University of Tartu
Institute of Philosophy and Semiotics

EPISTEMIC INJUSTICE IN THE TRANSGENDER AND GENDER DIVERSE PATIENT- DOCTOR RELATIONSHIP

Master's Thesis in Philosophy

Evita Bukonte

Supervisor: Kadri Simm (PhD)

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Table of Contents

Introduction

Epistemic injustice was coined by Miranda Fricker in her 2007 book *Epistemic Injustice: Power & the Ethics of Knowing.* She defines epistemic injustice as "a wrong done to someone specifically in their capacity as a knower" (Fricker 2007, 1). Fricker explains that being wronged as a knower is being wronged in the capacity for reason. The capacity to reason has historically been formulated as the basis of humanity; thus, being doubted in the ability to reason insults one's humanity. Fricker notes that often those already oppressed are those who experience being doubted in their capacity as knowers. (Fricker 2007, 44) Fricker's theory is primarily concerned with the ethical aspects of everyday epistemic practices. (Fricker 2007, 2) Her theory also reveals how knowledge gets or does not get distributed, and who gets to participate in the production of it and how that perpetuates prejudice and marginalisation.

In this thesis, I apply concepts of epistemic injustice , such as testimonial injustice and hermeneutical injustice, to empirical data from transgender and gender diverse patients and their interactions with healthcare professionals, collected by me. This thesis shows how, in the case of transgender and gender diverse patients, the predetermined epistemic asymmetry of the doctor-patient relationship can create epistemic injustice. The goal of this thesis is to show that epistemic injustice is applicable to the transgender and gender diverse patient-doctor relationship. This thesis consists of three parts: first, an introduction that includes a methods section, information about the interviewees and an introduction to the identified themes, later used in the analysis. Chapter two tackles Fricker's concept of testimonial injustice and related concepts of testimonial smothering. The second part of chapter two analyses the collected data trough the conceptual framework. Chapter three explains Fricker's concept of hermeneutical injustice and Gale Pohlhaus Jr.'s concept of willfull hermeneutical ignorance. The second part of the chapter analyses the data through the conceptual framework.

1.Background and Methodology

1.1. Epistemic injustice and medicine

Epistemic injustice has been applied to the field of medical humanities by authors such as Havi Carel and Ian J. Kidd, who believe that ill persons are especially vulnerable to epistemic injustice because of the epistemic asymmetry of the doctor-patient relationship. According to Carel and Kidd, doctors are epistemically privileged due to training and expertise, but the clinical training leaves out non-authoritative information, which is information held by patients. (Kidd et al. 2017, 355–65; Carel and Kidd 2014) The application of epistemic injustice to the field of medicine has received criticism. Nielsen et al., in their article "Fundamental issues in epistemic injustice in healthcare", point out that not a lot of empirical studies supplement the current literature on epistemic injustice in healthcare. (Nielsen et al. 2025) For example, writings on epistemic injustice in healthcare, such as Nick Clanchy's article "Tackling Hermeneutical Injustices in Gender-Affirming Healthcare" or *Epistemic Justice in Mental Healthcare* edited by Lisa Bortolotti, offer solutions to the issues that cause epistemic injustice. This solution-focused literature provides real-world applicability but does not focus on proving the occurrence of epistemic injustice beyond theoretical grounds. This thesis aims to fill some of the gaps.

Nielsen et al. also point out that to truly understand epistemic injustice, the biases of the doctors would have to be learned from the doctors themselves. (Nielsen et al. 2025) Kidd and Carel reference Christopher Hookway's article "Some varieties of epistemic injustice" to explain why it is important to focus on the patient's perspective. The informational lacuna can be noticed only from the patient's perspective, because the epistemic resources available already leave out this perspective. (Carel and Kidd 2017, 340) It cannot be noticed from the perspective of the practitioner, because it is not clinical information they are lacking. Carel and Kidd also address that there are separate cases in which doctors hold justified epistemic privilege. They give an example of a CT scan as something that a doctor has the right to assert epistemic privilege over, and deciding where a patient dies as something that a doctor does not have epistemic privilege in. (Carel and Kidd 2014, 536) This can also be seen with the example of pain, when a patient says they are in pain the doctor cannot decise that the patient is not in pain, but after making assessments, can have the final word on the cause of the pain. Other work on this topic, such as a chapter *in Epistemic Injustice and the Philosophy of Recognition* by Freeman and Stewart, "The Problem of Recognition, Erasure, and

Epistemic Injustice in Medicine", notes that in addition to the epistemic injustice all patients experience due to the medical system, trans patients experience the individual failure of medical practitioners. The examples of individual failures are: using the wrong pronouns, not recognising trans bodies as real and not recognising that not all problems are caused by a patient being trans. (Freeman and Stewart 2022)

Miranda Fricker addresses epistemic injustice in the context of trans people in her article with Katharine Jenkins in *The Routledge Companion to Feminist Philosophy* titled "Epistemic Injustice, Ignorance, and Trans Experiences". Fricker and Jenkins notice the historical medicalisation of the trans identity and the general tendency to popularise certain trans narratives over others. (Fricker and Jenkins 2017)

I use the following acronyms throughout the thesis: TGD: Transgender and gender diverse; GAC: gender-affirming healthcare; HRT: hormone replacement therapy. I use the shortened form of transgender, trans, interchangeably with TGD.

Transgender and gender diverse refers to people who do not identify with the gender and sex assigned at birth. Assigned gender at birth refers to the sex observed at one's birth, usually based on the anatomy of their external genitalia. With one being TGD, their social gender differs from the sex assigned at birth. [1]

Gender-affirming care, sometimes referred to as gender transition, or previously, sex-change, includes hormone replacement therapy and other hormonal treatments, surgical interventions, primary care, mental health care, which can include a psychiatric diagnosis and more. The Standards of Care for the Care of Transgender and Gender Diverse people list the following gender affirming interventions:

> … hysterectomy +/- bilateral salpingo-oophorectomy; bilateral mastectomy, chest reconstruction or feminizing mammoplasty, nipple resizing or placement of breast prostheses; genital reconstruction, for example, phalloplasty and metoidioplasty, scrotoplasty, and penile and testicular prostheses, penectomy, orchiectomy, vaginoplasty, and vulvoplasty; hair removal from the face, body, and genital areas for gender affirmation or as

[1] Transgender and gender diverse people include identities discussed in this thesis, such as: transgender woman, transgender man, transmasculine, transfeminine, nonbinary, as well as other identities, not further discussed in this thesis. A transgender man is someone who identifies as a man, and most likely was assigned female at birth; a transgender woman identifies as a woman. Someone who is transmasculine or transfeminine ascribes this identifier to themselves, usually because they identify with some aspect of masculinity or femininity, might consider themselves binary or nonbinary alongside. For example, everyone who is a transgender man is also transmasculine, but not everyone who is transmasculine considers themselves a man. This works together with non-binary gender identities, with one of the identities being nonbinary itself, which is an umbrella term that includes a variety of gender identities that fall outside of man and woman. Nonbinary can get supplemented by transmasculine or transfeminine, which indicates the person's alignment with either gender expression; it can be in the manner of social expression, receiving masculinising or feminising GAC or simply identifying with the term.

part of a preoperative preparation process; gender-affirming facial surgery and body contouring; voice therapy and/or surgery; as well as puberty blocking medication and gender-affirming hormones; counselling or psychotherapeutic treatment as appropriate for the patient and based on a review of the patient's individual circumstances and needs.(SOC-8 518)

The thesis discusses a small fraction of these procedures, such as gender-affirming hormones, puberty blocking medications, bilateral mastectomy and chest reconstruction and mental health counselling, because of the limited experiences of the people interviewed.

1.2. Background

To further discuss the healthcare received by TGD people, I will introduce the psychiatric diagnoses that TGD people receive and the importance placed on the psychiatric diagnosis in Latvia. The interviews were conducted in Latvia, and a significant amount of the examples are on interactions with psychiatrists.

For example, among TGD activists and theorists, it is discussed whether being TGD should or should not include a psychiatric diagnosis. . The primary argument against it is the medicalisation and pathologisation of an identity, because being TGD in itself is not a mental health issue. Emma Inch argues that it is in line with diagnosing other minorities as mentally disordered, as well as pronouncing any gender variance as disordered. Being *transgender* in itself, a mental health diagnosis may perpetuate negative attitudes towards it and marginalise TGD people further. Inch also argues that if TGD people experience higher rates of mental distress than cisgender people, it is because of societal treatment, which she calls transpredjudice. Transpredjudice expresses itself as employment discrimination, violence, hate crimes, and even outlawing gender affirming care in some regions. (Inch 2016)

The practice of diagnosing TGD people continues, primarily as a psychiatric diagnosis, but also in the category of "Conditions related to sexual health" in the International Classification of Diseases, 11th revision (ICD-11) and as a standalone category in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). One argument for keeping a diagnosis for TGD people could come from Allistair Wardrope. In his article "Medicalisation and epistemic injustice", Wardrope argues that medicalisation can help make sense of certain experiences for both patient and doctor. (Wardrope 2015) This is applicable to the case of TGD people who want to seek out GAC. To gain access to HRT or other medical interventions, the experience of being TGD is made clear through medical descriptors to both the patient and doctor.

There are three main diagnoses that TGD people get diagnosed with, depending on the healthcare system. I will describe the three to show the different aspects of being TGD that are brought to the front. First, the DSM-5- TR (The Diagnostic and Statistical Manual of Mental Disorders), clinically used in the United States, but also referenced in other countries, includes the diagnosis of F64.0 *Gender Dysphoria in Adolescents and Adults*. Gender dysphoria is defined as: "A marked incongruence between one's experienced/expressed gender and assigned gender…" [2] The DSM-5-TR centres dysphoria as the clinical problem and not the identity in comparison to the DSM-5, with *gender identity disorder.* (DSM-5-TR 512-513) This is an attempt to depathologize the identity.

The ICD-11, recommended to be in use by the World Health Organisation, includes the diagnosis of HA60 *Gender incongruence of adolescence or adulthood*. Gender incongruence is no longer classified under *Disorders of adult personality and behaviour and* is under the section of *Conditions related to sexual health;* thus is no longer classified as a mental health condition. Gender incongruence of adolescence or adulthood is defined as:

> Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis. (ICD-11)

The ICD-11 aims to be more inclusive and less pathologizing than the previous diagnoses, such as the ICD-10. It also emphasises that stereotypical gender behaviours and preferences are not central to the diagnosis. But most differently from the ICD-10, it removes references to the TGD individual preferring to identify with a sex they were not assigned at birth as, instead referring to an *experienced gender,* which is inclusive of non-binary gender identities. Technically *transsexualism* only refers to the binary trans experience.

[2] Cont. "of at least 6 months' duration, as manifested by at least two of the following: 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics). 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics). 3. A strong desire for the primary and/or secondary sex characteristics of the other gender. 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender). 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender). 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)." (DSM-5-TR 512-513)

The ICD-10, still used in Latvia and in other countries, includes the diagnosis of F46.0 *Transsexualism.* Transsexualism is classified under *Disorders of adult personality and behaviour*, *Gender identity disorders* and is described as:

> A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex. (ICD-10)

Besides the diagnosis of *transsexualism, the* legislative and socio-political context of the treatment of TGD people in Latvia is needed, as the interviews used for the application of the theories of epistemic injustice are conducted in Latvia. The situation with receiving GAC and TGD rights in Latvia lacks guidance and is rated on its legal and policy practices by ILGA (International Lesbian, Gay, Bisexual, Trans and Intersex Association) as far below the European average at 26%. (ILGA-Europe 2025) No official information on legal recognition or gender affirming care is available, besides the diagnosis of transsexualism and one article in "Regulations Regarding Registers of Civil Status Acts." That article is article 134.11. and in the official English translation states that changes to birth certificates can be made if:

> …the person has undergone complete or partial change of sex, and the entry regarding the sex of the person is changed in accordance with the sex indicated in a medical certificate issued by a medical treatment institution or a medical practitioner or another document confirming the change of sex.

Information provided by ILGA assumes that *sex change* and medical intervention assume sterilisation as a prerequisite to change one's legal sex in Latvia (ILGA-Europe 2025), but as found by the interviews conducted in this research, none of the interviewees who have changed their legal sex mention that they have undergone sterilisation.

What is usually sufficient is a doctor's note from one's endocrinologist. To get a doctor's note that confirms *complete or partial change of sex,* the endocrinologist, based on their own assessment, requires the TGD patient to take HRT for some time period. It does not seem possible to receive HRT from an endocrinologist without the psychiatric diagnosis of transsexualism. This is gathered from the descriptions of the TGD people interviewed for this thesis.

1.3. Methods

The objective of the data collection was to formulate the TGD patient-doctor relationship and show that epistemic injustice is applicable to it. The objective was proposed because previous research done on transgender and gender-diverse patient-doctor relationships notes

that patients often feel misunderstood, inadequate, and in need of better-informed specialists.(August-Rae et al. 2024; Akré et al. 2024)

Participants

The participants were recruited through a private messaging board that functions as a support and information network for the TGD community in Latvia. Four of the participants did not respond to the initial call for interviews, but were encouraged to participate through previous interviewees' recommendations, known as snowball sampling. The inclusion criteria were: adults (eighteen and older), identifies as transgender or gender diverse, has received gender-affirming care in Latvia. Seven participants responded and were interviewed. All participants signed an information and consent form, which also gave insight into the philosophical analysis that the data will be applied to. The research was approved by the Research Ethics Committee of the University of Tartu on the 20th of October, 2025, protocol number: 405/T-25.

The interviews were conducted online, via MS Teams. The interviews were from 32 minutes long to 75 minutes long, with one repeat interview conducted that was 8 minutes long. The average time of the interviews, excluding the repeat interview, was 45.7 minutes. All interviews were recorded and saved in audio format, then transcribed and pseudonymised. The central questions asked were: How would you describe the first doctor you ever saw with the intent of receiving gender-affirming care? How would you describe your best experience with a doctor when receiving gender affirming care? How would you describe the worst experience with a doctor? These and additional questions led to revealing the patients' histories with GAC. The interview process led to the revelation of the entire GAC journey of the interviewees and the attitudes of various healthcare providers. A large quantity of the encounters described are with psychiatrists and other mental health professionals.

The interview excerpts used were translated from Latvian to English.

I conducted interviews with two binary transgender men: Bill[3] and George, two binary transgender women: Lily and May, and three nonbinary transmasculine people: Sailor, Lou and Winter. In the thesis, I use the pronouns that were stated by the interviewees as their preferred in English.

[3] All names changed to ensure anonymity

All of the people interviewed, except for Lou, fit the same profile: early 20s, in higher education, started pursuing gender affirming care as soon as they turned 18, with five of them having discussed being trans with doctors as children or teenagers, they have been diagnosed with F.64.0 *Transexualism,* are currently receiving hormone replacement therapy, and all six of them have their legal name and gender marker changed or are in the process of doing so. Lou is an outlier; he is mostly socially perceived as a masculine person, but is not *out* to everyone, does not have a psychiatric diagnosis, and is not certain he wants to receive it. He has undergone chest masculinising surgery and wants to pursue a legal sex marker and name change. Bill is the only one who has been diagnosed with F64.2, *Gender identity disorder of childhood*.

Limitations

There are some limitations due to the method and scope of this research. The qualitative data is not representative of all TGD patient experiences in Latvia and does not qualify to represent the average TGD patient's experience. Most of the interviewees are in the same age range and of similar educational level, possibly as a result of snowball sampling.

The qualitative data also tackles only the patients' experience, so it leaves out the perspective of the practitioner. The analysis is also based on the memories of the experiences of the patients and applies the theory to the examples as given. This allows to see how the theories apply, but does not make any truth claims about the medical professionals described.

Although the data does not aim to be representative of the TGD experience or the average Latvian doctor's attitudes towards TGD people, it does give a sample of what the interaction could be like as well as landing itself to the analysis trough the concepts of epistemic injustice.

1.4. Thematic analysis

Thematic analysis , developed by Virginia Braun and Victoria Clarke to analyse qualitative data in psychology, tackles qualitative data through recognising reoccurring patterns which lead to developing themes. Thematic analysis includes six phases: familiarising yourself with your data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, producing a report. (Braun and Clarke 2006) Thematic analysis was applied to the collected data, and four themes were identified: age discrimination, gender identity discrimination, healthcare anxieties and gatekeeping attitudes. Thematic analysis

shows repeating patterns in the gathered experiences, which reveal the similarities between the individual experiences. The thematicization of the data allows to appropriately group together separate experiences, so that they can further be analysed as sets of attitudes displayed in the TGD patient- doctor relationship. All quotes selected for analysis and sorted into the themes can be seen attached in the appendix.

Identified themes

With the application of the thematic analysis, four themes were identified. The themes are: age discrimination, gender identity discrimination, healthcare anxieties and gatekeeping attitudes. I will introduce the themes and give context and examples as I will operate with the themes in the further analysis.

Age discrimination

The first theme that appeared was age discrimination, which at first glance does not seem related to the case of TGD patients, but the intersection of the identities reveals an additional layer of discrimination. Age discrimination appears in the interviewees' reports as not being taken seriously as children and adolescents by healthcare providers, especially in the intersection of their identity as underage TGD people. In adolescence, interactions in which they experience dismissal, in most cases, lead them not to receive any GAC or support. Three of the interviewees (George, Bill, May) describe receiving the suggestion that they will grow out of being trans. Attitudes of dismissal and talking down are prevalent in this theme.

Sailor (nonbinary transmasculine) describes seeing around eight psychologists as a child wanting support with being TGD. Recalling one of his experiences as an adolescent, he verbatim states not being taken seriously due to being underage, “When I was around 13, 14, for example, seeing the psychologists, it felt like they didn't take me seriously because I was a child. I was a teenager, and instead of doing something useful in the sessions, they made me play with sand.” (Sailor)

May (trans woman) recalls her transness being denied more directly while underage, “That [seeing a psychiatrist] was my earliest attempt to talk about trans things. I got told that I had rapid-onset gender dysphoria and was let go.” (May) The suggestion of rapid-onset gender dysphoria is a suggestion of out-growing being TGD, because the concept entails that it is a socially acquired sense of transness in children. Rapid-onset gender dysphoria was

constructed to disregard TGD youth and has never been a real diagnosis or proven true. (Ashley 2020)

Gender identity discrimination

The second theme is a more expected one, because TGD people experience discrimination due to their identity in all sectors of life. It groups together interactions with healthcare workers that display direct discrimination because of the TGD person's gender identity or expression. This theme includes both descriptions of healthcare interactions where outright negative attitudes are described, as well as the expressed fears of such attitudes. Fear or discrimination is also revealed in interviewees' thoughts on general attitudes towards TGD people that motivate these fears.

Some healthcare providers directly state their expectations of gender expression, “She [the psychiatrist] said, “Well, everyone else that sees me to receive this diagnosis [F.64.0] looks very masculine and maybe acts masculine, but I see a feminine woman in front of me.” (Winter, nonbinary) Being questioned on one's appearance while seeking GAC is an example of discrimination based on gender expression and is incompatible with the common aim of receiving GAC – changing one's appearance.

Healthcare anxieties

The third theme that appears in the interviews is healthcare anxieties and an expressed fear of doctors. This appears as described worries of doctors not being qualified to work with TGD patients, fear of doctors blaming being TGD on unrelated health issues, as well as two of the interviewees (Lily, Bill) saying that they got lucky with their healthcare interactions. Alluding to luck means that their expectations were low before pursuing GAC.

The concept of unrelated health issues being blamed on being trans is known as “trans broken arm syndrome” coined by Naith Payton (2015), and while none of the interviewees describe this happening directly, there is fear of it happening. “[What if] They basically say that “all of your problems are because you use testosterone” and/or [they say] “you have problems only because you are trans”.” (Bill, trans man)

The *bare minimum* positive attitudes are seen as exponentially positive, because the expectations of treatment are very low. "She [the surgeon] is professional, polite and takes people seriously. Which, like, sounds like nothing, but the bar is so low that every time I saw her, I was like, a literal angel has walked through the door" (Lou, nonbinary transmasculine)

The theme of healthcare anxieties is informed by both general attitudes towards TGD people, previous healthcare experiences and other TGD peoples experiences with healthcare shared in the community.

Gatekeeping attitudes

The last theme identified is gatekeeping attitudes. The theme of gatekeeping attitudes reveals interviewees experiences with the healthcare system. There is no official information on GAC in Latvia, the only available information is community-organised. That is also an example of gatekeeping of GAC. This concept is borrowed from Nick Clanchy's formulation of the United Kingdom's National Health Service's system of providing gender-affirming healthcare. (Clanchy 2024)

This theme is illustrated by reports of having to lie to psychiatrists to fit narratives of binary transness and psychiatrists and mental health providers insisting on a different cause and solution for mental strain after being told by the patient that it is TGD-related. This theme is closely related to the themes of gender discrimination and healthcare anxieties, but is separate, as it includes a specific kind of gender discrimination that is less concerned with the TGD person's gender expression and more with handling access to GAC with extra precaution. It is separate from healthcare anxieties, because this theme concerns only those interactions in which gatekeeping attitudes shape the healthcare anxieties.

I went to him [a psychiatrist] and said that I think that I am a woman, could I, please, get a diagnosis and a referral to an endocrinologist? Then he asked me questions that were useless. Started asking me about my sex life and love life, like what gender I like and which gender I want to sleep with and things like that. And then he prescribed me antidepressants for three months and said to take those and then come back. "Let's see if your thoughts have changed about this topic"...Then I come back after three months, and he looks at me and says, "Yes, okay, I'm giving you a diagnosis and referring you to the endocrinologist. " But there's important context. Before I went to the psychiatrist, I got a psychological evaluation from a psychologist, where I did the dysphoria test and a personality assessment, and I went to the psychiatrist with this document in hand. (May)

Not trusting both the TGD patient and her previous assessments is a form of gatekeeping access to GAC, even if it can also be seen as a form of further assessment.

The four themes: age discrimination, gender discrimination, healthcare anxieties and gatekeeping attitudes will further be analysed through the concepts of epistemic injustice to conclude if epistemic injustice occurs in the healthcare interactions of the TGD people interviewed.

2. Testimonial injustice

2.1 Theoretical framework

This chapter addresses the first type of epistemic injustice described by Miranda Fricker: testimonial injustice. This chapter consists of two parts. The first part explains the concept of testimonial injustice and testimonial smothering. The second part applies these concepts to the analysed interviews.

Testimonial injustice occurs when a judgment is made specifically disregarding someone's testimony because of their identity. Miranda Fricker illustrates it with the example of Harper Lee's *To Kill a Mockingbird.* The book is about the trial of Tom Robinson, a black man who is accused of raping a white girl in the 1930s. Tom Robinson is provably innocent, but the white jury finds him guilty and would find him guilty no matter what he says and what they believe the truth to be, because of prejudice. Fricker says, " …there are those on the jury for whom the idea that the black man is to be epistemically trusted and the white girl distrusted is virtually a psychological impossibility." (Fricker 2007, 23-26)

Miranda Fricker's conceptualisation of testimonial injustice can be traced in three steps. First, she establishes identity power that enables some identities to be assessed as holding specific kinds of power. Second, hearers' identity power leads to the making of credibility judgments based on a speaker's identity. Third, identity prejudice factors into creating the systematic nature of testimonial injustice. Testimonial injustice leads to two levels of harm: primary and secondary. (Fricker 2007, 9–29) Testimony here includes all cases of telling with the point of conveying knowledge. (Fricker 2007, 61)

Identity power is a type of social power. Social power is power held by agents that can impact the functioning of the social world. It is present even when it is not being directly put into action. Identity power is a social power that operates on an agential level, with a particular agent exercising power over another agent based on shared conceptions of their identity or identities. She illustrates this with the example of gender as the identity that lends itself to both identity power and identity prejudice. A man is able to dismiss a woman based purely on the fact that they are seen as a man and a woman, and that the particular roles get ascribed different characteristics, and are stereotyped. For identity power to work, concepts that enable it must be present. That is why Fricker emphasises the role of *collective social imagination* with the formulation of identity power.(Fricker 2007, 9–15)

In healthcare interactions, this appears in the roles of doctor and patient. It is certain that a doctor has some justified power over a patient. As H. Carel and J. Kidd point out, the doctor is trained and an expert in their field, thus receives epistemic privilege- identity power. Due to this, healthcare professionals are given power over the interpretation of patients' testimony and make credibility judgments. (Carel and Kidd 2014, 530)

Credibility judgements are the perceptions made of the speaker that allow or block the intake of the knowledge they are communicating. (Fricker 2007, 66) Credibility is also constructed based on shared social ideas of different social groups –stereotypes. (Fricker 2007, 17) Fricker calls the two types of credibility misjudgements credibility excess and credibility deficit. A credibility deficit is when a speaker does not get attributed with the credibility that she otherwise would have, if not for prejudice. Credibility excess is a speaker being attributed with too much credibility due to identity power. (Fricker 2007, 17) Fricker points out that making a wrong credibility judgement is not always prejudiced but can arise from a mistaken attribution of a lack of credibility to someone. Credibility deficit caused by prejudice is what constitutes testimonial injustice. (Fricker, 2007 23)

Testimonial injustice *tracks subjects through different dimensions of social activity.* Testimonial injustice is based on negative identity prejudice or tracker prejudice, which is prejudice against a subject's identity that has the quality of *tracking subjects.* (Fricker 2007, 27–28) Testimonial injustice is a structural injustice that operates on an agential level based on the persisting social identities of the agents involved in the exchange, in which the speaker experiences a credibility deficit and the hearer holds identity power.

It has been pointed out by Francisco Javier Gil Martin that a credibility deficit could be caused by other affects, such as envy or desire, but Fricker points out that in the case of testimonial injustice, the prejudice against a speaker is central, because in other cases, a credibility deficit can be justified and does not cause a testimonial injustice. (Fricker 2008)

The primary harm of testimonial injustice is epistemic objectification. Fricker formulates it as, “when a hearer undermines a speaker in her capacity as a giver of knowledge, the speaker is epistemically objectified.” (Fricker 2007, 133) Epistemic objectification occurs when a speaker is not seen as an informant but as a source of information. Not being seen as an informant does not allow a speaker to share knowledge. Being treated as a source of information is equitable to being treated as a *mere* object, which denies a person’s subjectivity. (Fricker 2007, 132-133)

The secondary harm branches into practical – direct tangible consequences and epistemic – losing belief in one's own *capability as a knower*. The secondary harm, when practical, can be a one-time occurrence of a personal disadvantage. Fricker gives the example of not receiving a promotion due to being a woman. (Fricker 2007, 46) The epistemic harm of the secondary harm of testimonial injustice leads to a speaker losing belief in their own testimony. It can be a one-off occurrence, but it can also impact one's entire impression of self and ruin future endeavours as a speaker and knower. (Fricker 2007, 47–48) The secondary harms have more direct, tangible consequences on the life of someone affected by testimonial injustice.

The practical harm could be illustrated with gender-affirming care being gatekept, as discussed by Nick Clanchy. The gender-affirming care model in the United Kingdom can be classified as that of a gatekeeping model. It requires, first, a referral and then two separate diagnostic instances and then a long way of waiting in lines. Receiving gender affirming care is treated with extreme precaution. (Clanchy 2024, 695) This can be a hurdle in the way, but it can also lead to Fricker's described epistemic harm of the secondary harm of testimonial injustice. Lorusso et al. refer to this as self-gatekeeping, in which a TGD patient does not believe themselves to be "trans enough" due to not having access to GAC, feeling like they do not fit diagnostic criteria or wanting to pursue GAC. (Lorusso et al. 2025)

Testimonial injustice occurs when an agent is dismissed as a knower based on their and the hearer's identity. This leads to two levels of harm: primary and secondary. The primary level harm is epistemic objectification, but the secondary level harm leaves an immediate impact on the speaker's life.

Testimonial smothering

Another type of epistemic injustice I want to address is testimonial smothering. Testimonial smothering occurs differently from testimonial injustice, but stems from similar areas of prejudice. Testimonial smothering occurs before the harms of testimonial injustice can be done to the speaker, but after one has recognised their own credibility deficit.

Testimonial smothering was formulated by Kristie Dotson in her 2011 article, "Tracking Epistemic Violence, Tracking Practices of Silencing." Building upon the idea of epistemic violence, Dotson establishes two types of epistemic violence: testimonial quieting[4] and testimonial smothering. Epistemic violence is based on the reciprocal nature of communication, in which a speaker is dependent on the hearer, or audience, to meet their linguistic needs, or as Dotson puts it, "meet them halfway." (Dotson 2011, 238) When the hearer refuses or fails to do so, epistemic violence has been enacted.

Testimonial smothering occurs when a speaker does not say exactly what they mean, because they are made to understand that their account will not be understood, will not be taken into consideration or will get misinterpreted. In the case of testimonial smothering, the speaker will alter their testimony so it is more easily digestible or less controversial to the listener. Testimonial smothering is a kind of coerced silencing, where the coercion is the testimonial incompetence of the hearer. Dotson formulates three conditions for testimonial smothering to occur: when the content of the testimony is unsafe and risky, the hearer is incompetent and pernicious ignorance is present in the hearer. (Dotson 2011, 244)

The first condition of testimonial smothering is not providing testimony that Dotson calls *unsafe.* It is unsafe in that it has the potential of reinforcing stereotypes about already heavily stereotyped groups, which can cause them *social, political, and/or material harm.* Dotson provides the example of women of colour staying silent in cases of domestic violence to avoid reinforcing the stereotype of violent men of colour. (Dotson 2011, 244)

The second condition of testimonial smothering is a listener who is unable to understand a potentially provided testimony. Dotson calls the ability to understand a speaker's testimony or to notice that she is not understanding *accurate intelligibility. Accurate intelligibility* from the speaker's point of view is *testimonial competence.* The demonstration of *testimonial competence* from a listener is assessed by the speaker. A speaker can tell if they are being comprehended. The opposite of *accurate intelligibility* and *testimonial competence* is *inaccurate intelligibility and testimonial incompetence,* which is a failure to demonstrate that she is understanding the testimony being provided to her. Dotson provides the example

[4] Testimonial quieting comes from pernicious ignorance. That is, from ignorance that causes harm to the speaker from the hearer not reciprocating in exchange of meaning. (Dotson 2011, 239) Not being understood disregards the speaker in a way that they might as well have stayed silent, because what they did say was not taken into consideration. Testimonial quieting could be seen as type of testimonial injustice.

of microaggressions against Black Americans as an expression of testimonial incompetence. (Dotson 2011, 245-246)

The third condition of testimonial smothering is when a *testimonially incompetent* listener also holds pernicious ignorance. Pernicious ignorance can come from social situatedness, which creates an *unknowing* of certain knowledge that other groups have available. Dotson states that this socially situated unknowing in a listener leads to *unconscious microinvalidations,* which let the speaker understand that they will not be understood/ are not being understood. (Dotson 2011, 248)

The situatedness of testimonial incompetence can be compared to Fricker's idea of identity power. The hearer that is testimonially incompetent also holds identity power in that testimonial exchange and in society. It is impossible to remove these agential interactions from their structural situatedness.

Testimonial smothering shows up in TGD patient-specific cases through patients keeping information from doctors and withdrawing from receiving healthcare entirely. Research done on Italian TGD people's interactions with psychologists shows that devaluation leads to avoidance, because TGD people feel like they must pre-emptively protect themselves from judgment and being misunderstood. (Lasio et al. 2025) Another case of smothering is TGD patients not disclosing their non-binary TGD identities to providers due to fear of not receiving care, due to expected gender essentialist and normative views from the doctors. (Wright et al. 2021)

2.2 Results

The second part of the chapter applies the described concepts to the collected and thematically analysed data to show how testimonial injustice occurs in the thematised interactions. Testimonial injustice is applied to the following themes: age discrimination, gender identity discrimination and gatekeeping attitudes. The criteria for testimonial injustice are the exercise of identity power and the ascribing of a credibility deficit to a speaker, which results in the primary harm of testimonial injustice of epistemic objectification and a secondary harm. Each theme and an example from each theme will be brought out to analyse the application of the concepts and to make the conclusion if testimonial injustice occurs across the theme.

This part of the chapter also applies Dotson's concept of testimonial smothering to the theme of gatekeeping practices.

Identity power

First, I will prove that the three themes: age discrimination, gender identity discrimination and gatekeeping attitudes, reveal identity power being exercised. Doctors hold identity power in the doctor-patient relationship as they decide over the patient's testimony and can make decisions based upon it. This is often justified due to the practitioner's knowledge and experience in the field. (Carel and Kidd 2014, 530-531) The doctors' identity power in itself does not mean that a testimonial injustice is occurring, but it is the setup for the injustice to occur, because one agent holds power over the other. With the analysed cases, it is not only the identity of the doctor that holds power. Identity power also comes from being the majority – cisgender and an adult. Identity power is exercised against other identities that are recognised in *the collective social imagination*, using Fricker's term. (Fricker 2007, 15)

With the theme of age discrimination, the doctors' identity as a doctor (or other healthcare provider) is tied up with their identity as an assumed, cisgender, adult against the social identities of underage TGD patients. First, they hold power over their patients as doctors due to their profession and expertise. Second, as the gender majority, they work in accordance with cisnormative expectations of gender and third, as adults working with children, they employ more authoritative attitudes:

> I wasn't the only trans person there [the hospital], and I could feel that the nurses simply didn't respect it. Because we were teenagers and we will grow out of it… But gender wasn't the defining cause for the disrespect [from the nurses], but it played a role… There was a daily schedule where my friend changed my deadname to my chosen name on it, and the nurses got disproportionately pissed. (Bill)

In this example, the nurses can change the name to what they see fit because they hold identity power over the underage TGD patients, even if the display of legal names was necessary. The disrespectful attitude referenced is also possible with no consequences due to the identity power of an adult against a child, especially an underage patient seeking care. Both are vulnerable positions.

The theme of discrimination because of gender and gender expression reveals two of the same previously described identities. That of a doctor and that of assumed cisgenderness. In this theme, cisnormative expectations of gender are imposed onto TGD people, with the identity power of being cisgender expressed over a transgender person. This impacts gender nonconforming and nonbinary individuals more prominently, as their identity is even more

marginalised than binary, gender conforming transgender people. In this theme, one's gender identity or expression gets questioned by those with normative gender expressions and identities because of identity power.

She [the psychiatrist] said, “Well, everyone else that sees me to receive this diagnosis [F.64.0] looks very masculine and maybe acts masculine, but I see a feminine woman in front of me.” "I don't know why. I had bright pink and purple hair then, that wasn't short, a little longer, but with the goal of getting a diagnosis [F64.0], I had tried to show my masculine side, I dressed very masculine, as much as I could." (Winter)

In this example, the psychiatrist has decided on what is *masculine* and what, she assumes, a transgender man should look like and is imposing this onto Winter. As the majority, the cisgender doctor holds the identity power to do so. As a doctor, she can make the final decision on whether to take their testimony into consideration and diagnose them or not.

Similarly, the theme of gatekeeping practices focuses on doctors' power over patients' healthcare outcomes. The identity power doctors hold as professionals in their field is the identity power revealed in this theme. Since a psychiatric diagnosis is required to receive further GAC, psychiatrists hold the key to accessing further GAC. If a psychiatrist is not convinced, further GAC is not possible, even if the psychiatrist has made a misjudgement.

If you can convince a psychologist, psychiatrist that you are trans, that you need to transition, then everything else goes smoothly. After that the doctors have something to base their trust on. That’s why, afterwards [receiving the F64.0 diagnosis], I haven’t had any problems convincing anyone. (Sailor)

In this particular example, it is revealed that the system requires practitioners to trust only those who hold the same position as them professionally in making decisions about access to GAC.

It can be seen that across the three themes examined, identity power is exercised. These expressions of identity power lead to credibility judgments.

Credibility deficit

In the occurrence of testimonial injustice, a speaker is ascribed a credibility deficit from the hearer due to tracker identity prejudice- negative identity prejudice against a subject's identity that has the quality of *tracking subjects.* The three themes reveal TGD patients not being believed due to being children, due to being TGD or their gender expression and due to the system in place that prioritises healthcare outcomes that do not lead to receiving GAC.

In the theme of age discrimination, the identities that lead to a credibility deficit are being underage and being TGD. Being a child is an identity that tracks one through all social

spheres, as well as being a TGD child. The people interviewed report that they were trusted far less as children, especially in cases in which they were not believed to be TGD and also not provided with any mental health support when seeking it. As children, their TGD identity is expected to be a phase. This is an example of a credibility deficit.

"That [seeing a psychiatrist] was my earliest attempt to talk about trans things. I got told that I had rapid-onset gender dysphoria and was let go." (May) Rapid-onset gender dysphoria was constructed to dismiss TGD children as TGD, pronouncing it a socially infectious phenomenon. (Ashley 2020) Here, May was not believed to be really transgender, but socially *infected*. Even if the psychiatrist believed that May was experiencing socially contagious dysphoria, he did not offer her any advice or refer her to another professional to improve her well-being.

The theme of gender identity discrimination reveals a credibility deficit afforded to TGD people, not explicitly because they are TGD, but because of their gender expression and the general lack of comprehension of non-cisgender identities. This leads to the identity that is being prejudiced against to be their gender identity anyway. The agents with identity power see TGD speakers as lacking credibility due to their gender identities not making sense to the hearers.

They called me from the reception [of a hospital] and asked, "Hey, do you as a male really need a gynaecologist's appointment?" Then, I had to explain that I have not made a mistake and that I have the right parts, and I basically had to justify that everything is correct, and I know who I am; I was born a woman. “I did not like that I had to argue about it. Sorry, but it’s none of your business. I made a gynaecologist's appointment. I don't have to reason about why I did that. (Bill)

While confirming if a mistake had been made would have been justified, questioning him further shows that the receptionist ascribed a credibility deficit to the legally male patient, because she could not conceptualise being transgender.

The theme of gatekeeping practices reveals how the requirement of a diagnosis from a psychiatrist and the mental health struggles related to being TGD, such as anxiety and depression, place the identity of a mental health patient onto TGD people, which in turn gives them the credibility deficit attributed to mentally ill people. This could be the case of a mistaken identity credibility deficit (Fricker 2007, 22) , as being TGD itself is not a mental illness, thus perceiving TGD people as mentally ill is a mistake and not an identity that tracks them through various social spheres. The mental distress caused by transpredjudice and a lack of access to GAC puts most people into the same vulnerable position as mentally ill people. The mental distress caused does track the TGD people throughout all social spheres

and the cause for the social marginalisation is structural, so the credibility deficit is not incidental and is a case of tracker identity predjudice.

"I wanted the diagnosis [F.64.0], but he [a psychologist] spent most of the time diagnosing me with Asperger's and trying to help with my anxiety, even though I had explained that my anxiety is most likely due to not being in my body." (Sailor) This example shows that the accompanying mental struggles experienced from the inaccessibility of GAC are being redirected to other causes or the symptoms, such as anxiety, are being treated without addressing the cause. Three of the interviewees (Sailor, Lily, May) recall instances of mental healthcare providers aiming to find a different cause or solution for the mental strain caused by a lack of access to GAC.

Harms of testimonial injustice

When those with identity power attribute a credibility deficit to agents due to an identity prejudice, a testimonial injustice occurs. The analysis of the themes shows that testimonial injustice occurs in different kinds of TGD patient-doctor (and other healthcare worker) interactions. Testimonial injustice leads to two types of harm. The primary harm of testimonial injustice is epistemic objectification, and the secondary harms are direct tangible consequences or a loss of belief in one's own capability as a knower. (Fricker 2007, 133; 46)

In all three of the themes, epistemic objectification can be seen. The healthcare employees take the testimony provided by the TGD people as information that supports their already held beliefs, or do not take it into account entirely, instead of taking the provided testimonies into consideration.

The theme of age discrimination shows that there is an expectation of *outgrowing* being trans, even if there is nothing that would point to that being the case. It is the healthcare providers' correct assumption that most people are cisgender, but it is incorrect in the cases presented here. The healthcare providers would be able to discern that the people are TGD if they considered the underage TGD patients as knowers. With the TGD people referring to their childhood experiences, it might even read as projected hope from the doctors that the TGD people will *grow out of it* and that the TGD people do not know that to be the case only because they are still children.

The theme of discrimination due to gender identity and expression shows that, again, TGD people are not believed in their claims of their own gender. If taken as knowers, it

would be enough for them to state their identity for it to be believed. The same occurs in the cases thematised under gatekeeping attitudes; the interviewees' reports show that there are practitioners who cannot be convinced of the speakers trans identity, and others take effort to be convinced.

The practical consequence in all three themes is denied or delayed access to GAC, and a cause for future healthcare anxieties. The theme of healthcare anxieties, in part, reveals the secondary harm of testimonial injustice in healthcare settings.

Testimonial smothering

For testimonial smothering to occur, all of Dotson's conditions have to be met. The conditions are: testimony being potentially unsafe, testimonial incompetence and pernicious ignorance. In this part of the chapter, I apply Dotson's conditions to the theme of gatekeeping practices to see how it proves that testimonial smothering occurs in the TGD patient-doctor relationship.

Four quotations from three different interviews (Winter, Sailor, Lily) in the theme of gatekeeping show the interviewees withholding or altering their testimonies out of fear of not receiving GAC. With knowledge and previous experience of how the healthcare system functions, they go into the interactions prepared to make their experiences more palatable.

I went to the psychiatrist, and I was like, yes, from the age of four, I've hated the colour pink, and I hate dresses, and then the same night, I went to celebrate getting the diagnosis in a skirt. I lied to her a lot. She gave me a psychiatric evaluation, and I acknowledge that it wasn't right to do, but I lied a little and said that everything's alright…I went to the psychiatrist with only one thing in mind, and that was that I needed the diagnosis, and I needed it in this visit, not the next one or after five. It is unfair to yourself to remove the opportunity to help yourself, but at the same time, I didn't want antidepressants or anxiety medications; I wanted the diagnosis, so it's understandable...If something is wrong [with you], then the chance of getting a diagnosis is very slim, which is, there isn't a better word for it than, stupid. (Winter**)**

The first condition that has to be met for testimonial smothering to occur, the testimony has to have the potential of being unsafe- cause social, political, and/or material harm. (Dotson 2011, 244) With the example given here, *telling the full story* is potentially unsafe to the speaker, as it could discredit them as TGD and redirect the attention to their mental health. The theme of gatekeeping attitudes reveals this theme throughout- being seen as mentally ill is unsafe if the goal is receiving GAC. A second layer of unsafe testimony is the reinforcement of gender stereotypes, because being gender nonconforming can enforce the idea that someone is not *trans enough,* which would again lead to the denial of GAC. The interviewees try to avoid their identities being denied.

It has always been hard. Believing myself that this (being trans) is real, and then in addition trusting another person, a person who is in a position of authority, and holds power. I can go to someone and say, “Hey, I am trans”, and that person can say, “No”, and deny me treatment. (Lou)

The second condition that has to be met is that of a listener who is unable to understand a potentially provided testimony, has to demonstrate testimonial incompetence. (Dotson 2011, 245-246) The descriptions of the practitioners in the theme of gatekeeping show that the interviewees see the practitioners as testimonially incompetent. They mention exaggerating and having to keep the conversation on track.

Specialists without previous experience believe that it's [being TGD] nothing serious or look for other causes, of other things they could prescribe, diagnose, or look for other explanations for the patients' complaints… With the specialists who weren't recommended to me, I was being honest, but at the same time, maybe exaggerated the impact that the feelings have on me a little. Or they would believe it's nothing serious and look for another cause. (Lily)

The conversations have to meet the healthcare providers on their level of understanding, instead of them understanding the unfiltered testimonies of the patients.

The third condition of testimonial smothering is when a testimonial incompetent listener also holds pernicious ignorance that leads to microinvalidations. (Dotson 2011, 248) With the offering of other causes for their mental distress, the mental health specialists invalidate the TGD experience to some extent. They offer other causes and other solutions while denying access to GAC.

[The psychologists asked] “So do you have anxiety when going to school?” I said, yes I am more anxious in social settings than at home, they were like, “ok, so you are getting bullied” I said, “no, I am just uncomfortable being surrounded by people if they don’t perceive me the way I perceive myself” and they go, “so you are being bullied” or maybe “you are overworked”, because I had really good grades and did a lot of extracurriculars." (Sailor)

This shows that in the theme of gatekeeping, the TGD people also experience testimonial smothering, because of how the healthcare system receives TGD patients who are seeking gender-affirming healthcare.

Conclusion

This chapter proves that the concept of testimonial injustice applies to the TGD patient-doctor interactions recorded. All three of the themes reveal the identity power of doctors and the credibility deficit assigned to the patients caused by tracker prejudice. Each one of the themes has examples of the primary harm of testimonial injustice- epistemic objectification and all of the themes show secondary, practical harms of testimonial injustice.

This chapter also shows that instances of testimonial smothering are common with the interviewed TGD patients. The interviewees report lying and being afraid of not being understood due to their social positions as TGD patients, which results in the coerced silencing of testimonial smothering.

3. Hermeneutical Injustice

3.1 Theoretical Framework

The third chapter will look at hermeneutical injustice. Hermeneutical injustice is the second type of epistemic injustice described by Miranda Fricker. This chapter consists of two parts. The first part introduces the concepts of hermeneutical injustice and willful hermeneutical ignorance. The second part applies these concepts to the interviews.

Fricker defines hermeneutical 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." (Fricker 2007, 155) She illustrates the concept with the example of sexual harassment described in Susan Brownmiller's memoir *In Our Time*. As an employee of Cornell University, Carmita Wood was experiencing unwanted attention and sexual advances from a professor, which led to her experiencing stress-related physical symptoms and, as a result, quitting her job. Then, she tried to apply for unemployment insurance but could not communicate what had occurred to the insurance investigator, because *sexual harassment* did not have a name yet. Fricker shows that without the concept of sexual harassment available, victims of sexual harassment experienced a hermeneutical injustice, because they were harmed and wronged by the lacuna in collective hermeneutical resources. (Fricker 2007, 150-151)

Hermeneutical injustice is caused by gaps in collective hermeneutical resources that come from *hermeneutical marginalisation,* which is perpetuated by *structural identity prejudice.* Just like testimonial injustice, hermeneutical injustice leads to a primary and secondary harm done to the subject. Fricker notes that hermeneutical injustice is different from testimonial injustice in the way that it is not perpetuated by agents; it is a purely structural injustice that comes from hermeneutical marginalisation of an agent, or usually, a social group. (Fricker 2007, 159)

Collective hermeneutical resources are shared tools of social interpretation. (Fricker 2007, 7) Groups that are prevented from adding valuable meanings to the shared interpretive resource pool are *hermeneutically marginalised.* It is a social powerlessness. (Fricker 2007, 153) For example, Fricker and Jenkins write that historically, "The healthcare worker learned very little of trans experience from the "patient", because the prejudicial pathologisation blocked crucial aspects of the informational flow." (Fricker and Jenkins 2017, 272) This means that trans people are hermeneutically marginalised in healthcare contexts.

Hermeneutical marginalisation tends to lead to *structural identity prejudice. Structural identity prejudice* is the biased rendering of the pool of hermeneutical resources, the misrepresentation of socially powerless groups' experiences. It is the persistent rendering of some groups as socially powerless. Structural identity prejudice and, as a result, hermeneutical injustice, track the subject through social activities, same as identity prejudice. Structural identity prejudice insists on not letting the hermeneutically marginalised access to meaning-making practices. (Fricker 2007, 155-156)

The primary harm of hermeneutical injustice is experiencing an unfair disadvantage of making ones experience intelligible. The secondary harms are the epistemic and practical consequences. (Fricker 2007, 162- 163) Fricker defines the primary harm of hermeneutical injustice as "that the subject is rendered unable to make communicatively intelligible something which it is particularly in his or her interests to be able to render intelligible". (Fricker 2007, 162) Returning to the example of sexual harassment, according to Fricker, neither the woman, Carmita Wood, being harassed nor the harasser could make sense of the treatment, but it harmed only Carmita Wood. Because even if the harasser could not make sense of what he was doing, it was not in his interests to render the experience intelligible. The professor and other harassers actually benefit from the victim's inability to communicate the wrongdoings. (Fricker 2007, 162)

The secondary harm splits into practical and epistemic, which both further *collective hermeneutical impoverishment*. It is the direct consequence of the unavailability of concepts to describe one's situatedness. The practical harm is the inability to describe one's situation to another, which can result in harmful effects to the subject. (Fricker 2007, 162-163) Fricker also notes that this can result in a distorted construction of selfhood. (Fricker 2007, 163;168) The epistemic secondary harm of hermeneutical injustice is losing faith in one's own ability to *make sense of the world.* (Fricker 2007, 163)

In Fricker and Jenkins article, both kinds of secondary harms are described. They describe misgendering as a practice of identity-related harm with practical consequences. Fricker and Jenkins give the example of a transgender woman being murdered in prison because of misgendering- being placed in a men's prison. They also address the distortion of selfhood as another type of identity-related harm, in which a trans person denies their identity and tries to live as the gender they were assigned at birth, either to fit in or due to not having other concepts available. (Fricker and Jenkins 2017, 275) Not having the concept of

transgender available as a trans person would have the consequence of not being able to make sense of oneself and the world.

Hermeneutical injustice occurs when structural identity prejudice prevents agents or social groups from being involved in producing epistemic resources, which in turn results in the perpetuation of their marginalisation.

To reveal another aspect of hermeneutical injustice, I bring in the theory of willfull hermeneutical injustice. Willfull hermeneutical injustice was introduced by Gaile Pohlhaus Jr. in her 2012 article “Relational Knowing and Epistemic Injustice: Toward a Theory of Willful Hermeneutical Ignorance.” This is another form of epistemic injustice that is both agential and structural.

Willful hermeneutical ignorance arises from the interplay of a knower's situatedness socially and the need to make sense of her world through collective epistemic resources. (Pohlhaus 2012, 716) A willful hermeneutical ignorance occurs when the situatedness and interdependence result in available epistemic resources not being utilised in understanding. That is, a marginalised speaker either is providing the necessary information, but is not understood due to the listener's inability to uptake information from said group, or the necessary hermeneutical resources exist, unlike in the case of hermeneutical injustice, but the structural identity prejudice keeps them from being added to the dominant pool of epistemic resources. (Pohlhaus 2012)

This occurs because, “…it is of no immediate use to those in dominant positions to acquire and use epistemic resources that make sense of experiences that are salient to those marginally situated.” (Pohlhaus 2012, 719) This leads to further structural issues of information that is marginal staying marginal, but also to practical issues such as not being understood in the moment, same as if the necessary concepts did not exist.

3.2. Results

In this part of the chapter, I will apply hermeneutical injustice to three of the themes: gender identity discrimination, gatekeeping attitudes and healthcare anxieties. Hermeneutical marginalisation perpetuates structural identity prejudice. Hermeneutical marginalisation leads to hermeneutical injustice, with the primary harm of the inability to make intelligible what is in the subject's interests to make intelligible (Fricker 2007, 162) and the secondary

harms that are the practical negative consequences and the loss of faith in one's own sense to render the world. (Fricker 2007, 163)

Hermeneutical marginalisation

As a marginalised community, TGD experiences do not construct the mainstream narratives about gender. The less conforming to binary cisgender imagery, the less recognised and familiar TGD experiences become.

Experiences thematised under discrimination and fear of discrimination due to gender identity and expression reveal that TGD patients are afraid that their experiences are unintelligible to healthcare professionals.

“I didn’t say that I’m a nonbinary person, because I was very scared that they wouldn’t understand and I would have to see a psychiatrist again. I said that I'm a trans man." (Winter) This is a case where the interviewee feels the need to simplify their identity to present it in a digestible way to the psychiatrist. Not mentioning one's nonbinary identity in the context of their transness shows that hermeneutical marginalisation is in power. The concept is assumed to be seen as out of place in a medical context by the speaker. While nonbinary people themselves understand their identity, communicating to others seems impossible in certain circumstances, which in turn reinforces the wider unfamiliarity of the concept and furthers collective hermeneutical impoverishment.

The theme of healthcare anxieties shows that there is a fear of general unfamiliarity with TGD identities among healthcare practitioners. This shows hermeneutical marginalisation, because TGD people know their identities to be so marginal that the chance of interacting with a doctor who has never heard of TGD people is a common fear. More so, there is no outwardly trans-friendly or specialised gender clinic in Latvia, and all of the information on trans-friendly doctors is word-of- mouth. Unless somebody has recommended a doctor, there is no certainty that one will not be the first TGD patient.

"It can just be awkward, unpleasant, because if I go to some kind of rural lady, who is a general practitioner, who has never heard about trans people, that wouldn’t be pleasant. It wouldn’t be pleasant for me, and it just wouldn’t be pleasant for her." (Lou) The possibility of never having heard of trans people shows hermeneutical marginalisation. It does not prove that there are doctors who have never heard of transgender people, but it does show that

TGD people feel hermeneutically marginalised and unable to add their experience to the collective hermeneutic resource.

In the theme of gatekeeping attitudes, hermeneutical marginalisation is also revealed through the practitioner's cisnormative attitudes. Even when stated otherwise by the patient, the assumption is made that the patient is more likely to be cisgender. This can be seen with TGD people expressing the feeling of going in circles and having to convince practitioners and mental health providers of their identity, lie about their gender expression and unrelated health conditions. Some interviewees recall or express fears that, if anything besides being trans is mentioned, the practitioner focuses in on that and dismisses their request for GAC.

The request for GAC from the interviewees seems to be an out-of-the-ordinary request for some of the doctors and mental healthcare providers described. The attitudes and fears described point to the hermeneutical marginalisation of TGD people in the healthcare system, where there is no certain or standardised way to receive it in the country. The system has not considered TGD people.

Transgender and gender diverse people experience hermeneutical marginalisation inside and outside of the healthcare system. As a minority experience, societal expectations of well-being and gender expression can differ from those necessary for TGD people. As that is not accommodated or is only accommodated partially in the experiences of the interviewees, it can be stated that TGD people experience hermeneutical marginalisation. If their experiences were not obscured, they would express less fear about practitioners' general unfamiliarity with TGD people in the themes of discrimination due to gender identity and healthcare anxieties. And with the theme of gatekeeping attitudes, if TGD people's experiences were not obscured, there would be a publicly available system in place in which to approach receiving GAC.

Harm of hermeneutical injustice

Primary harm

The primary harm of hermeneutical injustice is the inability to communicate something significant about one’s own experience to oneself/others due to the lack of available concepts caused by hermeneutical marginalisation. Among the TGD people interviewed, none of them mention not being able to understand their own identities due to a lack of available concepts, but not being understood by their healthcare providers appears in all of

their experiences. I continue to look at the three themes: discrimination due to gender identity and/ or expression, healthcare anxieties and gatekeeping attitudes, and show that hermeneutical marginalisation leads to the harms of hermeneutical injustice within the themes.

In the theme of discrimination due to gender identity and/or expression, the interviewees refer to being met with confusion about their gender expression or identity (Winter, Bill), being misgendered (Winter, Lou), lying or exaggerating to avoid being misunderstood (Winter, Sailor). Not understanding that a trans person does not have to present typically masculine or feminine, especially at the start of seeking out GAC, as it is in Winter's experience, shows an inability to render the experience of a trans person, especially a gender nonconforming one. Misgendering shows the inability to recognise a person's gender identity. Lying about one's gender identity and expression to appease more traditional gender roles and expectations shows an anticipation of hermeneutical injustice, a familiarity with the hermeneutical lacuna. The inability to communicate these concepts is present because they are being replaced with communicable ones.

In the theme of healthcare anxieties, the fear of not being understood on the basis of their identity in healthcare settings reappears three times (Sailor, Bill, Lou). This theme does not look at instances where this occurs, but the expressed fears show the structural positioning that TGD people experience with previous experiences, including doctors not being able to interpret their experience accordingly. Others' experiences also influence the development of these fears; two interviewees (Lily, Bill) say that they have gotten lucky with their healthcare experiences, despite describing unpleasant interactions, based on other TGD people's experiences.

The clearest example of an inability to render one's experience to others is Bill's concern with a lack of concepts to describe his sex accordingly. With being legally male, assigned female at birth and using HRT for multiple years, he believes neither male nor female applies.

> I don't understand myself if, when asked, I should count myself in more with cisgender men or cisgender women, because I have [higher] testosterone…Some kind of third option, right? For example, going to the doctor, there are some kinds of procedures for men and some for women. In these situations, a doctor can get confused. (Bill)

While the term transgender man is applicable and would describe him, the healthcare system does not include any way to identify a patient with it, with only two legal sex markers being available legally, as well as present in medical records.

The theme of gatekeeping attitudes shows that the system in place does not allow for communicating wanting to receive GAC directly, because it appears that that is seen as a *last resort*. This shows the practitioners not being able to render the trans experience, as for a lot of TGD people, gender affirming care is essential. The other experience not being communicated in this theme is being trans itself.

I explained my situation multiple times, but it felt like going in circles. Every time was a similar thing. I come and say "Hey, I still have these feelings [of dysphoria]. The only thing they could say was recommendations of exercises to achieve this figure, and then we'll see, and it started going in circles. I would come and say, "I am doing these things, I have this figure, I still have these feelings. I would like to start [hormone replacement] therapy and get that [F.64.0] diagnosis." I kept confirming that I still have these feelings, but they wouldn't diagnose me. (Lily)

Suggestions of other solutions besides medical gender affirming care, such as HRT, would not be harmful if paired with medical GAC that is outwardly stated to be desired by the patient. This reveals a possible gap in knowledge on providing psychiatric care for trans patients.

Sailor's multiple experiences with psychologists show that there is an inability to understand being trans in itself. With various other causes being offered even after he explicitly tries to communicate that he is transgender.

[The psychologists asked] "So do you have anxiety when going to school?" I said, yes I am more anxious in social settings than at home, they were like, "ok, so you are getting bullied" I said, "no, I am just uncomfortable being surrounded by people if they don't perceive me the way I perceive myself" and they go, "so you are being bullied" or maybe "you are overworked", because I had really good grades and did a lot of extracurriculars. (Sailor)

This shows that there are described instances of the primary harm of hermeneutical injustice in the three themes, as well as a fear of not being able to communicate their experience. The communicated fear is based on previous experiences and peers' experiences and points to hermeneutical injustice being present.

Secondary harm

Some of the harms done to the speaker from a hermeneutical injustice are practical. In the cases of TGD patient- doctor relationships, the practical harm is often delayed access to GAC. None of the themes appears to reveal the proposed epistemic harm of losing faith in one's own ability to make sense of the world, but if, as suggested by Fricker and Jenkins, misgendering is also an epistemic harm of hermeneutical injustice (Fricker and Jenkins 2017, 275), then this identity-related harm does occur.

The theme of discrimination based on gender identity and gender expression primarily draws out instances where the interviewees recall being either misgendered or doubted about their gender identity and/ or expression. It could be traced from Fricker that identity- related harms, such as misgendering, distort one's own view of selfhood. (Fricker 2007, 168; Fricker and Jenkins 2017, 275) None of the interviewees point to doubting their own identities due to misgendering or being questioned on their identity. Attitudes of dismissal and misgendering seem to primarily reinstate what some of the interviewees (May, Winter, Lou) already believe, that general society around them is transphobic or at least trans-negative.

The theme of healthcare anxieties shows how previous negative experiences and hermeneutical injustice, not being understood at the doctor's office, lead to avoidant and anxious attitudes towards medicine. The practical consequence is potential health risks caused by avoiding healthcare when necessary. Two of the interviewees (Bill, Sailor) mention not disclosing their gender affirming care to doctors not providing them with GAC, which could also lead to practical harm if they were to experience any side effects related to their medical gender-affirming healthcare. These practical harms are potential ones and not actual ones, but developing avoidant attitudes and distrust in doctors is a harm in itself.

The theme of gatekeeping attitudes reveals the practical harms of delayed GAC and fatigue from having to convince doctors and psychologists, as well as not receiving help for other health conditions. The inability to recognise the experience of transness leads some TGD patients to having to explain it multiple times to multiple healthcare providers, until someone believes them. This makes the process of receiving GAC longer and more frustrating. This could also be a case of identity-related harm, as their identities are dismissed, and other causes and solutions are suggested instead.

> Specialists without previous experience believe that it's [being TGD] nothing serious or look for other causes, of other things they could prescribe, diagnose, or look for other explanations for the patients' complaints… With the specialists who weren't recommended to me, I was being honest, but at the same time, maybe exaggerated the impact that the feelings have on me a little. Or they would believe it's nothing serious and look for another cause. (Lily)

Two interviewees (Winter, Sailor) explain not mentioning other health issues when aiming to gain access to GAC. They worry that revealing other health conditions will prevent them from accessing gender-affirming care. This has the same potential practical harm as the theme of healthcare anxieties, of being dangerous to one's health.

This part of the chapter shows that hermeneutical injustice occurs across the three themes: gender identity discrimination, healthcare anxieties and gatekeeping attitudes. The

interviewees' reports show that TGD people are hermeneutically marginalised in society and healthcare practices, which leads to their experiences not being decipherable to doctors and other healthcare employees. That causes hermeneutical injustice, which leads to both the primary and secondary harms of an inability to communicate an experience and practical harms that have the potential to be dangerous to the TGD people's health.

Willful hermeneutical ignorance

The cases for willfull hermeneutical injustice split into two. First, the practitioners are presented with the necessary concepts by the patients, but refuse to use them. Second, the concepts are formulated and available in the medical field, but have not been accessed by the practitioners discussed here. Alongside hermeneutical injustice, this can also be the case of willful hermeneutical ignorance conceptualised by Gale Pohlhaus.

Using the same themes as the analysis of hermeneutical injustice, there are standout examples in both the theme of gender identity discrimination and gatekeeping attitudes, where the patients are outright stating that they are TGD and request specific healthcare, but are denied it at first.

With gender identity discrimination, stating one's gender identity is not enough and people ask for explanations, even though the concept of being transgender exists and a concept for gender identity is being provided. It also shows a lack of understanding of the aim of receiving GAC in the cases where the patients' appearances are being criticised before receiving further GAC, even though that is stated in the description of F.64.0:

> A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex. (ICD-10)

In the theme of gatekeeping attitudes, it is even more prevalent that a statement of identity is not being taken as is and is being assessed. This assessment comes with the necessity of diagnosing the TGD patient to receive further GAC, but as the only diagnostic criteria are discomfort with current body and a wish to change it, a request for a referral for further GAC fit with the diagnosis, and ignoring this could be a case of willfull hermeneutical ignorance instead of medical assessment.

The theme of healthcare anxieties shows the fear of the second cause of willfull hermeneutical ignorance- doctors not knowing trans patients. It is not the case that no research

has been done on TGD healthcare, but it is the case that the practitioners described in the data lack experience or minimise the experience, thus appearing unfamiliar with the research.

This can be seen in the theme of gatekeeping as well, assuming that other mental health struggles are treatable, separate from providing GAC, shows a lack of knowledge in the field of TGD healthcare. It has been proven that mental health issues in TGD people are best relieved with further gender-affirming healthcare. (Grant et al. 2026; Coleman et al. 2022)

Willfull hermeneutical injustice appears alongside hermeneutical injustice because the concepts, even though developed and presented, do not enter the practitioners' epistemic *toolkits* due to the hermeneutical marginalisation of TGD experiences and overall prejudice.

Conclusion

This chapter shows that in the collected data thematised as gender identity discrimination, gatekeeping attitudes and healthcare anxieties, hermeneutical injustice occurs. TGD patients are hermeneutically marginalised on the basis of their identities as TGD, emphasised by the cases of gender nonconforming and nonbinary TGD people. Hermeneutical injustice occurs, and the primary and secondary harms of hermeneutical injustice can be noticed. The primary harm of the inability to render one's experiences tangible to others appears as not being understood fully in their identities and requests for GAC. Because of not being understood, the TGD patients suffer from delayed access to GAC and develop healthcare anxieties, as well as perpetuate their beliefs that society is transphobic and unwelcoming to them.

The analysis of willful hermeneutical ignorance shows that some of the cases met with the primary harm of hermeneutical injustice- an experience not being received as intelligible, are also cases of willful hermeneutical ignorance, because the concepts are actually available and being presented. It is still a case of hermeneutical injustice, because structural identity prejudice makes the concepts formulated and presented impossible to interpret and use, even if they are technically available. It is almost as if they were not available.

Conclusion

I have shown that epistemic injustice- wrong done to agents as knowers- occurs in the transgender and gender diverse patient- doctor relationship in the collected data. The analysis shows that the TGD patient-doctor relationship is prone to epistemic injustice due to the predetermined epistemic asymmetry of the doctor-patient relationship and the societal prejudice against TGD people.

The first part of this thesis reveals that TGD people experience identity prejudice in the forms of gender identity prejudice, age discrimination and as patients. These intersecting identities lead to a credibility deficit in healthcare interactions, where the doctor holds identity power and can decide over patients' testimonies. The credibility deficits experienced lead to testimonial injustice, where the TGD patients are epistemically objectified- seen as a source of information. Being seen as a source of information affirms doctors' ideas of the patients' needs instead of taking the knowledge being provided by the patient about their desired care. It is also shown in this thesis that the attitudes displayed by the healthcare employees discussed in this work lead to Kristie Dotsons concept of testimonial smothering. In some cases, being TGD becomes an unsafe testimony, but in most, it is a specific nonconforming way that is unsafe to communicate. Practitioners show testimonial incompetence when receiving testimony about being TGD and wanting to receive GAC to improve one's well-being, as well as committing microinvalidations when suggesting other causes and solutions to being TGD.

The second part of this thesis reveals that TGD patients experience structural identity prejudice, because of being a gender minority that most cisgender practitioners do not recognise and have little experience with. Structural identity prejudice leads to hermeneutical marginalisation, where the TGD people interviewed report that they cannot add concepts to the collective hermeneutic resource and sometimes even stop themselves from doing so out of fear, which is more proof that hermeneutical marginalisation is in action. Hermeneutical injustice occurs in the interactions described and leads to the primary and secondary harms of hermeneutical injustice. The primary harm being the inability to make one's experiences intelligible to oneself or others. This is shown as not being understood by practitioners and other healthcare employees, the experience of being TGD being redirected to other causes. The second chapter also reveals that in some cases, alongside hermeneutical injustice, structural identity prejudice might also lead to willful hermeneutical ignorance, where doctors do

not use the concepts technically available to them, which is different from the standard case of hermeneutical injustice, where the concepts do not exist, instead of not having entered into the epistemic *toolbox* of the agents or are being dismissed by them.

The analysis of the data was done by splitting it into four themes using thematic analysis: age discrimination, gender identity discrimination, healthcare anxieties, gatekeeping attitudes. Three of the themes, age discrimination, gender identity discrimination and gatekeeping attitudes were looked at in the context of testimonial injustice, but gender identity discrimination, gatekeeping attitudes and healthcare anxieties were looked at through hermeneutical injustice. Going through each theme as a complex of data shows the recurrence of the concepts in similar accounts of TGD patient-doctor and other healthcare employee interactions and proves that the emergence of epistemic injustice is not accidental or a one-off occurrence.

The fact that two of the themes reveal both testimonial and hermeneutic injustice show what Miranda Fricker already points out: the injustices have a family resemblance through both being caused by discrimination. (Fricker 2007, 155) This thesis shows that it can be the exact same discrimination that causes both injustices. And as well, the supplementing theories of testimonial smothering and willfull hermeneutical injustice show that other concepts of epistemic injustice can be applied and broaden the scope of the analysis.

This thesis proves that the collected data shows the occurrence of both types of epistemic injustice discussed by Miranda Fricker in her book *Epistemic Injustice* as well as revealing additional concepts of epistemic injustice occurring in the TGD patient-doctor relationship. This thesis also reaffirms that the two epistemic injustices can occur in the same settings, caused by the same prejudice.

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Abstract

In this thesis, I apply concepts of epistemic injustice- wrong done to one as a knower- to qualitative data that describes transgender and gender diverse (TGD) patients' interactions with doctors and other healthcare employees. The analysis of the data through the concepts shows that both kinds of epistemic injustice described by Miranda Fricker, testimonial injustice and hermeneutical injustice, as well as Kristie Dotson's concept of testimonial smothering and Gale Pohlhaus Jr.'s concept of willfull hermeneutical ignorance, occur in the TGD patient- doctor relationship. The data was collected through interviews with Latvian TGD people who have received gender-affirming healthcare. The data was split into four themes through a thematic analysis. Each theme reveals that at least one kind of epistemic injustice occurs throughout the theme. The epistemic kind of injustice reveals itself by blocking the intake of knowledge of TGD people's identities and access to gender-affirming care in medical interactions.

Annotation

This thesis reveals that in the transgender and gender diverse patient-doctor relationship, epistemic injustice occurs. This is shown by analysing qualitative data on transgender and gender diverse patient healthcare interactions through concepts of epistemic injustice: testimonial injustice, hermeneutical injustice, testimonial smothering and willfull hermeneutical ignorance.

Keywords: epistemic injustice, testimonial injustice, hermeneutical injustice, transgender and gender diverse healthcare, transgender patient- doctor relationship

Appendix

Age discrimination	**Gender identity discrimination, trans-negative and cis-normative attitudes and expectations**	**Healthcare anxieties, expressed fear of doctors**	**Gatekeeping attitudes**
“The doctors might have a lot less restraint when it is a small child. And then they can say literally anything that comes to mind, because the parent will probably agree…” (George)	“She [the psychiatrist] said, “Well, everyone else that sees me to receive this diagnosis [F.64.0] looks very masculine and maybe acts masculine, but I see a feminine woman in front of me.” "I don't know why. I had bright pink and purple hair then, that wasn't short, a little longer, but with the goal of getting a diagnosis [F64.0], I had tried to show my masculine side, I dressed very masculine, as much as I could." (Winter)	"[an unwelcoming attitude] makes a patient shut off and not say everything, because in the moment you want to get away from this person [doctor] faster. And even if you have any more questions, you won't ask them because, God forbid, I will get *chewed out* for the next 10 minutes." (George)	"I wanted the diagnosis [F.64.0], but he [a psychologist] spent most of the time diagnosing me with Asperger's and trying to help with my anxiety, even though I had explained that my anxiety is most likely due to not being in my body." "Maybe he, as a cis person, thought that there would be another cause that would not lead me to transitioning. That is my theory. Find something with fewer consequences; transitioning is physical." (Sailor)
Qa "For some reason, my parents decided that I had to go see some kind of endocrinologist when I was around 14,15. Maybe my psychiatrist had said that I had to see an endocrinologist…The doctor berated me, and that made me cry. She started to lecture me with the classic, "What are you doing? You will grow out of this. Such a beautiful girl, you just don't understand yourself yet." I think she also mentioned that, "I also used to think that looking boyish is cool." (George)	"They called me from the reception [of a hospital] and asked, "Hey, do you as a male really need a gynaecologist's appointment?" Then, I had to explain that I have not made a mistake and that I *have the right parts,* and I basically had to justify that everything is correct, and I know who I am; I was born a woman. “I did not like that I had to argue about it. Sorry, but it’s none of your business. I made a gynaecologist's appointment. I don't have to reason about why I did that. ” (Bill)	"There's a lack of supportive doctors and a lot of fear of going to a doctor, and him not understanding or saying something mean…I used to be very afraid, now I'm not afraid anymore. " (Sailor)	"I went to him [a psychiatrist] and said that I think that I am a woman, could I, please, get a diagnosis and a referral to an endocrinologist? Then he asked me questions that were useless. Started asking me about my sex life and love life, like what gender I like and which gender I want to sleep with and things like that. And then he prescribed me antidepressants for three months and said to take those and then come back. "Let’s see if your thoughts have changed about this topic"...Then I come back after three months, and he looks at me and says, "Yes, okay, I'm giving you a diagnosis and referring you to the endocrinologist. " But there's important context. Before I went

			to the psychiatrist, I got a psychological evaluation from a psychologist where I did the dysphoria test and a personality assessment, and I went to the psychiatrist with this document in hand." (May)
" [while underage] I had been to like eight psychologists before, and none of them were either qualified or able to really help." "They asked me, and I said, yes, I have anxiety, yes, I have depression, but I do think it's because I'm not in my own skin." (Sailor)	"I was seeing him [a psychologist], and often it was so that he would use feminine language, even though technically he should have been using masculine." (Winter)	"I am personally very anxious about seeing new doctors. Because, being trans, I am afraid of discrimination. I am afraid that I will get asked invasive questions. [What if] They basically say that "all of your problems are because you use testosterone" and or "you have problems are only because you are trans" … If I'm going to the doctor with a technically unrelated problem to me being trans, do I mention it, will it have any impact? I chose not to say it." (Bill)	"I explained my situation multiple times, but it felt like going in circles. Every time was a similar thing. I come and say "Hey, I still have these feelings [of dysphoria]. The only thing they could say was recommendations of exercises to achieve this figure, and then we'll see, and it started going in circles. I would come and say, "I am doing these things, I have this figure, I still have these feelings. I would like to start [hormone replacement] therapy and get that [F.64.0] diagnosis." I kept confirming that I still have these feelings, but they wouldn't diagnose me." (Lily)
"I wasn't the only transperson there [the hospital], and I could feel that the nurses simply didn't respect it. Because we were teenagers and we will grow out of it… But gender wasn't the defining cause for the disrespect [from the nurses], but it played a role… There was a daily schedule where my friend changed my *deadname* to my chosen name on it, and the nurses got disproportionately *pissed."* (Bill)	"To get top surgery, I had to see a gynaecologist. I had to get an ultrasound. The surgeon was calling me by my [chosen] name, which has not been legally changed. The administration called me by my [chosen] name. So I went to the gynaecologist and expected that, since it's a trans-friendly clinic, somebody would have told her about my name being [Lou], but no, I got called by my deadname...Then I went to get the ultrasound, and it was the same there." (Lou)	"I don't understand myself if, when asked, I should count myself in more with cisgender men or cisgender women, because I have [higher] testosterone…Some kind of third option, right? For example, going to the doctor, there are some kinds of procedures for men and some for women. In these situations, a doctor can get confused." (Bill)	"I went to the psychiatrist, and I was like, yes, from the age of four, I've hated the colour pink, and I hate dresses, and then the same night, I went to celebrate getting the diagnosis in a skirt. I lied to her a lot. She gave me a psychiatric evaluation, and I acknowledge that it wasn't right to do, but I lied a little and said that everything's alright…I went to the psychiatrist with only one thing in mind, and that was that I needed the diagnosis, and I needed it in this visit, not the next one or after five. It is unfair to yourself to remove the opportunity to help yourself, but at the same time, I didn't want antidepressants or anxiety medications; I wanted the diagnosis, so it's understandable...If something is wrong [with you], then the chance of getting a diagnosis is very

			slim, which is, there isn't a better word for it than, stupid." (Winter)
"When I was around 13, 14, for example, seeing the psychologists, it felt like they didn't take me seriously because I was a child. I was a teenager, and instead of doing something useful in the sessions, they made me play with sand. " (Sailor)	"At one point I was talking something about testosterone and she [a therapist] just asked me if testosterone had any negative side effects. And I told her some things that I had heard. And she said, "Well, I wouldn't want that to happen to you."" (Lou)	"I admit that I got very lucky, from what I hear from other people's experiences." (Lily)	"I don't think she [an endocrinologist] would give me hormones if in the first appointment I mentioned that I don't know what's going to happen to me" (Winter)
"That [seeing a psychiatrist] was my earliest attempt to talk about trans things. I got told that I had rapid-onset gender dysphoria and was let go." (May)	"Personally, I feel like first of all, people might not know what a trans person is, but if they do know what a trans person is, they most likely will only know what a binary trans person is." (Lou)	"It would be nice if there were options to consider in Latvia, all kinds of surgeries, instead of going abroad, that would be nice. One, I haven't heard anything from my friends that that's an option at all in Latvia. I don't know. The other is how many doctors do we have here, Latvia, with its two million people, where could a competent enough doctor come from?" (May)	"To start puberty blockers, a council of doctors had to be called, in which I didn't participate in. There were only doctors there, which I thought was weird… My father called the endocrinologist for two weeks straight to find out the results of the council. You had to chase them [to get the answer]." (Bill)
"I feel like my problems now, as an adult, are seen as more serious than when I went [to doctors] as a child. Then it was like, "You're just a child, you're just a teenager". They didn't say it, but the attitude was there." (Bill)	"I had an instinctual urge to add that I played with toy cars as a child. Something stereotypically masculine, even though as a nonbinary person, I still do, and did like dolls, dresses and make-up. If you want fewer problems, even with those [doctors] who are supportive, you have the tendency to lie a little." "In a way, it is the erasure of your own identity a little." (Sailor)	"It can just be awkward, unpleasant, because if I go to some kind of rural lady, who is a general practitioner, who has never heard about trans people, that wouldn't be pleasant. It wouldn't be pleasant for me and it just wouldn't be pleasant for her." (Lou)	[The psychologists asked] "So do you have anxiety when going to school?" I said, yes I am more anxious in social settings than at home, they were like, "ok, so you are getting bullied" I said, "no, I am just uncomfortable being surrounded by people if they don't perceive me the way I perceive myself" and they go, "so you are being bullied" or maybe "you are overworked", because I had really good grades and did a lot of extracurriculars." (Sailor)
"I had an experience when I was buying needles for my	"I didn't say that I'm a nonbinary person, because I was very scared	"She [the surgeon] is professional, polite and takes people seriously. Which, like, sounds	"If you can convince a psychologist, psychiatrist that you are trans, that you need to transition, then everything

testosterone injections, and the pharmacist acted very viciously. Because I was buying needles as a youth, and I don't know if it's because she knew what I was buying them for or just because a young person was buying needles. It was unpleasant, nevertheless." (Sailor)	that they wouldn't understand and I would have to see a psychiatrist again. I said that I'm a trans man." (Winter)	like nothing, but the bar is so low that every time I saw her, I was like, a literal angel has walked through the door" (Lou)	else goes smoothly. After that the doctors have something to base their trust on. That's why afterwards [receiving the F64.0 diagnosis] I haven't had any problems convincing anyone." (Sailor)
	"...Stigma and stereotypes. If you are a trans person, [it is assumed] you have to use hormones for the rest of your life. You have to get gender-affirming surgeries. You have to conform. This is personally painful to me as someone nonbinary...If I do not prove that I am a man, then, oh, I am immediately a woman." (Winter)	"I've been lucky in the sense that I haven't experienced discrimination… hearing about how others are doing, in my opinion, I have really been lucky with doctors." (Bill)	"With this psychologist, I poked him relentlessly, because I was pretty ,well ,tired, from all of it, of course. I poked him so we would stick to the topic. That might be part of the reason why he was convinced eventually, because I was so confident about it and determined and was fixating on it for so long." (Sailor)
	"It [legal protection] should be the responsibility of governing bodies, but as long as they hate us, there is nothing you can do about it." (May)		Specialists without previous experience believe that it's [being TGD] nothing serious or look for other causes, of other things they could prescribe, diagnose, or look for other explanations for the patients' complaints… With the specialists who weren't recommended to me, I was being honest, but at the same time, maybe exaggerated the impact that the feelings have on me a little. Or they would believe it's nothing serious and look for another cause. (Lily)
	"We constantly have to prove to everyone that we are of sound mind." (Winter)		"When asked if I have additional health conditions, I don't mention it [chronic pain] now. Because first of all, I can live with it, and I don't want to reveal it, so something doesn't diverge again. The experience is that mentioning something unrelated [to being

			TGD] diverts the conversation and something gets delayed." (Sailor)
	We can hear how people around us talk about us. That's why we're scared." (Lou)		It has always been hard. Believing myself that this (being trans) is real, and then in addition trusting another person, a person who is in a position of authority, and holds power. I can go to someone and say, "Hey, I am trans", and that person can say, "No", and deny me treatment… I had a hard time believing I was trans until I got top surgery. (Lou)
	"When I started my current job, I had to do a mandatory health check, where they asked me if I use any medication regularly. I said no, because I didn't want this random healthcare worker or my place of employment to know that I use hormones, etc." (Sailor)		"The idea that I have to prove something to someone and that I have to get a permanent diagnosis, about being trans. I don't know. Well, I don't fully agree with it." (Lou)
	" She [a psychiatrists] believed that a lot of children are pretending, but when I was describing my experience, she said, "You are one of the real ones" or something. She said that women, from her experience, do it less for attention and that her impression is that girls [people assigned female at birth] do it for attention." (Lily)		

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Evita Bukonte

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