the separation of mental and physical health care, or a lack of feedback mechanisms. These are instances of a category of *structural testimonial injustice.*

Understanding diagnostic overshadowing in terms of pathocentric epistemic injustice can moreover illuminate the harms involved. In terms of the primary harm done, testimonial injustice of both the transactional and the structural type undermine mentally ill patients in their capacity as knowers by unfairly discrediting their testimony of experiences of somatic symptoms. Importantly, this example of testimonial injustice is systemic, as it is connected to general mental illness stigma that affects the mentally ill in all aspects of their social lives.

Secondary harms of this epistemic injustice are also far-reaching. As can be seen from the interviews, patients described their experiences as very disempowering. Many reported that they delay visiting their doctor as they do not expect to be heard and helped, a learned behavior that contributes to under-utilization of physical health care by the mentally ill (cf. Brämberg et al, 2018; Ewart et al., 2016; Hamilton et al., 2016). Repeated experiences of diagnostic overshadowing thus lead to a self-silencing of patients. It also seems likely (or at least an interesting hypothesis for further empirical research) that *testimonial smothering* (Dotson 2011) occurs in patient-physician encounters. Dotson defines testimonial smothering as "the truncating of one's own testimony in order to ensure that the testimony contains only content for which one's audience demonstrates testimonial competence" (ibid., 244). In the current context, this would likely take the form of patients concealing their psychiatric diagnosis, if possible. Obviously, neither avoiding visiting the doctor nor truncating one's testimony to escape credibility deflation will make correct diagnosis and successful treatment any easier. Therefore, diagnostic overshadowing leads to worse physical health and is also detrimental to mental health via experiences of disempowerment and discrimination.

Some patients also reported starting to doubt themselves and losing confidence in their ability to distinguish psychological and somatic symptoms (Brämberg et al., 2018). Fricker (2007) has already identified the loss of epistemic self-trust as a consequence of persistent and systemic epistemic injustice. This seems especially pernicious in the case of interpreting one's one bodily experience, as this is an area where we usually grant people a certain privileged access rooted in their first-person perspective. After all, it is the patients who know best about what symptoms they experience and how far this resembles former episodes of somatic disease or mental disorder. The default assumption should thus be that patients are epistemically trustworthy, whether they are mentally or physically ill or both – unless there is a good reason in a particular case to distrust their testimony.

In addition to these harms on the individual level, diagnostic overshadowing contributes to the increased morbidity and mortality rates among the mentally ill, which is a significant public health issue. The harms of pathocentric epistemic injustice in diagnostic overshadowing are thus wide-ranging and call for remedies. Here, the distinction between a transactional and a structural form of testimonial injustice becomes consequential, as it calls for a combination of counter-measures on the individual and institutional level. With regard to the transactional type, physicians should practice the virtue of testimonial justice, as described by Fricker (2007). We should also find ways to support them in doing this (for instance, via education on bias in medical practice or by combating public mental illness stigma). Yet only targeting physicians will not solve the problem, because this does not alleviate institutional features that promote structural testimonial injustice. These institutional features are a

disservice to both patients and doctors. To fight epistemic injustice in diagnostic overshadowing, it is therefore important to improve medical education and health care services in a way that enables safe and successful communication.

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[i] The higher discrepancy in life expectancy found by the Scandinavian studies can be explained by their inclusion of substance-abuse disorders.

[ii] The contemporary wording of "mental retardation" has been replaced by "intellectual disability" in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013) because of its pejorative character and protests by patient advocates (Regier, Kuhl and Kupfer, 2013).

[iii] Jopp and Keys (2001) also note a phenomenon they call "treatment overshadowing", in which the patient with an intellectual disability and a concomitant mental disorder gets diagnosed but still not treated for that mental disorder (ibid., 418 f).

[iv] Sometimes, the disadvantaged members of marginalized groups create new concepts and understandings of phenomena (for instance, via discourse aimed at consciousness-raising, as was practiced during the 2nd-wave women's movement). In such cases, these new resources sometimes do not catch on, but are willfully ignored by more dominantly situated knowers (Pohlhaus jr., 2012).

[v] Gosselin also emphasizes that the application of these stereotypes differs depending on the kind of mental disorder at hand; e.g., patients with schizophrenia are feared to be uncontrollably violent, whereas those suffering from depression are considered as weak-willed. For discussions of epistemic injustice in relation to specific mental disorders, cf., e.g., Jackson (2017), Sanati and Kyratsous (2017), Miller Tate (2019).

[vi] By contrast, the lack of access to physical health care that often is an effect of the social marginalization of people with mental illnesses could be understood as a structural form of pre-emptive testimonial injustice: the patient does not get the chance to present his symptoms, but this is not the fault of any particular physician.

[vii] For instance, a possible symptom of schizophrenia is somatic delusions, where the patient suffers from the mistaken belief of having a terrible disease.

[viii] Another possibility would be that these assessments of patient reports are based on an assumption that people with mental illnesses are less likely to have somatic comorbidities. Such an assumption, however, would not provide a generally reliable stereotype either, as it is clearly incorrect (see section 2.1).

[ix] Another point mentioned in the interviews (see section 2.2) was that a pre-existing psychiatric diagnosis makes it easier and seemingly more permissible to dismiss a patient quickly and without investing time in lengthy diagnostic procedures (Shefer et al., 2014). This illustrates how prejudice and institutional structures often go hand in hand.