

Structural Inequality in Healthcare: Addressing
Epistemic Injustice in the Case of Life Esidimeni

by

Sasha Lee Smit

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SUPERVISOR: Emma Ruttkamp-Bloem

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ABSTRACT AND KEY TERMS

ABSTRACT:

This dissertation demonstrates that philosophical analysis has real-world applications. Although written in the field of political epistemology, the dissertation engages with knowledge representation and reasoning (KRR) in artificial intelligence (AI) in so far as it focuses on identifying and eliminating obstacles in knowledge acquisition, representation, and communication.

The dissertation focuses specifically on the concept of epistemic injustice. The concept, as coined by Miranda Fricker, refers to a kind of injustice that causes a knower to be undermined in their capacity to give, receive, or understand knowledge. Epistemic injustice is critically discussed in the dissertation and also expanded upon, seeing as Fricker does not address all forms of epistemic injustice in all contexts within which this kind of injustice may arise.

I analyse the concept of epistemic injustice within the specific context of structural inequalities in healthcare in South Africa. To do this, I identify and analyse conceptions of epistemic injustice that can be applied in this context, in the forms of hermeneutic, contributory and documental injustice. I then consider the recent Life Esidimeni tragedy in South African mental healthcare in the context of these kinds of injustice. Lastly, I present an analysis of virtue epistemology, and construct a virtue of epistemic justice that is richer than Fricker's, as a measure to combat epistemic injustice in the context of healthcare in South Africa.

KEY TERMS:

Epistemic injustice; Hermeneutic injustice; Contributory injustice; Documental injustice
Dominant and non-dominant hermeneutic resources; Identity power; Material power; Primary Healthcare (PHC); Mental healthcare user (MHCU); Virtue epistemology; Epistemology; Reliabilism; Responsibilism.

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INTRODUCTION

The focus of the broad discipline of knowledge representation and reasoning (KRR) is on representing knowledge in a sufficiently rich manner for codification into programmes so that they are responsive or sensitive to the world. While this dissertation does not focus on formalising knowledge of the world, it does interface with the objectives of KRR in so far as it focuses on identifying and removing obstacles to knowledge acquisition, representation, and transfer.

In the dissertation, I focus specifically on one such obstacle, namely: epistemic injustice. Epistemic injustice is an injustice that causes a knower to be undermined in their capacity to give, receive, or understand knowledge. It is caused by negative prejudices that may be held by individuals, may exist within particular social structures, or by a combination of both. It negatively affects knowers as it undermines a capacity that is essential for being human¹.

In this dissertation, I consider a particular context in which epistemic injustice negatively affects knowers' capacity for knowledge and thus their capacity to be treated as fully human: epistemic injustice as it emerges within the institution of healthcare in South Africa and mental healthcare specifically. As a basic necessity for all human beings, healthcare provides an example of the dangerous consequences of persistent epistemic injustice within social institutions. Analysing epistemic injustice, in this context, also demonstrates the real-world applications of philosophy. I use the case study of the closure of the Life Esidimeni mental healthcare facilities in Gauteng, South Africa, to demonstrate these real-world applications. Specifically, I identify epistemic injustice as it is evident within this case study; I show the extent to which epistemic injustice can cause serious harm in such situations, and offer suggestions on how to achieve epistemically just contexts in healthcare.

The concept of epistemic injustice gained academic traction after being coined by Miranda Fricker in her 2007 book *Epistemic Injustice: Power and the Ethics of Knowing*. Fricker's book considers the ethical consequences of bad epistemic practices and how such practices negatively affect peoples' ability to contribute to knowledge practices. Fricker aims to produce an epistemological framework for addressing a political and ethical problem, namely

¹ Fricker (2007, 44) and Code (2008) identify epistemic injustice as an injustice that undermines what it means to be fully human.

the problem of viewing all potential epistemic agents, in any given situation, as equally credible knowers.

The topic of epistemic injustice is not philosophically novel. Prior to Fricker's coinage of the term, debates on the topic were evident in fields like race and gender theory, for example. However, the problem of epistemic injustice in its structural forms was seldom addressed as compared to more agential forms of epistemic injustice, despite being prominent in most, if not all, social institutions. Moreover, and despite the focus on agential epistemic injustice, the pervasive nature of power dynamics necessitated a much wider consideration of epistemic injustice.

Fricker makes it clear that epistemic injustice must be identified prior to the idea of epistemic justice (Fricker 2007, viii). She subsequently provides a definite framework for identifying and analysing epistemic injustice, in its many different forms, as a feature of social life. The forms of epistemic injustice that Fricker identifies are, however, not sufficient for understanding and identifying all kinds of epistemic injustice. I therefore introduce other forms of epistemic injustice in this dissertation, insofar as they are relevant to the specific healthcare context that I address.

The dissertation has three main objectives. The first is to understand the concept of epistemic injustice as presented by Fricker as well as in its other forms. The second is to identify epistemic injustice as a structural feature of the South African healthcare and mental healthcare systems. And the third is to suggest virtue epistemology as a potential solution to the problem of combating² epistemic injustice in healthcare.

To achieve the first objective, I discuss how epistemic injustice is socially constructed. I outline Fricker's notion of epistemic injustice and show how this conception is too narrow to include all forms of epistemic injustice. Thereafter, I discuss other forms of epistemic injustice that are not contained in Fricker's conception and provide greater focus on epistemic injustice in its structural forms. This focus assists in addressing my second objective, which pertains to healthcare and mental healthcare in South Africa as social structures or institutions.

² I use the term 'combat' to illustrate that epistemic injustice is something that needs to be addressed as well as prevented. This term is further illustrative of the active process that must be taken up in order to address and prevent epistemic injustice.

To achieve this second objective, I first outline the structure of the South African healthcare and mental healthcare systems. With this outline in place, I analyse how epistemic injustice is, firstly, potentially evident in healthcare and mental healthcare in general, and, secondly, how epistemic injustice is potentially evident in the South African healthcare and mental healthcare systems more specifically. This requires an analysis of how epistemic injustice is actualised in these contexts.

I thus present a particular case study pertaining to the events surrounding the closure of the Life Esidimeni mental healthcare facility, and analyse how this case study is an example of the effects of epistemic injustice in South African healthcare and South African mental healthcare. This case illustrates how nearly 2,000 mental healthcare patients were rapidly moved from the Life Esidimeni care facility into unlicensed not-for-profit, non-government-organisations (NGOs), resulting in the confirmed deaths of 144³ of these patients. My objective is to interpret the events surrounding the Life Esidimeni tragedy as evidence of epistemic injustice resulting from structural inequalities in the South African healthcare and mental healthcare systems.

Finally, to achieve the third objective, I discuss the current debate in virtue epistemology surrounding responsibilist and reliabilist epistemic virtues. I discuss epistemic virtue as a potential tool for combating epistemic injustice through collective or institutional epistemic virtues. To meet this final objective, I construct a concept of the virtue of epistemic justice that is useful in both preventing and addressing epistemic injustice, specifically within healthcare. I apply this concept to the Life Esidimeni case study to assess the ways in which the virtue of epistemic justice may overcome epistemic injustice in such a context.

This third objective serves to fill a gap that exists in discussions regarding suggestions of potential ways to prevent and address epistemic injustice. Fricker herself suggests that a virtue approach is necessary for overcoming epistemic injustice as she defines it. However, critiques of the narrowness of Fricker's conception of epistemic injustice apply to her virtue approach of epistemic justice as well. Once new forms of epistemic injustice have been identified though, it becomes possible to suggest how these new forms of epistemic injustice ought to be acknowledged and addressed.

³ To date there are 144 confirmed deaths as a result of the closure of the Life Esidimeni facilities. However, this is not a final figure as there are still a number of patients missing.

In chapter 1, I aim to explain and critically discuss the concept of epistemic injustice. I start section 1 with a discussion of the socially situated knower, which facilitates an understanding of how social groups can be marginalised by more dominantly situated knowers. The concept of a socially situated knower is necessary in order to understand how a concept like epistemic injustice affects agents within social systems.

In section 2, I introduce Fricker's concept of epistemic injustice as presented in *Epistemic Injustice. Power and the Ethics of Knowing* (2007). First, I discuss the concept of *testimonial injustice*, which refers to the injustice that occurs when a hearer awards a speaker's claim less credibility than it deserves due to a prejudice held towards the speaker. I then outline Fricker's conception of the virtue of testimonial justice, which is intended to assist the hearer in being more epistemically just within testimonial exchanges. Fricker's conceptions of testimonial injustice and the virtue of testimonial justice are vulnerable to several lines of critique however. Therefore, the discussion of these conceptions is followed by an outline of some of these critiques.

Secondly, I deal with the second kind of epistemic injustice Fricker discusses, namely *hermeneutical injustice*. This kind of injustice pertains to hermeneutically marginalised agents who are unable to make sense of their social experiences due to gaps in the epistemic tools needed to understand these experiences. Fricker's conception of the virtue of hermeneutical justice is also outlined. As in the previous case, the critiques of hermeneutical injustice and the virtue of hermeneutical justice are also discussed.

Section 3 addresses alternative interpretations of epistemic injustice. Specifically, I discuss three alternative interpretations of epistemic injustice, namely: an extended view of hermeneutical injustice, contributory injustice, and documental injustice. These are the most relevant alternative interpretations of epistemic injustice for the purposes of this dissertation. I conclude chapter 1 by arguing that Fricker's account of epistemic injustice is too narrow and that the alternative forms of epistemic injustice I discuss enriches the concept.

In chapter 2, I aim to develop an understanding of the structures of the South African healthcare and mental healthcare systems. I begin with a discussion of the current state of healthcare in South Africa. Section 1 outlines the South African healthcare system in general. I discuss: the structure of the South African healthcare system; primary healthcare (PHC) in

South Africa; standards for healthcare in South Africa; and major challenges currently facing the healthcare system in South Africa.

In section 2, I outline the mental healthcare system in South Africa more specifically. I do this through: an overview of the structure of the South African mental healthcare system; a discussion of mental healthcare policy and legislation in South Africa; and, finally, a discussion of some of the major challenges currently facing the South African mental healthcare system. I conclude that healthcare and mental healthcare in South Africa face many challenges that affect the quality of care provided to users.

In chapter 3, I aim to show how epistemic injustice is evident within healthcare and specifically within mental healthcare systems in South Africa. I draw on chapter 1 and chapter 2 to analyse the potential for epistemic injustice in healthcare and mental healthcare. Section 1 presents a discussion of the potential for epistemic injustice in healthcare and mental healthcare in general. This section draws on literature that identifies testimonial, hermeneutical, contributory, and documental injustice in healthcare and mental healthcare, as a feature of these healthcare systems. In section 2, I discuss these epistemic injustices as they relate specifically to the structure of the South African healthcare system, based on the outlines presented in chapter 2 section 2.

In section 3, I outline the Life Esidimeni case study. I provide summaries of two testimonies from family members of deceased mental healthcare patients who were moved from Life Esidimeni into unlicensed NGOs. This case study forms the background to section 4, in which I analyse epistemic injustice in the case of Life Esidimeni. In this section, I identify areas of the case study that display features of epistemic injustice as a structural feature of the South African healthcare and mental healthcare systems. To do this, I present the analysis in terms of four main factors: the marginalising of mental healthcare users; the Gauteng Mental Health Marathon Project and policy; officials' responsibility and failure to listen; and, the overall treatment of mental healthcare users. I conclude that the potential for epistemic injustice in healthcare and mental healthcare is discernible. Moreover, epistemic injustice is actualised in cases like Life Esidimeni, because of structural inequalities in the South African healthcare and mental healthcare systems.

Finally, in chapter 4, I suggest that virtue epistemology may be a way to combat epistemic injustice in healthcare, specifically in South Africa. In section 1, I briefly explain the two

major trends in current virtue epistemology, namely: *virtue reliabilism* and *virtue responsibilism*. In section 2, I revisit the virtues of testimonial and hermeneutical justice as presented by Fricker (2007), as well as the critiques against them. I then construct an argument for a virtue of epistemic justice that is more inclusive than Fricker's. To do this, I use an analysis of Aristotle's concepts of moral and intellectual virtue to formulate an argument for a hybrid reliabilist and responsibilist virtue of epistemic justice. I then address the problem of structural epistemic injustice by analysing how an institution can come to display virtues through the individuals that belong to the institution.

In the final section, I apply this new conception of the virtue of epistemic justice to healthcare by outlining the virtues necessary for being epistemically just as a healthcare professional, or within the healthcare system more generally. I discuss how these virtues could have combated the kinds of epistemic injustice that were apparent in the case of Life Esidimeni. I conclude that, if used correctly, virtue epistemology is a useful tool for combating the kinds of epistemic injustice discussed in the dissertation, within the specific context of South African healthcare and mental healthcare.

I conclude the dissertation as a whole by indicating the relevance of this study as well as suggesting opportunities for further research.

CHAPTER 1: THE CONCEPT OF EPISTEMIC INJUSTICE

In this chapter, I give an overview of the impact social situatedness can have on knowers and the influence it may have on epistemic injustice. I discuss the concept of epistemic injustice as it is presented by Miranda Fricker as well as some of the critiques levelled against this concept. Lastly, I outline some alternative and extended conceptions of epistemic injustice.

1.1) The Socially Situated Knower

Debates surrounding knowledge acquisition and transfer raise important questions about what counts as knowledge, who is taken to be a credible knower, and who is in a position to contribute in contexts where social meaning is created. Knowledge acquisition and transfer is affected by numerous factors, of which social justice is of particular interest. Social situatedness has a direct impact on an agent's moral and epistemic practices. An agent's social positioning, influenced by factors such as race, gender, and class, determine what knowledge they have access to as well as how the tools with which they gain knowledge are developed.

Several thinkers⁴ working on recent debates in political epistemology and related fields address how knowledge acquisition is linked to the social situatedness and social position of knowers. Establishing a link between the kinds of knowledge people have and their social position, raises socio-political questions regarding who has access to certain knowledge and whether or not that knowledge is taken to be of value by people in positions of power.

Satya Mohanty (1993) provides a theory of how personal experience, arising through social processes, can “yield reliable and genuine knowledge” precisely because it is “socially and theoretically constructed” (1993,44-45). She does this through the construction of a realist-cognitivist account of identity that is neither essentialist nor postmodernist, but which still takes seriously what she calls the “epistemic status of cultural identity” (ibid. 42). Mohanty uses the example of Alice who, after joining a feminist consciousness-raising group, comes to realise that certain feelings of depression and guilt she experiences in fact arise out of a response to her actual feelings of anger. The true emotion of anger is no longer misunderstood in terms of feelings of guilt and depression, because the social situation Alice now finds herself in allows her to understand her personal experience in a more informed

⁴ This section will discuss the works of Mohanty (1993), Mills (1988), Pohlhaus, Jr. (2012), and Fricker (2007). Other thinkers engaging in this debate include Mason (2011), Medina (2011; 2012), Anderson (2012), Haraway (1988), and Spivak (2010).

manner (*viz.* Mohanty 1993, 47). It can therefore be said that Alice “comes to know something ... about her self, her personhood, and the range of its moral and political claims and needs” (*ibid.* 48).

This example illustrates two very important things. First, it shows that Alice can attain genuine knowledge through her social experiences (by joining the consciousness-raising group). Second, it shows that prior to the consciousness-raising group Alice was situated socially in such a way that she could misunderstand her social experiences. As a woman, Alice occupied a particular position in society and therefore the knowledge she had access to was determined by the social structure within which she found herself at the moment of interpreting her emotions. Social experience then, as Mohanty correctly states, “can be susceptible to *varying degrees* of socially constructed truth or error, and can serve as a source of objective knowledge or socially produced mystification” (*ibid.* 51).

In her 2012 article, Gaile Pohlhaus, Jr. also refers to the role social situatedness plays in shaping the knowledge that agents come to have. According to Pohlhaus, Jr. “social positioning” affects how one views the world as it allows for the conditions that constitute one’s lived experience (*viz.* Pohlhaus, Jr. 2012, 716-717). In this way, social positioning plays a role in the epistemic resources an agent has access to as “social position has a bearing on what parts of the world are prominent to the knower and what parts of the world are not” (*ibid.* 717). Pohlhaus, Jr. further states that the situated knower is also an “interdependent knower” (*ibid.*) insofar as the “epistemic resources ... *with which* we know operate collectively, not individually” (*ibid.* 718). These resources are developed in relation to the social experiences of groups with the aim of making sense of those experiences.

It is, however, not always the case that the epistemic resources developed collectively are the resources best suited to assist everyone in understanding their social experiences.⁵ It is often the case that marginally situated groups cannot know the world as equally as those in dominant social positions, seeing as the dominant groups constructs the epistemic resources that knowers make use of to understand their social experiences.⁶ Pohlhaus, Jr. claims that there should be a “dialectical relationship” between situatedness and interdependence that allows agents to develop new epistemic resources in case those already available are not

⁵ Mason (2011) makes a similar point by providing an in-depth look at the resources that marginalised groups have and are able to make use of. Mason will be discussed in more detail as a critique of Fricker’s notion of hermeneutic injustice.

⁶ See also e.g. Charles Mills’ (1988) *Alternative Epistemologies* for related points.

suiting to interpreting or comprehending persons' social experiences (ibid. 719). Those in positions of power have the ability to construct these resources, because they can affect which social experiences count in gaining new knowledge.

However, misunderstandings of an agent's social experiences, as in the case of Alice's misinterpretation of her feelings of guilt and depression, occur when there is a "tension" between one's social situatedness and one's interdependence (ibid.). Marginalised social groups do not have the same power as dominant groups to decide which experiences require new epistemic resources. Epistemic resources constructed by marginalised groups are dismissed as "of no immediate use" (ibid.) to those situated dominantly. Marginalised groups are therefore left to make use of epistemic resources that do not help them fully understand their experiences, as the best suited resources are dismissed by dominant groups. It is therefore the case that knowledge gained from their experiences may not be fully understood or accepted because of a tension between an agent's social situatedness and interdependence, despite it being possible (as Mohanty illustrated) that an agent can attain genuine knowledge from their experiences.

The tension between dominant and marginalised social groups in places where meaning is constructed, also reveals the link between knowledge and power politics. Our social situatedness depends on relations of power and is maintained through the organisation of societal structures. For Mohanty, the "political is continuous with the epistemological"; it is the social and political that gives rise to moral knowledge (*viz.* Mohanty 1993, 52-53). However, an injustice arises through the silencing of marginalised social groups and the rejection of their social meanings. Mohanty states that the relationship between knowers and social power "produces forms of blindness" (Mohanty 1993, 74) for those in dominant groups, seeing as they reject what Charles Mills has termed "alternative epistemologies" (Mills, 1988, 237).

Alternative epistemologies are developed by marginalised groups in relation to their social experiences, but are not accepted by those in positions of power as being of any value. Mills calls this a "societal blocking out of unwanted information" by dominant groups (ibid. 247). However, these alternative epistemologies are of value because those with "differential experience" may have a "better chance of developing schemas which objectively reflect their situation" (ibid. 254); they are capable of this as their frame of reference is not limited to their own social experience.

This limitation does, in fact, occur within dominant groups as they dismiss and reject the possibility of knowledge gained from the social experiences of marginalised groups. Mills claims further that, “those at the bottom of the social ladder have usually shown themselves quite well aware that the conditions of their social superiors were quite different from their own” (ibid. 249). It is this access to knowledge of the social system as a whole that can be beneficial to marginalised groups (*viz.* Mills 1988, 243). However, marginalised groups are still unable to fully comprehend and interpret (give meaning to) their own social experiences due to the tension between their situatedness and interdependence. Epistemic resources constructed by marginalised groups are therefore still dismissed by those in positions of power, despite marginalised groups having access to these alternative epistemologies.

It is necessary to understand this rejection and silencing of marginalised groups as a kind of injustice. Both the silencing of marginalised knowers, and the gaps in understanding that marginalised groups face due to their social position, fall under what Miranda Fricker (2007) terms *epistemic injustice*. Identifying this kind of injustice within social and political structures is the first step to overcoming such injustice. Mohanty states that “interpreting the world accurately requires knowing what it would take to change it”, and this is only done through “identifying relations of power and privilege that sustain injustice” (Mohanty 1993, 53). Only after such identification can we begin to take steps to ensure that knowledge acquisition and transfer occurs equally among social groups. Mohanty further states that “good social and political theories make it possible to detect new facts about the world rather than sustain ones already acquired” (ibid. 70).

The above encapsulates Fricker’s reasons for constructing a theory of epistemic injustice. However, her conception of epistemic injustice is vulnerable to several lines of criticism that should be addressed before epistemic injustice can be identified within a particular social structure. In the following sections, I provide a detailed analysis of Fricker’s concept of epistemic injustice and address some of the critiques against it. Based on this, I construct an extended notion of epistemic injustice, which can be applied to the case study in chapter 3, to show how epistemic injustice can potentially exist within the South African healthcare system.

1.2) Miranda Fricker’s Epistemic Injustice

In the previous section, I introduced the idea of epistemic injustice through an understanding of the situated knower. However, to analyse how epistemic injustice can potentially exist

within an institution, it is necessary to understand the concept of epistemic injustice fully. In this section, I explore the concept, as coined by Miranda Fricker, by firstly discussing her concept of *testimonial injustice* and, secondly, presenting some additions and critiques of it. I then do the same with Fricker's concept of *hermeneutical injustice*⁷.

In *Epistemic Injustice. Power and the Ethics of Knowing* (2007), Fricker aims to produce a theoretical framework for analysing an ethical problem with political dimensions, namely the problem of epistemic injustice and its occurrence in the everyday practices of members of society. Fricker's aim is to find a solution to the problem of epistemic injustice by finding ways to view all potential epistemic agents in any given situation as equally credible knowers. Fricker develops a conception of the term epistemic injustice in a way that makes clear to what extent this kind of injustice is present within everyday epistemic practices.

Except in the contexts of decolonisation or subaltern epistemic practices, this problem has not been widely addressed in mainstream Western epistemology up until now. Fricker stresses the urgency of finding ways to allow for fairer and more rational epistemic conduct (viz. Fricker 2007, 4), and provides us with the concepts needed to do so. She claims that, because we seem to take for granted that justice is the norm in epistemic practice, the only way to explore epistemic justice is by "looking at the negative space that is epistemic injustice" (ibid. viii). Fricker further states that it is necessary to explore epistemic injustice as an ethical problem before it can be addressed as a political problem, because the "political depends upon the ethical" (ibid. 8).

Epistemic injustice occurs when an agent is wronged "specifically in their capacity as a knower" (ibid. 1). Fricker explores this injustice by examining what she calls "two of our most basic ... epistemic practices": what she calls "testimonial injustice" and "[hermeneutic] injustice" (ibid. 1). Testimonial injustice is a distinctly epistemic kind of injustice as it wrongs an agent in their *capacity as a giver of knowledge* and hermeneutic injustice a distinctly epistemic kind of injustice as it *wrongs an agent in their capacity as a subject of social understanding* (viz. Fricker 2007, 7. Italics added). It is important to note that epistemic injustice operates on a level of social power that gives social agents the capacity to "influence how things go in the social world" (ibid. 9). This power takes two forms: (1)

⁷ Fricker refers to this kind of injustice as "hermeneutical". From this point I will refer to it as hermeneutic injustice.

agential, as in the case of testimonial injustice; (2) structural, as in the case of hermeneutic injustice.

Testimonial Injustice

Fricker addresses testimonial injustice first. Testimonial injustice is distinctively epistemic as it occurs when a hearer awards a speaker's claim less credibility than it deserves due to a prejudice held towards the speaker based on operations of power that come about as a result of given social identities. The prejudice held by a hearer in testimonial exchange causes a "credibility deficit" (ibid. 17) that Fricker identifies as the cause of this distinctively epistemic kind of injustice. She identifies it as a "deficit", because even though an excess of credibility could cause someone an injustice, it does not necessarily undermine a speaker's epistemic abilities *per se* and would therefore not wrong her "specifically in her capacity as a knower" (ibid. 20).

On the other hand, a prejudice that causes a credibility deficit relates to a person's social identity in that the hearer typically holds a level of social power over the speaker, which results in down-grading the speaker's epistemic agency. Fricker calls this an "identity-prejudicial credibility deficit" (ibid. 28). The prejudices causing this credibility deficit influences a hearer's judgements through stereotypes. The stereotype in question causes the hearer to develop a negative identity prejudice in relation to the speaker, which creates the credibility deficit resulting in testimonial injustice (*viz.* Fricker 2007, 4).

Fricker defines this "negative identity-prejudicial stereotype" as:

A widely held disparaging association between a social group and one or more attributes, where this association embodies a generalization that displays some (typically, epistemically culpable) resistance to counter evidence owing to an ethically bad affective investment (Fricker 2007, 35).

This kind of identity prejudice "distorts the hearer's perception of the speaker" (ibid. 36); it causes the hearer to perceive what the speaker says in a way that results in the hearer awarding less credibility to claims made by the speaker than they deserve.

Identity prejudice can be both structural and agential (*viz.* Fricker 2007, 10). Instances of structural identity prejudice operate at the level of institutions and require no agents.

Structural identity prejudice is seen in instances of hermeneutic injustice, which will be discussed later in this section. Testimonial injustice is agential and can occur only when a particular agent awards a speaker's claim less credibility than it deserves based on prejudice resulting from identity power. In this way, testimonial injustice is always perpetrated by an agent. It is also not the case that a credibility deficit on the part of the hearer can cause an injustice that is non-culpable. Testimonial injustice always occurs as a result of "ethical failure" (ibid. 26) on the part of the hearer, in the form of negative identity-prejudice.

Fricker makes it clear that while credibility excess and credibility deficits may be seen as issues of distributive justice, this is not the case. According to Fricker "credibility is not a good that belongs to the distributive model of justice" (ibid. 19). This is because credibility is not finite in the way other distributive goods are and so there is no competition for credibility as a good to be distributed fairly (viz. Fricker 2007, 19-20). Further, she claims that if credibility is to be seen in the distributive sense it would "fail to capture the distinctive respect in which the speaker is wronged" (in their capacity as a giver of knowledge) (ibid. 20).

Fricker makes use of two examples to illustrate instances of testimonial injustice. The first is taken from Anthony Minghella's *The Talented Mr Ripley*, the second from Harper Lee's *To Kill a Mockingbird*. The example from *The Talented Mr Ripley* presents a woman, Marge Sherwood, being silenced by her father-in-law, Herbert Greenleaf. This silencing comes about when Marge is attempting to convince Greenleaf that her husband, Dickie, was murdered by his friend Tom Ripley. The silencing of Marge takes the form of a single sentence: "Marge, there's female intuition, and then there are facts" (ibid. 9). Marge is silenced by Greenleaf because of the negative identity prejudice Greenleaf holds towards women. He therefore awards Marge's claim less credibility than he would have that of a man (despite the fact that she is telling the truth).

The second example, from *To Kill a Mockingbird*, presents Tom Robinson, a black man on trial for allegedly raping Mayella Ewell, a white woman. Despite several facts in Tom's defence that prove he could not have committed the crime, the white jurors find Tom guilty and he is sentenced to death. As in the previous example, this shows a negative identity prejudice that causes a credibility deficit where there should have been none. The jurors do not believe the defence for Tom Robinson, merely because he is black. Both examples illustrate how people can be victims of identity prejudice that leads to particular agents not

believing their statements true. In both cases, the speakers are undermined in their capacity as givers of knowledge.

Fricker then identifies the specific harms caused by testimonial injustice. Testimonial injustice is most harmful when it is both “persistent and systematic” (ibid. 43). While it is the case that testimonial injustice can inflict harms that are purely epistemic in nature (as it presents a direct obstacle to truth), Fricker focuses specifically on the immediate ethical harm that a hearer inflicts on a speaker in instances of testimonial injustice (viz. Fricker, 2007, 43-44). These harms can be both primary and secondary. The primary harm occurs when one is wronged specifically in their capacity as a knower, which Fricker equates to being “wronged in a capacity essential to human value” causing one to suffer an “intrinsic injustice” (2007, 44). This takes the form of a wrong done to someone in their “capacity as a giver of knowledge”, which partially makes up a person’s capacity for reason. Testimonial injustice’s primary harm is therefore one that undermines what it means to be human (viz. Fricker 2007, 44). Fricker further explains the severity of this harm as one that generates a “social meaning” through “symbolic power” that regards an agent as “less than fully human” (ibid. 44).

The secondary harm exists as “follow-on disadvantages” (ibid. 46) to the primary harm and may take two forms. The first is practical and occurs when an agent suffers even sporadic cases of testimonial injustice. This harm can take the form of, for example, a fine, arrest, rejected job applications, etc. The second form is epistemic and occurs when an agent loses “confidence in his belief, or in his justification for it” (ibid. 47). Systematic testimonial injustice would further cause an agent to “lose confidence in her general epistemic abilities” (ibid.) and, in severe cases, cause a loss of knowledge and intellectual virtues.

Fricker explains the harm of testimonial injustice in the context of an agent’s psychology and social identity: “Testimonial injustice excludes the subject from trustful conversation ... it marginalizes the subject in her participation in the very activity that steadies the mind and forges an essential aspect of identity” (ibid. 53-54). By being persistently disregarded in the ways allowed for by systematic testimonial injustice, an agent is impeded in their natural development as a human being. This may even, according to Fricker, entail a “self-fulfilling prophecy” whereby the agent eventually becomes the kind of person the stereotype identifies her as (ibid. 55).

To address an injustice such as testimonial injustice, Fricker constructs a virtue epistemological account of testimony and the “responsible hearer” (ibid. 66). The responsible hearer, in her view, is one that must adopt an open, critical, but non-inferential stance whereby they “shift from unreflective to reflective mode” to effectively receive an interlocutor’s testimony. She advocates for non-inferentialism, seeing as the responsible hearer ought to exercise their critical openness through perception rather than inference.

A hearer acquires this perception through a “well-trained testimonial sensibility” (ibid. 71). The responsible hearer is thus not one that applies rules in order to arrive at a fair credibility judgement. According to Fricker, “any such rules are after the fact of virtuous judgement” and should serve as guidelines for hearers who do not yet have this trained sensibility (ibid. 73). Rather, hearers attain this virtuous sensibility through “participation in, and in observation of, practices of testimonial exchange” (ibid. 83). This sensibility is always “in training” and should constantly change in order to adapt to individual and collective social experience (viz. Fricker 2007,84).

The responsible hearer must have what Fricker identifies as “the virtue of testimonial justice” (ibid. 86). To acquire the virtuous hearer’s sensibility, which allows a hearer to correct for credibility deficits in their judgement of a speaker’s testimony, a hearer must acquire this virtue. Fricker states that this requires a “distinctly reflexive critical social awareness”, which must be activated when one notices that a credibility judgment is being deflated by prejudice (ibid. 91). This allows the hearer to adjust the credibility they award accordingly, so that the speaker’s claim is treated fairly. As Fricker puts it: “the virtuous hearer neutralizes the impact of prejudice on her credibility judgement” (ibid. 92).

The virtue of testimonial justice can take two forms: (1) it can occur naïvely when an agent is prejudice free from the start; (2) it can take a corrective form through an agent assessing their credibility judgements and correcting them (viz. Fricker 2007, 92-93). Fricker is most interested in the corrective form since a person seldom remains prejudice-free when making credibility judgements; or, as Fricker states:

[T]he virtue will take [a] corrective form, because human societies have prejudices in the air, and these prejudices will tend to shape hearers’ credibility judgements regardless of whether they have succeeded in eliminating prejudice from their beliefs or not (Fricker 2007, 96).

Once the virtue of testimonial justice is fully acquired, a hearer will be able to correct for credibility deficits instantaneously as they have been reconditioned for “ready-corrected” credibility judgements (ibid. 97). However, this can only be attained through the constant practice of realising and correcting for credibility deficits.

In her discussion of testimonial justice as a virtue, Fricker makes the important claim that this virtue is both an intellectual and ethical one. She states that it is thus, in fact, a hybrid virtue as it is both intellectual and ethical.⁸ Moreover, “correcting for prejudice is necessary for avoiding missing out on truths offered by an interlocutor and necessary for avoiding doing them an injustice in their capacity as a knower” (ibid. 126). Therefore, in all cases where the virtue of testimonial justice is displayed, an agent will be both intellectually and ethically virtuous in correcting for any negative identity-prejudicial credibility deficit.

Fricker presents testimonial injustice as the central injustice within epistemic injustice, dedicating six of the seven chapters of her book to constructing the concept. However, several points of critique arise here. Firstly, I address the way Fricker links the epistemic, ethical, and political aspects of epistemic injustice.

Fricker takes epistemic injustice to be an issue that is primarily ethical, focusing specifically on the ethical harms our epistemic practices can and do have on epistemic agents. While I am in agreement with Fricker that epistemic harms have an ethical dimension, I disagree that epistemic injustice is primarily an ethical issue. Fricker’s statement that “the political depends on the ethical” (ibid. 8) in instances of epistemic injustice is problematic. Fricker makes this claim as she insists that epistemic injustice must first be explored as an ethical rather than a political issue. Lorraine Code (2008) points out that Fricker awards equal priority to the epistemic and the ethical “even though epistemology affords her point of entry” while insisting that the political implications of epistemic injustice remain secondary (Code, 2008). Code notes that Fricker’s notion of virtue is not separated from notions of power, and that Fricker’s “analysis in this book is as political as it is ethical” (ibid.). It cannot be the case, as Code points out, that the ethical is primary and the political secondary for Fricker, seeing as her concept of epistemic injustice and her concept of virtue are built on notions of social power.

⁸ In chapter 4, I too make a case for a hybrid virtue of epistemic justice.

This point can be made most clearly if we look at the title of Fricker's book. The title *Epistemic Injustice. Power and the Ethics of Knowing* indicates how power, ethics, and knowing are *all* primary elements in discussions surrounding the nature of epistemic injustice. Moreover, in a 2017 article, Fricker herself notes that the interpersonal is political (2017, 57), stating that the initial focus, when taking marginalisation into account, has to do with "individuals reacting to one another, standing in relations of power to one another" (ibid.). This seems to indicate that Fricker herself understands that power stands in direct relation to issues of epistemic injustice and therefore operates in tandem with the ethical.

As mentioned in the previous section, Mohanty and Pohlhaus, Jr. both illustrate how the epistemic resources we develop are directly linked to our social positioning in ways that allow people in positions of power to determine what it is we can know. In exploring the ethical dimensions of our epistemic practices, it becomes necessary to understand how the political affects these practices. Rather than attempting to separate primary ethical considerations from secondary political considerations, they should be addressed as having mutual relationships with each other. This allows us to see the full range of implications that unethical epistemic practices can, and do, have on agents given their social situatedness.

Perhaps this points out a way in which Fricker's view is too narrow. The views presented in the previous section are, in many ways, more suited to understanding the connections between power, knowledge, and ethics. Fricker raises important questions regarding the ethical implications of epistemic practices; these questions are necessary, seeing as some ethical aspects of our epistemic practices are indeed often pushed aside. However, I do not think this should cause us to view the political dimension as secondary. Rather, as illustrated by Mohanty and Pohlhaus, Jr., these elements should be continuous with each other and their effects explored, as such, when dealing with instances of epistemic injustice⁹.

A second point of critique, loosely linked to the first, is aimed at Fricker's rejection of epistemic injustice as an issue related to distributive justice. As mentioned earlier, Fricker wants to keep the notions of epistemic justice and distributive justice separate, because conflating them may lead to missing what is distinctly epistemic and ethical about epistemic injustice, namely that it undermines an epistemic agent in their capacity as a knower.

⁹ The political, ethical and epistemic should be considered as continuous with one another in instances of both testimonial and hermeneutic injustice.

As mentioned earlier in this section, Fricker claims that for a hearer to withhold credibility in cases of testimonial injustice is not the same as a competition for economic goods because credibility is not finite in the way other distributive goods are; there is no competition for credibility as a good to be distributed fairly. Yet, Fricker herself makes use of the term “credibility economy” (Fricker 2007, 30) to describe how credibility can be polluted by negative identity prejudice, thus allowing for testimonial injustice. By using this term, Fricker describes credibility as something that must be managed in terms of its distribution, as economic goods are.¹⁰ While credibility is not finite, it is still the case that when it is withheld or awarded unfairly, cases of testimonial injustice arise. I think there is something to be said for testimonial injustice involving a kind of distributive justice.

For instance, Elizabeth Anderson (2012) presents a “transactional theory of justice” (Anderson 2012, 163) that allows the credibility deficits within testimonial injustice to be addressed as an issue of distributive unfairness without compromising the ethical and epistemic seriousness of testimonial injustice itself. She states that testimonial injustice can be seen as a kind of transactional injustice, with testimony seen as an “epistemic transaction” (ibid. 165). An injustice would occur in transactions where a hearer is prejudiced towards a speaker and therefore does not fairly award credibility, resulting in the undermining of the speaker as a knower.

David Coady (2017) makes a similar argument for testimonial injustice as a form of distributive injustice. Coady argues that credibility should be seen as a good to be distributed and that, contrary to Fricker, credibility is in fact a finite good (*viz.* Coady 2017, 61-62). Coady draws a comparison between credibility and wealth (a non-epistemic good). He does this to show that Fricker does not actually draw any disanalogy between credibility as an epistemic good and other non-epistemic goods (Coady 2017, 62).

Firstly, he states that in both the cases of wealth and credibility, there is no clear indication of how much of either good any person deserves. This causes competition for these goods. Like in the case of wealth (and goods like education and healthcare), it is possible for someone to

¹⁰ In her 2017 article, Fricker does acknowledge that a kind of “*discriminatory* epistemic injustice” (Fricker 2017, 53) could exist whereby someone receiving less than their fair share of a good like education could be wronged in their capacity as a knower. However, she maintains that this reclassification should remain strict and “not [be relaxed] outwards to embrace the generality of unfair interpersonal manipulations” (ibid.). This strictness Fricker places on the definition of epistemic injustice in the distributive sense still leaves room for the critiques posed in this section.

gain credibility without it causing a loss for another person (ibid. 63). However, it is also the case that in instances of power struggle, one group is awarded more of the good at the expense of the other. This is definitely the case when thinking of credibility as Fricker (2007, 23-26) illustrates in the case of Tom Robinson being awarded less credibility than Mayella Ewell by the jurors of Maycomb County. This point allows Coady to argue against Fricker when she says that credibility is not finite like other distributive goods. According to Coady, credibility is finite and “unfortunately, often in short supply and, as a result, there is often competition for it” (Coady 2017, 62).

Both Coady and Anderson allow us to see that, because testimony is a kind of transaction and the good being transferred finite in such a way to cause competition, a testimonial injustice would definitely occur in instances where this transaction awards credibility unfairly because of a prejudice that someone holds.

Further, it may be the case that credibility is not the only good that requires just distribution in order to correct for testimonial injustice. In cases of testimonial injustice, the distributive issue is perhaps also that of social power. When agents are differently situated within the social structure, transactions cannot “begin from an initially just position” (Anderson 2012, 164). As Fricker states, identity-prejudicial credibility deficits arise when a hearer is in a position of greater social power than a speaker (*viz.* Fricker 2007, 28). It can therefore be said that we must strongly consider the unjust distribution of social power – the general inequality of societies – as a root cause of testimonial injustice.¹¹

This is also the cause for prejudicial deficits in the credibility economy leading to the unfair distribution of credibility. Linking the distribution of power and the distribution of credibility allows us to see credibility in the distributive sense without removing any importance from the ethical and epistemic dimensions of testimonial injustice. Power should therefore be considered in discussions of testimonial injustice, even though power is not an intrinsically epistemic good, as it is the unfair distribution of power that gives rise to testimonial injustice in the first place.

The critique regarding distributive justice is connected to my first critique. It is necessary for Fricker to broaden her view of epistemic injustice and allow that the political be continuous with the ethical and epistemic. Martin Francisco Javier Gill (2008) makes a similar argument

¹¹ This is also true of hermeneutic injustice which will be discussed in more detail in the following section.

regarding distributive justice by asking whether Fricker, in situating epistemic injustice in the broader pattern of social justice, thinks that “the model of recognition deserves priority over the model of redistribution in questions of social justice?” (Francisco Javier Gill 2008, 75).

Fricker (2008) responds to this question by stating:

I doubt, however, that the distributive model could be used to illuminate the phenomenon of testimonial injustice itself, since while matters of distribution can reflect patterns of discrimination, they are after the fact. My interest has been to reveal the structure of the discrimination itself, and for that I have needed to think outside the distributive paradigm. More generally, however, I certainly would not claim that we should not talk about social justice in terms of distribution. On the contrary. The point is simply that if we were to stick exclusively to the distributive framework, then we would not advance our understanding of the structure and ethical impact of injustices which are, at root, forms of discrimination (Fricker 2008, 85).

I disagree with parts of Fricker’s statement. To understand social justice within a distributive framework does not imply doing so exclusively. Because of this, we are able to, and should, understand how issues of social justice are also at the root of discrimination along with the ethical and epistemic dimensions.

Fricker, however, rejects the distributive model of credibility as she does not want the ethical implications of epistemic injustice to be overlooked or undervalued by a focus on the distribution of credibility. This is misguided, as shown by Anderson. Rather, if we look at the issues surrounding the distribution of credibility as directly linked to distributions of social power, we can address issues of testimonial injustice in its entirety without overlooking the ethical seriousness of testimonial injustice.

In her review of Fricker’s book, Kristen Toft (2007) argues along these lines:

[E]pistemic injustice exemplifies how power and ethics are entangled in the symbolic distribution of recognition in the virtual economy of modern knowledge society. The offence caused by epistemic injustice therefore constitutes a real problem in an economy in which knowledge, credibility and trust have become currencies equivalent to, as well as means to obtain, social status (Toft 2007, 117).

Toft clearly shows that our social power depends on the epistemic resources we have access to and vice versa. Furthermore, those without or with limited access to these resources are those who suffer testimonial injustice at the hands of those in power, due to the negative identity prejudices held against them.¹² The distribution of recognition is therefore related to the distribution of social power in a way that makes evident the link between theories of distributive and epistemic justice.

Fricker's concern is that agents should have fair and equal access to epistemic justice. However, she rejects the possible link between inequality of power and epistemic justice. This may be because she views ethical and epistemic considerations as preceding political considerations; it could also simply be that she thinks recognising why there is injustice is more important than redistributing unfairly distributed goods. Of course, the one does not necessarily exclude the other, but the focus is mostly on the latter in contexts of distributive justice whereas she thinks it should be on the former.

As I have argued previously, we achieve a fuller understanding of the causes of testimonial injustice if we see the political, ethical, and epistemological as occurring in tandem with one another. Further, by introducing discussions of distributive justice into discussions of epistemic injustice, we may be able to better ensure that people have fair and equal access to epistemic justice, which is also Fricker's goal.

This leads me to a third point of critique dealing with Fricker's notion of the virtue of testimonial justice. Fricker's idea of a virtuous hearer's sensibility could indeed be helpful in correcting for deficits in credibility. However, Fricker's suggestions on how one attains this sensibility runs into several problems. Fricker advocates for a non-inferential critical awareness that activates when a hearer notices that they are awarding credibility unfairly due to prejudice. However, it is not clear how Fricker expects the hearer to come to this realisation.

Code (2008) presents an argument against Fricker's virtue of testimonial justice indicating that those who hold prejudices often gain certain privileges from these prejudices. It is therefore not clear why a hearer would choose to forgo these prejudices in order to correct for unfair credibility judgements. Furthermore, Code asks whether Fricker thinks "virtue is its

¹² I refer here to systematic instances of testimonial injustice which constitutes Fricker's central case of testimonial injustice. It is possible that instances of incidental testimonial injustice are not caused by such severe imbalances in social power and therefore may not fall into the distributive model of justice in this way.

own motivation” (*viz.* Code 2008), a question Fricker provides no answers for. Code’s second critique of the virtuous hearer’s sensibility focuses on the “moral colour” (Fricker 2007, 71) that such sensibility is meant to create. Code leaves open the question of “who ... determines the colour scheme” (Code 2008). Who is it that determines the correct amount of sensitivity? Or who determines how much credibility is warranted in any given situation?

I think this too is dependent on the social situatedness of hearers and speakers. A marginalised speaker, advocating for a virtuous hearer’s sensibility, would remain unheard in their claims. Fricker makes no argument for why hearers in positions of power would all of a sudden come to know what kind of sensibility is virtuous, especially considering that Fricker claims this sensibility should be non-inferential.

S. E. Marshall (2003) makes a similar argument stating that the training required for a virtuous hearer’s sensibility is “essentially social and perhaps more active than Fricker suggests” (Marshall 2003, 175). It is not clear from a reading of Fricker how one comes to have the virtue of testimonial justice. It is also problematic that Fricker defines negative identity prejudice as resistant to counter evidence. How does one come to know their credibility judgements are prejudiced if they are resistant to evidence that would prove their prejudices to be harmful in the reception of testimony?

Lastly, Fricker claims that this virtue is in constant training and must constantly be practiced in order to adapt to changing social situations. This is problematic, as Anderson points out, as it is “hard for individuals to keep up the constant vigilance” needed to remain virtuous in all social situations (Anderson, 2012, 164). This is especially the case considering Fricker does not tell us how to attain or maintain such a virtue.

These objections do not remove any importance from Fricker’s notion of testimonial injustice. However, they do point towards opportunities for improvement in Fricker’s work. So far, I have discussed Fricker’s concept of testimonial injustice as well as addressed some of the critiques against this concept. I now present Fricker’s concept of hermeneutic injustice, which will receive greater focus in the rest of my dissertation¹³. I will further provide some general critiques of hermeneutic injustice before moving to discuss my first major critique of

¹³ Issues of testimonial injustice will only be discussed further insofar as they relate to issues of hermeneutic injustice and other kinds of structural epistemic injustice. However, this kind of injustice will be considered as secondary as it is not always the case that where there is hermeneutic injustice or other structural epistemic injustice there will also be testimonial injustice.

Fricker in the relation between structural inequality and hermeneutic injustice relating specifically to the structure of healthcare and more specifically, mental healthcare in South Africa.

Hermeneutic Injustice

In the final chapter of her book, Fricker addresses the second kind of epistemic injustice, namely hermeneutic injustice. This injustice arises out of “asymmetrical” (Fricker 2007, 161) power relations whereby those in power “somehow constitute the social world” (ibid. 147) and therefore have greater input in the places where social meaning is created. Social groups in positions of power have greater “epistemological advantage” (ibid.) than those who are not in positions of power. Fricker claims this advantage allows them to have proper tools with which to make sense of their social experiences and leave them with meanings “ready to draw on” whereas the powerless are left with “ill-fitting meanings to draw on” when trying to understand their social experiences. (ibid. 148). This lack of understanding one’s own social experiences is what Fricker terms hermeneutic injustice. Fricker calls those who are not in positions of epistemic power “hermeneutically marginalized” (ibid. 154).

Hermeneutic marginalisation can be the result of material power¹⁴ or identity power¹⁵ or both. Hermeneutic marginalisation occurs when an agent is excluded from hermeneutic participation due to their socio-economic situation – as a result of material power relations. This can be seen for example, when an agent does not have access to sufficient education in order to develop tools with which to understand their experience. On the other hand, hermeneutic marginalisation caused by identity power occurs when epistemic agents are seen in a negative light due to “prejudicial stereotypes in the social atmosphere” (ibid.) which prevents agents from developing the necessary hermeneutic tools needed to understand their experiences. Both material power and identity power may situate a person within a group of lesser power within society and therefore both may contribute to hermeneutic marginalisation in tandem with one another. The harm coming from hermeneutic marginalisation is that those in groups of lesser power are

¹⁴ Here, material power refers to the social inequalities that exist between social groups because one group has less access to material goods, such as education and healthcare, than the other.

¹⁵ Here, identity power refers to the social inequalities that exist between social groups because one group of epistemic agents are seen in a negative light due to socially constructed ideas, preventing them from developing the necessary hermeneutic tools needed to understand their experiences.

discriminated against by virtue of their social identity. This is likewise the case in instances of testimonial injustice. However, hermeneutic marginalisation that leads to hermeneutic injustice is not perpetrated by any particular agent as is the case with testimonial injustice. Rather, in cases of hermeneutic marginalisation, discrimination takes the form of “structural identity prejudice” (ibid. 155).

With the concept of hermeneutic marginalisation in place, Fricker defines hermeneutic injustice as:

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 (ibid. 155).

This definition only caters for the systematic cases of hermeneutic injustice (which Fricker is most interested in) as the structural identity prejudice will harm an agent in many aspects of their social lives. However, it is possible that a “more once-off” moment of powerlessness could cause a hermeneutic injustice (ibid. 156). These are incidental cases of hermeneutic injustice which occur without the structural identity prejudice needed for systematic hermeneutic injustice. Fricker provides an example of incidental hermeneutic injustice from Ian McEwan’s novel *Enduring Love*.

In this novel, a man named Joe is being stalked by another man, Jed, who harbours delusional romantic fantasies about Joe. When Joe is unable to deal with Jed’s behaviour any longer, he takes the matter to the police. However, Joe is not believed by the police or even by his partner, Clarissa, as he is unable to effectively communicate his understanding of his experiences to them. Joe, being a white, educated male is not a victim of social powerlessness due to inequalities in material or identity power. Despite this however, he still suffers a moment of hermeneutic injustice. There is an incidental moment where he is unable to fully communicate the understanding he has of his experience (*viz.* Fricker 2007, 156).

Systematic hermeneutic injustice is not incidental in this way. Cases of systematic hermeneutic injustice occur because either material power or identity power or both impact on an agent throughout several aspects of their social life (*viz.* Fricker 2007, 156). Systematic hermeneutic injustice is not caused by any particular agent but rather occurs purely structurally. However, the moment of injustice requires that an agent attempts to

make intelligible her experience either to herself or to someone else but fails to do so due to the lack of hermeneutic tools available to her (*viz.* Fricker 2007,159). Fricker states that this injustice creates “blanks where there should be a name for an experience which it is in the interests of the subject to be able to render communicatively intelligible” (ibid. 160). This gives hermeneutic injustice a communicative characteristic as the injustice is only realised once the agent lacks the terms with which to explain an experience. But Fricker states that it could also be a case of “expressive style” leading to a hindrance in communication of social experience. Both the concepts and style made use of by members of the hermeneutically marginalised group are not included in the places where social meaning is created.

Like testimonial injustice, hermeneutic injustice consists of both a primary and a secondary harm. Fricker identifies the primary harm in the “situated hermeneutical inequality” (ibid. 162) of resources that render a social experience communicatively intelligible to the agent herself, or to someone else. This, like in the case of testimonial injustice, excludes an agent from the “pooling of knowledge owing to structural identity prejudice in the collective hermeneutical resource” (ibid.). Because marginalised groups are excluded from places where social meaning is created, they are prevented from having access to the collective hermeneutic resource that would allow them to make sense of their social experiences.

The secondary harms, like in cases of testimonial injustice, are both practical and epistemic. Practical harms would include, for example, the symptoms of stress an agent experiences when realising they are unable to make sense of or communicate the meaning of what is happening to them. The epistemic harms occur because an agent, unable to make sense of her experiences, loses epistemic confidence which could lead to a “literal loss of knowledge” and even cause the loss of intellectual virtues (ibid. 163). Fricker further states that hermeneutic injustice can go as far as to “cram[p] the very development of the self” (ibid.) and prevent an agent from becoming the person they should have been, had they not been a victim of hermeneutic injustice. This is again very similar to the harms caused by testimonial injustice. However, Fricker makes it clear that testimonial injustice and its harms occur from individual to individual whereas hermeneutic injustice is not caused by any agent and so no single person is responsible for the harms it inflicts (*viz.* Fricker 2007, 168).

To illustrate hermeneutic injustice, Fricker uses the example of Carmita Wood, a woman facing sexual harassment in the workplace from her boss. This harassment came at a time before the term ‘sexual harassment’ had come into use. Without a way to understand the sexual harassment as anything other than office flirting, Carmita began to suffer physical symptoms caused by the stressful experience. This led to Carmita eventually quitting her job. When asked to provide reasons, in order to receive unemployment insurance, Carmita was unable to explain what had happened to her in any way that she or the investigator could understand, leading to the claim being denied (*viz.* Fricker 2007, 149-150). This example shows how a woman, hermeneutically marginalised due to a structural identity prejudice, is unable to make sense of her social experience due to a lack of necessary interpretive tools. She suffers firstly because she is unable to articulate what has happened to her, because she has no access to the collective hermeneutic resources that would help her make sense of her experience, and thus a gap in collective understanding is created. She further suffers physical harms because of her experience which goes so far as to her quitting her job. This example clearly illustrates the harms of hermeneutic injustice in its primary and secondary forms.

Finally, Fricker moves on to discuss combating hermeneutic injustice through what she calls the “virtue of hermeneutical justice”¹⁶ (*ibid.* 169). This virtue is one that must firstly be taken up by the hearer as a sensitivity towards the speaker who is having difficulty making sense of her experience, instead of seeing her as incompetent. Like in the case of testimonial justice, this virtue requires an element of reflexivity from the hearer rather than the speaker. However, unlike testimonial justice, this virtue is always corrective. This implies the hearer must always be aware of the impact that hermeneutic injustice could have on the speaker. The hearer must notice the “relation between his social identity and that of the speaker as impacting on the intelligibility” of what the speaker is trying to say (*ibid.*).

This sensitivity will allow that the hearer corrects for any credibility deficit that the impaired intelligibility may cause, or as Fricker puts it: “The mediate end of the virtue... is *to neutralize the impact of structural identity prejudice on one’s credibility judgement*” (2007, 173 original emphasis). A hearer who possesses this virtue will be able to rethink his credibility judgement and compensate for it when a speaker is having difficulty communicating their experience. The credibility the hearer awards the speaker would

¹⁶ From this point, this term will be referred to as the ‘virtue of hermeneutic justice’.

then be the same as if there were no hermeneutic gap impairing the speaker's communicative ability. Fricker states that this requires a "pro-active and more socially aware kind of listening" (ibid. 171). The hearer would need to be aware of the "background social theory" (ibid. 172) which could cause a hermeneutically unjust environment for the speaker and so to be able to correct for any credibility deficit that may have occurred on the hearer's part. As with testimonial justice, this virtue is a hybrid intellectual-ethical virtue. However, Fricker makes it clear that this is only a first step and that to further combat hermeneutic injustice, social and structural reform would need to occur.

Fricker's concept of hermeneutic injustice, like testimonial injustice, is open to several lines of critique. Unlike the detailed formulation of testimonial injustice that Fricker presents in the first six chapters of the book, hermeneutic injustice is dealt with in only one chapter. Fricker maintains that several of the ideas discussed in the sections on testimonial injustice facilitate the discussion of hermeneutic injustice. However, it may be the case that the concept of hermeneutic injustice is open to the following critiques because Fricker did not formulate it in as much detail as she did testimonial injustice.

My first critique of hermeneutic injustice suggests that the concept, as presented by Fricker, is too narrow. Firstly, Fricker's view is too narrow in that it rejects that there is an element of distributive injustice within issues of hermeneutic injustice.¹⁷ This links to the argument made against Fricker earlier in this section. Coady (2017) argues that "hermeneutic power, like credibility, is a finite resource" (Coady 2017, 65) and so there exists a competition for it. This links to the argument made earlier in this section stating that testimonial injustice may be caused by an unfair distribution of social power. Coady makes a point of stating that an unequal distribution of hermeneutic power is not necessarily unjust. However, it is the case that when a group is denied hermeneutic power because of an unfair structural prejudice, issues of hermeneutic injustice may arise. It is therefore necessary to distribute hermeneutic power in such a way that allows for agents to participate fairly in the pooling of knowledge and in so doing, allowing for hermeneutic justice.

¹⁷ Although Fricker does not explicitly address hermeneutic injustice as a kind of distributive justice, she does make it clear that epistemic injustice as a whole cannot be addressed as an issue of distributive justice.

Secondly, Mason (2011) addresses the problem that Fricker's view of hermeneutic injustice is too narrow when she claims that Fricker conflates collective hermeneutic¹⁸ resources and dominant hermeneutic resources in such a way that she misses two important points: First she misses that individuals in non-powerful social groups can and do understand their experiences even given their oppression¹⁹, and secondly she misses that it is "bad ethical practices" (Mason 2011, 300) that are responsible for non-dominant understanding remaining outside the collective understanding of the social world. Mason claims that despite the fact that non-dominant groups are excluded from the makings of dominant social meanings causing an inability to explain their social experiences to others, they are still able to make use of the non-dominant resources available to them in order to make sense of their experiences to themselves – she gives the example Fricker herself uses of Carmita Wood. Mason claims that Wood, despite having experienced the harms of hermeneutic injustice, like losing her job, would have been able to understand the wrong done to her, without having had access to the term 'harassment' beforehand (*viz.* Mason 2011, 297). Mason makes the case for an agent having access to tools with which they can understand their own experiences yet still experience hermeneutic injustice as those tools are not accepted by dominant social groups. "Fricker's account of hermeneutic injustice thus pays insufficient attention to non-dominant hermeneutic resources to which members of marginalized groups have access in order to render their social experiences communicatively intelligible" (Mason 2011, 298).

This problematises Fricker's idea that hermeneutic injustice is necessarily an injustice that has to do with language or having certain concepts to make use of to understand one's experiences. Mason explains that, in light of the example provided by Fricker, "women's newly found linguistic ammunition did not indicate that women were, until then, prevented from understanding their experiences of it... naming does not occur *ex nihilo*" (Mason 2011, 298). If Mason is correct, then it is not the case that hermeneutic injustice occurs when there are "blanks where there should be a name for an experience which it is in the interests of the subject to be able to render communicatively intelligible" (Fricker, 2007, 160). Rather, hermeneutic injustice can occur *despite* marginalised agents having some concepts with which to understand their experiences. The injustice occurs because the meanings that non-dominant groups draw on to understand their experiences are not

¹⁸ Mason also uses the term "hermeneutical injustice". I will refer to it as hermeneutic injustice.

¹⁹ Beeby (2011) and Pohlhaus, Jr. (2012) make similar points regarding marginalised agents' ability to understand their experiences. However, Mason coins the term "non-dominant hermeneutical resources" and provides a more detailed explanation of this idea.

accepted and acknowledged by the dominant group. Similarly, providing a term to describe an experience that previously had no name does not mean that the hermeneutic injustice has been overcome. The names of experiences could themselves be rejected by dominant groups and hermeneutic injustice would continue to occur. Naming is not sufficient in overcoming hermeneutic injustice nor is naming the only way through which non-dominant groups can understand their experiences.

Mason's argument links to Mills' notion of alternative epistemologies and Pohlhaus, Jr.'s. notion of situated and interdependent knowers, explained in section 1 of this chapter. An agent's situatedness determines the knowledge they have access to. In the case of those situated marginally, they will have access to non-dominant hermeneutic resources. It is the non-dominant resources that Mills would say give rise to alternative epistemologies, as the understandings non-dominant groups have of their own experiences provide insight into their socially situated position. It could also possibly be the case that marginalised groups have an understanding of dominant hermeneutic resources as well. Further, it is the tension between situatedness and interdependence, according to Pohlhaus, Jr., that allows dominant groups to reject non-dominant hermeneutic resources and makes it impossible for marginalised groups to contribute to the pool of dominant hermeneutic resources. Pohlhaus, Jr. identifies this rejection as a "wilful hermeneutical ignorance" (2012, 716) which allows dominant groups to actively reject information that allows marginalised groups to contribute to the pool of dominant hermeneutic resources. In rejecting this information, the dominant groups actively choose to reject information that may be of use to them in understanding elements of their own social experiences, as it relates to the experiences of non-dominant groups.

These ideas become evident when examining the example of Alice, provided by Mohanty and discussed in section 1. Alice, after joining a consciousness raising group comes to realise that feelings of guilt and depression that she has been experiencing may not be legitimate feelings of guilt and depression. Rather, within a safe environment among other women, Alice comes to realise that her feelings are actually feelings of anger. She also comes to realise that her feelings of depression and guilt came about in response to her anger, in order to cover her true feelings (*viz.* Mohanty 1993, 46-47).

The example of Alice is similar to that of Carmita. Both examples show that marginalised groups can come to have a real understanding and knowledge of their

experiences. Mohanty points out that by Alice coming to understand her true feelings of anger, she comes to know something about “the determining features of her social location” (1993, 71). This is because Alice would only be able to reinterpret her feelings once understanding that her feelings of guilt and depression came about as a result of her marginal position in society (as a woman). It is because of this marginal social positioning that a cover for her true feelings of anger would be necessary. Alice’s new understanding is what puts her in a privileged position of knowing. Her non-dominant hermeneutic resources now make up part of the alternative epistemologies as identified by Mills. Moreover, Alice now also has an understanding that her feelings of depression and guilt came about as a way for her to conform to dominant hermeneutic understandings. Alice therefore understands both the dominant and non-dominant hermeneutic resources that arise out of her situation.

However, Alice’s access to both the dominant and non-dominant resources does not mean that she ceases to be hermeneutically marginalised. It is still the case that those in positions of power will not accept Alice’s new found non-dominant hermeneutic tools. It is here that Alice will experience a tension between her situatedness and interdependence. Her situatedness has resulted in the forming of non-dominant hermeneutic resources, as she is now able to understand her true feelings of anger as being covered by her feelings of guilt and depression. However, Alice is still an interdependent knower as the tools with which she knows operate collectively and are determined by those in positions of power. It will still be the case that Alice’s feelings of anger, once expressed, will be rejected as unfounded. In this way, Alice will experience a tension between the new understanding she has and the understanding those in dominant positions say she should have.

This link makes it important to understand Mason’s notion of non-dominant hermeneutic resources. It is only once we acknowledge that agents do have some understanding of their social experiences to draw on that the tension between situatedness and interdependence becomes evident in the way Pohlhaus, Jr. explicates. Further, an understanding of non-dominant hermeneutic resources shows that alternative epistemologies, as explained by Mills, can provide insight into experiences that dominant groups either do not have access to or completely reject.

In this way, Fricker's notion of hermeneutic injustice being caused by a gap in the "collective [hermeneutic] resource" (Fricker 2007, 155) is too narrow. It is not always the case that agents have no understanding of their social experiences nor is it always the case that they are situated in such a way that they cannot construct new meanings with which to understand their experiences. Because of this, it is necessary to understand hermeneutic injustice also as arising from non-dominant hermeneutic resources not being recognised, rather than being caused by an agent's inability to understand their social experiences due to a gap in the collective hermeneutic resource. This is not to say that hermeneutic injustice cannot occur in the ways Fricker has outlined. It may very well be the case that an agent could potentially have no understanding of their experiences due to hermeneutic marginalisation. However, my argument is that it is not always the case that agents will have no meanings to draw on when making sense of their experiences in instances of hermeneutic injustice.

Taking into account Pohlhaus, Jr's. idea of wilful hermeneutic ignorance, Medina (2017) presents an argument further pointing out that Fricker's conception of hermeneutic injustice is too narrow. Medina argues against Fricker's claim that hermeneutic injustice is a purely structural form of injustice. Rather Medina claims that there are instances where individuals can be seen as perpetrating hermeneutic injustice. Such instances include wilful hermeneutic ignorance as described by Pohlhaus, Jr. In both these cases, dominant groups actively reject the alternative, non-dominant conceptions that agents use to make sense of their social experiences. By dominant groups rejecting the non-dominant resources of marginalised groups, Medina argues that they are perpetrating hermeneutic injustice (*viz.* Medina 2017, 44-45).

Medina challenges Fricker's claim that hermeneutic injustice cannot be agentially produced by making the above argument. However, I do not think Fricker is completely wrong in claiming that hermeneutic injustice is structurally produced. Further, without rejecting Medina's argument, I am of the view that hermeneutic injustice can only be *created* through a structural inequality. It is important that hermeneutic injustice remain a structural notion as it is institutional and structural prejudice (not an individual prejudice) that gives rise to this form of epistemic injustice. However, this is not to say that individuals or groups of individuals cannot hold this prejudice as well. More so, individuals or groups of individuals may also strongly *benefit* from these structural

inequalities. Taking both Fricker's and Medina's arguments into account, I think it would be correct to say that hermeneutic injustice is an injustice that is created through structural prejudice which may also be exacerbated by dominantly situated individuals who actively reject non-dominant hermeneutic resources²⁰.

A further critique of Fricker's discussion of hermeneutic injustice can be posed regarding Fricker's lesser focus on the virtue of hermeneutic justice than on that of the virtue of testimonial justice. Considering the previous argument, hermeneutic injustice is characterised as an injustice *caused* by structural identity prejudice. This distinguishes it from testimonial injustice as hermeneutic injustice cannot be caused by any one agent but is rather produced structurally and may in some instances be exacerbated by individuals. However, the virtue of hermeneutic justice is one that must be adopted by a hearer in order to correct for the credibility deficit that is caused by the speaker being unable to articulate their experience clearly.

There are several problems with this idea. First, I agree that it could possibly be the case that a hearer will be able to understand the problems of articulation that a speaker is having (in instances of hermeneutic injustice) if the speaker is not situated dominantly or if the dominantly situated hearer already has the *virtue of testimonial justice*. However, as mentioned in the previous section, hearers in dominant positions of social power are not so easily able to correct for their individual prejudices, let alone structurally embedded prejudices that cause structural identity prejudice. The virtue of hermeneutic justice is then left open to the critiques posed against the virtue of testimonial justice. There is nothing that distinguishes the virtue of hermeneutic justice from the virtue of testimonial justice if this is the case.

Secondly, Fricker emphasises the point that testimonial and hermeneutic injustice do not necessarily occur in tandem with one another since testimonial injustice is agential and hermeneutic injustice is purely structural. But if the virtue of hermeneutic justice is one that only the hearer can adopt, in cases where hermeneutic injustice occurs where there is no hearer involved, the virtue of hermeneutic justice cannot be applied. Fricker partially provides an answer for this critique when she states:

²⁰ This will be expanded on in the following section as a kind of contributory epistemic injustice rather than a form of hermeneutic injustice.

[T]he moment of [hermeneutic] injustice comes only when the background condition is realized in a more or less doomed attempt on the part of the subject to render an experience intelligible, either to herself or to an interlocutor (Fricker 2007, 159).

If this is the case then in all cases of hermeneutic injustice, there must either be a hearer involved who can apply the virtue of hermeneutic justice when a speaker makes a doomed attempt at articulating themselves out loud, or it would not be possible to carry out the virtue of hermeneutic justice. This is problematic as Fricker defines hermeneutic injustice as a purely structural notion where there is no agent perpetrating the injustice. Why is it then the case that Fricker's remedy for hermeneutic injustice is carried out by an agent? Further, if we accept Mason's idea that agents can make use of non-dominant hermeneutic resources, then this doomed attempt will not occur in such a way that the agent cannot articulate her experience to herself. This suggests that Fricker's virtue of hermeneutic justice should be revised to include remedies for epistemic injustice that occur at a structural level rather than at the agential level. If we take into account Medina's argument that individuals may be in positions to perpetrate hermeneutic injustice, then Fricker's virtue of hermeneutic justice may be effectively adopted by a hearer. However, I have argued that this is not the case. Therefore, the virtue of hermeneutic justice should still be revised in order to account for the structural element in hermeneutic injustice.

I will argue in the next section that hermeneutic injustice is not limited to the moment of a failed attempt at articulation. Rather, it is the case that hermeneutic injustice can occur without a hearer involved as it remains a purely structural kind of injustice with the possibility of individual agents exacerbating the injustice. This means that the injustice will arise from the fact that social structures (and perhaps individuals) deny the importance of non-dominant hermeneutic resources that marginalised groups construct rather than only arising at the moment of a doomed attempt at articulation. It is further necessary to expand the notion of the virtue of hermeneutic justice to include institutional virtues as well as virtuous hearers. A revision of Fricker's virtue of hermeneutic justice will be discussed in chapter 4.

This section provided an overview of Miranda Fricker's conceptions of testimonial and hermeneutic injustice as well as some of the critiques against each. The critiques of

Fricker's concept of epistemic injustice are not limited to the ones I have provided here nor do these critiques take away from the significance of Fricker's formulation of the concept of epistemic injustice. Rather, these critiques identify gaps where Fricker's work can be developed. This is evident based on discussions of how Fricker's conception of epistemic injustice, specifically hermeneutic injustice, is too narrow. In the following section I will present alternative and extended conceptions of epistemic injustice that may help to understand how epistemic injustice potentially exists in more ways than presented by Fricker, specifically regarding epistemic injustice within social institutions.

1.3) Alternative Interpretations of Epistemic Injustice

Many of the critiques against Fricker's notions of testimonial and hermeneutic injustice presented in this chapter relate to Fricker's conception of epistemic injustice being too narrow. This section will present some alternative views of epistemic injustice that will assist in better understanding the scope of such injustices. Through addressing these alternative (and extended) notions of epistemic injustice, it will become possible to analyse the specific kind of epistemic harm done to mental healthcare users in the case of the closure of the Life Esidimeni mental healthcare facility, in chapter 3. Further, this extended conception of epistemic injustice will make room for the discussion – in chapter 4 - of a revised virtue epistemological approach to epistemic injustice, one that can also be applied specifically to the case study presented, and one resulting in a wider interpretation of epistemic injustice than Fricker's original interpretation.

Hookway (2010), Medina (2017), Pohlhaus, Jr. (2017), Dotson (2012) and Lauer (2017)²¹ are among the theorists that have presented alternative interpretations of epistemic injustice. The alternative interpretations presented by Dotson, Pohlhaus, Jr. and Lauer will be explored in detail here as their conceptions link very closely to the arguments discussed in the previous section. Pohlhaus, Jr. presents an argument that shows why it is irresponsible to adopt a narrow, closed conception of epistemic injustice in the way that Fricker does.

Further, Dotson, in line with Pohlhaus, Jr's argument (2012), conceptualises a new kind of epistemic injustice that accounts for the ways that individuals can benefit from structural epistemic inequalities and in that way further perpetrate epistemic injustice. They therefore

²¹ The alternative theories of epistemic injustice by Hookway (2010) and Medina (2017) outlined in this section are brief due to the fact that they are not intended to further my conception of epistemic injustice. Rather they are included to indicate that such alternative interpretations exist and may be applied effectively in other instances of epistemic injustice.

contribute directly to my exploration of epistemic injustice within the healthcare system as epistemic injustice within the healthcare system is based on structural inequalities that do not necessarily fall within Fricker's conception of hermeneutic injustice. A further alternative conception of epistemic injustice that links very closely to epistemic injustice in the health sector is Lauer's idea of "documental injustice" (2017, 1). This conception is useful in that it shows how agents belonging to the dominant social groups may use their epistemic credibility excess to benefit from structural inequality and still further disadvantage marginalised groups.

Thus, the following alternative interpretations presented by Medina and Hookway will be explained only briefly below as they do not form part of the main parts of my argument but are nonetheless relevant to my study. I will then move on to a discussion of Pohlhaus, Jr., Dotson and Lauer. The purpose of outlining Medina and Hookway's views is to support my view that Fricker's conception of epistemic injustice is too narrow. Both Hookway and Medina present specific instances of epistemic injustice that Fricker's view does not take into consideration and although these conceptions do not contribute directly to my interpretation of epistemic injustice, they do show that there are many other possible ways of interpreting and applying the theory of epistemic injustice without remaining within the confines set out by Fricker.

Hookway provides an explanation of alternative forms of testimonial injustice which he calls the "participant perspective" and the "informational perspective" (Hookway 2010, 157). The informational perspective indicates that someone who is a victim of testimonial injustice will not be treated as a reliable informant when offering information. Hookway adds to this stating that such an injustice will also prevent a knower from offering testimony on a given matter at all (Hookway 2010, 157). On the other hand, Hookway explains the participant perspective as a kind of epistemic injustice that is different from both testimonial and hermeneutic injustice. This injustice occurs when an agent is prevented from carrying out an activity competently due to the epistemic injustice suffered (*viz.* Hookway 2010, 157). This results in a "refusal" to take the testimony of an agent seriously as they are believed from the outset to be unable to provide reliable testimony.

Another expansion of the concept of epistemic injustice I want to mention is presented by Medina (2017), namely: hermeneutic injustice as "hermeneutic death" (Medina 2017, 41). This kind of injustice comes as the result of extreme hermeneutic injustice which causes an

agent to lose their voice completely and so also lose their ability to participate in areas where meaning is created (*viz.* Medina 2017, 41). As Medina puts it “[h]ermeneutical harms can run so deep as to annihilate one’s self, so as to produce *hermeneutical death*” (*ibid.* original emphasis). This kind of epistemic injustice effects all areas of one’s epistemic life as it influences one’s “entire hermeneutical subjectivity” (*ibid.* 47). While Medina acknowledges that it is rare that an agent’s voice is entirely removed from epistemic practice due to hermeneutic injustice, he wants to recognise the fact that there are some instances where a subject is “barely recognised” in terms of knowledge and understanding (*ibid.*). This account differs from that of Fricker because although Fricker mentions that epistemic injustice can run so deep as to prevent an agent from participating in epistemic activity, Medina takes it a step further to say that an agent may be fully expelled from epistemic activity.

Returning now to Pohlhaus, Jr., Dotson and Lauer, let us consider how their alternative suggestions inform my study. Pohlhaus, Jr. outlines four possible epistemic lenses that can be used to “distinguish and trace relations among ways that epistemic agents and institutions can simultaneously harm knowers and distort epistemic values” (Pohlhaus, Jr. 2017, 16). The first lens is that of the “social contract and coordinated ignorance” (*ibid.*). This lens allows us to understand epistemic injustice in terms of power, domination and oppression. This kind of epistemic injustice separates dominant from non-dominant knowers in order to maintain structural injustice. The second lens is that of “interdependence and epistemic relations” (*ibid.* 18). This lens, rather than focusing on power relations, involves how epistemic agents are situated in relation to and with other knowers. This has to do with “trust [as] the relation that binds epistemic agents” (*ibid.*) as knowledge is passed from one agent to another. The third lens is the “degrees of change and/in epistemic systems” lens and speaks not of the injustice caused by oppression and power but rather the injustice that is caused by the epistemic systems themselves (*ibid.* 19). Lastly, the “epistemic labour and knowledge production” (*ibid.* 21) lens refers broadly to the kinds of injustice done when the epistemic works or labours of others is disregarded.

Pohlhaus, Jr. presents these alternative categorisations of epistemic injustice while also keeping in mind that certain categorisations and alternative explanations can in themselves cause epistemic injustice. Pohlhaus, Jr. does not want to offer alternative accounts of epistemic injustice in the form of an “exhaustive list” (*ibid.* 2017, 14) as doing so would perpetrate forms of epistemic injustice. She states that by presenting a list of exhaustive alternatives or claiming to put forward ideas concerning epistemic injustice as “new” she

would be “exploiting the epistemic labour of others to perpetuate the appearance of [her] own epistemic labour as singular” (ibid. 15). To do so would be to reject the validity of the work already produced on epistemic injustice and thus perpetrate epistemic injustice.

Rather, by presenting an open account of epistemic injustice, Pohlhaus, Jr. wants to ensure that an understanding of epistemic injustice does not remain finite. A single theory of epistemic injustice will not be useful in analysing epistemic injustice in every situation. Therefore, an open account leaves the concept open to theorists who will be able to construct theories of epistemic injustice that are fit for their own purposes (*viz.* Pohlhaus, Jr. 2017, 16). An open conception of epistemic injustice is thus very important in helping to analyse specific cases of an injustice as far reaching as epistemic injustice. This is important for my purposes as analysing epistemic injustice in healthcare and specifically within mental healthcare in South Africa requires an open conception that can be developed to effectively illustrate such specific epistemic injustices.

The main purpose of addressing alternative forms of epistemic injustice, as the theories mentioned above, is to avoid what Dotson calls “*epistemic exclusion*” (Dotson 2012, 24). This kind of exclusion occurs when an agent’s “ability to participate in a given epistemic community” is inhibited. By Fricker advocating for hermeneutic and testimonial injustice as umbrella terms under which all other forms of epistemic injustice fall, she is in danger of excluding other considerations that may have a legitimate place in the discussion of epistemic injustice. Dotson presents this argument stating that Fricker “inadvertently perpetrates epistemic oppression by utilising a closed conceptual structure to analyse epistemic injustice” (ibid. 25). While Fricker does leave room for an expansion of the concept of epistemic injustice, she does so within the confines of the framework that she sets out. This is evident in her rejection of epistemic injustice as a kind of distributive justice, explained in the previous section. In setting such strict boundaries for conceptualising epistemic injustice and closing the concept off to alternative interpretations, Fricker perpetrates the very thing she draws attention to and speaks out against in her book.

Dotson draws a third form of epistemic injustice from this argument, which she calls “contributory injustice” (ibid.). Dotson’s concept of contributory injustice draws on Pohlhaus, Jr’s. idea of wilful hermeneutic ignorance and Mills’ idea of alternative epistemologies explained in section 1 and section 2 of this chapter. Contributory injustice, according to Dotson, exists when “an epistemic agent’s... wilful hermeneutical ignorance...

maintain[s] and utilis[es] structurally prejudiced hermeneutical resources that result in epistemic harm to the epistemic agency of a knower” (ibid. 31).

In other words, structural inequalities are perpetrated by individual knowers through their rejection of hermeneutic resources that are not dominant. This argument links to that of Medina (2017), outlined in the previous section. Medina makes an argument for a kind of hermeneutic injustice that is perpetrated by an agent rather than an injustice that occurs purely structurally. My view, set out briefly in the previous section, illustrates how hermeneutic injustice should remain a structural kind of injustice rather than an agent focused kind of injustice. Further, contra Medina, I argue that hermeneutic injustice can be exacerbated by individual agents and still remain a structural injustice, and this relates – perhaps more strongly so than Medina’s – to Dotson’s view of contributory injustice.

As stated in the previous section, I maintain that hermeneutic injustice should remain a structural injustice that can be taken advantage of by particular agents rather than giving hermeneutic injustice an agential cause. Dotson acknowledges that there may be a kind of structural epistemic injustice that is made worse by particular epistemic agents rather than claiming, as Medina does, that particular agents can cause hermeneutic injustice. Rather than advocating for hermeneutic injustice as *caused* by an agent, Dotson creates a new kind of epistemic injustice that takes into consideration that individuals may cause further harm to marginalised agents by taking advantage of structural inequalities.

While Medina presents his argument in the context of Fricker’s conception of hermeneutic injustice, Dotson goes further to say that the kind of injustice she is suggesting is not an extension of hermeneutic injustice but rather that it is its own kind of epistemic injustice, namely *contributory* injustice. She defines it as “located within the gray area between agential and structural perpetration of epistemic injustice” (ibid.) and therefore contributory injustice cannot be said to fall neatly within either agential testimonial injustice *or* structural hermeneutic injustice.

Taking into account Dotson’s categorisation of contributory injustice, I agree that when a structural, hermeneutic inequality is perpetrated and taken advantage of by a particular agent in the form of wilful hermeneutic ignorance, there exists a contributory epistemic injustice rather than a variation of hermeneutic injustice. I accept Dotson’s view as she does not attempt to alter Fricker’s conception of hermeneutic injustice to include an agential aspect. Rather she illustrates a new form of epistemic injustice that has both a clear structural and

clear agential element. This allows the concept of hermeneutic injustice to be one that addresses a purely structural form of epistemic injustice.

Dotson's argument for this distinction between hermeneutic and contributory injustice lies in the fact that contributory injustice "does not render experiences equally unintelligible" (ibid. 32) as hermeneutic injustice does. This links directly to the argument outlined by Mason in the previous section. Because it is the case that marginalised groups do have their own non-dominant hermeneutic resources with which to understand their experiences, I argued in the previous section that it is not always the case, as Fricker claims is the case in instances of hermeneutic injustice, that agents have *no understanding* of their social experiences.

There is often a subtler process at work: If we agree with the conception of contributory injustice then even if a marginalised agent does have non-dominant hermeneutic resources to draw on, these experiences will still be rejected by the perpetrator of contributory injustice or as Dotson puts it:

In fact, those who experience contributory injustice find that they can readily articulate their experiences. However, those articulations generally fail to gain appropriate uptake according to the biased hermeneutical resources utilised by the perceiver (ibid. 32).

Thus, it is not that marginalised agents have no social conception of their experiences, it is that their experiences are not acknowledged by dominant groups of knowers. This refusal to acknowledge non-dominant experiences relates again, as mentioned, to Mills' notion of alternative epistemologies, Mason's notion of non-dominant hermeneutic resources, and Pohlhaus, Jr's. notion of wilful hermeneutic ignorance, because it considers that those in marginalised positions do have non-dominant or alternative resources to draw on to understand their experiences and that they may even have an understanding of the dominant resources as well. However, they suffer an injustice due to the fact that their knowledge systems and forms of understanding are disregarded or unacknowledged by the dominant group.

Understanding contributory injustice is important for this study as it illustrates a way in which patients' contribution to knowledge can be undermined despite having their own tools and resources with which to understand their experiences. chapter 3 will analyse in detail the ways in which patients' capacity to act as credible knowers as a result of contributory injustice is structurally undermined by virtue of the social positioning of healthcare users in

general and then further undermined by having patients' non-dominant hermeneutic resources rejected because of the wilful hermeneutic ignorance of agents in positions of power over them.

Lastly, Lauer's conception of documental injustice further illustrates how dominant agents that benefit from their epistemic privilege can further harm non-dominant groups. Documental injustice exists when agents in an epistemically privileged position "[fail] to honour basic codes of medical conduct and scientific rigour" in materially disadvantaged parts of the world (Lauer 2017, 2).

This failure to adhere to certain norms and standards occurs more evidently in materially disadvantaged areas as it is commonly accepted that people in these areas are "disproportionately disadvantaged as a norm" (ibid.). These failures are therefore accepted or overlooked due to the structural inequalities that exist between the dominant and marginalised groups. Further, the epistemic privilege, or as Lauer puts it, the "credibility excess"²² that certain authorities hold may cause them to undermine or disregard advice or opinions from other professionals given their location (*viz.* Lauer 2017, 6).

Documental injustice is a kind of injustice that illustrates how structural policy and hierarchy can be used to the advantage of individual agents and in so doing, further perpetrate epistemic injustice. It is possible, given their high positioning within social systems, that epistemically privileged agents can manipulate, disregard or undermine the legitimacy of policy within these systems that are created to protect members of a socially marginalised group.

This kind of epistemic injustice may be analysed within the healthcare system generally and mental healthcare system more specifically as policy within healthcare is essential in insuring patients firstly receive necessary care and further have their rights protected as patients. Exploring the possibility of a disregard for policy and the disregard of opinions and advice from other healthcare professionals as a kind of epistemic injustice will help to identify how such epistemic injustices can have severe, far reaching consequences for patients as a marginalised group. Addressing documental injustice in this context further stresses the need

²² As shown in section 2 of this chapter, Fricker (2007) maintains that testimonial injustice (in the sense she describes it) cannot be caused by a credibility excess does not necessarily undermine someone as a knower. (2007, 20). However, the conception of documental injustice outlined here shows how an epistemic privilege in the form of a credibility excess can cause a distinctly epistemic kind of harm.

for an open conception of epistemic injustice as Fricker's conception alone would not be able to capture the severity of such injustices in this specific context.

Each alternative theory of epistemic injustice presented in this section stresses the importance of avoiding closed conceptions of epistemic injustice. Fricker may have intended to create an umbrella concept of epistemic injustice that was applicative in all situations in order to give a name to a phenomenon that has gone widely unnoticed in the past. However, Fricker's conception does not fit every instance of epistemic injustice as there is still the potential for epistemic injustice in different ways within different social situations. It is because of this that we need to acknowledge alternative interpretations of epistemic injustice and allow that theorists create new conceptions to explain the kinds of epistemic injustice in different situations within particular social environments.

This chapter has outlined the concept of epistemic injustice by first looking at what it means for agents to be situated knowers. The concept of epistemic injustice as outlined by Miranda Fricker was presented along with several critiques of her concepts of testimonial and hermeneutic injustice. Lastly, alternative interpretations of epistemic injustice were addressed in order to demonstrate that no single concept of epistemic injustice can exist, that can be applied to every instance of epistemic injustice.

In the following chapter, I outline the structure of the South African healthcare and mental healthcare systems, laying the foundation for chapter 3 as an analysis of epistemic injustice within the South African healthcare and mental healthcare systems linked specifically to the case of Life Esidimeni.

CHAPTER 2: HEALTHCARE IN SOUTH AFRICA

In the previous chapter, I addressed the concept of epistemic injustice by, firstly, identifying the situated knower within this context. I then discussed and critiqued Fricker's conceptions of testimonial and hermeneutic injustice. Lastly, I presented alternative conceptions of epistemic injustice to indicate the extent to which knowers can suffer epistemic injustices, specifically at the hands of social institutions.

This chapter will outline one such institution, the South African healthcare system, in order to identify the potential for these kinds of epistemic injustice within healthcare and mental healthcare in South Africa specifically. Firstly, I outline the structure of the South African healthcare system in general. Then I discuss the structure of the South African mental healthcare system. This outline will be used in chapter 3, along with the analysis of epistemic injustice in the previous chapter, to identify the potential for epistemic injustice within the South African healthcare and mental healthcare systems, specifically in the case of Life Esidimeni.

Healthcare in South Africa has undergone extensive restructuring since 1994. This was necessary due to the unequal and inequitable access to healthcare that Apartheid rule implemented and maintained. While the National Department of Health in South Africa (NDoH) has made many attempts at creating a healthcare system that ensures quality care for all South African's, there are still major gaps within the system itself. These gaps result from issues including, but not limited to: poor governance; poor financial management; challenges in human resources; ineffective information systems; and poor infrastructure (*viz.* Naledi et al. 2011, 20-22).

Also contributing to healthcare challenges is the fact that South Africa faces a great burden of disease due to several health factors. South Africa faces the largest HIV epidemic in the world. Despite high expenditure on HIV treatment (Jobson 2015, 3) and well-constructed policy (Coovadia et al. 2009, 828), HIV remains a major contributor to the burden of disease in South Africa (Jobson 2015, 3). South Africa also faces a significant TB-burden. Even with the TB Control Programme²³ in place, cases of TB prevail due to the high number of TB patients "co-infected with HIV" (National Department of Health 2012, 1). Maternal, child

²³ National Department of Health (2012). *Comprehensive Standard Operating Procedures for the National TB Control Programme*. Available at: <https://ndoh.dhmis.org/owncloud/index.php/s/R5cmdp0gY4Fa43Z?path=%2FTB>.

and infant health is another challenge faced by the South African healthcare system as maternal, child and infant death rates remain high due to issues such as inadequate healthcare services for mothers, the lower status of women in society, and the prevalence of HIV and AIDS (*viz.* National Department of Health 2007, 7-9).

Finally, South African healthcare has experienced significant discrepancies between the provision of public and private healthcare. While private healthcare facilities focus on curative health services, these services are only accessible to those who can afford to pay for private healthcare out of pocket or those who can afford medical aid schemes meaning that private healthcare is “biased towards urban areas” (Jobson 2015, 5). This leaves the public health sector to deal with the greater part of the burden of disease in South Africa. It is therefore the case that the larger part of the population is affected by the problems that affect the public healthcare system in South Africa, which will be discussed in detail in this chapter.

The inequalities within the structure of the healthcare system are also not limited to the problematic provision of physical care to patients. While the main goal of healthcare may be to supply promotive, preventative and curative services for people and patients, respectively, there are several other areas that are affected negatively by inequalities in the structure of the healthcare system. Structural inequalities in the healthcare system can be interpreted and analysed philosophically from different perspectives. This dissertation will explore the political epistemology of healthcare in South Africa by analysing epistemic justice in healthcare in general and in mental healthcare specifically.

This chapter will firstly address the structure of South Africa’s healthcare system by outlining the specific levels of healthcare in South Africa as well as the policies in place within this system. Secondly, an overview of the current state of mental healthcare in South Africa will be presented. This will be followed by an examination of how the South African healthcare system in general, and more specifically the mental healthcare system, falls short of meeting desired goals and therefore fails to provide adequate care to all South Africans who need it.

2.1) The Structure of the South African Healthcare System

Overview of the Structure of the South African Healthcare System

The structure of South Africa’s healthcare system is made up of a large public sector; a smaller private, for-profit sector; a private not-for-profit sector; and not-for-profit non-

government organisation (NGO) sector (*viz.* Jobson 2015, 3). Although the not-for-profit and NGO sectors are private, they often work with the public sector to provide care to patients. The quality of public healthcare in South Africa is however substandard, forcing those who can afford it to opt for private healthcare services and leaving those who cannot afford private healthcare to make do with the free or less costly treatment available to them. The private, for-profit sector is largely funded by wealthier patients' contributions to medical aid schemes paid out of pocket to health service providers. The for-profit private sector provides services through private healthcare professionals who provide services at privately owned clinics and hospitals. This sector hosts over 200 private hospitals but only provides services to 16.2% of the population (*ibid.* 4). The private NGO sector is much smaller and relies on donated money in order to provide general healthcare services. However, this sector focuses mainly on HIV treatment making the distribution of donated funds disproportionate, giving favour to the burden of HIV (*viz.* Jobson 2015, 4.)²⁴.

The public health sector is more complex and made up of several different levels. The first level provides primary healthcare (PHC) services from local clinics and community health centres. Local clinics make use of nurses to provide daytime services while community health centres provide 24-hour care from nurses with the aid of community healthcare workers (CHWs). Both local clinics and community health centres offer services such as mother and child care, immunisation, family planning, sexually transmitted infection (STI) treatment and minor trauma treatment for chronically ill patients (*viz.* Cullinan 2006, 5). While local clinics and community health centres are run by nurses, doctor and specialist visits should occur regularly.

If patients require care that is more specialised than the care provided at primary healthcare (PHC) clinic level they should be referred to the second level of public healthcare, namely district hospitals. Since 2010, district hospitals have been included in PHC services as part of the primary healthcare reengineering programme.²⁵ District hospitals provide services that are not available at PHC clinics or community health centres. This includes 24-hour treatment and "should provide diagnostic, treatment, care, counselling and rehabilitation services" (*ibid.* 11). District hospitals should also provide some mental healthcare through a team of medical officers, psychiatric nurses, social workers, and occupational therapists (*ibid.* 12). Tertiary

²⁴ There are cases where NGOs receive funding from the government. The involvement of NGOs within governmental provision of healthcare services will be explored later in this section.

²⁵ This programme will be discussed in more detail in the following section.

hospitals make up the third level of healthcare in South Africa. This level consists of four kinds of hospitals: provincial tertiary hospitals, national referral tertiary hospitals, central referral tertiary hospitals and specialised tertiary hospitals²⁶.

The lack of effective treatment at PHC level along with an ineffective referral system has caused the secondary and tertiary levels of healthcare to take on more than they should. Patients who can and should be helped at a primary level are forced to make use of secondary and tertiary services without referral as they do not receive adequate care at a PHC level. This has compelled the NDoH to put in place a plan for the re-structuring of PHC in South Africa.

PHC in South Africa

Primary healthcare (PHC) is defined as “a public health strategy derived from the social model of health and is based on the philosophy that health gains are better obtained when people’s basic needs are met first” (Dookie & Singh 2012 ,2). This differs from the definition of primary care that “refers to services provided by general practitioners, nurses or other allied health professionals and is regarded as the first point of entry to the health system” (ibid.). Based on these definitions, primary care is offered within both the private and public sphere. PHC however is a model made use of only by the public sector. The poor state of primary healthcare in South Africa negatively effects all those in need of basic healthcare services who cannot afford private healthcare.

To improve the state of primary healthcare in South Africa, the NDoH put forward a strategic plan with goals to be achieved by the year 2020. These goals are separated into 8 broad categories, among which are: to “improve the quality of care by setting and monitoring national norms and standards, improving systems for user feedback, and improving clinical governance”; to “re-engineer primary healthcare”; and to “improve human resources for health by ensuring adequate training and accountability measures” (National Department of Health Strategic Plan 2014/15–2018/19, 14). The re-engineering of PHC is a strategy intended to create care that is more “patient-centred” and “encourages health promotion prevention and community involvement” (Whittaker et al. 2011, 60).

PHC re-engineering is intended to be driven through the District Health System (DHS) in order to provide a comprehensive package of care to all South Africans (*viz.* Jobson 2015, 11-

²⁶ For a complete list of services provided at each tertiary hospital see Cullinan, K. (2006). Health services in South Africa: *A basic introduction*. Health-e News Service.

12). Each district is intended to have three main kinds of facilities, district hospitals, community health centres and clinics (Naledi et al. 2011, 24). Re-engineering the DHS is intended to occur along with strengthening the services provided within the DHS (National Department of Health 2012, 1). In addition, DHS re-engineering intends for district management teams (DMTs), Sub-DMTs and district hospital CEO's to be "responsible and accountable for all the services that take place in all the facilities and communities in the districts" (ibid.).

The DHS consists of three streams of healthcare service provision namely, school health services, ward-based PHC outreach teams, and district based clinical specialist teams (ibid. 3). School health services provide basic healthcare services to school-going children delivered by a nurse headed team. This stream provides "health promotion, preventative and curative services" (Jobson 2015, 12). However, the high volume of schools in South Africa makes it impossible to have a single nurse at every school in the "short to medium term" resulting in poorer schools and certain services being prioritised (National Department of Health 2012, 6).

Ward-based PHC outreach teams are intended to address the multiple factors that limit the poor service output of community healthcare workers (CHWs)²⁷. Such outreach teams consist of six community healthcare workers (CHWs), each linked to a PHC clinic (Padayachee et al. 2013, 74). These teams are intended to "prevent disease through a variety of interventions based on the concept of a healthy individual, healthy family, healthy community, and a healthy environment" (ibid.). The roles of the PHC outreach teams include: "promoting health; preventing ill health; providing information and education to communities and households on a range of health and health related matters; environmental health...; psychosocial support...; early detection and intervention of health problems and illnesses; follow-up and support to persons with health problems...; treatment of minor ailments; [and] basic first aid and emergency interventions" (National Department of Health 2012, 4).

Lastly, district-based clinical specialist teams are intended to address high infant, child and maternal mortality rates throughout most of South Africa (ibid. 7). To do this, each district should receive the support of "a gynaecologist, paediatrician, anaesthetist, family physician,

²⁷ These factors include "inadequate training; inadequate support and supervision; random distribution [of CHWs] with poor coverage; no link between the community-based services and services offered by fixed health facilities; fund[ing] through NGOs with inadequate accountability [and]; limited or no targets for either coverage or quality to be reached (National Department of Health 2012, 3).

advanced midwife and primary healthcare nurse[s]” (ibid.). These specialists are further intended to ensure the quality of clinical services throughout the PHC facilities and should therefore work closely with the other streams of PHC re-engineering (*viz.* Voce et al. 2013, 46).

CHWs play a key role within the DHS as they are intended to bridge the gap between patients and healthcare facilities. CHWs are defined as “any health worker delivering health care, trained in the context of the intervention, and having no formal professional, certified or degreed tertiary education” (Clarke et al. 2008, 680). The tasks of CHWs include: promoting health and preventing illness; conducting structured household assessments to identify their health needs; providing community members with psychological support; conducting community assessments; identifying and managing minor health problems; supporting a continuum of care through service co-ordination with other relevant service providers; and supporting screening and health promotion programmes (*viz.* National Department of Health 2011, 2).

The general care that CHWs provide is essential as it is often the case that PHC facilities receive more patients than they are able to deal with. CHWs are able to reduce this number by providing care to those who do not necessarily need to access PHC facilities and by referring those who do to the correct facility. Policy for PHC re-engineering also requires that PHC facilities and CHWs work closely with private healthcare providers such as those provided by NGOs (*viz.* Clarke et al. 2008, 680). It is however necessary that these facilities, like all other governmental and non-governmental facilities, are accredited and comply with the outlined standards for healthcare in South Africa.

Standards for Quality Healthcare in South Africa

To provide quality healthcare to patients requiring care at all levels, it is necessary to ensure that all facilities providing healthcare services are doing so in a way that complies with certain standards for healthcare provision. However, although policy regarding the standards for healthcare does exist, the implementation of these standards is inadequate, causing major challenges for the provision of healthcare to South Africans. According to Moleko et al. “recent quality improvement initiatives have been largely uncoordinated and minimally monitored” (2013, 26).

In 2008, the NDOH attempted to standardise quality care within healthcare facilities in South Africa. This task was overseen by the Office of Health Standards Compliance (OHSC). The OHSC was “tasked with preparing for the establishment of an ‘independent quality management body’” (Moleko et al. 2013, 26). This included the establishment of a set of National Core Standards (NCS) to be used as a benchmark for all healthcare facilities (*viz.* Moleko et al. 2013, 26).

Further, the OHSC is intended to “protect and promote the health and safety of users of health services through monitoring, enforcing compliance with prescribed standards, and ensuring the investigation and disposal of complaints” (*ibid.* 28). Some of the more specific tasks of the OHSC include: “inspecting and certifying health establishments”; “monitoring indicators of risk” and “reporting serious breaches to the Minister”; “publicising information relating to norms and standards”; and “maintaining records of all its activities” (*ibid.*)²⁸.

The National Core Standards were created by the OHSC as a set of guidelines for healthcare facilities. These guidelines, although created for application specifically within the public healthcare system, are intended to be universal and applicable throughout all healthcare facilities. The NCS are made up of 7 domains each consisting of several sub-domains. Table 1 lists each domain along with the sub-domains that fall under each domain.

Table 1: Domains and sub-domains of the NCS²⁹

Domain	Sub-domain
Domain 1: Patient Rights The domain of Patient Rights sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with Batho Pele principles and the Patient Rights Charter.	Respect and dignity Information to patients Physical access Continuity of care Reducing delays in care Emergency care Access to package of services Complaints management
Domain 2: Patient Safety, Clinical Governance and Care The Patient Safety, Clinical Governance and Clinical Care domain covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to healthcare users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events, including health care-associated infections; and support any affected patients or staff.	Patient care Clinical management for improved health outcomes Clinical leadership Clinical risk Adverse events Infection prevention and control
Domain 3: Clinical Support Services The Clinical Support Services domain covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary	Pharmaceutical services Diagnostic services Therapeutic and support services Health technology services

²⁸ For a full list of the tasks of the OHSC, see Moleko et al. 2013, 28 in the SAHR 2013/2014.

²⁹ This table was taken from Whittaker et al. *Quality Standards for Healthcare Establishments in South Africa*. SAHR 2011, p.65.

<http://www.hst.org.za/sites/default/files/Chap%205%20Quality%20Standards%20pgs%2059-%2068.pdf>, [Accessed 28 February 2017].

medical technology, as well as systems to monitor the efficiency of the care provided to patients.	Sterilisation services Mortuary services Efficiency management
Domain 4: Public Health The Public Health domain covers how health facilities should work with NGOs and other healthcare providers along with local communities and relevant sectors, to promote health, prevent illness and reduce further complications; and ensure that integrated and quality care is provided for their whole community, including during disasters.	Population-based service planning and delivery Health promotion and disease prevention Disaster preparedness Environment control
Domain 5: Leadership and Corporate Governance The Leadership and Corporate Governance domain covers the strategic direction provided by senior management, through proactive leadership, planning and risk management, supported by the hospital board, clinic committee as well the relevant supervisory support structures and includes the strategic functions of communication and quality improvement.	Oversight and accountability Strategic management Risk management Quality management Effective leadership Communications and public relations
Domain 6: Operational Management The Operational Management domain covers the day-to-day responsibilities involved in supporting and ensuring delivery of safe and effective patient care, including management of human resources, finances, assets and consumables, and of information and records.	Human resource management and development Employee wellness Financial resource management Supply chain management Transport and fleet management Information management Medical records
Domain 7: Facilities and Infrastructure The Facilities and Infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and functional, well managed hotel services; and effective waste disposal.	Buildings and grounds Machinery and utilities Safety and security Hygiene and cleanliness Linen and laundry Food services

Based on these domains and sub-domains, the National Department of Health (2012).

Comprehensive Standard Operating Procedures for the National TB Control Programme.

Available at:

<https://ndoh.dhmis.org/owncloud/index.php/s/R5cmdp0gY4Fa43Z?path=%2FTB>. Identify

six areas of concern that create “non-negotiable priorities” for the provision of adequate healthcare, namely: “values and attitudes of staff”; “reducing waiting times and queues”; “cleanliness of hospitals and clinics”; providing patient safety by “providing reliable care”; “preventing infection from being passed on in hospitals and clinics”; and ensuring the availability of medicines, supplies and equipment (Moleko et al. 2013, 26). The goal of the NCS is therefore to ensure that these priorities are met through the development, assessment, and implementation of the domains and sub-domains listed within primary, secondary, and tertiary healthcare sectors.

According to Whittaker et al. the NCS provide guidelines for healthcare facilities to acquire licensure from the government (*viz.* Whittaker et al. 2011, 65). This licensure is mandatory for all healthcare facilities. In order to achieve this, a minimum standard of regulation must be met. Facilities must provide proof of competence and indicate that the minimum requirements are met through an on-site inspection (*viz.* Whittaker et al. 2011, 65). Further, healthcare facilities require certification, either from the government or from participating NGOs. This also requires compliance with a set of predetermined standards for quality healthcare provision.

Along with the mandatory licensure and certification, healthcare facilities can obtain accreditation from recognised NGOs. Rather than compliance with minimum standards, accreditation is achieved by complying with published standards. These standards are set by the not-for-profit Council for Health Service Accreditation of Southern Africa (COHSASA). Compliance with these standards is not compulsory however, the standards set by COHSASA set a “maximum achievable level to stimulate improvement over time” (Whittaker et al. 2011, 65).

NGO involvement plays a crucial role in the implementation of the NCS. As mentioned earlier, NGOs work very closely with public healthcare facilities, especially at a primary level. Because of this NGOs are able to provide support and training to public healthcare facilities, particularly within primary healthcare. NGOs also facilitate the certification and accreditation processes to evaluate healthcare facilities which according to Moleko et al., is “very helpful in ensuring continuous improvement” of the work carried out by the Office of Standards Compliance (Moleko et al. 2013, 30).

Challenges Facing the South African Healthcare System

Despite the commencement of PHC re-engineering, the implementation of the DHS with the help of community healthcare workers, and the creation of the national core standards by the OHSC, healthcare provision in South Africa, particularly within the primary healthcare sector, still faces several major challenges. These challenges are general and relate to the healthcare system in South Africa as a whole. More specific problems will be addressed in the next section particularly within the context of mental healthcare in South Africa.

The first problem the South African healthcare system faces relates to challenges surrounding access to the resources needed to adequately provide healthcare services to all people. Firstly, according to Naledi et al. many healthcare facilities are “inefficient in most provinces, which impact[s] negatively on service delivery and retention of staff” (2011, 21). Having decent facilities at which to provide healthcare services is no doubt one of the most necessary and most important factors in providing adequate healthcare services. This comes as a result of inadequate funding and poor funding management on the part of the NDoH. According to Jobson, South Africa’s health expenditure is high, yet health outcomes are low in comparison to other middle-income countries with similar healthcare expenditure (2015, 3). This is made even more evident when public health expenditure is compared to private health expenditure.

The private health system spends roughly R120 billion to provide services to 16% of the population whereas the public health sector spends around R122 billion to provide services for the other 84% (*viz.* Jobson 2015, 4).³⁰ Inadequate funding will result in the maintenance of healthcare facilities being neglected in order to cover the costs of other resources such as healthcare staff and medical supplies.

However, poor expenditure on healthcare facilities is not the only problem faced regarding the provision of adequate human resources in healthcare. Poor working environments has led to problems with retention of medical staff (*viz.* Naledi et al. 2011, 21). “On average, 70% of health science graduates are not retained in the public sector” (Matsoso & Strachan 2011, 52). Further, staff that are placed in public healthcare facilities are often not adequately trained for their roles or positions and are often ill prepared to deal with healthcare challenges especially at PHC level, causing a failure to “approach patient needs in an integrated or holistic fashion” (*viz.* Naledi et al. 2011, 21).

These problems are particularly evident in rural areas of South Africa. Section 27 of the Constitution guarantees the right to access healthcare to all South Africans.³¹ However, as Gaede and Versteeg point out, “legislation does not require the elected Government to fully realise this mandate with immediate effect” (2011, 100), causing those in lower income groups to suffer from poor access to healthcare indefinitely. Further, social determinants of health affect those in rural areas more greatly than those in urban areas (*viz.* Gaede & Versteeg 2011, 9). Lower income households have less access to necessities such as education, sanitation, and nutrition which puts these households at a higher risk of falling ill and requiring medical care. Although PHC re-engineering was intended to be implemented proportionately across healthcare facilities, people living in rural areas are largely unable to access these facilities. This is due to the large distances between households and healthcare clinics along with the high costs of transport to and from facilities. 15% of households live an hour away from the nearest clinic and 20% live more than an hour away from the nearest hospital (*viz.* Gaede & Versteeg 2011, 102). Once patients manage to access these healthcare facilities, they are often unable to deal with the volume of patients they receive. According to a study presented by Visagie and Schneider that collected data from a rural town in the

³⁰ These are not exact figures but rather rough estimates to indicate the differences in service provision between the public and private health sectors.

³¹ Republic of South Africa. The Constitution of the Republic of South Africa Act (Act 108 of 1996) p.11. Available at <http://www.justice.gov.za/legislation/constitution/SACConstitution-web-eng.pdf>.

Northern Cape province (2014), doctors were only present on certain days. Patients with certain conditions were given preference and others were forced to return home without care (2014, 6). Situations like this result in patients incurring further costs for transport or accommodation and in some instances, are left without receiving any medical care.

Rural areas would benefit greatly from services provided by community healthcare workers (CHWs). Instead of making long trips to clinics and health centres, CHWs would be able to assess patients and provide referral letters to those who really need it and treat those with minor conditions. This would minimise the number of patients seeking healthcare at higher levels. However, as mentioned above, the public healthcare system in South Africa suffers challenges in terms of human resources in general. Poor working conditions in rural areas is a deterrent for many health professionals. Because of this, distribution of healthcare professionals and CHWs in rural areas is poor.

Quality of care in rural areas is also cause for great concern. It is often the case that patients in rural areas are referred to higher level facilities based on the availability of services (*viz.* Gaede & Versteeg 2011, 102). These facilities are usually further away than the district clinics. However, even if the necessary facilities are in close proximity to rural households, the level of care is often very poor. Gaede and Versteeg note “shortages of staff, bad staff attitudes, large distances to health facilities and services, insufficient medication, lack of monitoring and evaluation... and shortages of ambulance services” (2011, 103) as major contributors to the poor quality of care in rural areas which are major cause for concern.

Finally, the healthcare system in South Africa, in both rural and urban areas, suffers many challenges in the area of governance and management. According to Elloker et al. it is the task of management systems to lead while working with “multiple lines of authority”, “challenging organisational culture”, as well as dealing with structural and organisational changes within the healthcare system (2012, 163). Poor governance and management within the healthcare system can result in several of the challenges mentioned above such as poor distribution of funds and resources. Strengthening leadership and governance is therefore key to improving the state of healthcare in South Africa. However, poor planning regarding PHC re-engineering has created “fragmentation” between the provincial and district health systems, despite clear guidelines presented in the healthcare policies (Naledi et al. 2011, 20). Poor management of PHC re-engineering has created discrepancies between policy and its

implementation causing the availability of PHC services to differ among facilities in different metropolitan areas.

Poor management at PHC level also affects the co-ordination between PHC facilities and NGOs. According to Clarke et al., CHWs providing services through NGOs are “unsure as to whom they are responsible”, public health services, NGO management or to the local community (2008, 680). Poor management and governance in this area greatly affects the quality of care provided at a community level. This is a major problem as the community health centres are patients’ first point of entry into the healthcare system. Further, if staff are unsure of the services they should provide and the responsibilities that belong to them, patients are in serious danger of receiving inefficient care. This is seen clearly in the aftermath of the closure of the Life Esidimeni mental healthcare facility.³²

Gaps between policy and implementation are also largely a result of the nature of several policies in place within the healthcare system. For example, compliance with NCS is not compulsory. The standards set to ensure quality care in the healthcare system are adhered to voluntarily (*viz.* Moleko 2013, 27), leaving facilities to develop at their own pace or not to develop at all. The Negotiated Service Delivery Agreement has set a target for the accreditation of healthcare facilities in South Africa. Such a target could be helpful in ensuring that as many facilities as possible are providing quality care to patients. However, this target has been set at a mere 25% (*viz.* Whittaker et al. 2011, 60). Such a standard is not nearly high enough to ensure that facilities are at least attempting to implement some of the guidelines provided by the NCS. The result could potentially be that 75% of healthcare facilities in this country fail to provide adequate care to patients. Evidence of this will be presented in the case of the closure of the Life Esidimeni mental healthcare facility in chapter 3.

In this section I presented an outline of the structure of the South African healthcare system as well as presented several problems and challenges that this healthcare system faces in general. I further discussed policy that relates to healthcare provision in South Africa in general. However, these policies are, for the most part, lacking in their mention of the state of mental healthcare. I will address this issue in the following section, starting with an outline of the structure of the South African mental healthcare system and a discussion of the recent

³² The case of Life Esidimeni and its implications within the healthcare system will be discussed in detail in chapter 3 and will serve as the primary example of epistemic injustice in the health sector in South Africa.

mental healthcare policy and framework for South Africa. I will then move on to explore the problems and challenges within the South African mental healthcare system.

2.2) Mental Healthcare in South Africa

Policy reform in the areas of primary healthcare (PHC) in South Africa as well as new developments in policy for healthcare overall has created a workable blueprint for quality healthcare for all. However, as seen in the previous section, the poor implementation of standards for quality healthcare has created many challenges for healthcare provision in South Africa. Policies that outline standards for healthcare in general are also lacking in their mention of standards, goals and guidelines for the provision of mental healthcare to patients. Such poor planning and neglect in the mental healthcare division has given rise to the deaths of 144 mental healthcare patients, after the closure of the Life Esidimeni mental healthcare facilities in Gauteng. Before presenting a case study relating to the closure of the Life Esidimeni facilities in chapter 3, the structure of the South African mental healthcare system must be outlined. Policy relating specifically to mental healthcare will be examined along with the tasks and challenges that mental healthcare faces.

The Structure of the South African Mental Healthcare System

Mental healthcare is intended to be provided within all levels of healthcare. This means that the structure of the mental healthcare system mirrors that of the healthcare system in general. Therefore, patients' entry into the mental health system should be through PHC services provided at community health centres and local clinics, with community healthcare workers (CHWs) providing home-based care. Secondary mental healthcare services should be provided at district hospitals by way of referrals from PHC clinics and healthcare centres. Lastly, tertiary services should be provided to mental healthcare patients with long term mental health needs at provincial or specialist hospitals. The World Health Organisation (WHO) created an "optimal mix of services pyramid" (WHO 2007, 1) as seen in image 1. This pyramid illustrates the organisation of mental health services in terms of cost, frequency of need and quantity of services needed (ibid.).

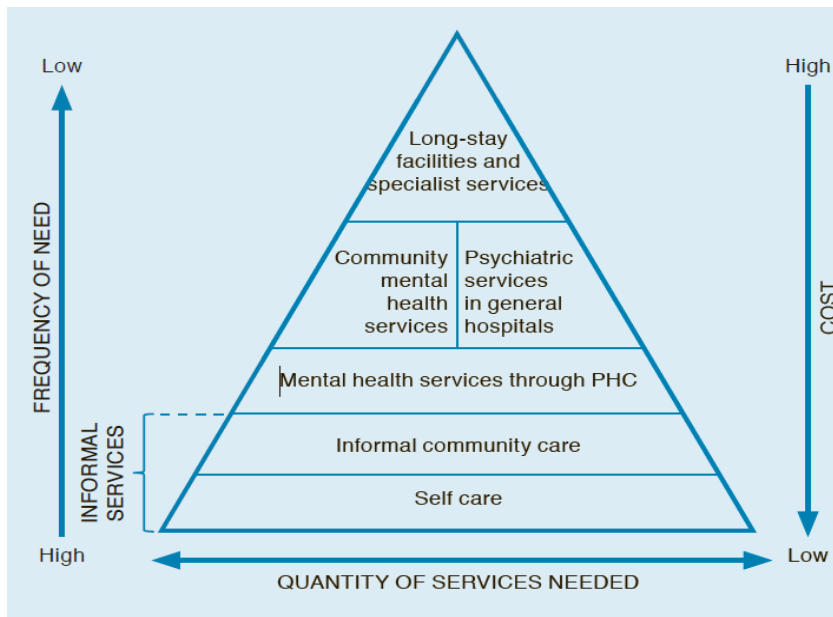


Image 1 Source: WHO, 2007³³

According to the pyramid, the services that should be most frequently available are “informal” services, which make up the first two tiers of the pyramid. This includes services from “traditional healers, professionals in other sectors such as teachers, police, village health workers” and “services provided by non-governmental organisations” (ibid. 4). These services should be accompanied by the promotion of self-care to allow patients to manage their conditions by themselves with assistance from family, friends and the informal services provided at the informal community level.

The third tier consists of PHC mental health services. As mentioned earlier, these services are provided at district clinics and community health centres. These facilities are more easily accessible than specialised facilities which would ensure greater access to necessary care.

The fourth tier consists of community mental health services and psychiatric services in general hospitals, allowing that services be provided along with other general healthcare services. Although the WHO suggests PHC services and community mental health services belong in separate tiers, the South African healthcare system is structured in such a way that community level care is provided by CHWs at PHC facilities and at district hospitals. Both of these tiers have been restructured under PHC re-engineering. Taking into consideration the structure of the South African healthcare system and the suggestions put forward by WHO,

³³ World Health Organisation. 2007. The optimal mix of services. Geneva: World Health Organisation. Available at: http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf.

this level of mental healthcare should provide services such as day centres, rehabilitation services, therapeutic and residential supervised services, along with assistance to families and services at lower tiers (ibid. 2). This tier should also work closely with NGO services within PHC.

The last tier is made up of long stay facilities and specialist services. These include psychiatric hospitals. WHO suggests that patient intake at this level be kept to a minimum due to the “high costs, poor clinical outcomes and human rights violations” that occur within tertiary facilities (ibid.).

The South African mental healthcare system is largely structured in line with the framework provided by WHO. The PHC re-engineering policy framework mirrors that of WHO framework, making it easier to provide services within each tier. The WHO-AIMS Report on Mental Health System in South Africa (2007) indicated that in South Africa there are 80 day treatment facilities, 41 community-based psychiatric inpatient units, 63 community residential facilities, and 23 mental hospitals (WHO-AIMS 2007, 11-12).

Despite the mental healthcare system in South Africa being largely structured around the framework provided by WHO, the standard of care remains low. This may be largely due to the fact that mental healthcare has remained a marginal consideration in general healthcare policy. Further, policy and legislation regarding mental healthcare seems to come as secondary to policy and legislation in other areas of healthcare.

Mental Healthcare Policy and Legislation in South Africa

The first policy for mental healthcare in South Africa was published in Chapter 12 of the 1997 White Paper for the Transformation of the Health System in South Africa. This policy came about as a result of the necessary restructuring that the South African healthcare system had to take after the end of Apartheid. This chapter outlines three major principles for the promotion of mental health. The first principle outlines “comprehensive and community-based mental health and other services... planned and coordinated at the national, provincial, district and community levels and integrated with other health services” (National Department of Health 1997, 84). Implementation of this principle required planning, monitoring and evaluation of mental healthcare services at a national level through the Mental Health and Substance Abuse Directorate (*viz.* National Department of Health 1997, 85). Implementation at a provincial level further requires the provision of a “sustainable

budget” for mental healthcare (ibid.). District level implementation requires the “comprehensive integration of mental health services with other services... with the active participation of various stakeholders, especially the community” (ibid. 86). The district level is also responsible for the training of healthcare staff. Lastly, implementation at a community level requires the involvement of NGOs and other organisations with community healthcare facilities to promote quality community-based care.

The second principle outlined in the White Paper indicates that “essential national health research should include an analysis of mental health and substance abuse to identify the magnitude of the problem” (ibid. 87). Implementation of this principle requires additional funds allocated to mental health research while promoting mental health research among new researchers.

The third and final principle states that “human resource development for mental health services should ensure that personnel at various levels are adequately trained to provide comprehensive and integrated mental health care based on primary health care principles” (ibid.). This principle outlines the necessary training of healthcare professionals needed to implement it.

A document providing policy guidelines, the “National health policy guidelines for improved mental health in South Africa” was also approved by the National Department of Health in 1997. However, this document was not published and was therefore not included in official policy (WHO-AIMS 2007, 7-8). This meant that the chapter in the White Paper on mental healthcare provided the only official guidelines for mental healthcare until the 2002 Mental Health Care Act (MHCA) was published and promulgated in 2004.

The 2002 MHCA provides general regulations that focus on patients’ needs and specifically patient rights, which had been largely left out of the 1997 White Paper. The 2002 MHCA aims:

To provide for the care, treatment and rehabilitation of persons who are mentally ill; to set out different procedures to be followed in the admission of such persons; to establish Review Boards in respect of every health establishment; to determine their powers and functions; to provide for the care and admission of the property of mentally ill persons; to repeal certain laws; and to provide for matters connected herewith. (National Department of Health 2002, 1)

The MHCA further indicates, very importantly, that health should be recognised as “state of physical, mental and social well-being” and attainment of this holistic state of health requires mental health services to be provided at all three levels of healthcare – primary, secondary and tertiary (ibid.). The Act further recognises that discrimination against mental healthcare users should be prohibited and that mental healthcare services should promote the “maximum” overall wellbeing of mental healthcare users within their communities (*viz.* National Department of Health 2002, 1).

Burns (2008, 47) outlines 9 important principles that summarise the 46-page MHCA. Firstly, all those with mental health problems are referred to as ‘users’ “since any individual is a potential user of mental health care services” (ibid.). The ‘user’ also includes all those who take decisions for patients unable to do so themselves (*viz.* National Department of Health 2002, 5). Second, “services should offer care, treatment and rehabilitation to users” (Burns 2008, 47). Third, mental healthcare users are afforded the same human rights as all other citizens. Fourth, “*All* health care practitioners are also regarded as mental health care practitioners... and should take some responsibility for mental health needs” (ibid. italics added).

This point is very important as the responsibility of the mental healthcare practitioner had not been outlined in the 1997 White Paper. By recognising that all health practitioners are seen as mental health practitioners, every practitioner is subject to the same responsibilities when it comes to patient care and patient rights. The potential effects of neglecting the wide-ranging responsibilities that all healthcare professionals have will be analysed in the case of Life Esidimeni in chapter 3.

The fifth principle states that mental healthcare services should be fully integrated with PHC services. Making mental healthcare services available at PHC level promotes the accessibility of mental health services as much as any of the other necessary services provided at PHC level. It is further the case that mental health facilities should benefit from operations like PHC re-engineering in the same way as all other PHC services.

Integration of mental healthcare into PHC links to Burns’ sixth and seventh points. Point six states out that “users have a right to be treated near their homes and within their communities, as far as possible” (ibid.). This stresses the importance of community-based care provided at PHC level with the help of CHWs. Point seven states that mental healthcare services should be provided to users “with the least possible restriction of their freedom” (ibid.). This implies

that all barriers to access to mental healthcare, including socio-economic factors, should be removed as far as possible. PHC based mental healthcare promotes this as clinics and district hospitals are more accessible than tertiary facilities to patients in remote areas. PHC services are also much less expensive than services provided at secondary and tertiary facilities.

Burns' eighth point states that "users have a right to representation, knowledge of their rights, and the right of appeal against decisions made by mental healthcare practitioners" (ibid.). This links strongly to Burns' third point and the overall theme in the 2002 MHCA of promoting patient rights in mental healthcare in South Africa. The final point refers to the creation of Mental Health Review Boards "to act as independent 'ombudsmen' concerned with the rights of the user, to review decisions made in terms of the Act, and to respond to and investigate appeals" (ibid.). The necessity of such review boards and the ombudsman services is evident in the case of Life Esidimeni. Without the report provided by the ombudsman, information regarding the treatment of patients at Life Esidimeni and the neglect for their rights may have gone unnoticed. This will be explored in more detail in the next chapter.

The 2002 MHCA provided a step towards recognising that mental healthcare is as necessary and important as all other forms of healthcare and that policy concerning healthcare in general should always include mental healthcare as well, especially where patient rights are concerned. Another system the 2002 MHCA introduced was that of 72-hour observation periods. This is a period of involuntary admission to assess the state of a mental healthcare user. This observation period allows mental health practitioners to assess whether a condition is caused by psychiatric and behavioural disturbances or whether symptoms have other medical causes (*viz.* Burns 2008, 47). This system also allows that patients can receive care close to their homes and many are released from involuntary care within this period (ibid.).

However, this system was not implemented correctly in practice and many patients suffered ill treatment and human rights infringements. Further, inadequate observation in this time came as a result of patients being heavily sedated or administered incorrect medication (ibid.). To address this problem, the National Department of Health released a document in 2012 entitled "Policy guidelines: 72-hour Assessment of Involuntary Mental Healthcare Users".³⁴ This document provides guidelines on the correct procedure of admission for 72-

³⁴ National Department of Health. 2012. Policy guidelines: 72-hour Assessment of Involuntary Mental Healthcare Users. Available at: <https://www.health-e.org.za/2016/04/29/policy-guidelines-72-hour-assessment-involuntary-mental-healthcare-users/>.

hour observation as well as guidelines on safety for both mental healthcare users and practitioners.

Between the publication of the 2002 MHCA and 2013, there was no official mental health plan published to provide guidelines for the implementation of policy and service delivery. However, in 2013, the National Mental Health Policy and Framework and Strategic Plan 2013-2020 (MHPF) was published. This official policy aimed to address the challenges in mental healthcare that were evident even after the release of the 2002 MHCA. In the MHPF these challenges are cited as a) the lack of official policy until the release of this document; b) the underfunding and poor resource allocation in mental healthcare; c) inequity in service distribution among different provinces; d) the lack of education and “public awareness” of mental health as well as the stigma surrounding mental health; e) the lack of collected data on mental health service provision; f) the “legacy of colonial health systems, with heavy reliance on psychiatric hospitals” and; g) the focus on treatment of severe mental disorders only rather than on the detection and treatment of other, more prevalent mental disorders (*viz.* National Department of Health 2013, 9). Further, this policy was developed in alignment with the National Department of Health’s 10 point plan (2014).³⁵

The 2013 MHPF includes 8 main objectives. The first objective states that decentralized integrated PHC services should be increased or scaled up. This is due to the fact that PHC services are more accessible to mental healthcare users. PHC services are also less expensive in comparison to secondary or tertiary services. The second objective calls for increasing the public health awareness of mental health as well as reducing the stigma surrounding mental illness. The third objective is to promote the mental health of all South Africans through collaboration between the National Department of Health (NDoH) and other sectors. This involves collaboration with, for example, NGOs, the police department, and the Department of Education, to name a few. The fourth objective states that local communities, and specifically mental healthcare users and practitioners, should be “empower[ed]... to participate in promoting mental wellbeing and recovery within their communities”. Objective five relates to the promotion and protection of the human rights of all mental healthcare users. Objective six refers to the adoption of the “multi-sectoral approach” in addressing the cyclical nature of poverty and mental illness.³⁶ The seventh objective states that a monitoring

³⁵ The NDoH’s 10 Point Plan (2014) was later adapted into the NDOH Strategic Plan (2014/15- 2018/19) mentioned in the previous section.

³⁶ Lund (2012) identifies two pathways linking poverty and mental health. The first is the “social causation pathway” identifies those living in poverty as more exposed to violence and trauma which increases the risk of

and evaluating system should be established for mental healthcare. Finally, the eighth objective states that the planning and provision of mental healthcare should be evidence-based (*viz.* National department of Health 2013, 19).

Along with the main objectives, the MHPF outlines several values and their corresponding principles. The values stated are as follows: mental health is part of general health; human rights; community care; accessibility and equity; inter-sectoral collaboration; mainstreaming; recovery; respect for culture; gender; social support and integration; participation; self-representation; citizenship and non-discrimination; efficiency and effectiveness; comprehensiveness and; protection and vulnerability (*ibid.* 20-21).³⁷

Unlike the 2002 MHCA, the MHPF presents a clear picture of the goals to be achieved within mental healthcare provision along with an outline of the processes of implementation to be used to achieve these goals. However, implementation of this policy has been slow and several major challenges still exist within the mental health sector and for quality mental healthcare provision.

Challenges Facing the Mental Healthcare System in South Africa

The establishment of the MHPF may have been intended to ensure that quality mental healthcare is provided in South Africa by setting out dedicated guidelines for its implementation. However, the mental health sector is not exempt from the challenges that exist within healthcare in South Africa in general by virtue of the implementation of the MHPF.

For 9 years, the 2002 MHCA served as the benchmark for health standards and legislation. While this Act was highly progressive even by global standards, according to Burns, the Act was an “unfunded mandate” (2011, 100). Because of this, no budget was allocated to the implementation of this act resulting in a lack of necessary training and adequate facilities at both district and PHC levels. Further resulting implications of poor financing and development after the release of the MHCA include: outdated and not fit for use in tertiary psychiatric hospitals; an inability to develop and improve important tertiary facilities; human

mental illness and substance abuse. The second pathway is the “social drift” pathway stating that those living with mental illness are more likely to fall into poverty due to the high costs of healthcare and poor levels of care that result in prolonged mental illness (*viz.* Lund 2012, 214).

³⁷ For a full list of the values and principles see: The National Department of Health. 2014. National Mental Health Policy Framework and Strategic Plan 2013-2020. Available at: <https://www.health-e.org.za/wp-content/uploads/2014/10/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf> or alternatively <https://ndoh.dhmis.org/owncloud/index.php/s/R5cmdp0gY4Fa43Z>.

resource shortages; underdeveloped community healthcare resources resulting in long term patient institutionalisation; and limited efficiency and effectiveness of the suggested mental health review boards (*viz.* Burns 2011, 104-105). Along with the lack of adequate funding, implementation of the 2002 MHCA was hindered by a poor understanding of the MHCA by officials and healthcare professionals as well as external departments and NGOs offering services to mental healthcare users. This is partially due to the fact that agent's roles are not clear, making the involvement of external services unhelpful (*viz.* Burns 2008, 48).

Until 2013, upon publication of the MHPF, no official policy existed to address the problems related to the 2002 MHCA. In light of the absence of an official mental healthcare policy, provinces like the Free State and North West had developed their own mental health policies with the 2002 MHCA as a guide (WHO-AIMS 2007, 8). While this may have improved the standard of care in those particular provinces, the lack of an official policy caused unequal mental healthcare provision throughout the country. The MHPF 2013-2020 aimed to address these gaps in healthcare by providing a comprehensive plan applicable to mental healthcare provision across South Africa. The MHPF retains a focus on the human rights of mental healthcare users as well as “address[es] a significant gap in public health” (Stein 2014, 115). However, challenges remain regarding the implementation of this policy which include poor financial and human resources; limited evidence-based treatment extending beyond medication; poor awareness of mental health and; a remaining stigma and negative attitude towards mental healthcare users (*viz.* Schneider et al. 2016, 155).

Mental healthcare remains under-funded in South Africa as a “low priority is given to mental health by provincial health departments” (Burns 2011, 104). Insufficient funding for mental health has caused problems for providing adequate human resources for mental healthcare. The 2002 MHCA as well as the MHPF 2013-2020 stress the importance of community-based healthcare provided by CHW. This allows patients to receive care close to home through PHC based mental healthcare services. Mental healthcare services at this level are funded through the PHC budget (*viz.* Robertson & Szabo 2017, 3). This means that all plans for PHC re-engineering should include plans for the improvement of PHC mental healthcare services. However, this is not the case. Robertson and Szabo point out that although CHWs had been introduced in all areas, their training manuals had not been updated to include mental healthcare (2017, 3). Whether this is due to lack of funding and therefore an inability to afford the cost of further training and updating training manuals is unclear. It is however important to note that without this training, CHWs will remain unable to make general

diagnosis, provide repeat medications, review the state of patients and provide necessary referrals for mental healthcare users.

Along with inadequate training, PHC healthcare remains understaffed both for general healthcare services and mental healthcare services. This is indicated by Robertson & Szabo in a study of Gauteng province. Their study shows that per 100,000 population, community healthcare services in all districts are “far below that recommended for minimal service cover” (Robertson & Szabo 2017, 4). This results in many patients who can be treated at PHC level moving to access care at secondary and tertiary facilities without referral. This results in higher costs for both the mental healthcare user and the National Department of Health (NDoH). The potential effects of neglecting the provision of services, funding and treatment of mental healthcare users become evident in the case of Life Esidimeni, which will be discussed in detail in the following chapter.

Deinstitutionalisation and task shifting are suggested as methods to improve mental healthcare provision while reducing costs. Deinstitutionalisation refers to the move away from high levels of patient admissions to tertiary facilities towards higher levels and standards of community-based mental healthcare. This model parallels that of WHO’s optimal mix of services mentioned earlier and sets out to reduce the cost of healthcare spending by reducing the number of mental hospitals, as tertiary care is more expensive than community-based care.

Further reasons for moving towards deinstitutionalisation include the poor level of care and human rights violations that are prevalent in mental hospitals among other tertiary institutions (*viz.* Parker 2014, 76). However, community healthcare services did not improve with the additional funding that followed the closure of high cost tertiary facilities. Infrastructure and human resources remain inadequate. Further, according to Peterson and Lund, the 72-hour observation period intended for the management and observation of patients before referral to tertiary institutions “has not been optimal” (2011, 752). Deinstitutionalisation was suggested in the process of closing the Life Esidimeni healthcare facility. This case shows the detrimental effects of employing policy without the necessary infrastructure and other services in place to do so. The next chapter will explore in detail the policy of deinstitutionalisation and its role in the case of Life Esidimeni.

Implementation of the “task-shifting” initiative has faced similar problems to that of deinstitutionalisation. Task-shifting is defined as the “redistribution of tasks among

workforce teams” where “specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make efficient use of the available human resources for health” (Spedding et al. 2014, 74). This initiative aims to employ more community healthcare workers (CHWs) to reduce costs by reducing specialist services without forgoing the necessary specialist care that some patients need. However, as mentioned previously, money saved from reducing specialist care has not been utilised in improving PHC community healthcare services, as healthcare workers are not being trained in mental health service delivery.

Task-shifting and deinstitutionalisation are aimed at reducing human rights violations in tertiary facilities, yet poor implementation of these initiatives has allowed human rights violations within mental healthcare to persist. The negative stigma surrounding mental healthcare patients has persisted since the time of mental asylums where those admitted were seen as insane or crazy. Previous legislation allowing involuntary institutionalisation only exacerbated the stigma against mental healthcare users. Patients faced a kind of “structural violence” that “disempowered, alienated and stigmatised the mentally ill” (Burns 2008, 46), due to the fact that those with mental illnesses were seen as unable to make decisions for themselves.

Although this outlook may not be as evident in recent years, a negative association still exists between mental illness and mental healthcare users. Peterson and Lund note two studies carried out after the publication of the 2002 MHCA that report on the “dehumanising experiences and human rights abuses in psychiatric institutions and general hospitals” (2011, 752). It is however also the case that mental healthcare patients receive poor treatment and face severe human rights violations at PHC and community levels. Ignorance and inadequate knowledge of mental illness exist among community healthcare workers (CHWs) as, in many cases, they remain untrained and so unfit to properly care for mental healthcare users. This suggests that those meant to benefit from the closure of large psychiatric institutions have faced even worse treatment due to the inadequate implementation of policy. Further discrimination exists from Government institutions as they do not afford mental healthcare the same importance as other departments. All these factors contribute to an acute marginalisation of mental healthcare users (MHCU). This is evident in the case of the closure of the Life Esidimeni mental healthcare facilities, which will be discussed in the following chapter.

Several other general problems facing mental healthcare are worth noting. Firstly, the cyclical nature of poverty and mental health make it difficult to address mental healthcare without also addressing the high levels of poverty in South Africa. Secondly, poor co-ordination exists between provincial and district mental healthcare facilities. Bateman notes that “Provincial health departments were free to address mental health according to their own priorities, with few financial incentives to increase efficiency or resource allocation for mental health services” (2015, 7). This creates several inconsistencies in resource allocation among districts and differing levels of care between provinces. Lastly, co-ordination between government healthcare departments and supporting NGOs at PHC level is highly inefficient. Robertson and Szabo note that 71 government funded community residential homes and day centres are provided by NGOs in Gauteng (2017, 4). However, these facilities are not equipped to deal with patients who require long term structured care. This too is evident in the Life Esidimeni case which will be discussed in the next chapter.

In this chapter, I outlined the structure of the South African healthcare and mental healthcare systems. Policy regarding healthcare and mental healthcare was discussed as well as the problems that exist within healthcare and mental healthcare despite these policies being in place. In the next chapter I will use the outline of the South African healthcare and mental healthcare systems as well as the discussion of the concept of epistemic injustice from chapter 1, to analyse how epistemic injustice may be present in a healthcare context. I will then present a case study regarding the closure of the Life Esidimeni mental healthcare facilities. This case study will be used along with an analysis of epistemic injustice within the healthcare and mental healthcare systems in South Africa to show how epistemic injustice within healthcare institutions may manifest in disastrous outcomes resulting in the deaths of over 144 mental healthcare users.

CHAPTER 3: EPISTEMIC INJUSTICE IN HEALTHCARE AND MENTAL HEALTH

In chapter 1, I discussed the concept of epistemic injustice, firstly as presented by Miranda Fricker (2007) in the forms of testimonial and hermeneutic injustice. Critiques of both forms of epistemic injustice were outlined before a discussion of several alternative interpretations of epistemic injustice including Dotson's contributory injustice and Lauer's documental injustice. Then, in chapter 2, I outlined the structure of the South African healthcare and mental healthcare systems as well as some of the problems facing healthcare and mental healthcare in South Africa in general.

This chapter seeks to address issues of epistemic injustice within the healthcare system in South Africa and more specifically, mental healthcare in South Africa. In section 1 of this chapter I will analyse epistemic injustice in healthcare and mental healthcare more generally. In section 2 I will examine epistemic injustice within the structure of the South African healthcare and mental healthcare systems specifically. In section 3 I will present the case study of Life Esidimeni. In the final section I will then look at the case of Life Esidimeni in order to identify epistemic injustice that may have contributed to the deaths of 144 mental healthcare users.

Several thinkers have explored the nature of epistemic injustice in healthcare contexts. Major contributions have been made by Havi Carel and James Ian Kidd. Carel is a professor of philosophy at the University of Bristol, working mainly in the area of the phenomenology of illness and has published work addressing³⁸ phenomenology as a tool to help patients. Kidd is an assistant professor of philosophy at University of Nottingham, working in several fields including but not limited to philosophy of illness and healthcare with a focus on the epistemic implications of these disciplines. Together, Carel and Kidd have published articles such as "Epistemic injustice in healthcare: a philosophical analysis" (2014); "Epistemic Injustice and Illness" (2016); and "Epistemic Injustice in Medicine and Healthcare" (2017). These articles focus on the ways in which epistemic injustice may potentially exist in healthcare more generally, using the conception of epistemic injustice provided by Fricker. These articles will be addressed throughout this chapter.

38 Carel, H. (2012). Phenomenology as a Resource for Patients. *Journal of Medicine and Philosophy*. 37(2), 96-113. Available at: <http://web.b.ebscohost.com.uplib.idm.oclc.org/ehost/pdfviewer/pdfviewer?vid=1&sid=2b518d9e-988f-4ccb-a666-e4ad59f1d1f0%40pdc-v-sessmgr06> [Accessed 20 August 2018].

Alistair Wardrope is another author who comments on epistemic injustice within a healthcare context. Wardrope is a researcher at the University of Sheffield Medical School, working in fields such as bioethics, philosophy of medicine, public health ethics and philosophy of science. Authors such as Anastasia Phillipa Scrutton and Josh Dohmen comment on epistemic injustice as it plays out in mental healthcare. Scrutton is an Associate Professor at the University of Leeds and works specifically in areas such as philosophy of religion, philosophy of psychiatry, and philosophy of emotion. Specifically, Scrutton has produced work on the link between mental illness and epistemic injustice (2017). Dohmen is a researcher at the University of West Georgia and produces work in line with the theme of disability in a philosophical context. These authors and some of their contributions will be discussed in detail in this chapter. Further, other contributions that do not deal with healthcare or epistemic injustice explicitly but that nonetheless provide insight into how structural and institutional inequality may allow for instances of epistemic injustice, will be analysed.

3.1) Epistemic Injustice in Healthcare

When analysing epistemic injustice as a systemic, structural kind of injustice, it is first necessary to understand how healthcare as a social institution has power over healthcare users. My analysis of epistemic injustice within the healthcare and mental healthcare systems in South Africa concerns primarily the structural inequality that exists between the healthcare systems and healthcare users. This means that my focus will be on the more structural and systemic forms of epistemic injustice such as hermeneutic, contributory and documental injustice³⁹. Agential cases of epistemic injustice, like testimonial injustice, will therefore not be discussed in as much detail as, in this context, it occurs in tandem with or as a result of the structural injustices outlined here and usually not, or not exclusively or primarily, as a result of agents' individual prejudices.

Institutions in general often afford themselves epistemic privilege in several ways. In particular, this privilege exists within healthcare systems firstly as a result of the importance placed on medical knowledge. Healthcare professionals have access to specialised knowledge that puts them in an epistemically privileged position over patients (*viz.* Buchman et al. 2017, 33). This training allows healthcare professionals to be seen as “more credible” than their

³⁹ These injustices do not always exist purely structurally as some cases may see particular agents influencing or taking advantages of structural inequalities. However, they remain structural instances of epistemic injustice as they are not caused by any one particular agent. Rather they are caused by structural inequalities that particular agents may become involved with.

patients and therefore in a position to make claims and judgements about patient's best interests (Buchman et al. 2016, 33).

It is important to note that often there may be an epistemic gap between the knowledge that healthcare users and healthcare professionals have. However, this occurs as a natural result of the epistemic privilege healthcare professionals have from their years of training which healthcare users do not have. Therefore, this epistemic privilege does not necessarily result in any epistemic injustice. Healthcare professionals are professionals by virtue of the fact that they have access to knowledge that the lay-person does not. This knowledge is necessary for providing care. However, if a healthcare user is *disadvantaged* either because their testimonies and non-dominant resources for understanding are disregarded based on the epistemic privilege of professionals, or because they are prevented from contributing to the pool of medical knowledge, then it is the case that epistemic injustice exists within healthcare. An epistemic gap is not a sufficient condition for epistemic injustice, but it is a necessary condition for epistemic injustice.

The importance placed on the medical knowledge that healthcare professionals have may cause certain prejudices against patients. Carel and Kidd (2014) point out that "patient's testimonies are often dismissed as irrelevant, confused, too emotional, unhelpful, or time consuming" (2014, 530). While it may be the case that certain patients are producing testimonies in these ways, it may also be the case that instances of these kinds of testimonies have created prejudicial stereotypes against patients. Healthcare professionals can therefore perpetrate testimonial injustice by ignoring or disregarding patients' testimonies because of the epistemic prejudices held against patients instead of judging the value of their testimonies independently. This may further result in patients taking on characteristics of the prejudices against them (*viz.* Kidd & Carel 2016, 186). For example, a patient who finds themselves unheard or disregarded may become frustrated and emotional when providing further testimony. However, instead of healthcare professionals realising that this frustration (and poor articulation) may very well be stemming from frustrations at the healthcare system or the healthcare professional, the patient may simply be seen as a stereotype patient and as such remain unheard.

James McCollum (2012) addresses the way in which hermeneutic injustice may exist within institutions as a result of the "specialised vocabularies" that institutions make use of (2012, 190). These vocabularies create various gaps in understanding for those who make use of the

services of the institution but who may not contribute to the creating and understanding of these specialised vocabularies. Patient epistemologies are marginalised in favour of more dominant, medical epistemologies. Healthcare institutions may in this way cause actual harm to the people the institution is intended to help.

Wardrope (2015) uses the example of “medicali[s]ation” in order to illustrate how medical knowledge undermines the conceptual tools employed by healthcare users. Medicalisation is the use of medical definitions and practices to explain experiences “not previously within the conceptual... scope of medicine” (Wardrope 2015, 341). This refers to the idea that the structure of the medical system has the ability to shape the resources that are used to understand medial experiences or other experiences related to medical experiences. Medicalisation of this kind implies that these medical concepts are the only concepts accepted when interpreting medical experience, even in cases where medical knowledge does not have sufficient resources to explain a given medical experience entirely. Yet instead of allowing non-dominant interpretations of medical experiences to be used, medical epistemologies maintain their dominance and continue to use epistemologies that do not necessarily fit a given experience. Thus, medicalisation implies that medical knowledge systems may subsume experiences that medical epistemologies may not have the concepts to adequately explain. Wardrope further explains how the healthcare institution has the power to “[transform] and [constrain] agents’ self-understanding” by prescribing the legitimate forms of conceptual tools (ibid. 342). This means that because agents are unable to use their non-dominant resources to come to the best understanding of their experiences, agents are forced to mould their understanding to fit the dominant tools available to them, as provided by the medical social institution.

Medicalisation therefore becomes a rejection of the non-dominant hermeneutic resources that patients construct to make sense of their experiences. This is the kind of hermeneutic injustice outlined by Mason in chapter 1, is much in evidence in the case study of Life Esidimeni, discussed later in this chapter. Healthcare users are often able to construct ways of understanding their experiences, but their understanding will not necessarily make use of the specialised knowledge that healthcare providers have access to. Kidd and Carel (2016) also make this link to Mason’s idea of non-dominant hermeneutic resources. They state that patients do have access to non-dominant hermeneutic resources but that using these resources

to explain their experiences is “largely considered inappropriate for public discussion and... play little or no role in clinical decision making” (2016, 184).

Kidd and Carel identify two kinds of strategies within healthcare institutions that prevent the development of non-dominant hermeneutic resources. The first set of strategies they identify is called “*strategies of exclusion*”. These are strategies which exclude patients from contributing to the dominant pool of medical knowledge and therefore not including them in the practices that legitimate social meanings (ibid.). The second kind of strategy Kidd and Carel talk about is “*strategies of expression*” which cause healthcare users to be excluded because the “expressive style” they use when articulating their experiences is not accepted by the healthcare institution in question (ibid.).

These strategies create contexts of hermeneutic injustice because patients are prevented from using their non-dominant hermeneutic resources either to explain or understand or communicate their experiences. Kidd and Carel note that patients often have to adopt the dominant expressive tools to explain their illnesses or “adopt an epistemically marginal role in consultative exercises” (ibid. 185). The primary epistemic injustice at work in these instances is hermeneutic in nature as it is the structural nature of institutions and their knowledge systems that undermine the knowledge systems of patients. Patients suffer because their non-dominant hermeneutic tools are not recognised or employed in healthcare systems as a valid tool for assisting both patients and healthcare professionals in fully understanding experiences of illness.

Contributory injustice may also be evident in strategies of exclusion and expression. As explained in chapter 1 section 4, contributory injustice requires an epistemic agent to perpetrate structural inequalities through their active rejection of non-dominant hermeneutic resources and thereby cause an epistemic injustice. This rejection of non-dominant hermeneutic resources takes the form of a wilful hermeneutic ignorance as actively rejecting non-dominant resources works to the advantage of the dominant epistemic agent. In a healthcare context, a healthcare professional that rejects the use of non-dominant concepts or expressive styles in order to maintain short consultation times, for example, would be perpetrating contributory injustice. Even a rejection of non-dominant concepts and expressive styles by a healthcare professional in order to come to a correct diagnosis would be perpetrating contributory injustice. This is because such a diagnosis is based on the assumption that the only relevant knowledge is medical knowledge. When a particular agent

excludes non-dominant resources due to a structural feature of the healthcare system (like the dominant knowledge systems mentioned here) they will necessarily be perpetrating contributory injustice. This is because the epistemic injustice stems from a structural feature of the healthcare system but is perpetrated by an individual agent.

By viewing experiences of illness in terms of a purely medical vocabulary, it is possible that patient care and treatment will be based on incomplete understandings of the patient's condition. The hermeneutic injustice is evident here because patients would be prevented from utilising their understandings of their experiences of illness and be disadvantaged as a result. Further, by healthcare professionals rejecting any knowledge that does not make up part of the dominant medical discourse, they may perpetrate testimonial injustice.

Testimonial injustice may arise in cases where healthcare professionals actively discredit testimony provided by patients as it arises out of non-dominant conceptual tools. This will be a disadvantage to patients as healthcare professionals may, for example, miss out on information necessary for a complete diagnosis of patients. Further, medical perspectives are taken to be authoritative (*viz.* McCollum 2012, 343) and so any attempts from healthcare users to challenge or question these perspectives may be disregarded as well.

The attempts by the healthcare system to obtain further information from patients may in and of itself marginalise patients as knowers rather than benefit them as intended. For example, McCollum identifies hermeneutic injustice within social institutions through the use of "forms, checklists and other administrative expedients" (2012, 192) in order to obtain information from patients, whether it be for diagnostic or feedback purposes. These embody the dominant medical perspectives and do not allow that patients give a full account of their experiences of illness using the conceptual resources that they are perhaps more comfortable with.

Carel and Kidd identify this kind of disregard for patient experience as a disregard for first-person knowledge. Rather, scientific, objective, third-person knowledge is preferred, and patient testimonies are used as sources of mere factual information (*viz.* Carel & Kidd 2014, 535). This implies that the understanding is that nothing useful can come from understanding patient experiences more broadly or understanding the means by which patients understand their experiences. However, it may in fact prove useful to healthcare professionals to pay more attention to the knowledge gained from patient experiences and conceptualisations.

As discussed in chapter 1 section 1 Mohanty (1993) points out how agents can come to have genuine knowledge of their experiences that were otherwise overshadowed by the dominant understandings they previously made use of. In the article, Mohanty outlines the difference between two views of cultural identity, namely “essentialism” and “theoretical post modernism” (Mohanty 1993, 42). According to Mohanty, essentialism refers to the idea that identity is based on shared experiences and are therefore stable and unchanging (ibid.). Knowledge according to essentialists is thus solely based on shared experiences. On the other hand, theoretical postmodernism makes the claim that knowledge cannot be based on shared experiences as experience is not a source of objective knowledge and thus cannot be identity constructing (*viz.* Mohanty 1993, 43). Mohanty raises the question of whether real knowledge is objective or subjective and therefore asks which of these forms of knowledge is valid.

Mohanty then moves on to claim that both these kinds of knowledge should be considered as valid, as experiences can yield reliable knowledge if they are interpreted properly (ibid. 44). This means that once identities are formed from personal experiences, they are given meaning through the collective social understanding in which the experience finds itself. This is evident in Mohanty’s example of Alice who came to understand that feelings of depression and guilt were in fact arising out of a response to her actual feelings of anger. This realisation may be the same for many healthcare users as well as healthcare professionals. In using non-dominant hermeneutic resources to understand their experiences of illness, patients may come to know better, more effective ways of coping with these experiences. Further, by rejecting these understandings, healthcare systems and professionals would be rejecting legitimate parts of the experience of illness, causing harm to patients that goes beyond epistemic rejection. This could, for example, take the form of a patient’s loss of self confidence in their epistemic abilities, or a loss in a patient’s desire to deal with being ill. This may seem irrelevant to healthcare professionals as these experiences do not necessarily affect the healthcare professionals’ job of treating the patient’s illness. Thus, rejecting articulation of these experiences is necessarily perpetrating epistemic injustice (*viz.* Carel & Kidd 2014, 537).

Let us now consider the above in terms of Mills’ (1988) concept of ‘alternative epistemologies’ also discussed in chapter 1 section 1. If it is the case that patients can come to have genuine knowledge from their experiences that may not be fully articulated through dominant resources, it may also be the case that in fact healthcare professionals do miss out

on relevant information by rejecting these non-dominant conceptions. This point draws on Mills' conception of alternative epistemologies. Although rejected, alternative epistemologies (in the form of non-dominant hermeneutic resources) may be of value, as those with "differential experience" may have a "better chance of developing schemas which objectively reflect their situation" (Mills 1988, 254). If more objective knowledge is desired by medical institutions, then it would be unwise to reject such objective knowledge just because it was produced from a first-person perspective. Further, Carel and Kidd point out that patients have access to knowledge of how a certain medical condition "feels" (2014, 535) in phenomenological terms. This first-person phenomenal knowledge may prove useful for, for example, coming to correct diagnoses, or providing adequate care, or ensuring that a patient does not incur further physical harm. To ignore this knowledge in favour of institutionalised medical epistemologies is to ignore a legitimate part of illness and could bring both epistemic and other harms to patients if ignored.

Another example of the way in which medical epistemologies marginalise patients as knowers is through medical policy. Policy allows for epistemic injustice through the epistemic privilege afforded to medical institutions. This is because the dominant knowledge produced by institutions creates the "conditions by which people can make claims upon institutions" through policy (McCollum 2012, 190). McCollum argues that this silences agents either by making such injustice seem "natural" or by "projecting alien values" upon agents (ibid.).

When considering healthcare as a social institution, policy is intended to ensure that all healthcare users receive necessary care while still having their rights protected. However, hermeneutic injustice can arise, as McCollum points out, because policy may prevent healthcare users from speaking out against practices that may remain harmful to them. Institutions manage to protect themselves from this sort of speaking out as policy does not compel the institution to do anything differently. Healthcare users are in this way prevented from contributing to the body of knowledge that the healthcare institution uses and are therefore silenced as knowers. Kidd and Carel point out that complaints often remain unnoticed until submitted under formal procedure and therefore play little role in policy formation and decision making (*viz.* Kidd & Carel 2016, 184). This silencing falls within Fricker's conception of hermeneutic injustice as it is perpetrated purely structurally.

As an example, institutionalised policy may cause epistemic injustice by turning an “institutionally mandated blind-eye” (McCollum 2012, 195). McCollum points out that the authorities within the institution are constrained by the dominant resources they use which may cause them to disregard patients and their non-dominant hermeneutic resources even if they think it is not correct to do so. There is thus the potential for this kind of epistemic injustice despite the views and actions held by individual agents.

Further, structural injustice of this kind may allow for documental injustice. As explained in chapter 1 section 4, Lauer identifies documental injustice as the failure of epistemically dominant groups to adhere to institutionalised norms and standards especially when the non-dominant group is also materially disadvantaged. If policy is misused or misinterpreted by officials within the dominant epistemic group of a given social institution, their epistemic privilege allows them to remain unnoticed, as challenges to their actions by non-dominant agents will be ignored. The same can be said for healthcare officials who take advantage of policy at the expense of their patients. Examples of this are evident in the case of Life Esidimeni, which will be examined in section 3 and section 4.

Policy may in some cases also allow institutions to focus on profits. When social institutions, like healthcare, put emphasis on economic growth instead of patient satisfaction, it may become easier for certain injustices to be ignored. Epistemic justice often takes a back seat to other forms of social justice. Even if it is the case that institutionalised policy allows for an economically just system, a focus on economic justice may overshadow epistemic justice. This may be seen in healthcare for example, in cases of for-profit medical services. For profit medical services were intended to increase competition among healthcare providers, giving healthcare users the chance to choose the kinds of care that best suited them while decreasing costs (*viz.* ten Have & Gordjin 2013, 123). This however usually only result in healthcare users only having a choice between insurance companies (*viz.* ten Have & Gordjin 2013, 123). This is because the high cost of private medical services made medical aids and health insurances mandatory.

Epistemic injustice can be identified here by analysing the fact that social institutions constrict the choices given to people and specifically patients (*viz.* McCollum 2012, 193); yet do not take patients’ complaints and suggestions into consideration when constructing socially institutionalised epistemologies, like policy. This sort of policy would therefore put patients at both a material and epistemic disadvantage. What becomes evident here, as Kidd

and Carel point out, is that medical institutions that are profit-driven seek to meet the needs of themselves and the professionals that belong to the institution rather than those of the healthcare users (*viz.* Kidd & Carel 2016, 176) An example of this will be discussed in detail in the following sections as such disadvantages are evident in the case of Life Esidimeni. Further, the next section will address deinstitutionalisation in South African healthcare policy which will be presented as an example of systemic epistemic injustice in South African healthcare. This will also be addressed again later in this chapter when examining policy's role in the silencing of patients in the Life Esidimeni case.

Epistemic Injustice in Mental Healthcare

The rest of this section will focus on epistemic injustice in mental healthcare more specifically. This will serve as an introduction to the case study of Life Esidimeni in section 3, which presents examples of the potential for epistemic injustice in South African mental healthcare, to be discussed in section 4.

Epistemic injustice in mental healthcare will often be visible in many of the same ways as it does within healthcare in general. This is because medical institutions are structured in much the same way for mental health as it is for other kinds of healthcare. However, there are several distinctive features of the structure of the mental healthcare system that allow for epistemic injustice.

Mental healthcare users, even more so than general healthcare users, face vast stigmatisation and negative prejudice. This is due to the misconception that mental disability is a “problem” (Dohmen 2016, 669) and that those that suffer from mental illness are not ‘normal’ like other people or even other patients. This has led to a “lack of respect” for mental illness and those who suffer from it “by lay people, journalists or medical staff” (Borelius et al. 2014, 225). Such stigma leaves room for the negative prejudicial stereotypes and the structural marginalisation that characterise epistemic injustice.

Medical models for mental illness, like models for more general medical conditions, are not completely suited to characterise the experiences of mental illness. This is because even those diagnosed with the same category of mental illness are often faced with these illnesses to vastly different degrees. Therefore, the criteria for diagnosis are often too vague to adequately fit the condition of every individual patient (Dohmen 2016, 677). This creates difficulties for healthcare professionals in awarding fair and just credibility to mental

healthcare users. A mental healthcare user, who, for example, suffers from severe delusions, would not be awarded very high credibility from a healthcare professional when offering information about their physical condition. This is due to the fact that the healthcare professional correctly perceives that the category of the healthcare user's mental illness may prevent the healthcare user from providing accurate information. However, using a vague criterion to classify mental illness may cause a healthcare professional to award the same amount of (lower) credibility to another mental healthcare user who is perhaps more capable of producing testimony that is accurate and trustworthy. Therefore, if a mental healthcare user with a certain mental illness is awarded low credibility based on a vague categorisation of or criteria for mental illness, it is not to say that every patient within that categorisation deserves the same level of credibility (*viz.* Dohmen 2016, 677).

An example of this kind of categorisation can be seen in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The DSM-5 is intended to define and classify mental disorders in order to improve treatment of such disorders (American Psychiatric Association, 2018). However, this classification is argued as not being reliable or representative of actual mental disorders (*viz.* Cuthbert 2014, 28). Rather, the DSM-5 makes use of rigid classifications that may only be modified if "problems with clinical utility arise" (Cuthbert 2014, 28). However, the DSM-5 remains the standard mode of classification for mental disorders⁴⁰. The development of the DSM-5 does in some way attempt to reduce the harm caused by the overgeneralisation of mental illness that has existed in the past. However, by enforcing a strict criterion on this kind of classification, the potential for boxing certain medical experiences becomes evident. It is therefore the case that medical epistemologies are either in danger of using classifications that are too vague, as pointed out by Dohmen, or they are in danger of over specifying classifications and becoming guilty of medicalisation, as pointed out by Wardrope. This means that there is room for epistemic injustice on either side of the spectrum. Epistemic justice in this case is situated between these two extremes. This will be discussed again in chapter 4.

Returning to Dohmen's article, he identifies 4 common themes among mental healthcare users that characterise the kinds of epistemic injustice they may face within the healthcare

⁴⁰ Other systems such as the Research Domain Criteria (RDoC) have been constructed in order to produce classifications more inclusive of neuroscience and behavioural science than the DSM-5 (*viz.* Cuthbert 2014, 28). However, the DSM-5 remains a clear example of the dominance of certain epistemologies as it remains the dominant classification method despite its strict criteria.

system. These are “testimonial injustices resulting from the use of technological or personal aides”; “epistemic injustices resulting from the use of generali[s]ed definitions or hyperbolic examples”; “epistemic injustices in interactions with professionals and service providers”; and “epistemic injustices faced by those attempting to organise for social or political change” (Dohmen 2016, 679). While each of these themes identify legitimate instances of epistemic injustices faced by mentally ill persons, my focus remains on the structural features of the mental healthcare system that perpetrate epistemic injustice. My focus remains on structural epistemic injustice as this kind of injustice has not been analysed in as much detail as agential forms of epistemic injustice. Further, structural epistemic injustice is less salient and therefore often easily ignored due to the nature of power struggles within institutions. For this reason, only Dohmen’s third theme is relevant to this analysis.

When explaining this theme, Dohmen sites the experience of Katie Aubrecht. Aubrecht provides an account of her experience with psychiatrists which resulted in a case of epistemic injustice. According to Dohmen, she reports an instance of constantly being “quizzed” by psychiatrists about “how well [she] knew the experiences [she] had were actually experiences” (ibid.). This resulted in Aubrecht becoming “more familiar with what doctors felt, liked, and wanted and that those things would be the *right* things to feel, like, and want” (ibid. emphasis added).

This, while being a case of testimonial injustice, should also be identified as hermeneutic and contributory injustice. Firstly, it is hermeneutic because the idea of what the *right* kind of knowledge or information is, is determined by institutionalised forms of accepted knowledge. Any testimony that exists outside this dominant framework is therefore considered useless. Secondly, this is an example of contributory injustice as the healthcare professionals are basing the kind of information they deem relevant on the foundations of the dominant hermeneutic resources in place. The healthcare professionals therefore use their own wilful hermeneutic ignorance to perpetrate epistemic injustice. Lastly, this may be an example of testimonial injustice as the testimony given by Aubrecht may be rejected or awarded less credibility because of the negative identity prejudice against her by virtue of her mental illness. However, as Dohmen points out, Aubrecht’s testimony is not rejected but is rather only used insofar as it produces information that the healthcare professionals deem important (ibid.).

Mental healthcare users seem therefore to be trusted only to produce knowledge that supports the dominant hermeneutic resources employed by mental healthcare institutions. This may serve as a way to shape conceptions of mental illness in the same ways described above in instances of medicalisation. Further, as Scrutton (2017) points out, if information from patients is only taken insofar as it is useful to the healthcare professional, “cognitive biases” regarding mental healthcare users “are applied and confirmed” (2017, 348). A mental healthcare user with a certain diagnosis may provide testimony about their condition that is only taken seriously to the extent that it reinforces the already known diagnosis. This may greatly affect the care a patient receives as any new conditions they may describe will be overlooked.

Another distinct feature of mental healthcare users is that at times it may be the case that the non-dominant hermeneutic resources they employ are immediately unintelligible to others due to the severity of their conditions. However, this does not mean that they do not produce knowledge that may be useful in helping healthcare professionals to better understand mental healthcare users and further to provide them with better care. Much like general healthcare users, mental healthcare users have knowledge of how their condition ‘feels’ in the phenomenological sense. This may be even more important in ensuring they receive adequate care as third-person resources cannot describe the experiential features of mental illness effectively. Often this will be expressed by mental healthcare users with severe ailments in the form of expressions of “pleasure, pain, preferences, and dislikes” (Dohmen 2016, 684). However, these expressions are not seen as useful as they do not necessarily make up part of the dominant medical discourse. A healthcare professional may dismiss these expressions as they are perceived as only further conveying that the mental healthcare user has a mental condition. This dismissal may then take the place of the healthcare professional rather ensuring these expressions are taken seriously in the extended treatment and care of the healthcare user.

A rejection of these expressions would therefore constitute an epistemic injustice. By ignoring expressions like these provided even by severely mentally ill patients, on the basis that they are not immediately recognised as providing useful information for treatment and care, healthcare professionals reject non-dominant hermeneutic resources for dominant ones. It is therefore necessary that healthcare professionals who provide care to mental healthcare users develop the skills to interpret these expressions in such a way that they do not miss out

on knowledge that may benefit the healthcare user. Suggestions of ways in which healthcare professionals can do this will be made in the following chapter.

Finally, Scrutton points out that “much epistemic injustice in mental healthcare arises as a result of factors beyond professionals’ control” (2017, 348). This is characteristic of the structural inequalities within the mental healthcare system that allow for epistemic injustice. Scrutton identifies these factors as “lack of time, training or resources, or responsibility for responding to situations that in fact require a far more systemic societal response” (ibid.). These factors are characteristic features of the healthcare system that disadvantage patients as knowers beyond their interaction with healthcare professionals. Further, when coupled with societal factors like material disadvantage and poverty and, lack of education regarding mental illness, mental healthcare users suffer stigma that prevents them from contributing epistemically to their care. However, the harms faced go beyond the epistemic as evident in the case of Life Esidimeni which will be explored in detail in the final section of this chapter.

The following section will identify features of the structures of healthcare and mental healthcare in South Africa that may allow for epistemic injustice. The final sections of this chapter will then present the case of Life Esidimeni and analyse the case in order to identify epistemic injustice and its contribution to the deaths of 144 mental healthcare users.

3.2) Epistemic Injustice and the South African Healthcare System

In the previous section I addressed epistemic injustice generally identifiable within healthcare and particularly mental healthcare by identifying the potential structural inequalities that exist within the structure of healthcare and mental healthcare systems. In chapter 2 I provided an outline of the structure of the South African healthcare and mental healthcare systems. In this section, I will analyse the information in chapter 2 to identify potential for epistemic injustice more specifically within the context of South African healthcare and mental healthcare.

Because the structure and policy of mental healthcare is based strongly on that of general healthcare in South Africa, I will address these two healthcare sectors together when identifying the potential for epistemic injustice within these sectors. This will allow me to address both sectors when analysing epistemic injustice in the case of Life Esidimeni.

South African healthcare faces a large discrepancy between the provision of private and public healthcare. As mentioned in chapter 2 section 1, the public healthcare system provides

services to a much larger portion of the South African population as fewer people are able to afford the necessary medical schemes that assist in the provision of private healthcare. This discrepancy creates a lack of material power for those unable to afford private healthcare as they may not have access to the kind of quality care they require. As discussed in chapter 2, poorly trained staff, poor access to care facilities and medication, and ineffective governance and management are only some of the challenges that materially disadvantage those seeking public care, especially in the case of healthcare users living in rural areas.

If we return to Fricker's conception of hermeneutic injustice, as outlined in chapter 1 section 2, she indicates that both material power and identity power can contribute to the hermeneutic marginalisation of agents. The kind of material advantage mentioned above may hermeneutically marginalise patients in two ways. First, by not having access to sufficient medical care through well trained medical professionals, patients may not have access to all the necessary information regarding their illness and treatments. Ward-based PHC outreach teams were the intended vehicle of promoting healthcare education within the PHC (primary healthcare) re-engineering strategy. However, the implementation of this strategy has been poor and uneven across South Africa.

Secondly, this kind of material disadvantage may cause hermeneutic marginalisation as it may perpetrate a stigma against poverty. In this way, material power and identity power both contribute to the hermeneutic marginalisation of healthcare users. While this kind of identity prejudice – prejudice against those living in poverty - is not characteristic of all healthcare users, it may well contribute to the identity prejudice against healthcare users who cannot afford private healthcare. Healthcare users may therefore be placed in a position of lesser power within the healthcare system firstly (as outlined in the previous section) because they are patients and further because they are materially disadvantaged.

These two forms of hermeneutic marginalisation may allow for hermeneutic injustice firstly, as patients may be prevented from having a complete understanding of their conditions and therefore prevented from fully understanding their experiences of illness. This is due to the fact that the healthcare system does not enable them to obtain all the necessary knowledge to understand these experiences and deal with them effectively.

Secondly, the divide between public and private healthcare users may add to the stigma against healthcare users which prevents them from contributing epistemically to their

treatment and care. This may be due to the way access to private and public healthcare divides those who are more materially advantaged from those who are materially disadvantaged. As mentioned in chapter 2 section 1, those who cannot afford private healthcare services are left to make use of substandard public services. In this way, those who make use of public health services suffer a distributive disadvantage and perhaps disadvantages due to class discrimination as well. This may take the form of prejudicial assumptions about lower levels of access to education among materially marginalised groups. If it is incorrectly assumed that those who access public healthcare are not capable of understanding and contributing to their own care because of their material disadvantage, the potential for epistemic injustice opens up.

The healthcare system may in this way allow healthcare users to miss out on certain kinds of care as well as allow them to remain uneducated about their conditions. For example, if it is assumed that a patient does not understand the nature of their illness, a patient may not be given all the necessary information about their treatment and care. This may cause patients to be epistemically disregarded firstly, as they are not as epistemically privileged as the healthcare professional in terms of medical knowledge and secondly, they are epistemically disregarded due to their material disadvantage. As seen in the previous section, this is problematic as patients may have access to non-dominant hermeneutic resources that enable them to know more, or perhaps have a different kind of knowledge, about their conditions than the healthcare professional. By disregarding these resources on the grounds that the patient is uneducated or materially disadvantaged, healthcare professionals may miss out on information necessary for the patient's care and potentially cause further harm to the patients both epistemically and physically.

Another example, especially relevant in a South African context, is that of TB medication development and administration. TB medications are required to be taken under very specific conditions in order to be effective. However, those in materially disadvantaged situations find themselves unable to adhere to these requirements. Mine workers, for example, cannot desist with work in order to administer their medication when necessary. This indicates a gap in understanding between those who are developing medications and those who need to take the medication. Those who are developing TB medications are not in such materially disadvantaged positions and are therefore in positions of power over those needing to take the medication. What is evident here is that it is not a case that TB patients do not understand

what to do in order to take their medication. Rather they are in situations where they are unable to take these medications and are therefore unable to get well. This example illustrates the link between material and identity power that Fricker says characterises epistemic injustice, as mentioned in chapter 1. This link will be explored in more detail in section 4 of this chapter.

The kinds of epistemic marginalisation mentioned above will also greatly affect mental healthcare users. Mental healthcare users who do not have the means to access private care suffer the same material disadvantage as other public healthcare users. However, as discussed in chapter 2 section 2, mental healthcare users are further disadvantaged in that provision of mental healthcare services is even poorer than general healthcare services as mental healthcare is often overlooked. This can be seen, for example, in the fact that policy regarding community healthcare services has not been made to include services such as psychiatry. Rather, these services are only available at secondary district hospitals (*viz.* Cullinan 2006, 12) which are often difficult to access for those living in rural areas. Moreover, mental healthcare users face greater discrimination than general healthcare users due to the longstanding stigma against people with mental illness. This, coupled with prejudices against people who are less materially advantaged, may create an even greater potential for hermeneutic injustice in the ways mentioned above.

Another way the discrepancy between private and public healthcare in South Africa may create the potential for epistemic injustice is through the reduction of patient choice in accessing services. As discussed in the previous section, a reduction in choice forces patients to opt for public services which binds them to the institutionalised policies within public healthcare. These policies, although intended to ensure quality care for patients as well as the protection of patient rights, may perpetrate epistemic injustice by neglecting patient epistemologies in favour of the dominant institutionalised epistemologies within policy. Further, healthcare professionals may perpetrate epistemic injustice by turning an “institutionally mandated blind-eye” to the injustices that policy may cause healthcare users (McCollum 2012, 195).

A specific example of this within South African healthcare is the policy of deinstitutionalisation. As mentioned in chapter 2 section 2, deinstitutionalisation refers to the move away from high levels of patient admissions to tertiary facilities and towards higher levels of community based mental healthcare. This is intended to provide home based care at

a lesser cost as well as to reduce the risk of patient human rights violations at tertiary facilities. While having deinstitutionalised care for mental healthcare users may benefit them in the ways stated above, it is first necessary to have adequate infrastructure and human resources to care for patients at a community level. This has not been the case in South Africa as community-based services are still inadequate for providing community-based care to mental healthcare users.

A policy like deinstitutionalisation implemented in this way, without the necessary resources in place, may cause several harms to the patients it is intended to assist. Implementing such a policy within South Africa may cause epistemic injustice as it rejects knowledge of what might be better for patients in favour of the institutionalised epistemologies that make up policy. Implementing this policy shows a further disregard for knowledge of the complexities of mental illness and the services needed to manage it. This is evident because community-based services have not yet been made to include psychiatric services for mental healthcare users. By allowing deinstitutionalisation to take place, a hermeneutic injustice may arise as a result of the rejection of this knowledge. This kind of epistemic injustice will be explored in more detail by analysing the result that the implementation of deinstitutionalisation had on the mental healthcare users in Life Esidimeni.

PHC re-engineering, although intended to improve the state of healthcare, has opened several other doorways for epistemic injustice. A focus on the improved provision of healthcare services in line with policy, as mentioned above, may cause the healthcare system to overlook some of the epistemic injustices such policy opens the door to. This is characteristic of the epistemic power afforded to institutions. These injustices are made worse by the fact that policy is not being implemented properly or effectively. An example of this is the implementation of the District Health System (DHS). As discussed in chapter 2 section 1, the DHS is intended to provide comprehensive, entry level care through service provision from community healthcare workers (CHWs). However, poor implementation of this system has left the many lines of authority in this system without proper governance and management. This has affected the quality of care provided to patients despite having clear policy guidelines. A reason for this, and further for the potential for epistemic injustice, is that CHWs do not know who they are accountable to. If healthcare workers do not know to whom they should report or who is responsible for providing certain services, the care of patients may suffer.

Epistemic injustices may occur in these instances as patient suggestions, complaints and other forms of knowledge provided by healthcare users may be overlooked as health officials aren't sure who should be dealing with patient testimony. This ignoring of testimony is however, not primarily a testimonial injustice. This is because the injustice is not caused by any one healthcare official. Rather it is a structural inequality that puts all healthcare officials in a position to ignore patients. Rather, this kind of epistemic injustice is contributory.

Patient epistemologies are disregarded by the implementation of more dominant, institutionalised epistemologies in the form of the policy of PHC re-engineering. Moreover, poor implementation of this policy may create a hermeneutic ignorance among healthcare officials who are unsure to whom they are responsible. Hermeneutic ignorance exists in this way, either wilfully or not, as a lack of understanding of the necessary procedures and policy that exist within healthcare to ensure quality care for healthcare users. This ignorance then may contribute to the epistemic injustice faced by healthcare users as their hermeneutic resources are ignored on the grounds that nobody knows whose job it is to consider patient epistemologies. This ignorance may not be wilful in the ways described by Pohlhaus, as the individual healthcare professional does not necessarily actively reject the non-dominant resources provided by the healthcare user. However, the ignorance can be seen as wilful on the part of the healthcare system that continues to allow poor implementation of policy to overshadow the needs of patients. In this way the healthcare system may allow the individual healthcare provider to contribute to epistemic injustice. This kind of injustice is evident in the case of life Esidimeni as the NGOs tasked with the care of the moved mental healthcare patients were unsure to whom they were responsible and what their duties were in terms of patient care. This will be analysed in detail in the next two sections.

Another potential avenue for epistemic injustice may be in the discrepancy between the policy and implementation of quality standards for healthcare and mental healthcare. In chapter 2 section 1, I discussed gaps between policy and implementation largely as a result of the nature of policies such as the National Core Standards (NCS) which are not compulsory but are rather adhered to voluntarily. Further, the institutionalised standard requirements that are compulsory remain low. This means that the quality of service within healthcare facilities may not be adequate to care for patients. This indicates that there is a structural gap in service provision and responsibility among service providers that may, among other things, create the potential for epistemic injustice. The NCS is intended to ensure standards with regards to

respect and dignity, clinical leadership, oversight and accountability, and safety and security, to name a few. However, if it is the case that governing bodies within healthcare and mental healthcare cannot ensure that patients physical needs are met when receiving care, domains within the NCS such as respect and dignity, information to patients, clinical leadership, oversight and accountability, and information management, may be seen as less important and therefore take a back seat.

Such disregard for domains of the NCS such as these may lead to a further disregard for epistemic justice. Things like patient complaints, suggestions or requests may be ignored to deal with supposedly more serious problems such as providing correct medication. While services like providing medication should not be compromised, such standards like respect for patients should not be compromised either. This makes it completely necessary to ensure accreditation is only awarded to healthcare facilities that can satisfy all the needs of the patients receiving care.

Such standards of quality, like respect for patients, may be overlooked more severely for mental healthcare users due to the stigma against mental illness. However, it may be the case that mental healthcare institutions should comply with even more specialised standards of care, as mental healthcare users may communicate in different ways and therefore require more attention. These sorts of expressions by mental healthcare patients, as outlined in the previous section, may take the form of expressions of “pleasure, pain, preferences, and dislikes” (Dohmen 2016, 684) which would form parts of mental healthcare users’ non-dominant hermeneutic resources. Complying with quality standards would ideally mean training staff to deal with and understand these kinds of resources. However, accreditation without such quality standards may cause these expressions of non-dominant hermeneutic resources to be disregarded as moaning or complaining. Such disregard would constitute a hermeneutic and contributory injustice if it compromised the care of the mental healthcare user. The risk to patients when institutions do not comply with certain quality standards is evident in the case of Life Esidimeni.

In this section, I outlined some of the potential gaps within the structure of the healthcare and mental healthcare systems in South Africa that may create the potential for epistemic injustice. In the next section I will outline a case study of the closure of the Life Esidimeni mental healthcare facility that led to the deaths of around 144 mental healthcare users. Further, the testimonies of two of the deceased patients’ family members will be outlined as it

was presented at the Life Esidimeni Arbitration on 8 and 9 November 2017. I will then use this case study to address these gaps within the South African healthcare system more specifically through an analysis of epistemic injustice as it occurred as a result of the closure of the Life Esidimeni healthcare facility.

3.3) Life Esidimeni – A Case Study of the Deaths of 144 Mental Healthcare Users

In 2015, the MEC for healthcare in South Africa, Qedani Mahlangu, announced that the Life Esidimeni mental healthcare facility would be closing due to the termination of the contract between the Gauteng Department of Health for South Africa (GDoH) and Life Esidimeni.

This section will outline the events that took place after the termination of the Life Esidimeni contract and present a case study illustrating the effects of the closure of the facility.

Information regarding this case is sourced predominantly from the Ombudsman's report "*The Report into the 'Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province'*" (2017) as well as the Life Esidimeni Arbitration hearings that were held from 9 October to 10 December 2017; on 18, 19, 26 and 30 January 2018; and on 19 March 2018.

The case study serves to highlight the problems facing mental healthcare in South Africa. Specifically, the focus will be on problems related to issues of epistemic injustice such as the silencing of mental healthcare users due to asymmetrical power relations within the South African healthcare system. This kind of injustice will be analysed as it links to the deaths of 144 mental healthcare patients after they were moved from the Life Esidimeni facility. This case study will then further be examined in the next section in order to analyse the nature and scope of epistemic injustice as a systemic kind of injustice within South African mental healthcare. I will show that the epistemic injustice at issue in the case study is predominantly hermeneutical, documental and contributory of nature.

For the remainder of this section then, I sketch the facts around the Life Esidimeni case, with the analysis in terms of epistemic injustice issues being addressed in the next section. I will begin by outlining the events that led to the closure of Life Esidimeni. I will then look at the agents involved in these events as well as the problems that followed the closure of the facility. Lastly, I will link the events and the involvement of the agents to potential gaps that exist in the healthcare and mental healthcare systems, allowing me to identify the potential for epistemic injustice in these systems in the next section.

According to Life Health Care (2017) the Life Esidimeni group provides mental healthcare services under contract to national and provincial Departments of Health in alignment with national and provincial guidelines. These facilities offer services such as “chronic mental health care; frail care; children’s mental health and frail care; intermediate care; primary health care and; substance abuse recovery” (Life Healthcare, 2017). These services are offered at prices to “suit departmental needs and budgets...for governmental health services” in order to provide necessary but “cost-effective” care to the public sector (ibid.). Further, Life Esidimeni facilities strive for community reintegration to reduce the effects of “institutionalised care” (ibid.).

The decision to close the Life Esidimeni mental healthcare facility was taken as part of what came to be known as the Gauteng Mental Health Marathon Project (GMMP). This project saw the termination of the contract between three of the Life Esidimeni mental healthcare facilities and the GDoH. The initial reason for this termination was said to be in line with the policy of deinstitutionalisation for mental healthcare facilities in order to reintegrate mental healthcare users (MHCUs) back into the community⁴¹. The GMMP was also supposedly intended as a “cost-cutting project” for the NDoH (Govender 2017, 1). However, this project was not adequately planned and information regarding this project was not made available to all relevant officials, service providers and service users (Makgoba 2017, 9). Further, as will be discussed later in this section, there was actually no pressure on the GDoH to cut costs by reducing core healthcare services to mental healthcare users. The reasons for the termination of the contract thus remain somewhat muddy.

Three main actors were involved in the implementation of the GMMP⁴². The first, the MEC for Health in Gauteng, Qedani Mahlangu; second, the HOD of the GDoH, Dr Tiego Ephraim Selebano; and finally, the Director of the Gauteng Department of Mental Health, Dr Makgoba Manamela. The HOD, Director of Health and the MEC were all in positions of authority with regard to carrying out the events of the GMMP.

The contract with Life Esidimeni was terminated by the GDoH on 31 March 2016 but was then extended to 30 June 2016 (ibid. 3). In the time between 31 March and 30 June, patients were transported rapidly from Life Esidimeni to either an NGO or a different tertiary care

⁴¹ Deinstitutionalisation was discussed in detail in chapter 2 section 2.

⁴² This is not an exhaustive list of officials involved in the GMMP. These agents are identified as the main role-players by the Ombudsman’s report (Makgoba 2017, 1).

facility. Before 31 March 2016, patients were being moved from Life Esidimeni at a rate of 13,3 patients per month. However, this figure increased dramatically to 457 patients per month during the 3-month contract extension (ibid.). The NGOs to which patients were transferred included: Precious Angels, Shammah, Kanana, Lapeng, Takalani, Mosego, Rebafenyi House 1 & 2, Ubuhle Benkosi, Hephzibah, Bophelong Suurman, Bophelong Mamelodi, Anchor, Tshepo and, Tumelo House 2 (ibid. 7). The tertiary facilities to which patients were transferred included Weskoppies Psychiatric Hospital, Sterkfontein Psychiatric Hospital and, Cullinan Care and Rehabilitation Centre (ibid. 35). A total of 1812 MHCUs were at Life Esidimeni when the GMMP started; however, the placements and transfers of these patients were not all accounted for by the GDoH (ibid. 32). In addition, several patients who were already admitted to the selected tertiary hospitals were transferred to NGOs in order to make space for Life Esidimeni patients who needed more specialised care. Moreover, several patients were moved multiple times between NGOs (ibid. 33). As a result of these transfers, 144 patients who were previously at Life Esidimeni, died.

One of the aims of the GMMP was to initiate a process of deinstitutionalisation. As discussed in chapter 2 section 1 and section 2, the 2002 Mental Health Care Act and the National Mental Health Policy and Framework and Strategic Plan 2013-2020 both indicate that mental healthcare providers should move away from the high rates of patient admission to tertiary facilities and aim rather to have patients receive community-based care as far as possible. As set out in the MHCA and MHPF, deinstitutionalisation aims further to reduce the cost of healthcare spending by reducing the number of mental hospitals, as tertiary care is more expensive than community-based care. However, deinstitutionalisation cannot occur without first having the necessary community-based facilities established. If these facilities and resources are not available to patients at a community level, patient's human rights are put at risk (*viz.* SyndiGate Media 2016, 1). Considering the state of healthcare in South Africa, it would not be possible to implement a policy such as deinstitutionalisation without first improving the level of services provided at a community level. This would mean that implementing deinstitutionalisation for the GMMP would therefore have required greater funding and incur more costs than keeping patients at Life Esidimeni.

Even though deinstitutionalisation is suggested in the 2000 MHCA and MHPF 2013-2030, PHC re-engineering in South Africa “does not cater specifically for mental health care at community level as evident by the fact that the district clinical specialist teams do not include

a psychiatrist” (Makgoba 2017, 27). A lack of regard for MHCUs becomes apparent in that primary mental healthcare services including community-based mental healthcare services do not receive the same level of attention and resource-provisioning accorded to other levels and kinds of health services. This is evident as community-based healthcare services, outlined in chapter 2 section 1 and section 2, are structured around services to be provided for general healthcare users and therefore may neglect to train and employ staff to care for healthcare users with more specialised mental disorders. If a project like the GMMP is to be implemented and requires the deinstitutionalisation of mental healthcare users, it is necessary to have these services (including competent and trained staff) available, as stated already. The difference in provision of services to general healthcare and mental healthcare at a community level indicates a marginalising of mental healthcare users, as outlined in the previous section. This issue relating to the potential for epistemic injustice will be discussed in more detail in the next section.

As indicated in the previous chapter, deinstitutionalisation is intended to reduce the human rights violations that patients still face at tertiary facilities. As indicated earlier, the Life facilities aim to reduce institutionalised care. However, the manner in which the GMMP was carried out infringed on principles of human dignity and patient rights. The human rights that were found to have been violated by the GMMP include “the Right to human dignity; Right to life; Right to freedom and security of person; Right to privacy; Right to protection from an environment that is harmful to their health or wellbeing; Right to access to quality health care services, sufficient food and water and; Right to administrative action that is lawful, reasonable and procedurally fair” (ibid. 2)⁴³. Further, “the right of persons to be treated humanely and with dignity”; “the right to participate in decisions regarding one’s health” and; “the right of everyone to have access to health care services which should not be hindered by limited available resources” were also violated (*viz.* Makgoba 2017, 49- 51).⁴⁴

These rights were violated due to a project that the GDoH implemented with the apparent necessity of cutting costs, but also the apparent necessity of adhering to the call for deinstitutionalisation present in the 2000 MHCA and MHPF 2013-2030. However, Gauteng MEC for finance Barbara Creecy indicated that “[t]reasury ha[d] never demanded that any

⁴³ According to the Ombudsman’s report, the human rights violations that occurred during the GMMP were direct violations of the Constitution of South Africa and further went against the National Health Act and the Mental Health Care Act (*viz.* Makgoba 2017, 2).

⁴⁴ The rights violations that occurred during the Life Esidimeni case are not limited to the list provided here.

department cut core services” in order to reduce government spending (Chabalala 2018). This statement was contrary to that made by MEC Mahlangu who claimed that the GDoH felt “pressured” to cut costs (ibid.). However, Creecy stated that Mahlangu was offered more funds if necessary. Further, Creecy indicated that the GDoH had indeed suggested a move of patients to government facilities, perhaps to implement the policy of deinstitutionalisation as far as possible but was told not to do so at the expense of quality services (*viz.* Chabalala 2018). Regardless of the funds available to the GDoH, they continued with the implementation of the GMMP under the guise of cost-cutting.

Patients were taken care of at Life Esidimeni at a cost of R320 per user per day. Once moved to the NGOs, the GDoH promised each NGO a subsidy of R112 per patient per day (*viz.* Makgoba 2017, 35). This figure is a direct indicator that patient’s needs and rights were not taken into account in the decision to transfer them. It is not possible to care for a MHCU on only R112 per day. Even so, it took the GDoH up to 3 months to pay the subsidies to the NGOs, according to the Ombudsman’s report (Makgoba 2017, 7). This was also contested by Creecy during the arbitration. She stated that R47 million was paid to NGOs and that “only three NGOs were not paid” (Chabalala 2018).

All these factors regarding GMMP and the movement of MHCUs from Life Esidimeni to NGOs ultimately resulted in the “accelerated” (ibid. 1) deaths of 144 patients. Each of these deaths occurred “under unlawful circumstances” (ibid.) and were directly linked to the unsuitable care provided to them at the NGOs (*viz.* Makgoba 2017, 2). Patients were transported in “inappropriate and inhumane” ways to NGOs that did not have the facilities to treat their conditions (Makgoba 2017, 2). Patients did not receive the correct medication at the NGOs; were not provided with necessities like sufficient food, water and clothing; and had unexplained injuries on their bodies (*viz.* Makgoba 2017, 5-7). These factors led to patients relapsing at the NGOs where the untrained staff could not adequately care for them. Moreover, NGOs did not keep adequate records of patients and did not receive nor record information regarding patient’s conditions (*viz.* Makgoba 2017, 21). A link can be found in the treatment of these mental healthcare users (MHCUs) and a lack of regard for the dignity of patients. This lack of regard is one that is based on political, ethical and epistemic factors impacting on just treatment of patients. In the next section, this case will be analysed in order to explore the role of epistemic injustice both in causing the transfers and in the subsequent unlawful treatment of MHCUs.

An arbitration process, led by Chief Justice Moseneke, was held in order to obtain information regarding the actual events surrounding the closure of Life Esidimeni. This process was further, and perhaps more importantly, intended to bring closure to the families who lost loved ones as a result of their transfers from Life Esidimeni to NGO facilities. This loss of life can be attributed to conditions including dehydration, starvation, sepsis and other forms of neglect, rather than their diagnosed illnesses.

The Ombudsman's report as well as the arbitration process brought to light that the NGOs to which patients were moved were not fit for purpose. Many of the NGOs were operating without valid licences. Furthermore, NGOs were not required to provide evidence of staff training before obtaining licences for their facilities (*viz.* Makgoba 2017, 36). Many NGOs were therefore given licences even though their staff were not qualified to care for mental healthcare users. Dr Manamela admitted to the Ombudsman that she was the one who signed off on all the licences for the NGOs. However, according to the Ombudsman's report, Dr Manamela "[was] not legally authorised nor [did she have] the delegated authority to sign licenses" (*ibid.* 38). At the arbitration, Manamela testified that she did not know at the time that the NGOs were not fit to take care of patients (*viz.* Mafokwane 2017, online). Moreover, several NGOs began receiving patients from Life Esidimeni before their licenses were issued (*ibid.*). The method of assessment of NGOs was irregular while some NGOs "never had an assessment for licensing" (*ibid.*). Obviously it is not acceptable to allow unlicensed NGOs to care for patients in need of mental healthcare. A material disregard of this kind may further lead to an epistemic disregard of mental healthcare users' lived experiences but may also have been a cause for the disregard to start off with.

Other indications that the NGOs were not fit for purpose included insufficient staffing, inadequate space for all received patients and resulting overcrowding, poor infrastructure and lack of financial support from government and external funders (*viz.* Makgoba 2017, 36-39). NGOs were under-resourced to the point of not being able to provide patients with food and water (*ibid.* 48). Despite the NGOs being largely incapable of caring for the MHCUs from Life Esidimeni, patients were moved to the NGOs at a rapid rate in order to meet the date of the termination of the contract with Life Esidimeni. Many patients were moved without the knowledge of their families (*ibid.* 36). To date, 52 patients moved from Life Esidimeni are still missing.

The Ombudsman's report indicated that patients did not die at the NGOs because of their illnesses or of "natural causes" as many of the patient's death certificates stated (*viz.* Makgoba 2017, 43). Rather, patients died "after falls" (*ibid.* 8); due to hunger, cold and dehydration (*viz.* Makgoba 2017, 10); from "community acquired pneumonia followed by uncontrolled seizures" (*ibid.* 37) and other infections (*ibid.* 38). These factors point to the fact that the deaths were preventable, and that people died in the NGOs because of negligence. The Ombudsman's report characterises these as silent deaths (*viz.* Makgoba 2017, 3); MHCUs, the most vulnerable of citizens, died because they were not considered by healthcare and government officials to be worthy of recognition. This silencing and lack of recognition is characteristic of epistemic injustice and these deaths therefore indicate instances where the potential for epistemic injustice in the healthcare system is actualised. This will be the focus of the following section.

NGOs without proper licencing remained open and continued to care for patients, even as the death toll rose from the time of the Ombudsman's report (94 deaths) to a total of 144 deaths. The report indicated that the "failure to listen" to patient's relatives, staff and other officials led to the deaths of MHCUs (*ibid.* 29). Staff members in subordinate positions stated that they felt "powerless" as the MEC would not listen to their concerns (*ibid.*). This failure to listen is characteristic of the power relations that allow for testimonial injustice as it indicates that the testimony of those marginalised by material and epistemic power are disregarded by those in higher positions of power. It also allows for hermeneutic injustice as those in marginalised positions either cannot interpret their lived experience due to a lack of conceptual skills; or, they are able to make sense of their experiences using non-dominant hermeneutic tools, but their voices are not heard as they do not have access to the dominant epistemological vocabulary employed institutionally. This discussion will also be picked up and expanded in more detail in the following section.

The use of improper unlicensed NGOs and the supposed necessity of deinstitutionalisation and cost cutting according to policy shows that the GMMP violated several policies and acts set in place to ensure that the rights of patients are protected. Because of this, the implementation of the GMMP can be linked directly to many of the Life Esidimeni deaths. According to the Ombudsman's report, when asked about the deaths that had occurred due to the closure of Life Esidimeni (a total of 94 deaths at the time), Dr Manamela was unable to give an accurate account of the deaths that had occurred (*ibid.* 11). Further, the report states

that Manamela admitted to signing off on the licences for the selected NGOs. Yet she maintained that the deaths that occurred were not due to the placement process (ibid.).

With regards to Dr Selebano, the Ombudsman's report indicated that he felt pressured to implement the GMMP but that he "could not reveal where the pressure came from" (ibid. 13). Later, when questioned during the arbitration, Dr Selebano indicated that he was pressured by the MEC to carry out the project (Nicolson 2017, online) and that it was the MEC who drove the GMMP (*viz.* SABC Digital News 2018, 24 January). Dr Selebano was reportedly unaware of the data surrounding the deaths of the patients moved from Life Esidimeni (Makgoba 2017, 11). Hannah Jacobus, the Gauteng deputy director of mental health, also stated that she was merely following instructions from above when carrying out the tasks of the GMMP (Nicolson 2018, online).

However, upon questioning, the MEC indicated that she was not an official or an administrator and therefore did not have the same responsibilities as Dr Selebano and Dr Manamela (*viz.* SABC Digital News 2018, 22 January). Rather, Mahlangu maintained that her role in the Life Esidimeni case was political and she could therefore not take any personal blame (*viz.* Child 2018). The MEC admitted in the Ombudsman's report that she was aware that certain NGOs did not have adequate infrastructure and that some NGOs were unlicensed (*viz.* Makgoba 2017, 15) but that this information was not made available to her in formal meetings by the relevant officials (*viz.* SABC Digital News 2018, 22 January). However, according to the Ombudsman's report, MEC Mahlangu received all her information regarding patient transfers and deaths from Dr Manamela and respective District coordinators (Makgoba 2017, 14). Moreover, MEC Mahlangu did not have to approve the plan to move patients from Life Esidimeni. Rather it was executed at the authority of the HOD (*viz.* SABC Digital News 2018, 22 January). This confusion among officials indicates that perhaps nobody wanted to take responsibility for what happened. MEC Mahlangu informed the arbitration hearing that she did not question the information she was receiving from officials regarding the transferred patients as she "work[ed] with people on the basis of the level of trust" (SABC Digital News 2018, 22 January). While MEC Mahlangu stated that she would take some kind of responsibility for what happened in the course of the GMMP (*viz.* Makgoba 2017, 16), she also stated that the decisions made with respect to this project were not hers alone, but rather that they were arrived at as a "collective decision" on the part of herself, Dr Manamela, Dr Selebano and other officials. (Makgoba 2017, 15). To date, there

has been no indication that any official involved in the GMMP will be held accountable for what happened after the closure of the Life Esidimeni facilities.

The responses of the officials involved in this project to questions posed in the course of the arbitration hearings indicate that they refused to take responsibility for their actions as they were, according to their own accounts, simply following instructions. But the lack of coordination among officials indicates an attitude of ignorance or even non-interest surrounding the information about the events of Life Esidimeni. Specifically, MEC Mahlangu made a point of indicating that her responsibilities were different to other officials as her role was purely political. However, this does not provide any clarity as to who needed to approve the plans to move patients from Life Esidimeni. Nor does it imply that she did not have the authority to head up a project like the GMMP.

The result of this lack of clarity is an apparent blame shift from official to official without any agent taking real responsibility. These actions set the scene for epistemic injustice as it seems that the structure of the South African healthcare system allows that orders may be given that cannot be questioned. This creates the possibility of the silencing of those that have orders imposed upon them. Whether this is indeed a case of orders having silenced those initiating the transfers, or rather, of them not caring to question the orders they were given for some reason, will be considered in the next section.

Each official, despite apparently lacking clarity regarding who was responsible for what, was situated in position from which they could not only make decisions that affected people's lives, but also a position from which they could have asked for clarification at any time. Due to this positioning of power, each agent therefore had a responsibility to ensure that official policy and the Constitution were upheld in order to protect patient rights. However, despite "expert... warnings and advice" (Makgoba 2017, 2) the officials continued to see the GMMP through, even after being made aware of patient deaths. The lack of responsibility upheld by these agents will be addressed in detail later on in this section.

Family Testimonies – Maria Phehla

During the Arbitration process, several family members stepped forward to provide their testimonies regarding the events that took place surrounding the deaths of their loved ones. Maria Phehla testified on 8 November 2017 regarding the death of her daughter Deborah

Phehla⁴⁵. Deborah was moved from Life Esidimeni to the NGO Takalani on 23 March 2016. Deborah had been receiving care at Life Esidimeni for 10 years. Deborah suffered from mental retardation and required constant supervised care and could not be left unattended. Deborah also required medication for epilepsy (*viz.* SABC Digital News 2017, 8 November).

Deborah's mother Maria was informed upon her last visit to see Deborah at Life Esidimeni that Deborah would be moved to Takalani. This was the last time Maria saw Deborah. Maria was provided with a contact number for Takalani, but the number given was not correct. Before Maria managed to visit Takalani, she received a call to inform her that her daughter had died. Deborah passed away on the 26th of March 2016, only 3 days after she had been moved from Life Esidimeni to Takalani (*viz.* SABC Digital News 2017, 8 November).

The staff at Takalani told Maria that Deborah had vomited and died. However, when Maria went to the mortuary to see Deborah's body, she saw that her face was full of blood. Deborah's body was put on a stretcher on the floor and she had one arm extended outwards. (*viz.* SABC Digital News 2017, 8 November). This treatment of Deborah indicates that she was ignored by the staff at Takalani when she asked for help. The disregard for Deborah's requests for help will be discussed in chapter 3 as indications of epistemic injustice.

Deborah's post mortem report showed that Deborah had not just vomited and died. Rather, Deborah died due to asphyxia due to aspiration of blood. Chief Justice Moseneke put it simply to Maria stating that Deborah had "drowned in her own blood" (SABC Digital News 2017, 8 November). Furthermore, Deborah's stomach contained two fist sized balls of rolled up plastic and several pieces of brown paper. Maria said she knew Deborah ate the paper and plastic because Deborah was starving (*viz.* SABC Digital News 2017, 8 November).

Maria explained that when she went back to Takalani to see where her daughter had died, she found that Deborah was left in a room by herself rather than placed in a ward like the other patients. Maria stated that it seemed as if the staff at Takalani had locked her in the room and forgotten about her. Deborah ingested the plastic and paper because she was left unattended even though she required constant supervision. It should necessarily have been stated in Deborah's medical records that she required constant supervision. However, the staff at Takalani had no medical records for their patients. This was contradicted by Life Esidimeni

⁴⁵ SABC Digital News. 2018. Life Esidimeni Arbitration Hearings, 08 November 2017. Available at: <https://www.youtube.com/watch?v=IJCK9feLJx4>. [Accessed 29 March 2018].

staff as they claimed that all patients had been sent to NGOs with their files (*viz.* SABC Digital News 2017, 8 November).

Maria closed off her testimony explaining how she wanted to know what actually happened to her daughter because nobody could tell her. Maria said that she blamed the GDoH for her daughter's death and pointed to negligence as the cause of Deborah's death (*viz.* SABC Digital News 2017, 8 November).

Family Testimonies – Luleka Khunjwa

On 9 November 2017, Luleka Khunjwa testified at the arbitration regarding the experience of her sister Maureen Khunjwa. Luleka's testimony shed light on the circumstances that led her sister to be admitted to Life Esidimeni, her stay at Life Esidimeni, her move from Life Esidimeni to Takalani and the events at Takalani that ultimately led to her death.

According to Luleka, Maureen was mute and unable to use her hands. Maureen was mentally disabled from birth, yet her family never knew exactly what condition she suffered from. It was only towards the end of Luleka's testimony that Section 27's Adila Hassim revealed to her that Maureen suffered from cerebral palsy (*viz.* SABC Digital News 2017, 9 November).

Maureen and her family became homeless after the death of her father. The family was evicted from a government mine house due to his death as the family no longer served the government. At this point, the family split up and went to live with different family members. Luleka did not know where her sister was as Maureen had left with their mother. Luleka would miss school to look for her sister. She eventually found her and her mother in 1974. However, Maureen and her mother relocated again. Eventually, Maureen was no longer under the care of her mother as her mother had to work. This prompted Maureen's move to Life Esidimeni in March 1975.

Maureen remained at Life Esidimeni for 41 years and was visited by her family often. Maureen, who was unable to bath and feed herself without great difficulty, received all the necessary care at Life Esidimeni. According to Luleka, the family was very happy with the care Maureen received at Life Esidimeni (*viz.* SABC Digital News 2017, 9 November). The family would visit Maureen on her birthday and host picnics on the lawn at Life Esidimeni. Maureen would also go home to her family every Christmas for 3 weeks. During the times that Maureen was away from Life Esidimeni, the family was provided with enough

medication for Maureen for the full 3 weeks. The family was also instructed on how to administer the medication to Maureen.

Maureen returned to Life Esidimeni for the last time in January 2016. At that time, Luleka had been informed via SMS that Maureen would be moved from Life Esidimeni to an NGO named Takalani on 1 April 2016. Initially, the family was happy with this as Maureen would be closer to home after the move to Takalani.

At the time of the move, Luleka's mother fell ill and Luleka needed to care for her. Because of this, Luleka was only able to visit Maureen at Takalani for the first time in June 2016. Upon Luleka's first arrival at Takalani at 4pm, she found the NGO staff leaving. Luleka was not allowed in to see her sister. Luleka said she did not question this, she just left (*viz.* SABC Digital News 2017, 9 November).

Luleka returned after 3 weeks, at the end of June 2016. Luleka visited Maureen from the reception of Takalani and did not see where Maureen was staying. Luleka was shocked at the sight of her sister. Maureen was very thin and dehydrated and could no longer walk by herself. Luleka had to hold Maureen up as she was too weak to do so herself. Luleka also took a picture of Maureen to record the change in her appearance.

Luleka called on a sister at Takalani to express her concern at the condition of Maureen. The sister said she did not know why Maureen was in that condition and that she was also surprised. Apparently at that time the staff of Takalani were still investigating Maureen's condition (*viz.* SABC Digital News 2017, 9 November). Luleka said it was difficult to ask Maureen how she was doing due to the nature of her disability.

Luleka would visit Maureen every two days after the first visit as she was concerned for Maureen's condition. Maureen always met Luleka at reception, never at the ward. Luleka only saw the ward once. She commented that there were about 20 beds in the ward. She also said the bathrooms were in good condition (*viz.* SABC Digital News 2017, 9 November). Every time Luleka visited Maureen it seemed as if Maureen's condition was getting worse. Upon asking Takalani staff again about Maureen's condition, Luleka was told that they still did not know what was wrong with her. This was when Luleka found out there were no doctors at Takalani and that if patients needed to see doctors they would be sent to either Koos Hospital or Chris Hani Baragwanath Hospital. Luleka then further assumed that there

was no medication available at Takalani as there were no doctors to prescribe medication (*viz.* SABC Digital News 2017, 9 November).

Maureen was eventually sent to Koos Hospital after an additional 3 weeks and was then transferred to Chris Hani Baragwanath Hospital. Maureen was at the hospital for two weeks and was then sent back to Takalani. Between July and September, Maureen moved back and forth between Takalani and the hospitals.

On 24 September, Luleka and her family went to visit Maureen at Takalani. When they arrived, the staff said that Maureen was taken to Koos the previous night but that they did not know where she was for certain. After arguing with the staff at Takalani, the family finally found out that Maureen was at Chris Hani Baragwanath. The family went to the hospital to see Maureen and noticed that she had fallen. Maureen was bruised along the side of her body. Luleka assumed that the fall occurred because the staff took Maureen's wheelchair away and she was no longer able to walk by herself.

Maureen was discharged from Chris Hani Baragwanath back to Takalani a further 3 weeks later. After about a week after returning to Takalani she was sent back to the hospital. Maureen died on 24 October 2016 at Chris Hani Baragwanath hospital. Luleka was only informed of her sister's death the following day. This made Luleka angry. She did not understand why she was only contacted the following day. Luleka went to collect the body on 26 October 2016. She was not told the cause of death. She was only given a death certificate stating the cause of death to be of natural causes (*viz.* SABC Digital News 2017, 9 November).

At the arbitration, Adila Hassim informed Luleka that the immediate cause of Maureen's death was a neuroglycopenic brain injury. Luleka said nobody ever explained this to her but that she assumed the brain injury occurred when Maureen fell. Luleka's injury had resulted in sepsis that led to her death. Hassim then told Luleka that Maureen suffered from cerebral palsy and although her illness contributed to her death, it did not cause it (*viz.* SABC Digital News 2017, 9 November).

Luleka attributed her sister's death to neglect on the part of the staff at Takalani. Luleka said Maureen died because she was not taken care of. She was not well fed, and she was not given her medication (*viz.* SABC Digital News 2017, 9 November). Luleka ended by saying that she would never have moved her sister from Life Esidimeni and that she was never consulted

about the move before it happened. Luleka did not receive any assistance when planning and paying for Maureen's funeral.

This section has outlined the events following the closure of the Life Esidimeni mental healthcare facility in general. Particular cases, based on the testimonies of Maria Phehla and Luleka Khunjwa, whose loved ones lost their lives because of the move from Life Esidimeni to unlawful NGOs, was also been presented.

This discussions in this chapter so far will be used as a foundation to the analysis of epistemic injustice in the case of Life Esidimeni laid out in this section. The next section will therefore apply the general discussions of epistemic injustice in healthcare and the more specific discussions of epistemic injustice in South African healthcare to the case study provided here.

3.4) Epistemic Injustice in the Case of Life Esidimeni

This chapter has so far presented a general analysis of gaps or inadequacies within the South African healthcare and mental healthcare systems that may create the potential for different kinds of epistemic injustice. After this analysis, a case study was presented. This case study discussed the closure of the Life Esidimeni mental healthcare facilities and the move of around 1800 mental healthcare users (MHCUs) to unlawfully licenced NGOs. It was explained that these events led up to the unnecessary deaths of around 144 mental healthcare patients. Further, this case study included two testimonies from family members of two of the deceased patients: Maria Phehla and Luleka Khunjwa.

In this section, I intend to use the general analysis of epistemic injustice in South African healthcare and mental healthcare to identify specific instances of epistemic injustice within the case of Life Esidimeni. My intention is to show how these gaps in healthcare, that create the potential for epistemic injustice, actualise in specific cases of epistemic injustice. Further, I will attempt to use the case study to show what the effects of such injustice are on the agents involved, healthcare provision and the healthcare system.

I will discuss epistemic injustice with regard to four main factors evident in the case of Life Esidimeni. The reason for selecting these four factors is that, while they are linked to each other, each one on its own explores a particular gap in the South African healthcare system that resulted in epistemic injustice in this case. The first factor is the marginalisation of healthcare users and particularly mental healthcare users (MHCUs) in South Africa in the case of Life Esidimeni. The second factor is the Gauteng Mental Health Marathon Project

(GMMP) and other policies that were used (or neglected) when carrying out the GMMP and moving patients from Life Esidimeni to the NGOs. The third factor is the failure of officials involved in executing the GMMP and the mental healthcare system in general to listen and to take responsibility for decisions. The fourth factor focuses on the actual treatment of MHCUs (patients and their families) during the move from Life Esidimeni and at the NGOs. These events are made evident through the testimonies provided by Maria Phehla and Luleka Khunjwa (these family members will be discussed as also falling within the scope of the mental healthcare user)⁴⁶.

Marginalising Mental Healthcare Users

A necessary condition for epistemic injustice is that one group stands in a position of power over another. In structural cases of epistemic injustice, this balance of power is caused by features of a particular social system that marginalises one group by favouring another. MHCUs are disadvantaged or marginalised in two ways, both outlined by Fricker and discussed in chapter 1 section 2. First, MHCUs in this case suffer at the hands of material power. Patients at Life Esidimeni suffered a material disadvantage as they were not able to access private healthcare. Especially in rural areas, this material disadvantage may prevent patients from having access to adequate care.

This kind of material disadvantage is evident in the testimony given by Luleka Khunjwa. This testimony shows how a materially disadvantaged family struggles to care for someone with a mental disability. Once Luleka's family became homeless, there came a time when Maureen (Luleka's mentally disabled sister) was left without care. This was because her family had separated when they lost their house and Maureen's mother had to leave her unattended in order to work. This material disadvantage prompted Maureen's admission to Life Esidimeni.

Life Esidimeni therefore provided services for MHCUs that were victims of material disadvantage. The execution of the GMMP in order to close the Life Esidimeni facilities can thus be seen as an exercise of material power as officials in more materially advantageous positions were making decisions affecting more materially disadvantaged MHCUs. Around

⁴⁶ The definition of the mental healthcare user, according to the 2002 Mental Healthcare Act, includes all people who make use of the mental healthcare services as well as those who are immediately involved in the decisions around a patient's care. The MHCU therefore includes both the patient as well as those who are involved in their care by making use of healthcare services in support of the patient. In this section, when referring to the general mental healthcare user I will use the term 'MHCU'. The terms 'patient' and 'family member' will otherwise be used in more specific contexts.

1800 materially disadvantaged mental healthcare users, making use of public healthcare services, were highly disadvantaged by the closure of the Life Esidimeni facilities. The decision to remove this service from the materially disadvantaged patients was obviously not taken by agents suffering the same kind of material disadvantage as the MHCUs and specifically the patients at Life Esidimeni. Rather the decision was taken by agents in a position of material power over the MHCUs. In this way, these MHCUs were marginalised by the system that placed certain agents in positions of power over them. This exercise of material power exists despite the intentions of the GMMP. Whether officials were motivated by either good or bad intentions does not change the fact that those in a materially disadvantaged position had decisions made for them by officials who were not disadvantaged in the same way.

Secondly, MHCUs in this case suffered because of identity power which further led to their marginalisation. Identity power exists when a particular group is seen in a negative light due to the prejudicial stereotypes that exist in connection to them. In the case of Life Esidimeni, the stereotype that exists in relation mental healthcare patients stems from the idea that mental healthcare patients are unable to contribute positively both to their care and their environment. This view is one that comes from early perspectives on persons with mental illnesses who were institutionalised and seen to be crazy. Although theoretically, mental health patients are no longer seen in this light, the stigma against them still exists in some form (*viz.* Davey, 2013). Perhaps this stigma is what led the officials of the GMMP to target MHCUs in their aim to “cut costs”. This will be expanded on later in this section.

When considering this particular group of MHCUs, this kind of stigma exists alongside negative prejudicial stereotypes against the poor. Here we see therefore how both material and identity power create room for epistemic injustice against a marginalised group. The MHCUs in the case of Life Esidimeni became potential victims of epistemic injustice, because of identity and material power, when they were prevented from contributing their knowledge in places where decisions are made regarding their care.

If we recall Fricker’s definition of hermeneutic injustice, this injustice occurs when an agent’s understanding of their social experiences is obscured due to a structural identity prejudice that exists against them. This is because they do not have the hermeneutic resources to make sense of their experiences. This further implies that these agents cannot contribute in the places where social meaning is constructed. However, as made evident by Mason in

chapter 1 section 2 (and expanded on in chapter 1 section 3), non-dominant or marginalised groups *do* have tools with which to understand their experiences. Yet they are still excluded from places where social meaning is constructed as the resources they use are not dominantly situated. It is only in extreme cases where agents will have no understanding of their experiences.

Using Fricker's definition of hermeneutic injustice along with Mason's idea of non-dominant hermeneutic resources, we can identify hermeneutic injustice in the case of Life Esidimeni. As seen earlier in this chapter, it is not the case that patients are unable to contribute to their care. This is because patients have knowledge of how their condition feels. This is knowledge that is not immediately accessible to officials or healthcare workers. Further, as indicated by Scrutton, MHCUs have "knowledge of what is good for them" (2017, 351). However, when making decisions regarding the closure of the Life Esidimeni facilities and the movement of patients into NGOs, this kind of knowledge was not considered. MHCUs were not consulted about the closure of Life Esidimeni. MHCUs were not asked whether the care at Life Esidimeni was sufficient or if they had thought they would receive better care at an NGO (*viz.* SABC Digital News 2017, 24 October). Even in cases where patients could not speak, as in the case of Maureen Khunjwa, the families of the patients could attest to the level of care that these patients were receiving at Life Esidimeni. It is not clear why this information was not sought when executing the GMMP. What is clear however is that taking this information onto account may have prevented the closure of Life Esidimeni and therefore prevented the deaths that occurred as a result.

Hermeneutic injustice is therefore identifiable in this case because the non-dominant resources of the MHCUs were not taken into account when carrying out the GMMP. Rather, these resources were dismissed in favour of institutionalised knowledge belonging to the officials in dominant positions of power within the healthcare system. This pool of dominant knowledge only consisted of information regarding the cost of running the Life Esidimeni facilities and the apparent need for deinstitutionalisation. Policy and epistemic injustice will be discussed later in this section. What is important to note here however, is that the knowledge that was considered when constructing and executing the GMMP belonged to the dominant group. This indicates how material and identity power can marginalise MHCUs. Marginalisation can therefore create a space for hermeneutic injustice in this case as non-dominant hermeneutic resources were neglected when it was very much in the interest of the MHCU for these resources to be considered.

GMMP, Policy, and Epistemic Injustice

Several policies were highlighted as having a role in the GMMP (Gauteng Mental Health Marathon Project). Most predominantly, the policy of deinstitutionalisation was put forward in support of the GMMP, as the Gauteng Department of Health (GDoH) supposedly needed to cut costs (Govender 2017, 1). As discussed earlier in section 3 of this chapter, it was found that cutting costs was not a necessity for the GDoH and so it was not necessary for deinstitutionalisation to occur as rapidly as it did in the case of Life Esidimeni. Furthermore, deinstitutionalisation is not a feasible means of cost cutting unless there are sufficient services in place to care for MHCUs at primary level. Because these services were not in place when the GMMP was carried out, caring for patients did not become cheaper. Costs at the tertiary hospitals that patients were moved to were higher than the costs at Life Esidimeni. This meant that cost cutting occurred at the NGOs. As noted in the previous section, NGOs were only offered R112 per patient that they housed. This is not enough to provide care to a patient based on a comparison of the R320 Life Esidimeni charged to adequately care for its patients. Even worse was the fact the GDoH did not pay the NGOs on time.

Epistemic injustice, specifically in the form of documental injustice, can be observed in the execution of the policy of deinstitutionalisation. In chapter 1 section 4, documental injustice was discussed as being a failure of agents in positions of power to adhere to “basic codes of medical conduct and scientific rigour” (Lauer 2017, 2). This failure is due to the epistemic privilege of those in positions of power and usually affects agents who are materially disadvantaged as it is commonly accepted that these people are “disproportionately disadvantaged as a norm” (ibid.). This imbalance of epistemic and material power allows the dominant agents to manipulate, disregard or undermine the legitimacy of policy within these systems that are created to protect members of the marginalised group. Further, those belonging to the dominant group will find it easier to undermine or disregard the advice or opinions of other officials that are perhaps in lesser positions of power.

Deinstitutionalisation as it exists in policy, discussed in chapter 2 section 2, seems to be very beneficial in theory, both for patients and the National Department of Health (NDoH). If carried out correctly, deinstitutionalisation may reduce human rights violations as they occur in tertiary mental healthcare facilities; allow for more effective community-based healthcare; and reduce the cost of healthcare as tertiary healthcare is more expensive than primary based healthcare. However, in order for deinstitutionalisation to achieve these goals in practice, it is

necessary for the healthcare system to provide the necessary infrastructure and adequately trained staff. These necessities were not met when deinstitutionalisation was suggested as motivation for the GMMP and when the GMMP was carried out.

The potential for documental injustice in this case came about as a result of the apparent need to cut costs, the speed at which the Life Esidimeni facilities had to be closed, and the speed at which patients had to be moved to NGOs. Again, the officials carrying out the GMMP were not materially disadvantaged in the same way as the MHCUs and patients at Life Esidimeni. Perhaps this disproportionate access to material power made it easy for officials to regard mental healthcare users as being “disadvantaged as a norm” (ibid.). This prejudice may have been exacerbated by the identity prejudicial stereotypes against MHCUs discussed earlier. With these prejudices in place, it may have seemed appropriate to close the Life Esidimeni facilities in an attempt to cut costs in healthcare. This may have been due to the implicit stereotypes that exist against MHCUs. From a position of structural power, officials may thus have identified the MHCUs at Life Esidimeni to be suited for being involved in the GMMP because of the underlying disregard for MHCUs based on the stigma against them. This stigma, as discussed earlier in this section, is a result of both material and identity power. However, this would have only been the case because of the negative stereotypes that existed in relation to MHCUs and would, as a result, effect the patients at Life Esidimeni. In actual fact, MHCUs like those that were in Life Esidimeni make up part of the most vulnerable groups in society. Because of this, this group requires the most care and assistance when it comes to their health, as they are unable to effectively care for themselves. This makes them the least appropriate target for a cost cutting project like the GMMP.

This kind of disproportional distribution of power can once again be linked back to the structure of the healthcare system. Individual agents are awarded positions of power due to the nature of hierarchy within social institutions. This hierarchy is often necessary in order to carry out tasks that are to the benefit of those that the system is intended to help. However, when officials in power are allowed to take advantage of their dominant position at the expense of those in the marginal group, we are left with the potential for structural epistemic injustice. This is therefore a kind of epistemic injustice that is tolerated by unjust healthcare systems and which advantages agents in positions of power.

Documental injustice can therefore be identified as at least one of the reasons for selecting or targeting this group of MHCUs for inclusion in the GMMP. Officials in a high position of

power over a group of mental healthcare users as vulnerable as this one, would have found it easy to manipulate policy in order to implement a project like the GMMP. Firstly, with regards to deinstitutionalisation, officials were able to suggest it as a means to cut costs without having any of the necessary structures in place to effectively do so (*viz.* Child, 2018). This shows a rejection or disregard for policy. Specifically, the Mental Health Policy and Strategic Plan 2013-2020 states that without the necessary development in community-based services, deinstitutionalisation is not feasible (*viz.* National Department of Health 2014, 9). Policy thus appears to have been manipulated by officials under the guise of the necessity of reducing costs – a necessity that did not even exist. This marks the first instance of documental injustice as a disregard for and manipulation of the policy of deinstitutionalisation.

Secondly, policy regarding the National Core Standards (NCS) for healthcare in South Africa was also ignored. As explained in chapter 2 section 1, the Office of Health Standards Compliance created the NCS as a benchmark for standards of healthcare provision, to be applied universally among different kinds of healthcare services. These standards further provide guidelines for facilities to obtain licensure. Facilities are required to meet a minimum standard of compliance in order to obtain these licences. However, as it came to be known in the aftermath of the closure of the Life Esidimeni facilities, Dr Manamela awarded licences to NGO facilities that did not meet the minimum standard of compliance. Further some facilities started operating before licences were awarded and, worst, Dr Manamela was not actually even permitted to provide licensure to these NGOs in the first place.

This can be noted as a case of documental injustice as officials in high positions of power, Dr Manamela specifically, ignored the necessary policy guidelines that were put in place to ensure facilities are able to provide adequate care to healthcare users. As stated earlier, this blatant disregard for policy seems to have been tolerated by the healthcare system due to the dominant positioning of officials over the severely marginal positions of the MHCUs at Life Esidimeni. The domains and sub-domains of the NCS are set out very clearly in a policy document published by the National Department of Health (National Department of Health, 2011). This document further indicates the purposes of the NCS as well as the uses of these standards and the necessities for compliance of health facilities.

Despite the publication and enforcement of this document, the GMMP violated several of the domains and the sub-domains of the NCS when awarding licenses to NGOs and allowing

them to take in patients. The first domain of national core standards violated is the standard of Patient Rights. At the unlicensed NGOs, MHCUs (families included) suffered gross violations of their rights. This violation will be explained now by pointing to each relevant neglected sub-domain of the domain of Patient Rights: 1) MHCUs were not treated with respect and dignity. 2) Information about the movement of patients, death of patients, and treatment of patients, among other things, was not provided to the patients' families. 3) Patients did not receive the same level of care at the NGOs as they did at Life Esidimeni, thus not ensuring continuity of care. 4) MHCUs experienced many delays in care, as seen in the example of Maureen, discussed in section 3 of this chapter, when she was not immediately transferred from the NGO to the tertiary facility when her condition worsened. 5) The sub-domain of access to emergency care was not adhered to, as is also illustrated by the case of Maureen. This may be an indication of why Maureen's fall caused her death. 6) MHCUs were not given access to a package of services at the NGOs. Rather it was the case that NGOs took as many patients as they had space for, without ensuring they had the capacity to care for their particular conditions or even provide adequate food and medication. 7) Lastly, the complaints made by MHCUs to the NGO staff were not managed effectively.

The second domain violated at the respective NGOs is the domain of the national core standard for Patient Safety, Clinical Governance and Care. This domain is intended to ensure quality nursing and clinical care and ethical practice to reduce harm to patients. The relevant neglected sub-domains in this case are as follows: 1) Patients were not adequately cared for at NGOs. 2) There was a lack of clinical leadership. 3) There were high levels of clinical risk as a result of low clinical risk management. And 4) there was a severe lack of infection prevention and control, resulting in many patient deaths due to sepsis. Violations of this domain are highlighted by the fact that the NGOs were not required to employ staff that was adequately trained. Many of the staff at the NGOs were not suited to provide medical care to patients and thus compromising patient safety and quality care, leading in many cases, to death.

The third domain regards the national core standard for Clinical Support Services to ensure the necessary services are made available to healthcare users. This was not provided by the NGOs as a result of a lack of adherence to the relevant sub-domains which are intended to ensure services such as: 1) Pharmaceutical services, 2) diagnostic services, 3) therapeutic and support services, and 4) mortuary services. Several NGOs did not have on-site doctors and therefore could not provide pharmaceutical services or diagnostic services. There was further

no provision of therapeutic or support services to patients or other MHCUs at the NGOs. Mortuary services secured by NGOs were also substandard. As seen in the case of Deborah Phehla, her body was not cleaned at the mortuary and she was left on a stretcher on the floor.

The fourth domain of national core standards violated is that of Public Health. This domain of standards is intended to provide guidance for how public health facilities like NGOs should work and what their duties are. When selecting NGOs for the implementation of the GMMP several sub-domains were violated such as: 1) Population-based service planning and delivery: Patients were not sent to NGOs on the basis of what the patients' needs were (in terms of illness, geographical location etc). Rather they were sent to NGOs that simply had the capacity to house them. Some NGOs did not even consider capacity and were caring for more patients than they had space for. 2) Health promotion and disease prevention: The goal of sending patients to NGOs during the GMMP was not to promote health or prevent disease. Rather it was simply to "cut costs" and close the Life Esidimeni facility as per the cancellation of the contract (*viz.* Section 27 n.d). Lastly, 3) disaster preparedness: NGOs could not even feed or ensure quality care for the MHCUs, let alone prepare for any sort of disaster that may occur.

The fifth domain of NCS regards Leadership and Corporate Governance. The sub-domains in this area were violated by the officials carrying out the GMMP more so than the NGOs. These include: 1) Oversight and accountability: As will be discussed later in this section, no official took responsibility for the state of the NGOs and the events that followed the closure of Life Esidimeni. There was further no 2) strategic management, 3) risk management or 4) quality management at any of the NGOs as no officials from the GMMP were involved in the running of NGOs after patients were moved. This is related to the sub domain 5) effective leadership as well.

The sixth domain of the NCS, Operational Management, indicates violations of the sub-domains of: 1) Financial resource management, as funds were never adequately distributed to NGOs by the Gauteng Department of Health (GDoH). Poor financial management can further be observed in the cost allocated to each patient at the NGOs per day (R112). The domains of 2) information management and 3) medical records were also violated during the move of patients and the events following as patients were moved without their medical records. A more severe violation of these sub-domains is evident in the fact that there is still an unconfirmed number of patients missing after the move from Life Esidimeni. This indicates

that information regarding these patients was not managed or even thought about during the move.

Finally, the seventh domain of NCS concerns Facilities and Infrastructure. Every sub-domain in this case was violated by the licencing of these particular NGOs. 1) The buildings and grounds of some of the NGOs were not adequate. NGOs had in some instances converted garages of homes into wards for patients; 2) Necessary machinery and utilities were not available at the NGOs. Even though NGOs are only required to provide basic care (and wouldn't need specialised machinery) there were some NGOs that did not even have adequate wards for patients. This is evident in the case of Deborah, discussed in section 3 of this chapter, who was described as being left in a room rather than placed in a ward; 3) Safety and security for patients was not a priority at NGOs. This is evident in the fact that it was possible for Deborah to be left in a room without any care or for Maureen to fall as she was not aided when moving around; 4) Many of the NGOs were also lacking in hygiene and cleanliness; 5) NGOs were found to have insufficient linen and laundry for patients. In some cases, patients were clothed in overalls and were not given shoes (*viz.* SABC Digital News 2017, 24 October); Lastly, 6) NGOs did not provide patients with adequate food services. Both case studies presented in section 3 of this chapter show evidence of the starvation of patients at the NGOs. Further, the Ombudsman's report indicated that several deaths at the NGOs could be attributed to starvation (*viz.* Makgoba 2017, 10). This was predominantly due to the fact that the NGOs did not receive the promised stipends from the GDoH.

This list, taken directly from policy regarding the NCS, shows how negligent officials were in allowing these NGOs to operate. It is not the case that only one or two rules were broken or that one or two domains were dismissed. Almost the entire list of recommendations was ignored. These NGOs were clearly not fit for purpose and allowing them to operate by completely disregarding policy is an almost text-book instance of documental injustice.

While these failings on the part of NGOs and officials are of immediate ethical importance, it is further very important to note that, with regard to violations of the NCS and policy of deinstitutionalisation, the cause of these ethical failings can be attributed to an epistemic failing as well. This is evident in the fact that those in positions of power were able to disregard the necessary guidelines in healthcare policy, and in that way to close off participation in knowledge exchange to the MHCUs in question. Had policy been upheld and the information therein used as it was intended, unlicensed NGOs would not have been

allowed to exist or be involved in the process of deinstitutionalisation. However, as already stated, the social positioning of officials in this case made it easy for them to disregard the policy that would affect an already marginalised group, due to the stigma that they are disadvantaged as a norm.

Here we see how the political, ethical and epistemic work in tandem with one another. This reminds of the discussion in chapter 1 section 2 where Fricker's conception of epistemic injustice as a primarily ethical issue was critiqued. Although the ethical elements of this case are the ones that are more immediately salient, it does not imply that the epistemic and political failings carry any less weight when analysing the epistemic injustice at play. Documental injustice in the case of life Esidimeni shows that power, knowledge and ethics each play a role in the lives of healthcare professionals and MHCUs and when these elements are not correctly socially institutionalised, it creates the potential for epistemically unjust practices which may result in such severe consequences as loss of life. This interplay of ethics, power and epistemology is also evident in cases of contributory injustice which will be discussed next.

Officials, Responsibility, and the Failure to Listen

The events surrounding the closure of the Life Esidimeni facilities have been characterised by what has been called a “failure to listen” (Makgoba 2017, 29). This failure materialised in several ways. First, as indicated earlier, there was an evident failure to listen to policy with regard to the execution of the GMMP. Second, before the closure of the Life Esidimeni facilities, the officials that implemented the GMMP failed to listen to warnings provided by other officials and members of the staff at Life Esidimeni. This failure can be said to fall into Lauer's conception of documental injustice as well. This is because officials involved in the GMMP carried the project out under the guise of following the policy of deinstitutionalisation. However, officials did not adhere to policy correctly. This disregard manifested in a project that allowed for the closure of Life Esidimeni and the use of unlawfully licenced NGOs. Under normal circumstances, such a disregard for policy would not have been allowed. But in the case of the GMMP, the high levels of power held by the officials involved made it easy for a manipulation of policy to exist under the guise of something like cost cutting and to further get away with providing at best, muddled reasons for the termination of the Life Esidimeni contract. This is evident as the officials who defended their actions during the GMMP used cost-cutting as their defence (*viz.* Chabalala, 2018). This

guise would then act as a shield against any concerns raised against the GMMP, even if it was made by other officials involved in the project.

However, manipulation of policy and a failure to listen in the sense of disregarding policy and thus perpetrating documental injustice, were not the only cases of officials in the GMMP creating the potential for epistemic injustice. Contributory injustice, as examined in chapter 1 section 4, is also evident in the case of Life Esidimeni. This kind of injustice comes into play when individual agents in positions of power actively reject the non-dominant hermeneutic resources of groups in positions of lesser power. This rejection is an active one as the dominant agents involved use their wilful hermeneutic ignorance⁴⁷ to maintain the dominant and structurally prejudiced hermeneutic resources, both in their favour and at the expense of those in marginal positions of power. Further, unlike Fricker's conception of hermeneutic injustice, contributory injustice accounts for the fact that non-dominant groups do have resources with which to understand their experiences. Contributory injustice therefore occurs when these resources are actively prevented from being viewed as credible contributing resources to the dominant pool of hermeneutic resources.

This kind of injustice is evident in a third way that officials failed to listen. The third failure to listen involves a direct disregard for the concerns of MHCUs. Power relations are made more evident in the fact that most MHCUs were not consulted about the move of patients from Life Esidimeni. Luleka made it clear in her testimony that she would not have moved Maureen out of Life Esidimeni if she had been given the choice, but the choice was never presented to her. Even in instances where MHCUs were consulted, their requests were not taken into consideration when making the decision to close Life Esidimeni (*viz.* SABC Digital News 2017, 24 October). Contributory injustice becomes evident in this case when the reasons for not considering the concerns of MHCUs are examined.

The GMMP was a project that was carried out very quickly, supposedly due to the fact that the GDoH needed to cut costs as soon as possible (*viz.* Chabalala, 2018). If the GDoH had acknowledged the legitimate concerns of MHCUs and other officials, it may have caused the realisation that the GMMP needed more time to be implemented. If so, the GMMP may have been carried out over a period of years instead of a period of six months. This would perhaps have given sufficient time to improve the infrastructure and services needed for the kind of

⁴⁷ Wilful hermeneutic ignorance, as discussed in chapter 1 section 2, allows dominantly situated groups to actively reject information that allows marginalised groups to contribute to the pool of dominant hermeneutic resources.

deinstitutionalisation called for by the GMMP. Alternatively, an acknowledgement of concerns may have even caused the discontinuation of the GMMP, upon realising that the time frame set out by the project was insufficient. Even though cost-cutting had been named as one of the reasons for carrying out the GMMP (*viz.* Govender 2017, 1), the “real” reasons for the rushed execution of the GMMP are still unclear (*viz.* Mkhabela, 2018). However, the assumption can be made that if the GMMP was discontinued, the GDoH would have suffered some kind of disadvantage. By neglecting to listen to concerns about the GMMP, the officials involved maintained their wilful hermeneutic ignorance by rejecting the non-dominant knowledge presented by the MHCUs. The knowledge from non-dominant resources, provided in this case, would have been highly beneficial to the situation of MHCUs if it had been allowed to contribute to patient care. A contributory injustice therefore exists in the fact that these resources were rejected in favour of resources that were more beneficial to the officials and the GDoH rather than considering what would be most beneficial for the MHCUs at Life Esidimeni.

A similar kind of contributory injustice can be identified in the cases of patient care at the NGOs. Staff at NGOs perpetrated contributory injustice by failing to let patients and their families contribute to their care. As seen in the testimonies outlined in the previous section, both patients and family members provided indications that care was not sufficient. Firstly, in the case of Maureen, her sister Luleka would often engage the staff at Takalani regarding concerns for Maureen’s care. These concerns were met with a sense of indifference. The only information Luleka would receive from the staff was that they also did not know what was wrong. This indifference can be seen as a kind of contributory injustice as the urgency of Luleka’s concern was not taken seriously.

The reason for this is not entirely clear but it seems reasonable to expect that it lies in one or in an intersection of the following: A failure to listen to Luleka could indicate that the staff at Takalani did not find Luleka’s contribution useful. This may have been due to the structural prejudice that exists against MHCUs specifically and the layperson in general, that their contributions are not useful in improving levels of care. Perhaps the Takalani staff did not think Luleka could offer useful information about Maureen as Luleka is not a healthcare service provider. Or perhaps Luleka’s contribution was treated with indifference on the basis of it being presented as a general concern rather than a medical fact.

Even though the precise reason for the rejection is not immediately clear, the point remains that this rejection – which did in fact happen - presents a form of wilful hermeneutic ignorance as it undermines the fact that MHCUs can in fact contribute to the care of patients. They are able to do so because of the non-dominant hermeneutic resources they use to understand their experiences of illness. Therefore, this rejection constitutes a contributory injustice as non-dominant tools for understanding a patient's condition were rejected by more dominantly situated knowers, in favour of more dominant medical epistemologies.

Secondly, in the case of Deborah, a failure to listen is presented by the state of Deborah's corpse. Maria testified that upon visiting Deborah's corpse at the morgue, she found Deborah with her arm stretched out in front of her. Deborah's body language is a clear indication of a cry for help. This cry was clearly not taken seriously by the staff at Takalani. Like in the previous example, this rejection may be indicative of the fact that the NGO staff did not take seriously the fact that MHCUs are able to contribute to patient care. However, a lack of regard for patients presents in many ways a more severe kind of injustice than a lack of regard for their families or the MHCU in general. This is because of the stigma that exists against people with mental disabilities. It is assumed that because they have mental disabilities they are unable to contribute to their care effectively or to contribute at all to how they live their lives in general (in cases where they are unable to speak, for example). However, as indicated earlier, it is the case that patients (even those unable to speak) have both knowledge of how their conditions feel and at least some intuitive knowledge of what is good for them. In Deborah's case, it was clear that she knew she needed help. This was made evident in the fact that she was reaching out with her hand. However, when asking for help, using the only tools Deborah had available to her, she was ignored by the NGO staff.

This case provides another example of how wilful hermeneutic ignorance, on the part of NGO staff, undermines the non-dominant resources used by patients. A rejection of these resources constitutes a contributory injustice as Deborah was not given any opportunity to ask for help and contribute to her care and wellbeing. Thus, this example illustrates the severe consequences of rejecting non-dominant resources. It further indicates the importance of proper training for those who care for or interact with MHCUs. Staff trained to care for MHCUs should be able, at least to some extent, to understand when a MHCU is in need of help. What is clear in the case of Deborah is that she was not considered able to contribute at all and so her stretched out arm was not seen as a means of communicating. She was therefore not considered worthy of care and was disregarded in her attempts to ask for it. This

is evident as Deborah seemed to have been left in a room at the NGO and forgotten about, therefore not receiving any of the care she needed. Deborah was not even given basic human necessities like food, as evident from the fact that she ate plastic (*viz.* SABC Digital News 2017, 8 November). This is an extreme failure on the part of the healthcare system which did not employ trained staff as well as an extreme failure on the part of the staff at Takalani themselves. Even without training, the NGO staff should not have ignored Deborah's cries for help by leaving her in a room unattended. Perhaps, had there been a greater emphasis on the importance of caring for patients and greater desire to listen to them, these events would not have taken place.

Lastly, we can observe instances of epistemic injustice in the lack of responsibility taken by officials during and after the implementation of the GMMP. As outlined in the previous section, it became evident during the arbitration hearings that none of the major officials involved in the GMMP wanted to take any individual responsibility for the events and deaths that occurred as a result of the GMMP. Each of the three main officials involved made statements that indicated either a refusal to admit responsibility or to shift blame elsewhere. Firstly, in the case of Dr Manamela, she maintained that although she admitted she had illegally signed off on licences for unfit NGOs, the deaths that occurred were not as a result of the placement process of patients at these NGOs (*viz.* Makgoba 2017, 11). Secondly, Dr Selebano indicated that he continued to carry out the GMMP without having knowledge of the deaths that had occurred at NGOs (*viz.* Makgoba 2017, 11). Further, he made claims that he was not the driving force behind the project. Rather, he claimed to have received instruction from MEC Mahlangu and claimed he was therefore carrying out instruction given from an official in a higher position of power (*viz.* Nicolson 2017, online). Lastly, MEC Mahlangu stated in opposition to Dr Selebano that she was not an official administrator of the project. This implied that she did not have the same responsibilities as Dr Selebano or Dr Manamela. Further, the MEC claimed that information was not being provided to her formally by these officials, particularly with regard to the licencing of NGOs (SABC Digital News 2018, 22 January). MEC Mahlangu absolved herself of personal blame by stating that her role in the GMMP was political (*viz.* Child 2018). It is unclear if she intended that she should hold political blame as an individual or if the political system as a whole should be blamed.

These statements indicate that each of the three officials believed that they were not to be held responsible. This kind of blame shifting and refusal to take responsibility can be seen as

a form of silencing, not necessarily of any particular MHCU but rather as a silencing of MHCUs as a whole. This kind of refusal to take responsibility shows how officials in positions of power can remove themselves from the line of fire by maintaining the hierarchical social structures they belong to⁴⁸.

This can be attributed to a wilful hermeneutic ignorance as each of these officials tried to absolve themselves of blame by enforcing their positions of power within the healthcare system. Epistemic injustice can potentially be identified here in a number of ways. Firstly, officials in lower positions of power, like the Gauteng deputy director of mental health Hannah Jacobus (discussed in the previous section), are silenced by the officials that are in more dominant positions. This injustice is similar to the documental injustice that occurred when the GMMP officials would not listen to the Life Esidimeni staff. However, this is not a documental injustice in entirely the same sense as it does not involve a manipulation of policy. Rather, we see a kind of hermeneutic injustice that silences even those who belong to the particular social system (who hold somewhat lesser positions of power) in order to further silence and take advantage of those in the non-dominant group.

However, the blame shift that occurred in the case of Life Esidimeni may not have been as active and thought out as stated above. As indicated in the previous section, each of the officials was in a position of power that afforded them the opportunity to lessen the negative effects of the GMMP. Perhaps it was not a case that they were silenced by orders as much as they claimed. Perhaps it was the case that no initiative was taken to question these orders. MEC Mahlangu indicated herself that she had no reason to question the (incorrect) information she received as she trusted those she was working with. However, despite perhaps lacking clarity on who was intended to perform each role in the GMMP, who was intended to provide information, and who was responsible for what, all the officials involved were responsible for the lives of the MHCUs who were affected by their decisions. And this remains the most important reason why the door was opened for various forms of epistemic injustice. The intentions of the officials are still unclear but this does not take away from the

⁴⁸ By doing this, in this case, they were able to shift the attention away from the severe consequences of the GMMP. This is observed firstly in the case of Dr Manamela. By implying that her actions did not directly cause the deaths of patients, she was also implying that her actions were without blame. Secondly, in the case of Dr Selebano, it was implied that he did nothing to warrant blame as his instructions came from a higher authority and further implied that blame lies with this higher authority. Lastly, MEC Mahlangu placed blame on the political role she held rather than on herself as an individual, due to the political nature of her involvement of the project. Each of these actions shows an attitude of disinterest or perhaps denial of the severity of the events of Life Esidimeni.

fact that each official had the responsibility of ensuring that patients were taken care of. By neglecting this responsibility, the officials placed themselves in positions whereby they could potentially cause epistemic injustice.

The second way epistemic injustice could potentially arise in this case is evident in this denial of responsibility. The officials in this case used their dominant social positioning to mute the severity of the injustice that came about as a result of their actions. This in turn creates a situation where justice cannot be found for MHCUs. By refusing to take responsibility, officials perpetrate epistemic injustice by silencing (ignoring) the need for justice to be done. This is therefore a kind of contributory injustice as officials use their social positioning to undermine the MHCU. The MHCU is undermined in this case because without any official or even the healthcare system as a whole taking responsibility, there can be no justice for the MHCU. MEC Mahlangu's claim that she is without personal blame because of the political nature of her involvement is a perfect example of this. The MEC used her position of political power to remove any other sort of responsibility that might befall her. However, I have argued earlier that epistemic injustice is as much political as it is epistemic and ethical. By aligning herself with the GMMP politically, MEC Mahlangu necessarily aligns herself with the GMMP both epistemically and ethically. By enforcing her position of power to absolve herself of personal blame, she commits a contributory injustice. This is because her political position has now further silenced the MHCU. She is therefore politically, ethically and epistemically responsible for the contributory injustice that occurs when patient rights are not upheld, and when justice for the patient is muted for the sake of a powerful social system. Once again, the rights of MHCUs are silenced in favour of the dominantly situated official.

Family Testimonies: The Treatment of Mental Healthcare Users

Up to now I have been considering how the structure of South African healthcare system and the actions of officials that belong to that system allowed or led to several cases of epistemic injustice against the MHCUs that were involved in the closure of the Life Esidimeni healthcare facilities. While these cases include some specific instances of epistemic injustice against MHCUs, they were discussed as being resultant from manipulation of policy or failure to listen or take responsibility. However, the potential for epistemic injustice in cases like the case of Life Esidimeni are not limited to these three situations. This can be seen in the events following the deaths of patients and the treatment of their families during the arbitration process.

The deaths that occurred because of the events surrounding the GMMP were termed “silent deaths” by the health ombudsman (Makgoba 2017, 3). This term indicates that those who died were not considered worthy to be heard or worthy of recognition. This silencing, as discussed above, caused these patients to be treated in a way that led to their deaths. These deaths were both preventable and unnecessary, as proper care would have ensured that these patients did not die under such unlawful circumstances. However, the silencing of MHCUs did not stop after the patients had died. Silencing of MHCUs continued in the form of providing incorrect information on their death certificates.

In both examples provided in the previous section, that of Deborah Phehla and Maureen Khunjwa, the cause of death was not a direct result of their mental disabilities. Rather, Deborah died of asphyxia due to aspiration of blood and Maureen died of a neuroglycopenic brain injury that she incurred after her fall. These causes of death were however not the causes of death stated on each patients’ death certificates. Instead, both certificates indicated that the patients had died of natural causes.

Reasons for this misinformation are unclear. However, a kind of documental injustice is observable simply in the refusal to provide the correct causes of death on the death certificates. Providing incorrect causes of death can constitute documental injustice as this can be seen as a kind of manipulation of evidence and therefore a manipulation of information⁴⁹. Death certificates are issued by the South African Government after and application is made following a person’s death (Department of Home Affairs, 2018). Those issuing the certificates are therefore in positions of power over those who are unable to formalise information regarding deaths. As stated above, the reasons for not providing the correct information are unclear and a discussion thereof is beyond the scope of this chapter. However, what can be said is that by providing incorrect information on official death certificates, the severity of the causes of death, in the sense that they are direct results of epistemically unjust actions, is undermined.

In a discussion held by the Public Affairs Research Institute (2018) Dr. Leslie Robertson commented on the idea that altering information with regards to the deaths of mental healthcare users can undermine what it means for people to live with mental illness and disability. Failing to mention that patients’ deaths may have to do with their mental illnesses

⁴⁹ Although this is not necessarily a case of manipulating policy, I think it can be identified as a documental injustice as it occurs from a manipulation of another sort of legal document.

is a way of silencing patients as mental healthcare users. Even, as in the cases of Deborah and Maureen, their mental health conditions were not a direct cause of death, it is the case that their mental health state played a role. Maureen was only unable to walk because her condition had worsened in the time she was at the NGO and Deborah could not find food for herself because her condition made her physically unable to do so. Failing to mention this as a contributing factor to patient deaths therefore constitutes a kind of silencing of those who have mental illnesses and disabilities. This means that mental illness and mental disability as a potential cause of death are overlooked and thus the legitimacy of mental illness and disability as potential causes of death is removed. It needs to be made clear that mental illness and disability can cause and contribute to death and that these deaths are even more likely when the seriousness of mental illness is disregarded as in the case of Life Esidimeni.

By stating that deaths occurred from natural causes rather than from asphyxiating on blood, as Deborah did; or from sepsis due to a brain injury from a fall, as Maureen did; or in other cases where death occurred from starvation and dehydration; those issuing the death certificates are muting the severity of injustice that occurred at the NGOs. As stated above, this can constitute a silencing of the MHCUs that suffered this injustice leading to patient deaths. We are therefore able to see how this constitutes an epistemic injustice with consequences as severe as death.

Lastly, in the aftermath of the GMMP, during the arbitration hearings, a kind of contributory injustice is evident. In a 2018 article in the Rand Daily Mail, Kate Sidley commented on how families of patients who had died were being mistreated during the arbitration process.

Commentators on social media have popped up to imply that the families of the victims were somehow to blame for this tragic situation, or at least complicit. They were negligent. They didn't pay enough attention. They didn't make enough of a fuss, early enough. Most recently, Helen Zille's controversial Tweet asked: "What did they do, before these tragic deaths, to raise the alarm about their loved ones starving [and] living in profound neglect?" (Sidley, 2018).

Sidley then makes the claim that this sort of accusation "ignores the facts" and that the disregard for patient rights and dignity cannot be undermined by accusations of lack of familial concern (Sidley, 2018). Here we see a contributory injustice in the fact that, like in the cases above, blame is being shifted in order to misdirect blame and mute the severity of

the injustice done to patients at the NGOs. What is happening here is that marginalised families and marginalised patients are used as a scapegoat in order to bypass the serious charges placed against those in dominant social positionings. This is therefore a kind of contributory injustice as the voices of families and the voices of those defending the deceased patients are silenced to the advantage of those in power.

In this chapter, I discussed the potential for epistemic injustice in a healthcare context, first by looking at epistemic injustice in healthcare in general and then looking at epistemic injustice specifically within the healthcare and mental healthcare systems in South Africa. I then presented the case study of Life Esidimeni so as to illustrate some of the ways epistemic injustice may have been actualised in the case of Life Esidimeni. This section has by no means identified every case of epistemic injustice identifiable in this case study. What this section has aimed to do is to indicate that the power structures that exist in healthcare create gaps where injustice is allowed to slip through. Further, this injustice is not just primarily an ethical issue. What I hoped to show in this section is that considerations of epistemic injustice are as relevant in these cases as ethical or political considerations. Epistemic injustice should therefore be addressed with as much drive as other forms of injustice, so as to lessen the harm done to those who hold marginal positions in society.

In the next chapter I will outline a possible approach to help address epistemic injustice, both in specific instances and as a whole. I will discuss virtue epistemology as a potential means of reducing possibilities for epistemic injustice and in that way, lessening or preventing the harms discussed in this dissertation.

CHAPTER 4: VIRTUE EPISTEMOLOGY AND EPISTEMIC JUSTICE IN HEALTHCARE

This dissertation has so far included three chapters; each presenting a necessary theme to assist the understanding and analysis of epistemic injustice in healthcare in South Africa. In chapter 1, I introduced the concept of epistemic injustice by presenting and critically discussing the concept as coined by Miranda Fricker (2007) as well as presenting conceptions of epistemic injustice that go beyond Fricker's initial conception of the concept of epistemic justice. In chapter 2, I outlined the structure of both the South African healthcare system and the South African mental healthcare system. In chapter 3, I used the previously discussed conceptions of epistemic injustice in chapter 1, and the exposition of the South African healthcare systems in chapter 2, to present three analyses of epistemic injustice in healthcare and mental healthcare. The first was a general analysis of the potential for epistemic injustice in healthcare and mental healthcare. The second was an analysis of epistemic injustice in healthcare and mental healthcare specifically within a South African context. The third analysis introduced the case study of Life Esidimeni in order to link the structural gaps in South African healthcare and mental healthcare to an event that indicated evidence of epistemic injustice within these systems.

In this chapter, I will introduce the idea of virtue epistemology as a tool that may be used to reduce the negative effects of epistemic injustice in healthcare and mental healthcare, both in general and specifically within a South African Context. I will begin with an outline of the current debates in virtue epistemology. I will then explore virtue epistemology as it exists within conversations surrounding epistemic injustice. Finally, I will identify potentially epistemic unjust areas within healthcare - specifically as they relate to the case of life Esidimeni – that would potentially benefit from a theory of epistemic virtues.

4.1) Current Trends in Virtue Epistemology

Virtue epistemology is the study of the 'excellences' that are required to achieve knowledge (*viz.* Greco 2002, 287). Virtue epistemology is largely divided into two predominant approaches, namely *reliabilism* and *responsibilism*. In the form of reliabilism, it was first introduced by Ernst Sosa in his article entitled *The Raft and the Pyramid* (1980). In this article, Sosa critically reflects on theories of epistemic justification in terms of the coherentism/ foundationalism debate. Supporters of the foundationalist theory claim that a belief is justified if it is supported by a foundation that does not require support from any

other belief. This theory resembles a pyramid in the sense that all beliefs are built up from a foundation (based on sense experience) that leads up to the justified belief in question. Coherentists reject this pyramid metaphor in favour of a theory where justified belief is one that “cohere[s] with a comprehensive system of beliefs” (Sosa 1980, 6). This theory can be explained with the metaphor of a raft. The raft is a body of knowledge that is not tied to any one foundational belief but that is connected to the beliefs around it.

Sosa suggests that a virtue epistemological approach can help solve the justification debate between the foundationalists and coherentists. Rather than constructing our beliefs as the coherentists of foundationalists would, Sosa claims we should construct our beliefs through the use of “stable dispositions” that we come to have through “stable virtues” (ibid. 23). For Sosa, a justified belief should be rooted in epistemic virtue whereby “primary justification would apply to intellectual virtues, to stable dispositions for belief acquisition, through their greater contribution toward getting us to the truth. Secondary justification would then “attach to particular beliefs in virtue of their source in intellectual virtues or other such justified dispositions” (ibid.). Here Sosa implies that stable intellectual faculties are required for true belief formation and that these beliefs are further justified because they are sourced from such virtuous intellectual faculties. Sosa makes this claim through making (an Aristotelian) assumption that moral and intellectual virtues stand in a mutually enabling relationship to each other. This is evident when he suggests that virtuous intellectual dispositions or faculties are most reliable in bringing about true beliefs and are good or virtuous because they stem from virtuous moral faculties. Some examples of reliabilist virtues identified by Sosa include memory, perception and inference (ibid. 15).

In response to Sosa’s concept of reliabilism, Lorraine Code presented the first conception of what she termed a “responsibilist epistemology” (1984) or responsibilism. Code claims that there is something more to knowledge than just having the faculties that make an agent reliable in coming to true beliefs. Rather, there is something important about the character of the agent seeking knowledge (*viz.* Code 1984, 49). In order to determine how an agent can be intellectually virtuous, it is necessary to understand the agent’s “orientation toward the world” as virtues have more to do with one’s positioning within the world than with the “‘content’ of particular actions or knowledge claims” (Code 1984, 41). Epistemic responsibility, the core intellectual virtue for Code, makes up part of the knower’s character. Having the virtue of epistemic responsibility does not however automatically make the

virtuous agent's claim true. Nonetheless, Code makes the claim that provided the agent is epistemically responsible, it would be "reasonable to consider the claim seriously, even to accept it, provisionally at least" (ibid. 48-49).

Reliabilism and responsibilism therefore differ in that reliabilism focuses on the intellectual dispositions or faculties that are reliable in bringing about truth. These are "broad cognitive abilities or powers" that are necessary for finding truth (Greco 2002, 287). Responsibilism, on the other hand, focuses on the character traits of an agent that allow truth to be reached in a responsible way. Responsibilist virtues are thus more like "personality traits" rather than cognitive abilities (ibid.). Code further distinguishes the two approaches by stating that reliabilist virtues may be accurate, but they achieve truth passively, whereas responsibilist virtues emphasise the active choice that knowers make when seeking to construct true beliefs and thus agents can be held accountable for those choices (*viz.* Code 1984, 39-40).

Following the introduction of these two concepts of virtue epistemology, several thinkers adopted their own or extended notions of epistemic virtue. For instance, John Greco, following strongly from Sosa, takes on a reliabilist standpoint. Greco (2002) argues that although reliabilist and responsibilist virtues differ, they are both useful to address different kinds of epistemological questions (*viz.* Greco 2002, 302). However, he maintains that a reliabilist notion of virtue epistemology is most "useful for constructing and account of knowledge" (Greco 2002, 302).

Greco advocates for what he terms "agent reliabilism" (1999). Greco defines agent reliabilism as a form of reliabilism that adopts two features in order to address two major problems of "simple reliabilism" (Greco 1999, 286). The first problem is that "strange and fleeting" reliable processes cannot be said to produce actual knowledge (ibid. 285). Strange and fleeting processes are those which are reliable in bringing about truth but are either not part of the agent's cognitive character or are not habits and are therefore only reliable some of the time (*viz.* Palermos 2014, 1941). An example of such a process, provided by Greco, is taken from Platinga's "Case of the Epistemically Serendipitous Brain Lesion" (Greco 1999, 285). Say for instance, one has a brain lesion that results in a cognitive process that allows one to believe that they have a brain lesion. Although the brain lesion allows one to come to this true belief, the process that led to the belief is strange and fleeting and therefore not considered to be one of proper cognitive ability.

Greco says that by adopting Sosa's idea that knowledge be grounded in the "stable dispositions or *character*" of a knower (ibid. 287 original emphasis), it is possible to restrict cognitive processes and avoid strange and fleeting reliable processes. Processes guided by intellectual virtues of Sosa's kind, according to Greco, are not strange because they are the result of an agent's intellectual character and they are not fleeting because they are based on habits formed through possessing stable dispositions (*viz.* Greco 1999, 287).

The second problem that simple reliabilism faces is that it is not enough to claim that beliefs are only objectively reliable as "knowledge *does* require that the knower have some kind of sensitivity to the reliability of her evidence" (ibid. 285). Therefore, it is necessary that beliefs are also "subjectively appropriate" (ibid.). Greco claims that agent reliabilism solves this problem, as according to his definition of agent reliabilism, agents who have reliable cognitive processes are usually also in a "default mode" of trying to be accurate in forming their beliefs (ibid. 289). Greco therefore states that subjective appropriateness in forming beliefs comes from "thinking conscientiously", which all agents will do by default if they are in possession of objectively reliable belief forming faculties (ibid.). Based on these two arguments, Greco adopts a virtue reliabilist view that also takes into consideration the character and default subjective positioning of an agent forming beliefs.

James Montmarquet (1987), unlike both Greco and Sosa, advocates for a purely responsibilist virtue epistemology. Montmarquet makes the claim that the "truth-conduciveness" of reliable processes cannot be the "distinctive mark of epistemic virtues" (Montmarquet 1987, 482). Further, Montmarquet states that an agent who is only conscientious is not sufficiently epistemically virtuous⁵⁰ (ibid. 483). The virtuous agent then for Montmarquet is one that possesses some 'necessary' personality traits in order to be morally conscientious. Agents should adopt epistemic virtues that relate to moral conscientiousness such as "virtues of *impartiality*" and "virtues of *intellectual courage*" (*viz.* Montmarquet 1987, 484 original emphasis). Montmarquet's conception of epistemic virtue therefore does not require an agent to only have reliable belief forming faculties as there is "no *general* demand that one's belief-producing processes be reliable" (ibid. 495 original emphasis), as his emphasis is on personality traits engaged in bringing the truth about. He thus rather claims that a virtuous agent's character traits need only be connected to the "*desire*, not the likelihood, of attaining

⁵⁰ Montmarquet links moral conscientiousness to previous ideas of epistemic responsibility. However, he claims this is too weak as one could be said to be epistemically virtuous by simply "*trying* his best to arrive at the truth" (Montmarquet 1987, 483 original emphasis).

truth” (ibid. 495). This allows for cases where agents “differ radically in truth-conduciveness” but are nonetheless all epistemically virtuous (ibid. 495).

As a last example, Linda Zagzebski (1996) adopts a virtue responsibilist approach without completely rejecting the need for reliable cognitive processes⁵¹. In her book, “Virtues of the Mind”, Zagzebski (1996) identifies virtue epistemological theories as being parallel to theories in virtue ethics and argues that “almost all epistemological theories are modelled on act-based moral theories” (1996, xiii) like deontology (rule-based moral theories) or consequentialism (outcome-based moral theories). She argues against reliabilist act-based moral theories as she feels they focus on avoiding blame rather than achieving “moral praiseworthiness” (ibid 28). While other authors claim to base their theories on a theory of virtue, Zagzebski claims that this has not been accomplished successfully enough. Zagzebski therefore constructs an epistemological theory based on a “pure virtue theory” or what she calls a “motivation-based” theory that defines a right act as derived from “the concept of a virtue or some inner state of a person that is a component of a virtue” (*viz.* Zagzebski 1996, 79-82). Zagzebski therefore argues that an intellectual virtue derives from the right motivation for knowledge and allows for “reliable success in attaining the ends of these motivations” (ibid. 166).

Each of these thinkers adopts a standpoint with regard to the two main divisions within virtue epistemology. I have outlined their theories here to present a brief and general overview of the debate that exists within virtue epistemology⁵². What seems evident however, is that each of these thinkers seems to maintain a strong loyalty to either reliabilist or responsibilist theories. I will argue throughout the rest of this chapter that when discussing virtue epistemology in relation to epistemic justice in healthcare, it is necessary to suggest a hybrid reliabilist-responsibilist theory of epistemic virtue – one perhaps heralded by Zagzebski, as she acknowledges a place for both in her virtue epistemology. In the following sections, I will recount Fricker’s conceptions of the virtues of testimonial and hermeneutic justice and the points of critique against them. I will then explore how virtue epistemology, specifically an epistemology based on a hybrid responsibilist-reliabilist epistemological theory, is useful for

⁵¹ Zagzebski presents a critique against reliabilism stating that reliable processes are not sufficient for knowledge (*viz.* Zagzebski 1996, 304). However, she maintains the necessity of a reliability component for attaining truth.

⁵² Several other thinkers including Kvanvig (1992), Plantinga (1993), Hookway (1994) and Goldman (1993) have also made contributions to this debate.

understanding the concept of a virtuous social institution and further, how such institutions are necessary for combating epistemic injustice.

4.2) Virtue Epistemology and Epistemic Justice

In the previous section, I provided a general outline of the current debate within virtue epistemology. In this section, I will discuss how virtue epistemology is linked to the idea of epistemic justice. First, I will revisit Fricker's conceptions of the virtues of testimonial and hermeneutic justice as well as the points of critique these virtues face in terms of successfully addressing cases of epistemic injustice. I will then explore the concept of a virtuous social institution⁵³ and further, how and why such institutions are necessary for combating epistemic injustice.

Fricker's Account of the Virtues of Testimonial and Hermeneutic Justice

In chapter 1 section 2, I outlined Fricker's conception of testimonial injustice and along with it, Fricker's conception of the virtue of testimonial justice. We recall that for Fricker, it is the responsible hearer that must adopt the virtue of testimonial justice. This hearer must adopt an open, critical but non-inferential stance in order to effectively receive a speaker's testimony without awarding the speaker a deflated level of credibility due to negative identity prejudices. Fricker states that the virtue of testimonial justice requires a "distinctly reflexive critical social awareness" which must be activated when one notices that a credibility judgment is being deflated by prejudice (Fricker 2007, 91). This will allow the hearer to adjust the credibility they award accordingly so that the speaker's claim is treated fairly.

Furthermore, this virtue is acquired through a trained sensibility involving "participation in, and observation of, practices of testimonial exchange" (ibid. 83). Fricker takes this idea from Aristotle's notion that moral virtues are acquired through practice and habituation (ibid. 81). It seems therefore that it is through 'bad training' or lack of training that agents allow negative prejudice to affect their credibility judgements. Likewise, a well-trained sensibility will result in the virtuous reception of a speaker's testimony (ibid.). Once the virtue of testimonial justice is fully acquired, a hearer will be able to correct for credibility deficits

⁵³ The term "virtuous institution" here does not imply that institutions possess virtues in the same way people do, as they are not agents and do not have will. Rather, I use this chapter to explain what is required from institutions in order to promote and maintain virtue in individual agents. Fricker (2009) also makes use of the term "institutional virtue" (Fricker 2009, 2) as a similar concept with which to assess whether or not institutions can come to display virtues through the collective virtues manifested by the individuals that belong to such institutions.

instantaneously as the hearer would have been ‘reconditioned’ to having “ready-corrected” credibility judgements (ibid. 97).

Fricker makes a link between moral and epistemic (intellectual) training in that both require an element of socialisation (ibid. 82). In both cases, an agent acquires virtue first through “passive” collective socialisation and then through “sometimes-passive-sometimes-active” individual interpretation and internalisation (ibid. 82-83). In the case of the virtue of testimonial justice, this sensibility is always “in training” and must constantly change in order to adapt to individual and collective social experience (ibid. 84).

Importantly, Fricker constructs the virtue of testimonial justice as a hybrid virtue, in the sense that it is both an intellectual and a moral virtue. This is because the ultimate end of this virtue can be either truth or justice and still produce the same result: the neutralisation of prejudice in one’s credibility judgements (ibid. 122). For this idea, Fricker draws on Zagzebski’s notion of virtues having a motivational component, in this case, the motivation is either truth or justice. Along with links to Zagzebski’s, Fricker’s ideas about the virtue of testimonial justice as acquired through socialisation and it being of a hybrid intellectual-ethical nature provide further links to the ideas of Aristotle that will be discussed later in this section.

In chapter 1 section 3, I moved on to outline Fricker’s conception of hermeneutic injustice as well as the virtue of hermeneutic justice. The virtue of hermeneutic justice takes the form of a sensitivity on the part of the hearer that allows the hearer to correct for any gap in hermeneutic resources that might hinder the speaker in effectively conveying meaning. The hearer must always be aware of the impact that hermeneutic injustice could have on the speaker. The hearer must notice the “relation between his social identity and that of the speaker as impacting on the intelligibility” of what the speaker is trying to say (ibid. 169). This requires a “pro-active and more socially aware kind of listening” (ibid. 171) that would allow the hearer to adjust their credibility judgement upwards, to award the same level of credibility that the speaker should have received, had there not been a gap in the collective hermeneutic resource. It is therefore the job of the hearer to disregard any negative assumption against the credibility of the speaker’s testimony, if they believe that this testimony is negatively affected by a hermeneutic gap, and to “seek out extra corroborating evidence” in order to arrive at a more correct credibility judgement (ibid.172). Furthermore, the virtue of hermeneutic justice, as with the virtue of testimonial justice, is a hybrid intellectual-ethical virtue.

Problems with Fricker's Accounts of the Virtues of Testimonial and Hermeneutic Justice

Issues surrounding these two conceptions of virtue were also discussed in chapter 1 section 2 and section 3. However, it is important to briefly recount them here in order to assess the possibility of applying these virtues to the kinds of epistemic injustice discussed in chapter 3 and to assess further whether or not these virtues would be helpful in addressing the kinds of epistemic injustice evident in the case of Life Esidimeni.

I will firstly recount the problems with Fricker's conception of the virtue of testimonial justice as outlined in chapter 1 section 2. It is important to note that this kind of virtue operates mainly in interactions between specific individuals. Therefore, it can be said that this virtue may not be helpful in addressing the systemic and structural kinds of injustice discussed in chapter 3, making a critique of this virtue irrelevant. However, this is not the case. Fricker models her conception of the virtue of hermeneutic justice on the concept of the virtue of testimonial justice very strongly. This means that many of the critiques posed against the virtue of testimonial justice will apply to the virtue of hermeneutic justice as well. Thus, if we are to use Fricker's notion of the virtue of hermeneutic justice, even in part, to address systemic and structural epistemic injustice, we must first understand the problems associated with the virtue of testimonial justice.

Recalling briefly the critiques posed against the virtue of testimonial justice in chapter 1 section 2, Fricker is firstly unclear about how a hearer comes to notice that they are awarding a speaker's testimony a deflated level of credibility. Secondly, it is unclear who determines what kind of sensitivity is required or how much or what level of this sensitivity is needed in order to be fair to a speaker. And lastly, it may be hard for agents to constantly remain in a state of training their sensibility. Fricker provides no indication of how agents are meant to receive this training.

A further critique, not discussed in chapter 1 section 2, is presented by Benjamin R. Sherman (2016). Sherman claims that if Fricker commits herself to a virtue theory of testimonial justice, that a virtue theory "comes with its own costs" (Sherman 2016, 233). The first problem Sherman describes, is that virtue theory usually concerns individual virtues and vices which are not so useful in correcting for harms that arise out of social and structural inequality (*viz.* Sherman 2016, 233). Secondly, Sherman states that "virtue theory must claim that there are, in fact, *virtues*" and that even if virtue theory is correct, it is unclear what these

virtues *actually* are (ibid. 234). While my aim is not to discuss whether a virtue theory is correct in general, these two points made by Sherman are useful in examining Fricker's virtue of testimonial justice.

I agree with Sherman that the individualist virtue of testimonial justice is not sufficient to address the structural kinds of epistemic injustice that we have seen to potentially exist within specific institutions. And further, I agree that often, individuals that belong to certain institutions will not know what virtues to practice without proper guidance. Because of these two points, it becomes necessary to explore the nature of a virtue (the virtue of being epistemically virtuous) that is useful for combating all kinds of epistemic injustice, that can be adopted individually and structurally – which I will do in the next section. This kind of virtue would address at least some, if not all, of these problems with the individual virtue of testimonial justice (which is similar in many ways to the virtue of hermeneutic justice). This virtue can then be used to address the agential kinds of testimonial injustice; the structural kinds of hermeneutic injustice; and the kinds of epistemic injustice that are both structural and agential, like contributory and documental injustice.

Moving now to a critique of the virtue of hermeneutic justice, it seems, given the above, that the virtue Fricker proposes to combat structural hermeneutic injustice, should be a kind of structural virtue, if it is already evident that even the virtue meant to establish testimonial justice between individuals should, in fact, be a more structural, intuitional kind of virtue and not an exclusively individualised one. However, as seen in chapter 1 section 3, the virtue of hermeneutic justice in Fricker's terms, is critiqued for being, like the virtue of testimonial justice, a virtue possessed by an individual. As discussed in chapter 1 section 3, Fricker does not present a virtue that can be used in instances where an epistemic injustice does not involve any particular hearer. If her conception of hermeneutic injustice is purely structural, then it is not sufficient for an agent who possesses the virtue of hermeneutic justice to correct their credibility judgement upwards when a speaker is struggling to render their experiences intelligible to address hermeneutic injustice. This is because there isn't necessarily a speaker or hearer involved in purely structural forms of hermeneutic injustice.

If we recall the critiques of Fricker in chapter 1 section 3, it becomes even more clear that Fricker's virtue of hermeneutic justice, as a virtue of an individual, may not be applicable in all cases of hermeneutic injustice. For instance, if we look back at Mason's critique of Fricker, we see that it is not always the case that a speaker has no resources with which to

communicate their experiences. Rather, it is the case that the non-dominant resources they use are not accepted by those who are dominantly situated. In cases such as these, it is not sufficient for a hearer who has the virtue of hermeneutic justice to just award the speaker more credibility to account for a gap in hermeneutic resources. This would not address the fact that the speaker may have a different set of resources to make use of to explain their experiences. The virtue of hermeneutic justice would only account for a speaker who has no tools with which to understand their experiences.

This links to the critiques posed by Pohlhaus, Jr. and Medina, that agents who are dominantly situated maintain a wilful hermeneutic ignorance that prevents non-dominantly situated agents from contributing to the dominant pool of hermeneutic resources. The virtue of hermeneutic justice, as Fricker conceptualises it, does not automatically allow non-dominant groups to contribute to the dominant pool of knowledge. Even if an agent making use of non-dominant resources is awarded the correct amount of credibility by a dominantly situated hearer, this does not mean that these resources are automatically accepted into the dominant discourse. Again, Fricker's virtue of hermeneutic justice is insufficient to deal with these kinds of hermeneutic injustice.

Fricker's proposed virtues of testimonial and hermeneutic justice therefore do not address all kinds of epistemic injustice. Firstly, Fricker's virtue of hermeneutic justice does not address the kinds of hermeneutic injustice discussed above. Secondly, these virtues do not address the other kinds of epistemic injustice discussed in chapter 1 section 4 and throughout chapter 3, namely documental and contributory injustice. We will recall that documental injustice exists when structural inequalities are used by those in positions of power for their own advantage, at the expense of those in lesser positions of power. This is because those in power may get away with failing to adhere to certain norms and standards because the structural inequality allows these failures to be overlooked. Further, contributory injustice exists when an agent supports or contributes to structural inequalities through the rejection of non-dominant hermeneutic resources.

These kinds of epistemic injustice have an agential element, but even so, I am not convinced that the virtues of testimonial and hermeneutic justice, as proposed by Fricker, will do well to address these injustices. A socially powerful agent who is able to adjust credibility upwards in order to correct for the effects of prejudices impacting on their credibility judgement may still find themselves in a position of disregarding the norms and standards of their institution

at the expense of less powerful agents, and thus perpetrate documental injustice. Likewise, being able to adjust for a prejudiced credibility judgement will not prevent a socially powerful agent from disregarding non-dominant resources, and thus perpetrate contributory injustice. This is because it is first necessary for the agent to recognise that these non-dominant resources exist and are valuable in the transfer of knowledge. It is therefore necessary to suggest a kind of virtue of epistemic justice that may help combat these kinds of epistemic injustice that Fricker does not address, and that her virtues of testimonial and hermeneutic injustice are not fit to combat. There is still a gap to be filled as a virtue of epistemic justice needs to address *all* kinds of epistemic injustice, be it agential, structural or a combination of the two. In order to address this gap, I will now explore an argument for a hybrid reliabilist-responsibilist epistemic virtue.

Reliabilism, Responsibilism and the Virtue of Epistemic Justice.

The current debate within virtue epistemology suggests that a decision should be made as to whether the virtue of epistemic justice is reliabilist or responsibilist in nature. I will suggest here that a virtue of epistemic justice requires both reliabilist faculty virtues and responsibilist character virtues. In order to demonstrate this, I will draw on Aristotle's notion of moral and intellectual virtues as well as Fricker's conception of a hybrid ethical intellectual virtue, discussed in chapter 1 section 2 and section 3.

In the *Nicomachean Ethics*, Aristotle distinguishes between moral and intellectual virtues. In Book 2, he focuses on the conception of moral virtues as "characteristics" that we must develop in order to 'perform actions well', i.e. to live a morally good life in terms of (virtuous) excellence (1103b20-25). One becomes virtuous by acting virtuously. Thus he explains that these moral characteristics are developed through "habit" (1103a15-20) and it is therefore only by doing and practicing these actions that we come to do them well and become virtuous. It is further necessary that these virtues are acquired by choice. An agent can only be virtuous if she acts knowingly, chooses the action for its own sake, and acts in a steady and unwavering state (*viz.* 1105a30). Once an agent has made the choice to be virtuous, they practice acting virtuously by discerning particular virtuous acts as a mean between two vices, one of excess and one of deficiency. This mean is one that is "relative to us" and so it is necessary for the agent to decide which virtue and how much of that virtue is necessary in light of the relative situation in which they find themselves (1106b35-1107a1-

5)⁵⁴. However, finding the mean in every situation is not an easy task (1109a25-30). The mean can only be defined through the use of reason, “as the prudent person would define it” (1106b35-1107a5).

It is in this sense that Aristotle makes the link between moral virtue and intellectual virtue. In Book 6, Aristotle identifies intellectual virtue in terms of five kinds of knowledge – the three theoretical ones are science (‘science’ here meaning the pursuit of causal, universal, abstract, necessary knowledge), rational intuition of first principles or self-evident truths, and wisdom (1141a1-10). Furthermore, prudence, as practical wisdom, in particular, is the virtue that Aristotle associates with what is just and good (1143b20-25), as it refers to the ability to discipline oneself through reason. However, simply knowing what is just and good is not sufficient. Prudence must be possessed in accordance with moral virtue and must further be accompanied by moral virtue (1144b25-30). According to Aristotle, this is because “it is not possible to be good in the authoritative sense⁵⁵ in the absence of prudence, nor is it possible to be prudent in the absence of moral virtue” (1144b30-35). This implies a necessary and sufficient conditional relationship between intellectual virtue and moral virtue. We need moral virtue in order to make our ends good and we need intellectual virtue to decide what a good end would be in the given situation, and to provide the tools with which to achieve this end. According to Aristotle, “virtue makes the target correct, prudence the things conducive to that target” (1144a5-10).

If we accept Aristotle’s conditional link between moral and intellectual virtues, and therefore see them as both necessary and sufficient for acting justly, then I want to explore whether something similar could perhaps be said for epistemic virtue in the forms of reliabilism (focused on intellectual virtue) and responsibilism (focused on moral virtue). In a discussion of the debate surrounding virtue reliabilism and virtue responsibilism, Battaly and Slote (2015) make a link between Aristotle’s notions of moral and intellectual virtues on the one hand, and responsibilist and reliabilist virtues on the other. Specifically, responsibilist epistemic virtues are taken by them to be modelled on Aristotle’s analysis of moral virtues

⁵⁴ Aristotle tells us that the mean is always situated between the vices of excess and deficiency, and that this mean is always one and the same (1104a25-35). However, when acting virtuously in accordance with the mean, we do not apply the mean as one that lies exactly in the middle of the vices of excess and deficiency. Rather, one should apply the mean appropriately within the situation, “not a middle belonging to the thing in question but rather the one relative to us” (1106b5-10).

⁵⁵ The good, in the authoritative sense, refers to the good that has been guided or trained through prudence. In this way, an agent moves from being in a natural state of virtue to an authoritative state of virtue by developing a virtuous character, in the presence of prudence (1144b5-20).

(Battaly & Slote 2015, 255). This is because responsibilists conceive of epistemic virtues as being acquired through the development of an individual's character (Code 1984, 49), much like Aristotle conceives of moral virtues as being virtues of character. On the other hand, reliabilist epistemic virtues are taken to be modelled on Aristotle's analysis of intellectual virtues (Battaly & Slote 2015, 256). Reliabilist virtues are qualities that allow an agent to produce more true beliefs than false beliefs (ibid.). This reflects Aristotle's idea that the intellectual virtues assist "the rational part of the soul to perform its function well", and that function being "to produce truths over falsehoods" (ibid. 257).

If reliabilist and responsibilist virtues are indeed understood in this way, then Aristotle's necessary and sufficient link between moral and intellectual virtues may be extended to imply that such a necessary and sufficient link exists between reliabilist and responsibilist epistemic virtues as well. When Aristotle speaks of intellectual and moral virtue, he does so to explain what is necessary for agents to live morally good and wise lives, as both moral and intellectual virtue are necessary for agents to do this. Aristotle is not necessarily concerned, as I am, about the particular virtue of epistemic justice.

However, Aristotle's conception of moral and intellectual virtues is useful in an analysis of what it means to have the virtue of epistemic justice, because of the necessary and sufficient relation he determines between moral and intellectual virtues. Fricker's virtues of epistemic justice do not explicitly include any link or relation between reliabilist and responsibilist virtues. I hope that by using Aristotle's conception of a necessary and sufficient conditional relation between moral and intellectual virtue we can come to a more effective formulation or conception of a virtue of epistemic justice than the one provided by Fricker. Thus, I suggest that in the same way that Aristotle suggests we come to live morally good lives through adopting both moral and intellectual virtue, by adopting both reliabilist and responsibilist epistemic virtues, we may come to be more epistemically just. Further, a virtue of epistemic justice that addresses the relation established by Aristotle (and therefore, in my terms, the necessary and sufficient conditional relation between reliabilism and responsibilism) may be more effective in addressing other kinds of epistemic injustice apart from testimonial and hermeneutic injustice, as it is more inclusive of different kinds of epistemic virtues.

This conditional link would imply that in order for us to be epistemically virtuous, it is necessary that we have both reliable faculty virtues as well as responsible character virtues. It is important to use reliable faculties like memory and perception in discerning the truth, as

these stable dispositions allow us to actively seek truth. For instance, in terms of reliabilist approaches, if an agent is unable to accurately interpret or recall information, they will be unable to assess whether that information is in any way true or false. However, being epistemically virtuous should also require that agents choose to come about the truth in a responsible way. This is similar to the suggestion made by Zagzebski in that intellectual virtue should be motivated by what is good and also be reliable in attaining truth (by suggesting reliable routes to achieve truth), as discussed in the previous section. If we relate this to Aristotle, it could be said that reliabilist virtues are those that are conducive to our goal of attaining truth, and responsibilist virtues are those that we use to know that the goal is morally good and how to attain it in the correct moral way.

I therefore suggest that the virtue of epistemic justice should be understood as a virtue that adopts both responsibilist and reliabilist virtues, as they are necessary and sufficient conditions for coming about truth (epistemic beliefs) in a way that is just and morally good. Despite the critiques posed against Fricker's notion of the virtues of testimonial and hermeneutic justice, this idea is very close to her conception of a hybrid ethical-intellectual virtue, discussed in chapter 1 section 2 and section 3. While Fricker does not explicitly deal with the divide in the reliabilist-responsibilist debate, she does make the suggestion that both her virtues of testimonial and hermeneutic justice are hybrid virtues in the sense that they avoid injustice as well as avoid missing out on truth (Fricker 2007, 126). Based on the discussion of Aristotle above, Fricker's hybrid virtue may then perhaps be interpreted as a precursor to a hybrid reliabilist-responsibilist virtue.

However, Fricker's virtue approach is still missing a way for the virtue of epistemic justice to address systemic and structural epistemic injustice, in cases where the individual hearer is not able to accurately identify epistemic injustice or combat it alone. In order to address these kinds of epistemic injustice, it is necessary to have a virtue of epistemic justice that is both agential and is applicable to social institutions, so as to create an atmosphere that enables agents to cultivate and maintain (as a habit) various moral and intellectual virtues in order to avoid both testimonial and hermeneutic injustice, as well as contributory and documental injustice – and even perhaps some other kinds of epistemic injustice not discussed in this dissertation. This brings us to the next section.

The Role of the Institution in Cultivating the Virtue of Epistemic Justice

In a later article, Fricker (2009) addresses whether or not institutions can be virtuous. Fricker argues that there are 3 kinds of institutionalised groups, namely: “a number of individuals”; “a collective”; and “an institutional structure” (Fricker 2009, 2-3). Fricker’s focus is on the third kind of group. This is her focus, because she wants to assess “group conduct, including epistemic conduct, in terms of virtue and vice” (ibid. 2). She advocates for institutions consisting of a “plural subject” (ibid. 10) that commit themselves to achieving a shared goal. This plural subject can come to have “plural virtue” in terms of both ‘motive-based’ or ‘skills-based’ conceptions of virtue (ibid. 11-12)⁵⁶.

Firstly, motive-based virtues come to be collective when there is a “joint commitment to achieving the good end of the motive *because* it is good” (ibid. 12 original emphasis) and are further reliable in achieving the end of the motive (ibid. 13). Given this definition, motive-based virtues seem to be broadly responsibilist virtues. Secondly, skills-based or faculty-based⁵⁷ virtues can come to be collective when they are applied as the “*pooling* of wills” (ibid. 14 original emphasis). Faculties should be directed at a collective end rather than a collective motive and also be reliable in achieving that end. Given this definition, skills-based virtues seem to be broadly reliabilist virtues. Here Fricker states that this conception of different kinds of collective virtue should not be seen as competing with one another “but rather as applying to different kinds of virtue” (ibid.12).

Fricker does not argue, as I have, that motive-based virtues and skill or faculty-based virtues have a necessary and sufficient relationship with each other. Rather, she addresses motive-based (responsibilist) and faculty-based (reliabilist) virtues, as collective virtues, separately. However, this does not suggest that her two conceptions of collective virtue cannot be implemented together, as she also states she does not view them as in competition with each other. I suggest, based on the conception of the virtue of epistemic justice as based on an Aristotelian necessary and sufficient causal relation between moral and intellectual virtue, and the nature of the virtue of epistemic justice as a hybrid responsibilist-reliabilist virtue, that motive-based and skills-based collective virtues also relate to each other in a necessary and sufficient manner. This necessary and sufficient relationship thus suggests that the collective virtue of epistemic justice incorporates both motive and skills based collective virtues and

⁵⁶ Here I take Fricker’s notion of motive-based virtues – “kindness, compassion, charity, generosity” - to mirror responsibilist virtues and skills-based virtues - “vigilance, honesty, justice, inventiveness” - to mirror reliabilist virtues (Fricker 2009, 12).

⁵⁷ Fricker seems to use the terms ‘skill’ and ‘faculty’ interchangeably when discussing skills-based collective virtues (Fricker 2009, 14-16).

reliabilist-responsibilist virtues as a means to combat epistemic injustice, in its structural forms specifically. This conclusion is further strengthened by Fricker's conception of epistemic justice as a hybrid ethical-intellectual virtue, as discussed above and in chapter 1. The application and power of this kind of collective virtue of epistemic justice will be illustrated in the next section with reference to the healthcare system in South Africa.

Before we turn to this illustration, it is first necessary to discuss whether or not institutions can be virtuous, in order to understand fully what is required for a more inclusive virtue of epistemic justice. Fricker states that structures themselves cannot be virtuous or vicious as they are not agents and do not have will (*viz.* Fricker 2009, 25). Therefore, it is only "in combination with the individuals and groups" that belong to the institution, that the institution may display virtues (*ibid.* 25-26). Institutional structures are therefore encouraged to promote and maintain virtue in the individuals and groups that belong to it, so as to display virtue as an institution. According to Fricker, institutions are the "skeleton... that must be given flesh by the people whose activity animates it" (Fricker 2009, 26).

Elizabeth Anderson (2012) makes similar points when addressing the idea of virtuous institutions. Anderson states that in institutions "structural remedies are put in place to enable individual virtue to work" (Anderson 2012, 168). According to Anderson, it is often the case that we are unaware of our stereotypes and therefore need structural remedies to assist with this (*viz.* Anderson 2012, 168). It is the job of the institution to put these remedies in place by offering "favourable conditions" for individuals to act more virtuously (*ibid.*).

Both Fricker and Anderson therefore suggest that institutions need to put in place the conditions for those who belong to it to cultivate and display individual or group virtue. The virtuous institution is thus one that cultivates and motivates virtue in individuals and collectives. Fricker says that an institution achieving such a moral and just atmosphere displays the institutional virtue of epistemic justice (Fricker 2009, 26).⁵⁸ This virtue is achieved, to recap, by cultivating individual and collective moral (motive-based, responsibilist) and intellectual (skills-based, reliabilist) virtues through an enabling atmosphere that help lessen the effects of epistemic injustice caused by both individuals and the collectives within an institution. Further, as pointed out by Anderson, institutions should be reconfigured in such a way that they prevent epistemic injustice from potentially occurring

⁵⁸ Fricker suggests that this should primarily take the form of the virtue of testimonial justice (Fricker 2009, 26). However, as I have argued, this is not sufficient to deal with other kinds of epistemic injustice.

in the first place (Anderson 2012, 171). In this way, epistemic virtue should be adopted on both “individual and structural scales” (ibid.).

It can therefore be claimed that the virtue of epistemic justice can be a feature of institutions. This is because institutions should cultivate virtues in the individuals and collectives that belong to the institution, in order to promote epistemic justice as an overarching institutional virtue. In the following section, I will suggest ways in which the South African healthcare system, as an institution, can help promote virtue in order to achieve epistemic justice. I will do this specifically in relation to the case of Life Esidimeni and the kinds of epistemic injustice that were evident in that case.

4.3) The Virtue of Epistemic Justice in Healthcare

In the previous section, I used an analysis of Aristotle’s conception of virtue ethics to outline a hybrid motive-skills-based, reliabilist-responsibilist, moral-intellectual virtue of epistemic justice. In this section, I want to make some suggestions as to what the virtue of epistemic justice may look like in relation to healthcare as a social institution. Further, I specifically want to illustrate how such a virtue of epistemic justice may be useful (or may have been useful) in combating the kinds of epistemic injustice identified in the case of Life Esidimeni.

Studies surrounding the idea of virtue as means to overcome epistemic injustice in healthcare are scarce. This may be due to the fact that research is currently focused on identifying the kinds of epistemic injustice in certain social environments. Fricker herself stresses the need to identify epistemic injustice first, in order to then find out what is necessary for epistemic justice (viz. Fricker 2007, viii). Further, work aimed at discussing epistemic justice as a virtue in healthcare focuses more on ways for individual agents (most often the healthcare professional) to adopt virtues so as to combat testimonial injustice. Such virtues would be practiced at the individual level for example, when engaging with a patient in consultation in order to come to a true diagnosis in the right way (Marcum 2009); or being epistemically just in acts of psychotherapeutic communication with mental healthcare patients (Prijjić-Samaržija 2017). While these kinds of virtuous healthcare professionals are necessary in the overarching aim of achieving epistemic justice in healthcare, advocates of this view, like Fricker herself, focus on combating testimonial injustice.

Epistemic justice is therefore neither really afforded attention as a virtue of healthcare as an institution, or as a virtue to overcome the other kinds of epistemic injustice, such as

documental or contributory injustice. A reason for this, as pointed out by Kotzee and Ignatowicz (2016), may be that measuring virtue in medicine or healthcare is very challenging. This is due to the fact that “no complete empirical method exists to study the development of morality along virtue lines” in healthcare (Kotzee & Ignatowicz 2016, 158). However, this should not stop inquiry into the kinds of virtues that may be useful in combating structural epistemic injustice in healthcare. Further, virtues that assist in identifying and preventing testimonial injustice in healthcare may, after all, also be useful in combating structural epistemic injustice in healthcare. As seen in the previous section, it is the individual who comes to display virtue with the aid of the institution.⁵⁹

In chapter 3, I discussed the different kinds of epistemic injustice that could potentially exist in healthcare (chapter 3 section 1) and mental healthcare (chapter 3 section 2). Both kinds of epistemic injustice outlined by Fricker, testimonial and hermeneutic, can potentially occur within these two kinds of institution. Testimonial injustice may, for example, occur when a healthcare professional does not award a healthcare user’s claim the credibility it deserves because of an identity prejudice that the healthcare professional holds against the healthcare user. Hermeneutic injustice may occur in healthcare when a healthcare user has no hermeneutic tools with which to understand their experiences relating to their illness, injury or care, for example. Further, hermeneutic injustice may occur in healthcare when healthcare users’ non-dominant hermeneutic resources are not accepted as a legitimate means for them to understand their experiences. This second kind of hermeneutic injustice is an extension of Fricker’s original conception of hermeneutic injustice.

Along with these two conceptions of epistemic injustice in healthcare, a further two kinds of epistemic injustice were identified in the context of healthcare as an institution. Firstly, contributory injustice may occur in healthcare contexts when particular healthcare professionals perpetrate structural epistemic injustice by actively rejecting non-dominant hermeneutic resources by maintaining their wilful hermeneutic ignorance. And secondly, documental injustice may occur in healthcare contexts when healthcare professionals and

⁵⁹ Although testimonial injustice and testimonial justice are not the focus of this dissertation, it is possible to observe how virtues displayed in once off testimonial exchanges, by individual healthcare professionals, may too be useful if adopted outside of mere acts of communication, within the broader scheme of healthcare as an institution. These virtues, if applied correctly, may be useful in combating once-off cases of testimonial injustice as well as more systematic cases of testimonial injustice.

other relevant agents in positions of power fail to adhere to institutionalised norms and standards that are intended for the benefit of the healthcare user.

It is therefore necessary for a healthcare institution to cultivate and maintain epistemic justice, by promoting virtues that combat these kinds of epistemic injustice. My focus in this section will be on particular epistemic virtues that may be useful in combating epistemic injustice, rather than particular moral virtues *per se*. However, the overarching virtue of epistemic justice is one that has the aim of achieving both truth and justice, as a hybrid moral-intellectual virtue, as explained in the previous section. I therefore suggest that in adopting certain reliabilist and responsibilist epistemic virtues, healthcare professionals (and thus the healthcare system as an institution) will also be more epistemically virtuous. This also refers once again to the Aristotelian necessary and sufficient conditional relation between moral and intellectual virtues as discussed in the context of reliabilist and responsibilist epistemic virtues in the previous section. The necessary and sufficient link made by Aristotle allows us to see the necessity of adopting both reliabilist and responsibilist virtues in order to be epistemically just, in the same way that, for Aristotle, one must have both moral and intellectual virtues in order to live a morally good life.

Reliabilist and Responsibilist Virtues in Healthcare

Marcum (2009), a Professor of Philosophy at Baylor University working particularly in philosophy of science and medicine, presents an outline of both reliabilist and responsibilist virtues specifically relevant in a healthcare context.⁶⁰ With regard to reliabilist virtues, Marcum suggests that a virtuous healthcare professional – the “epistemically reliabilist clinician” (Marcum 2009, 254), in Marcum’s words – should display both ‘perceptual’ and ‘conceptual’ reliabilist virtues. Perceptual virtues are virtues that relate to an agent’s senses and allow an agent to “perceive the world” directly (ibid. 255). These virtues may also be “developed” and improved through training (ibid.).⁶¹ Marcum mentions sight or vision as a unique perceptual virtue as it is more prominent than the other perceptual virtues (*viz.*

⁶⁰ Marcum presents these virtues in relation to a case study regarding a healthcare professional and a patient (Marcum 2009, 252-254). I have not suggested these virtues in relation to that specific case study as it is not one that is completely relevant for my purposes. However, the virtues he mentions can be applied and analysed in a wider healthcare context, which is what I intend to do here, without the use of his case study.

⁶¹ Marcum states only that these skills can be developed through training. However, this is only true if an agent is born with the perceptual faculty in question. A person who is born blind will not necessarily be able to develop the faculty of sight over time. Because of this, I add that perceptual virtues can be improved over time, if the agent in question already has the given faculty. The virtue of these faculties is thus to hear and see well, through the development of these faculties beyond mere function.

Marcum 2009, 255). With this virtue, healthcare professionals are able to observe the healthcare user who requires their services. This is necessary, for example, when a doctor needs to assess a patient to provide an “accurate diagnosis” (ibid.) or when a healthcare professional (a nurse for instance) needs to observe the effects of medication on a patient.

While sight or vision is indeed an important faculty as Marcum suggests, I do not think that in a healthcare context that it is the only or most prominent perceptual virtue, especially considering the goal of epistemic justice. I suggest that along with sight, hearing is another prominent and necessary perceptual faculty within a healthcare context. Healthcare professionals need to be able to hear healthcare users who are communicating with them. The faculty of hearing is necessary for developing the virtue of listening well, and not missing out on any important information communicated by the healthcare user. Both these faculties are also necessary for perceiving written information well. Sight is necessary for the act of reading written information and hearing, perhaps more metaphorically, is necessary for ‘hearing’ what this written information ‘has to say’.

Marcum then moves on to discuss conceptual virtues, the second kind of reliabilist virtue he identifies. Conceptual virtues are cognitive faculties rather than sensory faculties that allow an agent to “think about” the world (ibid. 256). These virtues may also be developed and improved over time. Further, they allow an agent “indirect access to the world” as these virtues allow an agent to develop theories about the world (ibid.) from information received through their perceptual faculties. The relevant conceptual virtues for Marcum include “memory, intuition, inferential reasoning, insight or introspection” (ibid.).

In a healthcare context, memory is a necessary conceptual virtue for healthcare providers as they would need to remember details about, for example, relevant medical knowledge and information from previous patient consultations. The conceptual virtue of intuition is necessary as healthcare professionals need to make good judgements in uncertain situations (*viz.* Hams 2000, 310). Inferential reasoning is a necessary conceptual virtue for healthcare professionals to have in order to draw valid conclusions, “deductively, inductively, or abductively” (Marcum 2009, 256), by taking into account medical knowledge, knowledge from experience and knowledge presented by the healthcare user. And finally, insight and introspection are necessary conceptual virtues for healthcare professionals as they allow the healthcare provider to assess the context in which they find themselves in relation to the healthcare user. Insight and introspection will assist the healthcare provider in understanding

both the nature of their own social situatedness as well as the situatedness of the healthcare user. Further, these virtues will help the healthcare professional understand the potential effects that their social positioning may have on the healthcare user.

Moving on to the responsibilist virtues, Marcum identifies four responsibilist virtues that are relevant in a healthcare context. The first is epistemic curiosity. This virtue may motivate the healthcare professional to engage with the healthcare user in order to find out all the information necessary to assist the healthcare user as well as possible. Marcum describes this as an “epistemic openness or receptivity” (ibid. 257) that the healthcare provider shows the healthcare user. Furthermore, intellectual curiosity “does not allow the agent to be satisfied with the status quo of epistemic goods; rather, it drives him or her to extend those goods in terms of epistemic goals” (ibid. 257-258). Intellectual curiosity further allows the healthcare provider to assess information in a “larger social context” in order to understand the healthcare user and their situation fully.

The second responsibilist virtue identified by Marcum is intellectual courage. This virtue encourages the healthcare professional to accept what is true and to not be fearful in communicating that truth (*viz.* Marcum 2009, 258). This virtue includes not giving in to the “pressure and fear to conform to epistemic beliefs or dogmas that he or she believes are false or propose reckless ideas that hinder acquiring or communicating the epistemic goods” (ibid. 258-259). This virtue is important for healthcare professionals, for example, when they are given instructions from agents in higher positions of power that may not be ethically or epistemically acceptable and may negatively affect the healthcare user – think of financial reasons not to do a certain procedure, for instance. The intellectually courageous healthcare professional will be able to resist the pressure from more dominantly situated agents, to think and act in the correct way.

Third, is the virtue of intellectual honesty, which, similarly to intellectual courage, is necessary for healthcare professionals to communicate the truth that they acquire without altering or distorting it to “deceive other epistemic agents” (ibid. 260). Quoting Zagzebski, Marcum states that intellectual honesty prevents the agent from using dishonesty to gain an unfair advantage or to “indulge [in] laziness” (ibid. 259). This is important as healthcare professionals have access to knowledge that healthcare users do not necessarily understand. Being intellectually honest means that instead of taking advantage of this gap in

understanding, healthcare professionals will engage honestly with healthcare users in matters concerning diagnosis, care, and treatment.

Finally, the virtue of intellectual humility will ensure that healthcare professionals do not ascribe more intellectual excellence to themselves than they deserve or actually possess (ibid. 260). It is important that healthcare professionals realise that they do not know everything and that they avoid making “unwarranted intellectual entitlement claims on the basis of [their] (supposed) superiority” (ibid.). In cases where a healthcare professional is epistemically unsure, this virtue, like intellectual honesty, will prevent healthcare professionals from distorting truth at the expense of the healthcare user. Epistemic humility will allow that the healthcare provider is “always aware of the limits of their epistemic power” and will further allow them to be “open to different and especially opposing views” (Ahmadi Nasab Emran 2014, 134). For example, if a healthcare provider is making use of policy in order to implement a strategy but are not entirely sure of what exactly that policy entails, the healthcare provider will admit their lack of understanding and try to improve it, with the help of others, rather than implementing the policy without the necessary relevant knowledge of that policy.

All these responsibilist virtues make up the overarching virtue of epistemic responsibility. According to Prijić-Samaržija (2017) the virtue of epistemic responsibility is a general concept that encompasses all the above virtues along with others such as kindness, intellectual conscientiousness or prudence, impartiality, open-mindedness, and willingness to exchange ideas (*viz.* Prijić-Samaržija 2017, 1067-1068), and I suggest others such as patience and respect for dignity.⁶²

Taking into consideration the discussion of Aristotle’s ethics and the idea of collective epistemic virtue in the previous section, healthcare professionals should strive to develop perceptual and conceptual (reliabilist) virtues as well as the overarching virtue of epistemic responsibility because, as I have shown, there is a necessary and sufficient relationship between reliabilist and responsibilist virtues. Marcum does not explicitly make this link in his discussion of perceptual, conceptual (reliabilist virtues) and responsibilist virtues. However,

⁶² This is not an exhaustive list of all the relevant responsibilist virtues. This list simply serves to show, to some extent, the scope of epistemic responsibility.

it is important to show here that these virtues have to be in a necessary and sufficient relationship when adopted by a virtuous healthcare professional.

The reliabilist virtues are necessary for being virtuous as it is impossible to gain any sort of knowledge without having perceptual faculties like sight and hearing. Furthermore, in order to be sure that you are perceiving information correctly, you necessarily have to be able to hear and see well, thus having the faculty virtues of sight and hearing. The same is true of the conceptual reliabilist virtues. Once information is gained well through the perceptual virtues, in order to form beliefs in the right way, it is necessary to have conceptual virtues. Without, for example, the conceptual virtue of memory, a healthcare professional may not correctly recall the information gained perceptually, thus potentially leading them to form incorrect and possibly unjust beliefs. Another example is that of the virtue of inferential reasoning. If a healthcare professional is unable to infer an accurate diagnosis from the information they have gained perceptually, then the potential for forming incorrect beliefs about a patient's condition becomes evident. These examples therefore show that reliable faculty virtues are necessary for coming about beliefs in the right way.

However, reliable faculty virtues are not sufficient for forming beliefs well on their own. Once information is gained through the perceptual and conceptual virtues, this information must be used in a responsible way in order to establish an epistemically just environment. It is possible that a healthcare professional may come to have correct information by using her reliabilist faculty virtues. However, if they for instance, do not have the intellectual honesty to communicate this information as the truth, there is nothing good or just about the use of their true belief. Without responsibilist virtues, a healthcare professional could therefore easily misuse or misrepresent the information they come to know through their reliabilist faculty virtues, even if these beliefs are true (because they were arrived at in a reliably virtuous way).

But, on the other hand, although responsibilist virtues are obviously necessary for virtuous healthcare practices, it is not sufficient for an agent to only have responsibilist virtues in order to be just. It is possible for a healthcare professional to be completely honest, for example, about what they know and still be unjust in their having or communicating these beliefs, if the beliefs were never true to begin with. For instance, a healthcare professional who communicates a diagnosis to a patient honestly, but initially came to an incorrect diagnosis through less than virtuous reliable faculties, is unjust in the distribution of their knowledge

and beliefs.⁶³ In another example, let us say for instance that a healthcare professional comes to believe that carrying out a particular policy is the correct thing to do in light of the given circumstances (the details here do not have to be specific). This healthcare professional may be intellectually courageous in deciding to carry out this policy, and even intellectually humble so as to not take advantage of this policy. However, if in lacking reliabilist virtues they had misunderstood the policy to begin with, they are in danger of being less than epistemically virtuous by advocating for a belief that arises out of misunderstanding, even though they are epistemically responsible. These examples illustrate how it is not enough to have just one set of either reliabilist or responsibilist virtues. In order to be an epistemically just knower the two sets of virtue must be in a necessary and sufficient relationship.

It is further the task of the healthcare professional to determine which reliabilist and responsibilist virtues are appropriate given the situations they find themselves in. Certain epistemic virtues are more useful than others in combating the different kinds of epistemic injustice. Much like the context for attaining Aristotle's mean, a healthcare professional needs to practice applying these virtues in different situations in order to fully develop the virtue of epistemic justice, although this does not remove the importance of having both reliabilist and responsibilist virtues that make up the virtue of epistemic justice. In this way, developing epistemic virtue in healthcare is an active role taken up by the healthcare professional (ibid. 1067) in order to improve the provision of healthcare services to healthcare users.

Epistemic Virtue and the Virtue of Epistemic Justice

With this outline of the epistemic virtues that healthcare professionals may cultivate, it is now possible to analyse how these reliabilist and responsibilist virtues combat the different kinds of epistemic injustice and in this way make up the virtue of epistemic justice. The reliabilist perceptual and conceptual faculties mentioned above, are not necessarily virtues in and of themselves. However, if used in the right way, they may allow the healthcare professional to be more accurate and just when coming about truth and understanding in healthcare contexts. It is thus the role of the institution to assist the healthcare professional in cultivating reliabilist

⁶³ This is unjust, not because the healthcare professional happens to have a false belief, as false beliefs may just be a result of epistemic bad luck. The injustice here would however, come about from the neglect for reliabilist virtues. Rather than a case of epistemic bad luck, the incorrect belief was gained through a lack of developing the necessary reliabilist virtues.

and responsibilist virtues to ensure just epistemic conduct and to therefore combat epistemic injustice.

In order to do this, the goal of a virtuous healthcare system should be firstly, to motivate healthcare professionals to listen to the testimonies of healthcare users and award credibility justly, to combat testimonial injustice. Secondly, in order to combat hermeneutic injustice, the healthcare institution should create a climate in which healthcare users are given access to tools that may assist them in understanding their experiences within this institution. Further, with regard to the extended definition of hermeneutic injustice, the healthcare institution should promote the acceptance of other non-dominant hermeneutic resources that healthcare users make use of. Third, healthcare institutions should prevent healthcare professionals from taking advantage of their wilful hermeneutic ignorance to actively reject non-dominant hermeneutic resources to maintain dominant social understandings, in order to combat contributory injustice.⁶⁴ And lastly, institutions should ensure that healthcare practitioners adhere to policy guidelines that are intended to help healthcare users, so that such policy and guidelines are not manipulated or disregarded, in order to combat documental injustice.

The perceptual reliabilist virtues are firstly useful in combating epistemic injustice in healthcare. The virtuous healthcare professional needs these virtues in order to accurately perceive a speaker, their actions and their testimony, in order to gain correct information about the environment they perceive. This is the first step in combating testimonial injustice as perceiving testimony correctly is necessary to award credibility fairly. These virtues are also useful for assessing whether or not the hermeneutic climate of the healthcare institution is inclusive of less dominantly situated knowers. Perceptual virtues are important for having correct information that may help in knowing how less dominantly situated knowers are disadvantaged.

The conceptual reliabilist virtues, like memory, intuition and inferential reasoning, will assist the healthcare provider in recognising when an agent is struggling to articulate their experiences or when the hermeneutic tools they are using do not correspond with those that

⁶⁴ Here the similarities between the extended definition of hermeneutic injustice and contributory injustice are clear. However, recalling chapter 1 section 4, contributory injustice differs from hermeneutic injustice in that it involves an individual agent's perpetration of epistemic injustice by actively rejecting non-dominant hermeneutic resources. Hermeneutic injustice on the other hand, can exist purely structurally, when non-dominant hermeneutic resources are kept from contributing to the dominant pool of social knowledge, as discussed in chapter 1 section 3.

make up the dominant pool of hermeneutic resources. In this way, these virtues link to Fricker's conception of hermeneutic justice as they allow the healthcare professional to be aware of the impact that hermeneutic injustice could have on the healthcare user. However, instead of using these virtues to simply adjust credibility appropriately, the healthcare provider should further assist the healthcare user in creating more effective tools for understanding their experience. The task of the healthcare professional is then to use their conceptual virtues to create a more inclusive hermeneutic climate. Further, insight and introspection will allow that healthcare professionals are aware of their dominant position over healthcare users and perhaps over other less dominantly situated agents within the healthcare system.

The virtue of epistemic responsibility is then required for healthcare professionals to further take up the role of actively ensuring that their epistemic conduct is just, with regards to healthcare users as well as other less dominantly situated agents within the greater scheme of healthcare provision. In terms of combating hermeneutic injustice, epistemic curiosity would firstly, not allow the healthcare professional to be satisfied with the evident gap in epistemic goods between themselves and the healthcare user. This is because such a gap would not allow the healthcare provider to provide the best level of care to the healthcare user. Rather, the healthcare professional will seek to "extend those goods in terms of [the] epistemic [goal]" (Marcum, 257-258) of providing adequate care. Such a virtue will in this way allow the healthcare professional to assist the non-dominantly situated healthcare user in contributing to the dominant pool of hermeneutic resources by accepting alternative view points and understandings. Secondly, intellectual courage and humility may motivate the healthcare professional to accept that their dominant positioning may create an environment that disregards non-dominant resources. Further, it may motivate them to accept that these non-dominant resources may at times be more valuable than the dominant hermeneutic resources available to the healthcare professional. Once they accept this, they may be further motivated in allowing non-dominant hermeneutic resources to contribute to the dominant pool of hermeneutic resources. This growing pool of resources may then be helpful to those agents that cannot articulate their experiences at all. In this way, these virtues help healthcare professionals reduce the potential for both Fricker's hermeneutic injustice as well as the extended notion of hermeneutic injustice discussed in chapter 2 section 3.

These virtues will be useful in the same way for combating contributory injustice as contributory injustice is linked very closely with hermeneutic injustice. Firstly, the conceptual and perceptual virtues allow the healthcare professional to be aware of their dominant position over the healthcare user. Once the dominantly situated healthcare professional is aware of this, responsibilist virtues such as intellectual courage and humility will ensure that the healthcare professional does not take advantage of this position at the expense of the healthcare user or any other less dominantly situated agent within the healthcare institution. The intellectually courageous and humble healthcare professional would not take advantage of their wilful hermeneutic ignorance in order to maintain dominant modes of thought for their own benefit, as they would understand that this moves them away from the goal of the healthcare institution, which is to provide the best care to the healthcare user. Therefore, a healthcare professional with these virtues will also combat the more agential contributory injustice by creating a more hermeneutically robust climate, that includes non-dominant hermeneutic resources.

Therefore, when adopting virtues to combat hermeneutic and contributory injustice, conceptual reliabilist virtues like intuition, inferential reasoning and insight or introspection are helpful in allowing the healthcare professional to realise that they are in a privileged and powerful social position over the healthcare user as well as over many other agents within the healthcare institution. However, even if healthcare providers realise this imbalance in power and even if they are further able to exercise responsibilist virtues in creating a more inclusive hermeneutic environment for these less dominantly situated agents and healthcare users, there is still the potential for documental injustice in the form of taking advantage of medical codes of conduct, policy and other norms and standards within healthcare. Epistemic virtue, in the form of reliabilist and responsibilist virtues, thus needs to be exercised in different ways to avoid documental injustice.

Firstly, memory as a conceptual virtue is necessary for healthcare professionals to accurately remember and recall information from policy, codes of conduct etc. If healthcare professionals remember this information correctly, they are less likely to misinterpret and manipulate it. Virtues of epistemic responsibility are then necessary to prevent the healthcare professional from taking advantage of this information. It is possible, as said earlier, that having access to information that less dominantly situated agents do not have access to, creates the potential for healthcare professionals to convey this information to these agents

incorrectly. Healthcare professionals thus need to be honest to themselves and to less dominantly situated agents about what codes of conduct and policy entail. Further, healthcare professionals need to be intellectually humble, so as to not ascribe themselves a greater level of excellence than they deserve or possess. This will prevent the healthcare professional from thinking that policy is intended to benefit them rather than the healthcare professional. This virtue, as well as intellectual honesty, will further prevent the healthcare professional from thinking that they are epistemically powerful enough to reinterpret and change policy for their benefit and at the expense of others. Lastly, to combat documental injustice, healthcare professionals need to be epistemically courageous enough to speak out against other healthcare professionals that are taking advantage of healthcare policy and codes of conduct, even if the healthcare professional at fault is more dominantly situated than them.

These virtues are in these ways potentially useful for combating the different kinds of structural epistemic injustice that may occur within the healthcare system. Because the focus of this dissertation was on such structural epistemic injustice, I have not addressed testimonial injustice in as much detail. Because of this, a detailed discussion of how epistemic virtues may combat testimonial injustice is beyond the scope of this dissertation. However, it is worth noting that the awareness of structural inequality that the virtues discussed above may afford the healthcare professional, may also prevent testimonial injustice. This is because healthcare professionals may be more aware of the impact that such inequality has on their credibility judgements of healthcare users and other less dominantly situated agents. These virtues then assist in exercising Fricker's virtue of testimonial justice.

The discussion has so far been on the virtues that the individual healthcare professional can adopt to potentially combat the various kinds of epistemic injustice. If we recall the discussion of the virtuous social institution in the previous section, it becomes clear that the healthcare institution as a whole can become more virtuous if it promotes, cultivates and maintains these virtues among the agents that belong to the institution. The goal of providing adequate healthcare motivates healthcare professionals to be epistemically and morally virtuous as a collective, in order to achieve this goal. The role of the institution is then to support virtuous healthcare professionals in achieving this goal.

By introducing the virtuous collective in a virtuous institution, it is possible to move beyond Fricker's conception of epistemic virtue. The critique against the virtue of testimonial justice presented in the previous section and in chapter 1 section 2, that agents are often not aware of

the impact of prejudice on their credibility judgements, is addressed when virtue is promoted, cultivated and maintained by the healthcare institution, as the institution as a whole is able to inform healthcare professionals of the impact of their dominantly situated social positioning and their prejudices. This is even more so the case if the healthcare institution promotes a more robust and inclusive hermeneutic climate within the healthcare system, as there will be a greater pool of resources to ensure better understanding for both healthcare professionals and healthcare users which in turn may ensure that healthcare users receive better care. Further, considering Fricker's virtue of hermeneutic justice, agents are no longer only required to adjust credibility upwards because of a gap in interpretive skills. Rather, agents are supported in creating a more inclusive hermeneutic climate by also taking into account non-dominant hermeneutic resources and allowing non-dominant resources to contribute to the wider pool of social knowledge.

The virtue of epistemic justice in healthcare should therefore at least include each of the virtues mentioned above. This is not to say that these are the only epistemic virtues that can combat epistemic injustice. However, the virtues I have discussed here are ones that may have a more direct impact in overcoming epistemic injustice in healthcare. The virtue of epistemic justice is also a goal that should be taken up by healthcare as an institution as a whole, so as to always promote, cultivate, and maintain these individual epistemic virtues in the goal of combating epistemic injustice. This is because the goal of removing epistemic injustice will bring the healthcare institution closer to achieving the overarching goal of healthcare; to provide healthcare users with the best care possible.

The Virtue of Epistemic Justice and Life Esidimeni

It is now left to be discussed how the virtue of epistemic justice may have been useful in correcting for or even preventing epistemic injustice in the case of Life Esidimeni. In chapter 3 section 4, I discussed epistemic injustice in the case of Life Esidimeni relating to four main factors namely, the marginalising of mental healthcare users (MHCUs); officials, responsibility, and the failure to listen; the GMMP (Gauteng Mental Health Marathon Project) and policy; and the treatment of MHCUs. Here, I will illustrate how the virtue of epistemic justice may have been useful in combating epistemic injustice with regard to these same four factors.

The virtue of epistemic justice could have prevented the marginalising of MHCUs in several ways. First, perceptual and conceptual virtues would have created an awareness of the material and identity power differences between those belonging to the healthcare system and the MHCUs at Life Esidimeni. Further, this awareness would have prompted officials to not take advantage of such a gap in identity and material power. As discussed above, the virtue of epistemic responsibility may allow for a more robust and inclusive hermeneutic climate. These virtues would therefore have allowed for an environment where the patients at Life Esidimeni and other mental healthcare users were not disregarded because of this difference in identity and material power. This would have created an environment where healthcare professionals, especially at NGOs, listened to MHCUs when they tried to communicate information about how best to care for the mental healthcare patients. This may have resulted in the better overall care of the Life Esidimeni patients.

This relates closely to the idea that the officials that carried out the Gauteng Mental Health Marathon Project (GMMP) failed to listen to MHCUs and other officials of lesser power. Epistemic curiosity and courage would have implored the GMMP officials to take the concerns of MHCUs and the warnings of other officials into account, as not doing so would cause them to miss out on knowledge that was necessary to provide the Life Esidimeni patients with adequate care and furthermore, knowledge that was necessary for keeping these patients alive. Having the intellectual courage to listen and the intellectual humility to accept that perhaps the GMMP was not in the best interest of the patients at Life Esidimeni may have prevented the closure of the Life Esidimeni facility in the first place and thus prevented the deaths of 144 mental healthcare patients.

Regarding the GMMP and policy, the actions of the officials carrying out this project caused many instances of documental injustice. Had these officials adopted the virtue of epistemic justice, as outlined above, it may have been the case that policy would not have been as manipulated and misunderstood as it was in the case of Life Esidimeni. Intuition, insight and inferential reasoning would have prompted officials to understand that the South African healthcare system was not well enough equipped to allow for a policy like deinstitutionalisation to be carried out. These virtues, along with memory, would also perhaps have encouraged officials to pay more attention to the policy regarding the National Core Standards for Healthcare when choosing NGOs to care for deinstitutionalised patients. Intellectual courage, honesty and humility may have further prompted officials to realise that

cutting costs was for their own benefit and not for the benefit of the patients at Life Esidimeni.

The events surrounding the closure of Life Esidimeni indicate a failure of those in power to take responsibility. As discussed in chapter 3 section 4, this was evident in the testimonies of officials provided at the arbitration hearings; it was evident in the ease at which officials just followed orders, despite them being potentially dangerous for the patients at Life Esidimeni; and it was evident in the way officials shifted blame for the deaths of the patients. These actions muted the severity of the injustice done to the patients and other MHCUs. Further, these actions show that officials displayed no epistemic responsibility. Each of these factors already discussed relate directly to the treatment of MHCUs. A lack of epistemic virtue in this case caused a lack of regard for the MHCU firstly as a patient, and also as a human being. Each if these epistemic failings can be attributed to a disregard for patient and mental healthcare user rights. As stated in chapter 3 section 4, an epistemic failure of this kind, as perhaps a failure to adopt the virtue of epistemic justice, is a large part of the overall ethical failure that the entire case of Life Esidimeni represents.

In this chapter I presented an overview of the debate in current virtue epistemology, in section 1. In section 2 I revisited Fricker's conception of the virtue of epistemic justice and the critiques against them. I then used an analysis of Aristotle's ethics to establish a necessary and sufficient relation between moral and intellectual virtues and responsibilist and reliabilist virtues to suggest that the virtue of epistemic justice is a hybrid ethical-intellectual virtue as well as a hybrid reliabilist-responsibilist virtue. This link was used in relation to the concept of a virtuous social institution as one that motivates and cultivates the virtue of epistemic justice among collective individuals. Finally, in section 3, I discussed how the virtue of epistemic justice may be successful in combating epistemic injustice within healthcare. I then moved on to discuss how the virtues of epistemic justice may have been useful in combating epistemic injustice in the case of Life Esidimeni.

CONCLUSION

In this dissertation, I showed that epistemic injustice ought to be identified, analysed, and addressed not only in a general sense, but also in the specific social contexts in which it arises to negatively affect the lives of people in a particular social group. Fricker attempts to show this in her conceptualisation of epistemic injustice. However, there are certain (more specific) social contexts that show evidence of kinds of epistemic injustice that Fricker does not fully address. I have demonstrated that an analysis of these different kinds of epistemic injustice, as well as the ways to address such injustice, need more than just Fricker's notions of testimonial and hermeneutic injustice and the virtues of testimonial and hermeneutic justice, as put forward by her.

In this dissertation, I aimed to do three things. The first was to understand fully the concept of epistemic injustice and to further show that the concept of epistemic injustice, as constructed by Fricker, is too narrow to address all kinds of epistemic injustice. To do this, in chapter 1, I presented an analysis of Fricker's conceptions of testimonial and hermeneutic injustice and further identified areas of critique that indicate that this concept is too narrow to address all kinds of epistemic injustice. I then moved on to identify alternative kinds of epistemic injustice that Fricker misses out on, specifically ones that relate to more structural kinds of epistemic injustice. Specifically, I outlined an extended conception of hermeneutic injustice, contributory injustice, and documental injustice.

Secondly, I aimed to identify epistemic injustice as a structural feature of the South African healthcare and South African mental healthcare systems. To do this, I outlined the structure of the South African healthcare system and the South African mental healthcare system in chapter 2. Then in chapter 3, I presented an analysis of the potential for epistemic injustice within a healthcare context in general. This led to an analysis of the gaps within the South African healthcare and South African mental healthcare systems specifically; gaps that create the potential for the kinds of structural epistemic injustice explained in chapter 1. The final task to meet the second aim was then to outline a case study that demonstrated the effects of epistemic injustice in South African healthcare and South African mental healthcare. The case study outlined was that of the closure of the Life Esidimeni mental healthcare facilities which led to the deaths of 144 mental healthcare patients after they were moved to unlicensed NGOs. This case study was used as an example of the potential effects of structural epistemic injustice, specifically hermeneutic, contributory and documental injustice.

My third and final aim was to suggest that virtue epistemology is a useful tool to combat epistemic injustice. To do this, I outlined the current themes in virtue epistemology in the forms of virtue reliabilism and virtue responsibilism. After having critiqued Fricker's suggestions for the virtues of testimonial and hermeneutic justice for being too narrow, I then used the outline of virtue epistemology in the previous section to construct a concept of the virtue of epistemic justice that is useful in combating epistemic injustice as it may exist specifically within healthcare. I formulated an argument for such a virtue firstly through a link to Aristotle's concepts of moral and intellectual virtue and secondly, through a discussion of the concept of a 'virtuous social institution'. Lastly, I identified the specific reliabilist and responsibilist virtues that make up the virtue of epistemic justice necessary for combating epistemic injustice in healthcare and discussed how these would be useful in combating or even avoiding epistemic injustice in the case of Life Esidimeni.

In carrying out these aims, I have come to three major conclusions. The first is that Fricker's conception of epistemic injustice, in the forms of testimonial and hermeneutic injustice, is incomplete. Fricker does not afford structural kinds of epistemic injustice enough weight in her discussions of hermeneutic injustice. Therefore, Fricker's conception of hermeneutic injustice is too narrow as it misses out on the kinds of understanding non-dominant epistemic agents *do* have of their social experiences. Further, Fricker misses out on other distinctly different kinds of epistemic injustice that arise out of social inequality, such as contributory and documental injustice. Fricker's conception of testimonial injustice thus does not fully explain the agential aspect of these injustices, nor does her concept of hermeneutic injustice fully explain the structural aspect of these injustices.

Secondly, I conclude that epistemic injustice, especially in its structural forms, is evident and prominent in the health sector in South Africa. The identification and analysis of epistemic injustice in this context is widely ignored in favour of more salient kinds of moral and social injustice. However, I hope to have shown, through my use of the case of Life Esidimeni, that the potential for epistemic injustice is vast due to the structural gaps in healthcare provision in South Africa. Further, I hope to have shown that epistemic injustice can contribute greatly to the overall patterns of injustice evident in healthcare and mental healthcare in South Africa and therefore should be considered when dealing with patterns of injustice in this context.

Finally, the third conclusion I draw is that current virtue theory is not formulated well enough to address epistemic injustice in all cases. Fricker's suggested virtue theory approach to

combat epistemic injustice, in the form of the virtue of testimonial and hermeneutic justice, much like her theory of epistemic injustice, is also incomplete. Although Fricker is clear that epistemic injustice rather than epistemic justice is the focus of her book, it remains the case that the ideas she puts forward for combating epistemic injustice would not help to fully address either the two kinds of epistemic injustice she identifies, or the other kinds of epistemic injustice identified in this dissertation. This leaves a gap in the development of a virtue of epistemic justice to potentially combat all these kinds of epistemic injustice.

Further, there is a gap relating to how virtue theory may be useful in combating structural kinds of epistemic injustice in healthcare. This is largely due to the fact that when virtue epistemology (and even virtue ethics) is applied to healthcare, it is done in such a way that the focus remains on the virtuous healthcare professional as an individual. As I have pointed out in chapter 4 section 2 and section 3, the virtuous healthcare professional as an individual is very important. However, there is little done in addition in the way of explaining how healthcare professionals as a collective may be able to combat structural epistemic injustice.

I have addressed the first gap through my construction of the concept of the virtue of epistemic justice that emphasises more strongly the causal relationship between reliabilist and responsibilist epistemic virtues, by linking these virtues to Aristotle's concepts of moral and intellectual virtue. I have addressed the second gap by suggesting specific reliabilist and responsibilist virtues that a healthcare professional should have in order to potentially identify and combat epistemic injustice. I suggested that these reliabilist and responsibilist virtues stand in a necessary and sufficient relation to each other. An analysis of Aristotle's moral and intellectual virtue strengthened this link between these two virtues. These virtues are then further strengthened by healthcare professionals committing to goals as a collective and having the support of the healthcare institution to achieve these goals in the right way. The idea of collective virtue, and the healthcare institution that displays these virtues through the collective, go further than discussions of epistemic virtues that are held or possessed by the individual only. This, as I aimed to show in this dissertation, is a more useful conception of the virtue of epistemic justice when considering how to combat structural epistemic injustice in healthcare.

Yet the problems of epistemic injustice in healthcare and mental healthcare are far from resolved. Structural injustice in South Africa has persisted, resulting in a lack of accountability for those who perpetrate epistemic injustice in these institutions. This is

evident in the re-election of Qedani Mahlangu to the ANC Gauteng's provincial executive committee (Sekhotho, 2018). By allowing Mahlangu, as a political leader, to maintain such a high position of power in this way, after clear involvement in the events surrounding the deaths in the Life Esidimeni case, governing political institutions are in many ways absolving her of any responsibility. This indicates structural inequality on a much larger scale than just the structural inequality as it exists within healthcare. This leaves open opportunity for further study in the terms of structural epistemic injustice in greater political institutions. Research is necessary in the way of identifying the kinds of epistemic injustice that begin within governing institutions and then filter down into areas such as healthcare, education and the financial sector, for example.

In the face of the persisting and far reaching effects of epistemic injustice, in South Africa specifically, and in political institutions on a global scale, I have argued here that the identification and analysis of such epistemic injustice in specific contexts are absolutely necessary in the exploration of wider social injustice. Without an acknowledgement of the damage that can be done when epistemic practices are infringed upon, social injustice will continue to occur in ways that are perhaps more obvious than previously thought. This can be seen in a recent event regarding healthcare and mental healthcare in South Africa. The Daily Maverick has reported that the Health Ombudsman Malekgapuru Makgoba, the same Ombudsman who investigated the misconduct that occurred in the case of Life Esidimeni, “threw another whistle-blower under the bus” (2018) when he released a report denying allegations made by the whistle-blower about patient maltreatment in an Eastern Cape psychiatric hospital. The details of this case cannot be studied here.⁶⁵ However it is worthwhile to note how this case highlights again the need for sensitivity to a kind of documental injustice where health officials do not act on or report on events responsibly. This strengthens my claim that epistemic injustice in healthcare institutions must be identified and analysed in further research.

From another perspective, this dissertation provides the groundwork for studying obstacles in representing knowledge of a particular context or system, as mentioned in the Introduction. Thus, this dissertation is also written in the broader context of knowledge representation and reasoning (KRR), apart from its obvious placement in political epistemology and its

⁶⁵ For more information surrounding this case, see the article in the Daily Maverick, ‘Another whistle-blower is humiliated’. Available at: <https://www.dailymaverick.co.za/article/2018-08-27-another-whistle-blower-is-humiliated/>

application in the specific context of South African Healthcare and Mental Healthcare. Epistemic injustice is an obvious obstacle to representing knowledge correctly, given that it prevents the just distribution of knowledge among credible knowers. It is important to point out that this research also plays a role in terms of KRR, since there is a lot of interest from AI researchers in determining how they can play a role in addressing the issue of epistemic justice in healthcare. A good example of this interest is the MomConnect project.⁶⁶

In this dissertation I have shown that the potential for epistemic injustice within social institutions cannot be underestimated. By making the link between epistemic injustice and cases within healthcare such as Life Esidimeni, I have shown that if epistemic injustice is allowed to persist because of structural inequality, it can have consequences as severe as death. This dissertation is unique as it has shown that an application of philosophical theory can bring to light injustice that was not considered previously in a particular context. This is important as it indicates that cases of social injustice, like Life Esidimeni, should not only be analysed within legal, medical and financial perspectives. While these perspectives are necessary, such cases should also be looked at from a philosophical perspective. And again in a philosophical context, the perspective must not only be a moral or political philosophical perspective but also an epistemological one (as argued for in chapter 1). It is only if we analyse situations of epistemic injustice in this holistic way that we can come to have a full understanding of the full moral implications of our social practices and can hope to combat social injustice more effectively.

⁶⁶ Discussions surrounding projects such as these goes beyond the scope of this dissertation. However, projects like MomConnect, part of a bigger project promoting digital health, focus on making necessary information and knowledge digitally available to healthcare users. See Mehl et al, 2018. More information on this project can also be found at <https://www.westerncape.gov.za/general-publication/new-project-connects-expectant-moms-government-health-services> and <http://www.health.gov.za/index.php/mom-connect>. There is also a new Nurse Connect project – see e.g. <http://www.health.gov.za/index.php/mom-connect?id=369>.

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