

The art of medicine

Seen but not heard: children and epistemic injustice

How do we listen to children? How do we decide whether we believe a story relayed to us by a child? We don't often reflect on our listening practices, which can rely on unrecognised presuppositions. This issue is particularly important when listening to patients: how do we decide what level of credibility to assign to testimonies and interpretations offered by children? We suggest that a philosophical framework can encourage reflection on this important, yet neglected, topic.

In her book *Epistemic Injustice*, philosopher Miranda Fricker argues that there is a distinctively epistemic kind of injustice, which is a wrong done to someone in their capacity as knower. She identifies two such wrongs: testimonial injustice and hermeneutical injustice. Testimonial injustice occurs when prejudice causes a hearer to unfairly assign a lower level of credibility to a speaker's testimony or report. This can be done by doubting, ignoring, or failing to take someone's testimony seriously until it is corroborated by another. For example, a person who is biased against people of a particular race or gender may unfairly assign lower credibility to testimonies given by speakers from those groups. Another kind of epistemic injustice is hermeneutical injustice, which occurs when a gap in collective interpretative resources puts a speaker at a disadvantage. This injustice occurs when society as a whole lacks an interpretative framework to understand particular experiences. For instance, society in the 1960s did not recognise sexual harassment, and the behaviour of harassers was typically tolerated or even excused. As a result, women were victimised because the wider social context did not label such behaviours as sexual harassment.

Armed with this notion of epistemic injustice, we now ask: are children readily believed, or indeed heard, compared with adult patients or carers? Are adults biased in a way that makes children more vulnerable to epistemic injustice? Do adults believe, tacitly or explicitly, that children cannot tell the difference between fact and fiction, or readily make things up? This issue merits consideration in areas such as education, child rearing, and the developmental sciences. But it is of particular importance in health care, because health care is fundamental to wellbeing and involves treating the child's own body. So children's views, information, and stories inform critical decisions that affect their health.

Consider the case of a 5-year-old girl who presented with acute headache and was found to have double vision on examination of her eye movements: a concerning feature warranting a CT scan. On repeated examination she was, however, found to complain of double vision even with one eye closed. As a result, the girl's testimony was then dismissed. Fortunately, another physician reviewed the patient and realised she was trying to describe blurred

vision. Result: this and the headache were fixed by a trip to the opticians and the CT was cancelled. The girl lacked the epistemic resources to describe her symptoms accurately but was in fact conveying important information. This scenario shows how easy it can be to overlook the intended meaning of a child's testimony.

Children are also more vulnerable to epistemic injustice because of differing epistemic abilities at different developmental stages. For example, very young children are usually incapable of lying although their descriptions may be vaguer than those of older children. An 18-month-old toddler who limps or does not use his arm has something wrong with the limb until proven otherwise. But an older child may do this out of fear—anticipating a pain that has actually resolved—or because the behaviour has been positively reinforced by the attention it has gained. Here lies the great challenge for doctors to sift the serious complaints from the seriously complaining. In other words, doctors make distinctively epistemic judgments when assessing patients' statements, even if they do not explicitly recognise this skill as such. Assigning credibility to patients is an important aspect of their work; in the case of children the difficulty is compounded by children's varying epistemic abilities.

Testimonial injustice in the case of children arises from these very features: children may seem irrational, with reduced powers of reasoning, flawed or non-existent memories, and be easily swayed. With limited language as well, younger children are at risk of being assessed as poor givers of testimony. It is important for health-care professionals who care for children to distinguish between characteristics that are genuine descriptors of a particular age group, and potentially harmful biases.

Not only children's testimonies, but also their interpretative frameworks are at risk of rejection by adults, who, with few exceptions, cease to readily understand the child's world. When the two interpretative frameworks clash, the adult interpretation usually trumps the child's. This is a problem when we consider the ways in which children perceive illness in themselves or in an adult, and how it is explained to them (or not) by adults. It is also a problem when a child interprets or reports a symptom in ways that do not make it salient enough for adult attention. For example, abdominal pain is a common presenting symptom in children. It is also common for young children suffering sexual abuse to present with "tummy ache" because they might be fearful or ashamed of disclosing or because they do not know what is really wrong or what to describe. Children of a certain age will always lack the concept of sexually motivated actions.

Children will always be at a hermeneutical disadvantage within an adult-governed health-care system, because

their interpretative frameworks are foreign to such an adult system. The adults who wish to understand them need to make the effort to enter their interpretative frameworks, or world, and to understand their testimonies from within it. It is, therefore, up to health professionals and paediatricians, in particular, to spot the clues in children's stories. Of course, this is true in many other contexts as well, such as education. But as we suggest, the acuteness, intimacy, and personal nature of health make the stakes higher in health care.

There are two ways in which clinical judgment might be epistemically skewed: doctors may assign too little or too much credibility to patients. Take the example of a teenager who is a frequent attender to the paediatric ward with bouts of unexplained abdominal pain. She is also known to say she cannot pass urine but always does if given time. She is finally discovered in so much pain that her bladder is scanned and she is found to have severe urinary retention. The bladder had been filled so far beyond its capacity (by intention or otherwise) that the muscular wall can no longer contract and empty. She has "cried wolf", claiming she could not pass urine in the past, and suffered a deflated testimonial credibility as a result. Sometimes, patients and carers are afforded too much credibility. Consider the baby (unable to provide any testimony) who presented with bleeding from his ears. He was treated for an ear infection but re-presented with the same symptoms a short time later. After the third episode of bleeding, for which no cause could be found, the mother was confronted and admitted to using an implement to cause the bleeding intentionally. This is an example of fabricated or induced illness, which is a rarity. It is also an example of child abuse. Sadly, child abuse is a common example of deflated credibility being afforded the child along with inflated credibility to the carer who is also the abuser. Despite child protection training requirements for all health-care professionals who work with children, some cases of abuse are still missed because of the tendency to believe the usually more articulate adult over the child. We suggest that giving attention to these epistemic issues could be valuable in this area.

Denying someone the credibility they deserve is one form of epistemic injustice; denying them the role of a contributing epistemic agent at all is a distinct form of epistemic exclusion. The tragic case of Victoria Climbié in the UK illustrates this exclusion in the worst possible way. She was systematically abused and came into contact with health professionals on a number of occasions before she died. She spoke French. Her testimony regarding her symptoms was not sought, despite being old enough to contribute; she was not regarded as an epistemic agent. One of the most important outcomes from the subsequent enquiry was underlining the need to always seek "the voice of the child". Sadly, since Climbié's death in 2000 further cases of horrific child abuse have occurred in which the testimony of the child was not heard or not sought, either by health-care or other



Study of a Child (c. 1915–20) by Gwen John (1876–1939)

professionals such as police, education, and social care. Two recent examples in the UK are the death of 4-year-old Daniel Pelka, as well as the currently unfolding story of children who were abused by adults whilst in the care system in Rotherham, despite complaints to social services and police.

Children are more vulnerable than adults to epistemic injustice in the health-care setting because of developmentally shifting needs and reliance on the testimony of carers. As a result, there is a unique communication skill set required of the health professional who must be able to reach and understand children of all developmental stages, as well as their carers. They must also continuously question the validity of the patient's and carer's testimonies and the diagnosis itself. Achieving epistemic justice in a time-scarce environment is often a challenge, but is particularly important in the case of children, who should not just be seen but also heard. Ultimately, the age-old medical school adage should not be forgotten in practice—"listen to the patient, for they are telling you the diagnosis"; except of course when they can't.

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Further reading

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