

Vicious Metaphysics? Mind-Body Dualism and Epistemic Injustice in Medicine

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Abstract

Recent developments in the debate on epistemic injustice have expanded the original concept to include abstracta as epistemically unjust. Drawing on these arguments, we propose to distinguish between inherent *conceptional epistemic injustice* and contingent *conception-mediated epistemic injustice*. Applying this distinction to mind-body dualism in medicine, we argue that it falls within the latter category. Dualistic patterns can be found in organizational structures, research methodologies, and beliefs among clinicians and patients. The mutual reinforcement of these different dimensions systematically promotes epistemic injustices, especially toward patients whose ailments resist a clear categorization as either mental or somatic.

1. Introduction

We all have experiences of our mental and physical states being interconnected. Your hands may get sweaty before a job interview, receiving a compliment can make your face blush, a stressful week at work may trigger a migraine. Likewise, it is hard to be in a good mood when dealing with kidney stones. The strong impact of our expectations on the efficacy of medical treatments has also long been realized, which is why the gold standard in medical research is to test drugs against placebos. Scientific explorations of such interactions between physical, psychological, and social factors promise to advance our understanding of many conditions that have hitherto proved hard to tackle.

For example, one current research frontier concerns the relation of immunology and mental health. Robert Dantzer et al. (2008) hypothesize that inflammatory processes not only play a causal role in sickness behavior but also in the onset of depression. Camilla L. Nord and Sarah N. Garfinkel (2022) report that pharmacological interventions targeting physical conditions (for example, statins, anti-inflammatory drugs, or antihypertensive drugs) show efficacy in treating psychiatric conditions such as depression, psychotic disorders, or post-traumatic stress disorder (PTSD). It is well established that traumatic



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psychological experiences significantly increase the risk of developing autoimmune diseases like multiple sclerosis or rheumatoid arthritis (see, for example, Dube et al. 2009; Mandagere et al. 2025). Other relevant research topics include functional neurological disorders, where individuals suffer from symptoms such as seizures without an apparent physical cause (Espay et al. 2018), or new approaches to the treatment of chronic pain, in which the intensity and duration of symptoms lack a physical correlate at the location of the pain (Ashar et al. 2022).

Importantly, these new approaches go beyond one-directional psychosomatic explanations of symptoms. They focus on the complex and dynamic interrelations of, for example, immunological processes, interoceptive pathways, the brain's predictive processing, the role of behavioral responses to symptoms, and the meaning patients assign to their ailments. This complexity resonates with current cognitive science, which, for example, attempts to elucidate the phenomenon of chronic pain in terms of 5E frameworks (Coninx and Stilwell 2021; Stilwell and Harman 2019).

While these are promising advances in research, their way to clinical application has yet to be fully paved—not least because healthcare systems are still characterized by a strong separation into different disciplines treating specific conditions or organ systems. In particular, there exists a sharp distinction between mental and somatic healthcare (see section 3). Many authors have diagnosed this split as an outcome of mind-body dualism and criticized its pervasive and detrimental role in both research and clinical practice. Mathew H. Gendle expresses this critique poignantly: “In Western medicine, traditional Cartesian dualism facilitates the biological reductionism of disease, supports medical practices that do not necessarily support healing and wellness, promotes a dispassionate and mechanistic approach to patient care, disempowers patients, and discourages humanistic ways of thinking that focus on the whole patient” (2016, 142).

Irene Switankowsky (2000, 567) likewise argues that stressing “the interaction of mind and body is essential to treat patients with dignity and compassion.” Cartesian or mind-body dualism, according to these critics, is an obsolete metaphysical position that has hampered our understanding of complex medical phenomena for a long time by “separating mind and body,” as George L. Engel (1977, 130) puts it (though this diverges from how philosophers of mind understand dualism, as we will later argue). What is more, this metaphysical conception is said to have severe negative effects on how patients are treated.

While these authors posit a relation between metaphysical beliefs and ways of treating patients that may be overly strong, it is of course plausible that general views of humans, and of diseases, affect our response to these. If clinicians view back pain as solely a matter of biomechanics and tissue damage, for instance, they may be less inclined to pay attention to a patient's sociopsychological situation, or to believe the patient's testimony about the pain they experience despite the MRI coming back clear. Likewise, if a condition is considered purely psychological or psychogenic, physical symptoms may be dismissed. Patients with conditions that involve both psychological and physiological symptoms or mechanisms are particularly likely to end up between a rock and a hard place. Dualistic beliefs structuring and guiding medical practice can create a divided system and promote binary clinical reasoning, which makes it exceedingly difficult for such patients to receive proper care. We can see these effects, and myriads of patient complaints about it, in many contested medical phenomena such as fibromyalgia, chronic Lyme disease, chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME), irritable bowel syndrome (IBS), or, again,

chronic lower back pain. Patients may either be subjected to inefficient physical treatments, such as unnecessary surgeries, or their complaints may be dismissed as exaggerated.

The flourishing literature on epistemic injustice in healthcare has brought many such cases and problems into the spotlight (for example, Kidd and Carel 2017). In pathocentric epistemic injustices, patients' testimony is unfairly discredited (testimonial injustice), or patients' ability to make sense of and communicate their experiences is limited due to their perspectives being marginalized (hermeneutical injustice). Recently, the debate has been expanded to include (healthcare) institutions as potential bearers of epistemic injustices (Bueter and Jukola 2025; Carel and Kidd 2021). In addition, Ian James Kidd and Havi Carel (2018, 2019) have argued that abstracta such as theoretical conceptions of health and disease can be epistemically unjust.

In this paper, we further explore the question of whether and when theoretical conceptions can be understood as epistemically unjust, using mind-body dualism as a case study. *Prima facie*, it seems plausible that a dualistic framework, conceived as the very division of mind and body, would lead to a loss of credibility and intelligibility of patient testimonies that resist a clear psychological or physiological characterization. However, while such effects of mind-body dualism are epistemically and ethically problematic, the question is whether this renders mind-body dualism as such unjust, as well as how to understand the relation between theoretical conceptions and epistemic agents. We argue that while theoretical conceptions can in principle be unjust themselves, the more common case is of conceptions facilitating epistemic injustices depending on their context of use.

However, it is important to pay attention to this mediating role of conceptions, as they can systematically promote both testimonial and hermeneutical injustices, as well as underlie institutional injustices. While conceptions in such cases do not cause epistemic injustices on their own, they play an essential part in a network involving structural and agential factors. Conceptions provide an intellectual scaffolding that makes certain inferences plausible; institutional structures standardize corresponding responses; agents choose the path of least resistance or best fit with matching background assumptions. Given this complexity, the contribution of conceptions to epistemic injustices cannot be determined by conceptual analysis (alone) but requires a detailed look at how such conceptions are implemented and used.

Accordingly, our aim here is twofold: to develop a framework for understanding the role of conceptions in epistemic injustice, and to investigate mind-body dualism in medicine based on this framework. This leads us to the conclusion that while previous critiques of dualism in medicine have often rested on oversimplifications, dualism still promotes epistemic injustices toward patients with complex conditions unbefitting the binary mold.

The paper proceeds as follows: In section 2, we introduce recent developments in the debate on pathocentric epistemic injustice that expand the realm of entities that can be epistemically unjust to include institutions and abstracta. Based on this discussion, we propose a distinction between *conceptional epistemic injustices* and *conception-mediated epistemic injustices*. Section 3 applies this to the issue of mind-body dualism in medicine and psychiatry. We argue that it is important to distinguish between metaphysical and "practical" dualism at the level of organizational structures, methodology, and clinical practice. These different levels impact and reinforce but do not necessitate one another. Based on this, section 4 argues that mind-body dualism fulfills the conditions for conception-mediated but not conceptional epistemic injustice within medicine. We

illustrate this with several examples, before concluding with some remarks on what might be gained by focusing on the role of abstracta in debates on epistemic injustice.

2. Conceptions as Epistemically Unjust

2.1 The Various Perpetrators of Epistemic Injustice

Miranda Fricker's concept of epistemic injustice has been increasingly adapted and applied to issues within healthcare. At their core, epistemic injustices signify wrongs committed toward people in their capacity as epistemic agents and traditionally take on two forms: *testimonial* and *hermeneutical* injustices (Fricker 2007, 1). Where the former denotes instances of epistemic agents being ascribed an inaccurately low level of credibility because of vicious stereotypes about their identity, the latter signifies structural cases where a society lacks conceptual resources for certain predicaments because of the hermeneutical marginalization of social groups. This leaves individuals who suffer from these predicaments without the ability to properly make sense of or protest against their situation. Within healthcare contexts, testimonial injustices may, for example, occur in cases of endometriosis, where diagnosis is often severely delayed because of harmful stereotypes about women that influence how patient complaints are perceived (Melgaard et al. 2023; Hallström 2024). Hermeneutical injustices may take place in paternalistic medical systems where the patient's perspective is deemed irrelevant from the outset (Kidd and Carel 2017).

Since Fricker's initial formulation of the idea of epistemic injustice, a burgeoning literature has evolved and considerably widened its scope. For example, it has been argued that testimonial injustice need not be transactional but can be structural (Anderson 2012) and that institutions can be epistemically unjust (Bueter and Jukola 2025; Carel and Kidd 2021; Fricker 2023). Kidd and Carel have additionally suggested that not only individual agents or institutions can perpetrate epistemic injustices but *abstracta* as well (2018, 2019). They identify one kind of abstractum in biomedical and naturalistic understandings of health and medicine, which "[is] epistemically unjust insofar as [it] promote[s] and require[s] the exercise of epistemically unjust behaviours" (2018, 226). Though biomedicine and naturalism of health are not entirely equivalent notions, here they refer to understandings of health and disease as reducible to biological (dys)functions. On such views, the purpose of medicine overwhelmingly becomes to investigate and treat health and disease at the purely bodily level. What is epistemically unjust about such conceptions is that they facilitate a way of practicing medicine that marginalizes other equally important dimensions of health and disease, be they existential, phenomenological, or social. They may further, according to Kidd and Carel, exclude the patient from playing an active part in their own care, downplay the patient's perspective as less important, and establish the medical professional as the primary expert on what is wrong with the patient because of their clinical expertise.

Though the force of this critique should not be exaggerated, as a more naturalistically oriented practice of medicine is compatible with patient-centered care, it is plausible that certain conceptions facilitate epistemic injustices. Conceptions of health and disease structure the hermeneutical space, thereby shaping attitudes toward illness phenomena, patients, and care practices. Kidd and Carel treat this as a form of hermeneutical injustice.

They argue that a theoretical conception is hermeneutically unjust if it fulfills at least one of these three conditions:

- a) “promotes hermeneutically unjust attitudes or actions;
- b) requires the exercise of hermeneutical injustice for its enactment in agential conduct, structures, or institutions;
- c) could only be regarded as attractive by agents with at least some disposition to cause or accept hermeneutical injustice.” (Kidd and Carel 2019, 165)

A theoretical conception is epistemically unjust if it promotes, requires, or attracts epistemically unjust agents or actions. According to Kidd and Carel, naturalism fulfills all these conditions, as it renders subjective experiences and interpretations irrelevant. However, Kidd and Carel also hold that this is not an intrinsic, necessary feature of the theoretical conception but contingent on its institutional and practical implementation. The real issue, they contend, is the *privileging* of conceptions such as naturalism to the exclusion or detriment of others (such as, for example, holistic conceptions of health): “Crucially, the injustice only occurs with the *privileging* of those conceptions in ways that reject, derogate, or marginalize alternative hermeneutical resources and practices pertinent to experiences of illness” (2019, 165; see also 2018, 224f.). They conclude that “insofar as theoretical structures cause the harms constitutive of hermeneutical injustice, those structures *are* hermeneutically unjust, just as the very concept and institution of slavery are cruel and unjust, over and above the cruelty and injustice of individual slave-owners, practices, and so on” (2019, 166).

While Kidd and Carel’s application of the concept of hermeneutical injustice to theoretical conceptions is insightful and important, we believe it could benefit from further development. First, according to Kidd and Carel, concepts such as naturalism are not epistemically unjust per se but rather facilitate such injustices through their privileging in institutions and cultures. We therefore believe that it is most apt to say that the epistemically unjust nature of such conceptions is a *relative* rather than intrinsic property. This is important to emphasize both because it implies a need to analyze exactly how certain conceptions are used and embedded within concrete practices, and because one and the same conception may lead to epistemic injustice or not. While certain conceptions seem almost sure to facilitate epistemic injustice when endorsed, it is a much more contingent matter whether conceptions like naturalism and dualism will, as we argue below.¹ Second, the relations between theoretical conceptions and agential vice remain underexplored. Under what conditions can a conception be said to promote, require, or attract vicious acts, dispositions, or structures? Is this a conceptual or an empirical relation? To elucidate some of these questions, we propose a distinction between *conceptual epistemic injustice* (CEI) and weak versus strong *conception-mediated epistemic injustice* (CMEI) in what follows.² Afterward, we will apply this distinction to the case of mind-body dualism in medicine.

¹ For example, it can be questioned whether the empirical diagnosis of naturalism dominating medicine to a problematic extent is empirically accurate. Lalumera (2025) makes the contrasting diagnosis of a “babel of health concepts,” which calls for conceptual clarification as well as privileging certain conceptions of health in those contexts in which they are best suited. If Lalumera is right that naturalist conceptions excel regarding some purposes but not others (for example, in acute versus chronic care), it becomes a more intricate, case-dependent question whether their use is warranted or epistemically-ethically problematic.

² These kinds of injustice are to be distinguished from (albeit related to) *conceptual injustice*, a notion developed by Lisa Bastian (2024). Bastian defines conceptual injustice in terms of wrongful application conditions of

2.2 Conceptional and Conception-Mediated Epistemic Injustice

If epistemic injustices are originally conceived as being committed by a socially dominant epistemic agent toward a marginalized agent, who is discredited or disbelieved on prejudicial grounds, one might wonder whether extending the category of epistemic injustices to include conceptions overly dilutes the original notion. To avoid an inflation of the concept of epistemic injustice, as well as shifting responsibility for epistemic injustice from agents to abstracta, we do not argue that the very existence of such conceptions typically constitutes an epistemic injustice in and of itself. Rather, such conceptions *enable* or *promote* epistemic injustices in variable ways. They enable epistemic injustices, insofar as they make them possible, and promote them by making them more likely to occur. For example, a certain conception might support a biased attitude in epistemic agents that makes them more likely to commit epistemic injustices, or it might influence societal structures that inadvertently marginalize certain demographics or make it difficult for them to interpret their social experiences.

Naturally, some abstracta run a greater risk of facilitating epistemic injustices than others. Certain conceptions even seem designed for this specific purpose. An extreme example of this is *sluggish schizophrenia*, which was a diagnosis of mental disorder only recognized within the Soviet Union and solely attributed to political dissenters. In this way, the classification was weaponized to sow doubt about the sufferers' sanity and cognitive abilities to silence them, which exemplifies how a conception may facilitate epistemic injustices by moral agents with ill intent. Another example would be the conception of *white supremacy*, which expresses a set of beliefs about a racialized hierarchy that applies (among other things) to intellectual abilities.

Though illustrative, sluggish schizophrenia and white supremacy lie at the extreme end of a spectrum of conceptions that facilitate epistemic injustices because they were designed with the express purpose of creating credibility deficits, and their coinage and usage are deeply intertwined with asymmetrical power structures. Conceptions like these contain built-in biases or are introduced with the explicit intent of causing (epistemic) harm and furthering oppression. However, here we are interested in more complex cases, in which the injustices that abstracta may facilitate are often unintentional features of conceptions that are normatively neutral or useful and valid in other respects. For instance, the conception of psychosomatic conditions was designed to capture cases with somatic symptoms that arise as a response to psychological distress. Yet, in folk conceptions it has gradually been associated with the stigmatizing belief that these conditions are less real, or all in the patient's mind, or even a form of malingering (O'Sullivan 2015, 2021). Folk beliefs surrounding the conception can, accordingly, lead to epistemic injustices when patients with psychosomatic disorders are disbelieved or not taken seriously because of this label. The same conception may therefore, depending on its use and the circumstances, either prove useful and epistemically virtuous, or harmful and epistemically vicious.

existing concepts such as "woman." In contrast to our notion of conceptional epistemic injustices, conceptual injustices can be epistemic in kind but need not be. Moreover, we focus on "conceptions," as we refer to larger networks of beliefs and normative commitments. These may be explicit or implicit, and they affect attitudes, behaviors, and institutions in ways going beyond application conditions of given concepts.

This implies a need to discuss which conditions must be fulfilled for a conception to be epistemically unjust. A case in point is the aforementioned naturalistic understanding of disease and health. Kidd and Carel have convincingly argued that this concept may lead to epistemic injustices when marginalizing the patient perspective. Yet the converse argument may similarly be made; namely, that naturalism can promote epistemically just practices in healthcare. Dan Degerman (2023) has argued that the inherent reductionism and neglect of the social perspective is not a bug but a feature of naturalistic approaches, especially within psychiatry. Naturalism may decontest mental disorders by granting them the same medical status as other conditions and thereby circumvent the normalization or trivialization of patients' experiences. By removing the blame from the patient as a person and locating it within the biological disorder, it may similarly reduce stigma and identity prejudice, which is a core facet of testimonial injustice, thereby supporting the credibility of the patient. Moreover, by providing an explanation for the experiences of the patient that is also acknowledged by others, the naturalistic understanding provides them with the epistemic resources to make sense of and successfully communicate their situation. If granted, naturalism need not lead to epistemically vicious practices or epistemic injustices (even when strongly privileged) but may even promote epistemic justice. This engenders the need to attend more closely to how such conceptions are embedded in institutions, practices, and attitudes of agents.

To capture this, we distinguish between *conceptional epistemic injustice* and strong versus weak *conception-mediated epistemic injustice*, each of which can come in testimonial or hermeneutical form. They are ordered here according to the degree of probability by which they give rise to unjust inferences about the credibility, intelligibility, or relevance of someone's contribution.

1. *Conceptional epistemic injustice (CEI)*: A conception is epistemically unjust if, in all cases it is employed in an endorsing way,³ it results in unfair discrediting. This will be the case if a conception *logically implies* epistemic deficiency, even though this is unfair (as in the case of sluggish schizophrenia). These cases are properly understood as conceptional epistemic injustices; that is, their usage *constitutes* an epistemic injustice. Usually, respective conceptions arise out of deeply asymmetric power relations and play an instrumental role in oppression. Amelioration should then target the linguistic and institutional norms governing their usage (they should just never be employed or enacted), as well as the underlying power asymmetries.⁴

³ Critical usage must be exempt from this. Interesting in this regard are also cases in which marginalized groups "reclaim" problematic concepts such as "mad" or "slut." While this is voluntary usage of problematic terms, it usually involves a rejection of central elements of the related conception (for example, beliefs that female promiscuity is inherently problematic). Just usage of such reclaimed concepts, however, is usually strictly limited to members of the marginalized group.

⁴ Mapping this onto the distinctions drawn by Kidd and Carel (2019, 165), it seems that their categories b) and c) of hermeneutically unjust conceptions would both exemplify this, as they either "require" epistemic vices for enactment or could "only be regarded as attractive" by someone with a disposition toward such vice (see section 2.1). All endorsing usage, accordingly, is problematic, and the respective conceptions cannot be used in epistemically just ways. Degerman's (2023) counterargument could be understood in terms of locating naturalism under conception-mediated epistemic injustices (at most), but not as conceptional epistemic injustice. Kidd and Carel's category a) of "promoting" maps onto our category of strong CMEI, in which we specify promotion in terms of default inferences.

2. *Conception-mediated epistemic injustice (CMEI)*: As argued above, most conceptions, even problematic ones, facilitate epistemic injustices dependent on the context of use. We distinguish between a strong and a weak form.
 - a. *Strong CMEI*: This refers to cases in which conceptions *promote* testimonial or hermeneutical injustices in a systematic manner. They do so by encouraging assessments that unfairly discredit speakers or hermeneutical frameworks, to a degree that makes such assessments the default. For instance, a rigid interpretation of naturalism might lead clinicians to systematically disregard subjective patient reports as irrelevant. If this interpretation were very common, it would turn such unfair assessments into the typical response to patient testimony. The reason for such systematic unjust effects here does not lie in logical implications of the conception but stems from its institutional, educational, theoretical, and social embeddedness. Taken together, these make epistemically unjust inferences about patients the path of least resistance. Ameliorative measures, consequently, should target the development and implementation of hermeneutical alternatives but also, for example, institutional structures, formal or informal (evidence) hierarchies, or educational measures.
 - b. *Weak CMEI*: This refers to cases in which conceptions are logically compatible with and thereby *enable* prejudicial assessments of testimonies or hermeneutical alternatives on a more case-by-case basis, dependent on individual biases. For instance, a clinician might base a discrediting of patient perspectives on a naturalist conception of health and disease—not because this is institutionally anchored or strictly implied, but because it resonates with their own prejudices. Ameliorative measures should target the epistemic vice causing the problem here, for instance via debiasing initiatives in healthcare, and avoid shifting the blame from agents to abstracta.

As these examples show, whether CMEI is strong or weak does not only depend on the conception itself but also on how it is used in practice, built into institutional structures, and embedded in power relations. This has important consequences. Firstly, conceptions can shift from one category to the other. For example, naturalist conceptions of health could change from systematically structuring all healthcare encounters to “only” justify prejudiced assessments by individual clinicians, if they were complemented by a greater pluralism of health concepts and, correspondingly, of kinds of evidence considered relevant. In contrast to CEI, the relation between conception and epistemic injustice is not a conceptual or semantic one in CMEI. While conceptions in CMEI are logically compatible with epistemically unjust inferences, to which degree they raise the probability of such inferences is contingent. Strong CMEI starts at the point where an unjust assessment becomes the standard; that is, where vicious acts are easier than virtuous ones because they appear to be more commonsensical, evidence-based, efficient, or familiar than the alternative.⁵

⁵ This also relates to the assignment of blame. Whereas at one end of the spectrum, in clear cases of weak CMEI, the individual agent is morally blameworthy for weaponizing a conception, this becomes more intricate when the vicious act is normal for a certain environment. As Fricker (2007, 98–108) discusses with the example of sexist credibility judgments, historical actors may be said to have failed at epistemic justice in a non-culpable

Second, the complex network of conceptional, epistemic, institutional, and agential factors described here might seem rather diffuse and better described by established categories of institutional, testimonial, or hermeneutical injustice. Conceptually mediated epistemic injustice, as we understand it, provides intellectual scaffolding to such injustices in ways that go beyond shared prejudices and make certain ways of doing things or assessing testimony seem natural, maybe even as without alternative. In such cases, being attentive to the conceptional background adds essential nuance toward explaining epistemic injustices. For example, it can help to understand the persistence of problematic tendencies in healthcare, which hopefully allows for more targeted countermeasures.

Here, we are especially interested in strong CMEI, where the role of the conception in epistemic injustices must be frequent and systematic, not merely incidental. To establish whether a conception falls within this category, then, detailed attention to its use and enactment is needed. In this spirit, we will now take a closer look at a case study; namely, mind-body dualism within medicine as a theoretical conception, and argue that it falls under (2a) but neither (1) nor merely (2b). The ambition is to show, first, how certain conceptions, in this case a form of dualism within medicine, can become deeply embedded in institutional structures and epistemic frameworks, affecting the way that this practice is organized and enacted; second, how this potentially leads to various epistemic injustices without the conception being inherently problematic, in this case for patients with complex conditions.

3. Mind-Body Dualism in Medicine

Modern medicine is often criticized for being *dualistic*, but what does this entail? Though the exact origins of this claim are difficult to locate, it has played a significant role in critiques of biomedicine. For instance, Engel (1977), the inventor of the biopsychosocial model, famously criticizes modern medicine for being reductionist and attributes this to the dualistic roots of modern medicine. The claim, in brief, is that medicine has conceptualized and treated mind and body as two separate parts of a human being that function independently, which has allowed the reduction of all conditions to their physiological properties while simultaneously discrediting or neglecting the social and psychological dimensions of health. According to critics, this conception of the human being dates all the way to René Descartes's philosophy, which perceived mind as a distinct substance independent from body and conceived the latter as nothing but a machine. In this view, dualism and reductionism are closely intertwined. The same critique has been reiterated since Engel—see, for example, Toombs (1988), Mehta (2011), and Shelton (2013), among many others—and is usually accompanied by pleas for more holistic models of medicine that understand and treat the human being as a whole.

Though influential, this narrative contains significant flaws both conceptually and historically. From the point of view of philosophy of mind, equating dualism with reductionism, or somehow suggesting that one inevitably leads to the other, is contradictory. Dualism as a metaphysical theory proposes that both minds and bodies exist, and are fundamentally distinct from and irreducible from each other, while physicalism as

way. Contingent on the sociocultural environment, what can be morally expected of agents are just credibility judgments that are routine, not those that are exceptional. At least some of the culpability would, accordingly, shift away from the individual to the abstractum in strong CMEI.

a form of reductionism, which is often the target of critique within medicine, conversely reduces mind to body (O’Leary 2021). As metaphysical positions, these conceptions are therefore polar opposites and do not logically entail each other. However, this does not entail that there is no interactive potential between mind and body within dualism, for though mind and body are distinct, they are connected and influence each other in all manner of ways. Accordingly, there need not be any contradiction between dualism and holism either. Historically, depictions of Descartes’s dualism as the source of reductionism are also misleading, and his views on medicine were more holistic than critics assume (Brown 1989).

The main issue in this context, however, is that *medical theory is often not dualistic* but indeed perceives itself as *explicitly anti-dualistic* in the way that this conception is interpreted by the critics of dualistic medicine. Important organizations of healthcare are to a great extent formally avowed to a certain form of holism, which does not sharply separate the mental from the bodily and therefore treat these in isolation. Take, for instance, the World Health Organization (WHO), which defines health as a state of complete physical, mental, and social well-being (WHO 2020) and posits that the mission of healthcare is to promote this goal. Or take the American Psychological Association (APA), whose president in a column titled “Health Care for the Whole Person” explicitly disavows “Cartesian dualism”: “Mind-body dualism, is, in a word, bankrupt” (Levant 2005, 5). Instead, the APA has formally pledged to “improve mental, behavioral, and physical health by promoting clinical practices based on the best available evidence” (APA 2020).⁶ These are influential healthcare organizations with global outreach, whose policies are dedicated to non-dualistic as well as non-reductionistic strategies of health promotion.

It is not at the theoretical or political level, then, but rather in medical *practices and institutions* that one finds dualism. It presents not as a theoretical adherence to a dualist metaphysics in the vein of Cartesian substance dualism but as a “practical dualism,” so to speak. That is, though dualism is explicitly rejected within medical theory, dualistic tendencies still influence healthcare practices. When we therefore claim that dualism is still operative within healthcare, we do not take this to mean that practitioners or theorists hold a set of explicitly endorsed beliefs concerning the nature of reality as consisting of distinct and non-reducible mental and physical entities. Rather, dualism here refers to certain background beliefs, pre-reflective attitudes, or inferential habits that shape, and are shaped by, the organization of healthcare as a social discipline and the conceptualization and classification of diseases, as well as practitioner-patient relations according to a strong split between mind and body. To be clear, this is what is meant by dualism from this point onward, unless otherwise specified.⁷

There are several reasons why dualistic patterns of thought might influence healthcare. Though models such as the biopsychosocial model of medicine (which takes itself to be anti-

⁶ Cf. also guideline 10 of the official guidelines of APA on evidence-based practice (APA 2021).

⁷ Despite the disparity between philosophical and medical understandings of “dualism,” we have elected to maintain the term to keep in line with the tradition in medical theory described above. Though it might appear grating to philosophers of mind to speak of dualism in this way, “dualism” as a term is notably much broader than the purely philosophical understanding thereof and simply denotes any sort of division between two things of fundamentally different kinds, as evident in, for example, ethical or religious forms of dualism. Fundamentally, we argue that there is a pervasive and domain-specific dualistic mode of thought in medicine, involving a stark division between mind and body, which manifests itself in how healthcare organizes itself, how it classifies diseases, and how practitioners and patients think.

dualistic) have found favor among healthcare organizations, the uptake among practitioners and researchers has been limited (Benning 2015), in part because these models rarely provide useful answers to how these dimensions interact and what this entails for ideal care (De Haan 2021). Generally, the more holistic and complex the model of medicine, the more cumbersome it becomes to, for example, pinpoint causal pathways in pathogenesis or provide appropriately inclusive care. This makes it likely that healthcare professionals revert to dualistic modes of thought—not because they necessarily hold dualistic metaphysical beliefs, but because it provides a more straightforward approach to the problem that the clinical encounter presents, which is constrained by various practical and ethical matters.

In the following subsections, we aim to show that such dualistic tendencies still hold sway within three dimensions of healthcare; namely, (1) at the organizational level; (2) in medical epistemologies and disease classifications; and (3) in attitudes and beliefs of health professionals and patients. Afterward, we argue that dualistic conceptions in healthcare systematically facilitate epistemic injustices.

3.1 Dualism at the Organizational Level

Dualism at the organizational level of medicine is primarily a consequence of increasing specialization. Premodern medicine, in effect, did not sharply distinguish mind from body because it was exercised by general practitioners with holistic understandings of disease and health, as well as the art of healing (Jewson 1976). However, scientific landmarks within medicine enabled a much greater and detailed knowledge of bodily subsystems and their semiautonomous workings. Medicine was accordingly split into specialties, which entailed a siloing of medical disciplines within clinical practice, education, and research. While this specialization entails greater knowledge of specific bodily subsystems and means of treating conditions, it also entails a greater *fragmentation* of healthcare that has undesirable consequences.

As it stands, medicine is roughly divided into the disciplines dealing with the body versus the mind, each of which comprise a host of subdisciplines, with their own specialized forms of expertise, methods, nosological systems, and so on. Historically, psychiatry as a discipline emerged in the Western world with the rise of private madhouses and public asylums for the mentally ill in the eighteenth and nineteenth centuries (cf. Foucault 1961; Kendler et al. 2022). The medicalization of mental illness was based on the conceptualization of it as a distinct kind of illness, with special institutions, scientific disciplines, and modes of treatment being established to deal with it. This dualistic professional split arguably continues to shape our current healthcare systems.

Such a division into somatic and mental illness need not in principle entail that the practice of medicine is similarly divided into isolated treatment of body and mind. Integrated care that treats the patient as a whole has been and continues to be the ideal within medicine, as the examples from the WHO and the APA illustrate. Despite best intentions, however, fully integrated care and collaboration between multi-professional teams is difficult to achieve and may itself lead to epistemic injustices (Bueter and Jukola 2025). It is generally difficult to realize true interdisciplinarity within science and practice because of the domain specificity of different scientific disciplines. While domain specificity may be quite bridgeable between two subdisciplines of somatic medicine that are alike, the

difference between the areas of expertise and mindset of a doctor of somatic medicine versus psychiatry can be stark. Therefore, while the issue is acknowledged and measures are implemented to counter the siloing of medical disciplines, these are not always effective, and the organizational separation of medicine into bodily and mental disciplines still constitutes the norm. This separation can be witnessed not only in distinct institutions for mental and somatic healthcare, but also in varying levels of funding of such institutions and of their respective research programs, in educational practices, or in differences in insurance coverage.⁸ This organizational dualism has consequences for the care provided and interacts with the epistemic frameworks underlying our understandings of somatic and mental health.

3.2 Medical Epistemology and Disease Classifications

There is an extant history behind the rise of dualistic tendencies in medical epistemology and disease classifications, of which we will have to omit many details. What is crucial in this context is that medicine adopted *methodological reductionism* as an approach to both research and intervention. Modern medicine increasingly aimed at identifying underlying dysfunctions for specific disease states and situating pathological phenomena in specific bodily sites, rather than perceiving them as broad and systemic (Jewson 1976). Discrete disease entities (rather than the suffering patient) became the primary object of interest in medical research (Lynch et al. 2022), which made it conceptually possible to suffer from several distinct diseases, as well as from distinct problems of somatic and mental illness. Modern medicine still largely subscribes to this *modus operandi* by explaining distinct diseases in terms of underlying, ever-more fine-grained micro-physiological parts and processes. This approach has proven immensely successful; we now understand many diseases much better than we did a few centuries ago and can cure or treat more of them.

The success of reductionist medical research has, however, led to a level of dominance that some consider problematic (Bishop 2009, 329). As reductionist strategies have a directionality that makes them go for ever-more detail and ever-smaller subsystems, their success has also contributed to the organizational fragmentation of our current healthcare systems. Adopting a reductionist methodology, moreover, has implications for what kinds of evidence are considered most salient in research and practice. Since reductionist approaches aim to explain surface-level phenomena in terms of lower-level causal mechanisms, it is here that decisive facts are to be discovered. Patient testimonies of their symptoms, for instance, may serve as a guide in a clinician's search for a diagnosis, but the ultimate proof comes from blood parameters, urine cultures, imaging technologies, and similar. It lies in the logic of the reductionist strategy to prioritize these kinds of evidence as more foundational and reliable than patients' descriptions and interpretations of their own lived experience.

This approach has created a schism between psychiatry and somatic medicine. Early psychiatry followed the same medical epistemology of reductionism by conceptualizing and

⁸ As Raese (2015, 173) states: "There has been systematic discrimination against patients with mental illness for many decades by insurance companies." Lower levels of reimbursement, as well as of funding for mental healthcare institutions and research, indicate that not only is there an organizational split between the two, but this split also comes with differences in the evaluation of their relative importance. Raese argues that this is a consequence of mind-body dualism and mental illness stigma.

classifying madness as a disorder of the brain and nervous system (Kendler et al. 2022). However, the success of biological and reductionistic psychiatry has been quite limited (Harrington 2019). Reductionist explanations (and cures) for mental illness have largely eluded psychiatry and continue to do so. Historically, these developments grounded the tension between biologically and psychologically oriented approaches within psychiatry, which persists today (Harrington 2019; Aftab and Ryznar 2021), and they also led to a division between psychiatry and somatic medicine in terms of disease classifications.

While somatic medicine uses an etiological or pathophysiological nosology—that is, a system that classifies diseases according to either their causes or to abnormal physiological mechanisms involved—the authoritative classifications in psychiatry classify disorders according to patterns of symptoms. This is exemplified by the most dominant classificatory system, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. The DSM shifted to this syndromal approach with its third edition in 1980, aiming for a classification that was atheoretical and therefore widely usable, as well as for an increased reliability of diagnosis facilitated by the introduction of explicit, observable criteria. While it was hoped that greater reliability of diagnostic criteria would lead to validity in the long run (that is, etiological or pathophysiological understanding of diagnoses), this hope has not come true so far. It has been argued that this is not just a matter of more time and research, but that the DSM may rest on mistaken assumptions about mental illness and needs to be replaced by other systems (Hacking 2013; Hyman 2010; Tabb 2015; for an overview of alternatives, see Aftab and Ryznar 2021).

For the most part, however, psychiatry's inability to achieve a diagnostic system similar to those of somatic medicine, and in general to provide causal explanations of mental illnesses, has been interpreted as a problem of psychiatry, not as a problem of the reductionist approach to illness. Reductionist explanation as a standard thereby perpetuates the appearance of mental and somatic illness, as well as of the respective disciplines, as fundamentally different. This also fuels skepticism toward psychiatry and patients with psychiatric symptoms or diagnoses, because given this standard, psychiatry seems a small sibling, not an equal contributor to medicine. Mental illness, in lack of “hard” evidence such as biomarkers and clear causal pathways, may seem less real or less deserving of resources. Consequently, many attempt to frame mental disorders as being “just like diabetes” (Arpaly 2005), but this need for reconceptualization reveals both that many do not perceive mental disorders as equivalent with somatic diseases and an implicit value ranking. No one argues that diabetes is just like depression; rather, mental disorders must live up to the criteria for “proper” pathologies like somatic diseases.

3.3 Dualism in Clinical Practice

Finally, dualistic tendencies can affect clinical practice despite official organs of healthcare largely rejecting dualism. Dualism among health practitioners manifests not necessarily as explicit metaphysical beliefs but may rather show in practical approaches. For example, health professionals may exhibit a bias toward disjunctive thinking in the way that they interpret and perceive patient complaints. It is not uncommon for patients who suffer from mental disorders and seek out healthcare for somatic problems to be disbelieved, because their complaints are perceived as expressions of delusions or the like. This phenomenon is known as *diagnostic overshadowing* and has severe consequences for the physical health

of the mentally ill (Bueter 2023). Depending on the patient's medical history and the attitude of the doctor toward the patient, there may be a tendency to either psychologize patient complaints of somatic symptoms or conversely to somatize complaints of psychological distress.

Dualistic thinking promotes a tendency to place patients into *either* the somatic *or* the psychiatric category. The cause of dualistic thinking, moreover, may also partly lie in the tendency toward specialization, which makes the health practitioners' areas of expertise increasingly focused on specific domains of medicine. Except for general practitioners, doctors have a highly specialized knowledge and will aim toward specificity in explaining and treating pathologies. Dualistic attitudes, clinical practices, and organizational bifurcation in the healthcare system co-align and can mutually stabilize.

Even within the disciplines concerned with the mental, dualistic thinking may prevail. The divide between mind and brain still plagues psychiatry and influences clinical reasoning and normative evaluations of disorders. For instance, mental conditions perceived by practitioners and laypeople as more firmly rooted in biology are sometimes considered to lie outside the individual's control and therefore to be less blameworthy compared to conditions more strongly founded in psychological circumstances (Miresco and Kirmayer 2006).⁹ These findings are also congruent with the stigma and blameworthiness attached to mental rather than somatic disorders (Buckwalter 2020; Raese 2015). Such lines of thought extend to other disciplines of medicine as well, such as the divide between neurology and psychiatry. Despite both psychiatric and neurological disorders ostensibly being disorders of the brain—at least according to the dominant field of biological psychiatry that established psychiatry aspires to (Walter 2013)—these fields utilize highly different methods of clinical reasoning that lead to different normative appraisals of patients' problems. Whereas neurological disorders are only recognized as such when demonstrably rooted in brain (dys)functions, the same does not hold for psychiatry, which (in lieu of biomarkers) focuses on psychological phenomena in themselves. This supports the thesis that a mind-brain divide influences certain clinical practices.

Furthermore, dualistic background beliefs can be present among practitioners as well as patients. Paul Bloom (2005, xi) has argued that we are all “natural born dualists” as part of our human cognitive makeup. Critics respond that such dualism is rather learned in certain cultural environments. For instance, a predicting factor for dualist attitudes among both health professionals and laypeople are religious belief systems that involve the existence of an incorporeal and immortal soul (Demertzi et al. 2009). In any case, empirical evidence supports that many people hold dualist beliefs about mind and body. For instance, thought experiments about the duplication of persons reliably elicit dualist attitudes in people's responses (Forstmann and Burgmer 2015).

Dualistic attitudes are thus likely to be prevalent among patients as well and can affect healthcare encounters in a variety of ways. First of all, it is a common phenomenon that both patients and patient organizations push for somatic explanations and treatments of their suffering and resist psychosomatic approaches, as can be witnessed especially in people with complex or controversial diagnoses, such as chronic fatigue syndrome, chronic Lyme disease, fibromyalgia, or long Covid (Blease et al. 2017; Dumes 2020; O'Sullivan

⁹ However, Miresco and Kirmayer assume that dualism is inherently incongruent with psychiatry, though this is not the case (Cooper 2007, 122; O'Leary 2021). Cf. section 4.1.

2025). This may be the outcome of the internalization of a hierarchy between somatic diseases and mental disorders. Patients will then *perceive* psychological or psychosomatic explanations as having their symptoms dismissed as less real and less disabling. This may actually match the attitudes and prejudices of the respective clinicians; that is, it can (and often will be) the case that patients are taken less seriously if they have no clear physical cause (or “proof”) of their suffering. However, it may also occur in cases where clinicians are not prejudiced in this way—yet patients take them to be. This indicates how difficult it can be to properly communicate psychosomatic interactions within a dualistic system.

It is important to see how the dimensions of dualism we distinguish here interact. For instance, patients may not hold dualistic beliefs themselves but still resist psychosomatic accounts of their ailments, because of a well-founded fear that accepting these may put them in a difficult position in the system. Once labeled as a psychiatric patient, there may be no coming back: The label can make it harder to access somatic care in the future, as the phenomenon of diagnostic overshadowing shows. It might even put an end to receiving any care at all, given the limited access to (and reimbursement for) mental health care. Careful communication of integrated mind-body approaches, then, can only be successful insofar as it is coupled with offers of integrated help. Furthermore, patients might recognize the legitimacy of the label but be wary of accepting it because of the stigma attached to it. In this case, the resistance consists in a self-defensive maneuver, shielding the patient from further marginalization as a result of the different social statuses of somatic and psychologically founded disorders.

4. Dualism and Epistemic Injustices in Healthcare

4.1 Exemplary Cases

Despite the broad rejection of metaphysical dualism within medical theory, certain dualistic tendencies therefore still influence healthcare organization and clinical practice. And while mind-body dualism is not designed to cause epistemic harm, we argue that in certain instances dualism facilitates epistemic injustices. Especially vulnerable to this are patients who suffer from disorders that fall between the cracks; that is, those that resist binary categorization and therefore do not fit within the domains of either psychiatry or somatic medicine. This includes, for example, *functional disorders*, which is an umbrella term for disorders with physical symptoms but no (known) pathophysiological etiologies, such as functional neurological disorders. Another example are *medically unexplained symptoms*, which also often defy neat classifications by sometimes resulting from hidden biomedical disorders, other times somatizations of psychological distress, or interacting mental and somatic mechanisms. This makes this category of symptoms difficult to handle in more dualistic practices, which vacillate between somatic and psychological explanations and treatments (O’Leary 2018). Moreover, it has been argued that certain diagnoses within psychiatry fit this picture as well—for example, PTSD (McFarlane 2017), whose bodily symptoms and causes have been neglected because of the prevalent understanding of the condition as psychological. The results of these dualistic structures can be conception-mediated epistemic injustices—for example, when patient complaints are relativized or not given proper credence because of dualistic patterns of thought in clinical reasoning, or when

medical epistemologies leave patients in a worse-off position in terms of understanding the nature of their predicament. We exemplify these injustices below.

There is, however, a caveat to this story. Analogous to biomedical or naturalistic conceptions, dualism does not cause conceptional epistemic injustices per se. As Diane O’Leary (2021) has argued, confusions regarding dualism abound within the literature because it is mistakenly conceived as leading to reductionism. It has therefore been assumed that medicine can only become truly holistic when dismissing dualism (Kendler 2005). This, curiously, led to the view that the mental and the somatic should not be distinguished sharply from each other, but that the mental is, at heart, somatic, thereby in effect deflating the experiential dimensions of disease. However, this is, as stated, not what metaphysical dualism entails, and it need not be the consequence of applying this conception in medicine (Cooper 2007, 104–106). Dualism—philosophically conceived—is entirely consistent with an emphasis on the lived and experiential dimensions of disease (Maung 2019). Dualism can counteract tendencies to not take the mental and experiential seriously by staking out the mind as distinct from the body and thereby safeguarding it against undue reductions. This insistence may carry over to clinical practices, where it entails that the experiential dimensions should not be neglected or underprioritized. Notably, several writers within the literature on the biopsychosocial model have emphasized that metaphysical dualism may promote this exact goal (Marcum 2008, 20; Borrell-Carrió et al. 2004, 581). Under the right circumstances, dualism could therefore promote virtuous epistemic practices in healthcare. Thus, in terms of the distinction introduced in section 2.2, it does not constitute a conceptional epistemic injustice (CEI) because there is nothing inherently problematic about it.

Yet in certain cases, dualism, as understood within medicine, may prove highly problematic. For instance, sufferers of CFS/ME have most likely long been subjected to epistemic injustices (Blease et al. 2017),¹⁰ resulting from dualistic tendencies in healthcare. In all relevant respects mentioned above, CFS/ME is greatly exposed to such problematic effects of a strong divide between body and mind. It has, for instance, been heavily disputed whether CFS/ME falls under the jurisdiction of psychiatry or somatic medicine at the organizational level. Because causes of and biomarkers for CFS/ME are insufficiently known, it has historically been—and still is—contested whether it should be classified as a bodily or mental disorder; that is, as a condition that contains clear somatic symptoms with no (known) somatic etiologies or as a condition with a stronger psychiatric component that, however, displays somatic symptoms to a great extent. Though current evidence supports that it is a biological condition (Clayton 2015), patients with CFS/ME routinely suffer stereotyping, prejudices, and consequently credibility deficits when faced with healthcare professionals who cannot find objective biomarkers, leading them to conclude that the issue is purely or predominantly psychological. Patient attitudes exhibit dualistic patterns as well, insofar as they justifiably push back against one-sided psychological explanations of CFS/ME, though practitioners currently may not be able to provide sufficient somatic explanations (O’Sullivan 2015, 242), perhaps in part because of conceptual impoverishment surrounding this diagnosis (Byrne 2020). Dualistic attitudes potentially obstruct more fitting and integrative understandings of the syndrome, which would move beyond the question of *either* physical *or* psychological condition.

¹⁰ Though this is also a matter of contention within the literature (cf. Byrne 2020).

We therefore find it likely that at least some of the epistemic injustices that sufferers of CFS/ME face are systematically promoted by dualism that still thrives within healthcare systems. Dualist structures require conditions to be classified as mental or somatic illness; dualist attitudes make it plausible that symptoms without a physical correlation are psychological; more integrative explanations are lacking but may not even be perceived as lacunae. The dualist conception of mind and body underlying these structures, attitudes, and lacunae can make epistemically unjust inferences about the credibility or relevance of patient complaints the default response. In other words, the experience of being dismissed can become the standard, not the exception, for such patients.

A similar picture emerges regarding patients suffering from chronic pain, particularly in the absence of a corresponding physical cause at the location of the pain. As Grant Duncan (2000) argues, the phenomenon of pain has often been cast as one whose understanding and treatment has been hampered by Cartesian dualism, despite being a pivotal point for Descartes's thinking about the interactions between body and soul, and non-reductionist approaches being present throughout modern medicine. In any case, current pain science clearly holds that pain and tissue damage do not necessarily correlate, and experiences of pain are not simply nociceptive signals but modulated by an array of physical, psychological, and social factors. Chronic pain, in particular, is understood as neuroplastic; that is, as pain that the brain has learned (and can unlearn) to produce. This new perspective on pain has, however, superseded a long history of thinking about pain as either direct outcome of biomechanical problems or as purely psychosomatic (Stilwell and Harman 2019). Dualism therefore still shapes the organization of chronic pain treatment, as well as professional and lay attitudes.

The gold standard in chronic pain treatment nowadays is one of integrated care and multimodal treatment. For instance, a report from the US Institute of Medicine (2011) points out that because of what has been learned in recent decades about pain, interdisciplinary and biopsychosocial approaches are needed. However, the report also identifies a range of obstacles to such care, including the number of resources needed to implement it (given the enormous scale of the problem) and issues with insurance reimbursement. Other factors cited are a lack of pain specialists as well as a lack of education among nonspecialists, which leads to stereotypical, biased assessments of many patients as being overdramatic.

Patients, in turn, are also considered in dire need of better education measures, so as to support their understanding and self-efficacy in managing chronic pain. To improve pain treatment, both clinicians and patients thus need to be informed about the complex multidirectional processes involved. For instance, a study by Jana Declercq (2023) shows how communication is hindered even in cases where chronic pain patients have access to pain specialists. In this qualitative analysis of clinical encounters, it becomes obvious how patients may perceive any kind of psychological factors being mentioned, or psychological help being offered, as dismissal of their experience as being "just in their head." Even if the psychological aspects are explicitly not framed in a dualistic manner, they are often heard as such and taken to cast doubt on whether the patient's pain is real. This problem is likely exacerbated by specifics of the case of chronic pain; namely, that patients' testimony may not only be discredited in terms of their competence but also in terms of their sincerity and moral character. In a nutshell, patients may be afraid to be considered as drug-seekers and consequently to be denied any relief. Daniel Z. Buchman et al. (2017) show that this fear is

well founded and argue that a climate of distrust facilitates epistemic injustices toward chronic pain sufferers.

In contrast with the case of CFS/ME, the scientific understanding of chronic pain has thus advanced considerably in the last decades, in a way that integrates psychological, social, and physiological factors. Yet, widespread implementation of this knowledge is lagging, and chronic pain patients often experience epistemic injustices that target their epistemic and moral credibility—for example, clinicians may mistakenly infer that they are exaggerating their pain if no clear correlate at the location of the pain is found. The picture is further complicated by patients who internalize such beliefs themselves. A dualist conception of pain being either in the body or in the head here helps to explain the persistence of related attitudes and institutional inertia.

4.2 Connecting the Dots

With all this in place, let us revisit the question of whether mind-body dualism can be understood as epistemic injustice. In section 2, we argued that theoretical conceptions relate to epistemic injustice in various ways: (1) In proper conceptional epistemic injustices, any endorsing use of a conception comes with unfair implications about credibility, intelligibility, or relevance. This is because of ill-intent in the design of such concepts and their central role in social oppression. The relation between the conception and judgments of epistemic deficiency is one of logical implication. (2) In conception-mediated epistemic injustices, conceptions lead to epistemic injustices contingent on the environment and the way they are used. Strong conception-mediated epistemic injustices (2a) make unfair inferences about credibility, intelligibility, or relevance the standard or default, and fair inferences the exception. This is because of widespread prejudices and beliefs but also enactment via institutional structures or a problematic dominance within the hermeneutical field. In weak CMEI (2b), the connection between conception and unfair inferences is more incidental.

Many of the previous critiques of mind-body dualism in medicine (cf. section 3) can be reinterpreted as arguing that this dualism falls under category (1). Drawing a straight line between dualistic thinking and the (mis)treatment of patients as mere objects rather than epistemic agents, they seem to claim that dualism in medicine necessarily undermines any kind of non-dualistic testimony or makes it impossible to even put non-dualistic interpretations into intelligible words. While this critique is not entirely without grounds, it does seem overly strong. It is possible to employ dualistic thinking within medicine without diminishing patients' credibility. For one, many patient testimonies will fit the dualistic mold well. For another, even if they do not, dualistically minded clinicians might take this as a reason to further investigate a diagnostic puzzle, not to dismiss the patient experience. Crucially, dualism can also have positive effects where it safeguards patient experiences from problematic reductionism. As argued above, mind-body dualism is not the official paradigm in modern medicine and has never been without alternatives.

Yet, we argued that Western medicine has been historically shaped and is still characterized by dualistic tendencies in research methodologies, the organization of healthcare, and beliefs and attitudes of practitioners and patients. These dimensions interact and reinforce one another, even if they are not mutually dependent in a strong sense. While mind-body dualism does not necessarily exclude all other perspectives and

alternative conceptions, its pervasive effects have made it more difficult for diverging interpretations and testimonies, and systematically privilege those that fit the dualistic picture. Mind-body dualism therefore also encourages prejudicial assessments of patient testimonies that fail to fit its template.

Empirical studies show a myriad of patients complaining about experiences along these lines; that is, being dismissed or disbelieved because their conditions do not fit within a particular box, exemplified above with the cases of CFS/ME and chronic pain. Mind-body dualism as a theoretical conception structures the hermeneutical field of medicine and psychiatry in a way that systematically encourages a dismissal of unyielding symptom reports. In such a situation, it will always be easier to somehow blame the problem on the patient, and much harder to remain open-minded and exhibit patience instead. Especially under pressured working conditions, mind-body dualism contributes to an environment that furthers epistemically vicious behavior and makes epistemically virtuous conduct the harder route to take. Such problems are only exacerbated by the fragmented state of current healthcare and medical education. When clinicians are trained to specialize in particular subsystems of human physiology, and there are no accessible options for integrated care, patients are likely to end up not being given full credit—not because the clinician is necessarily prejudiced against them, but because they are operating under strained conditions with a lack of interpretive and practical alternatives. In consequence, we hold that mind-body dualism constitutes a strong conception-mediated epistemic injustice (2a).

5. Conclusion

To sum up, we claim that mind-body dualism in medicine is a case of strong conception-mediated epistemic injustice, though not conceptual epistemic injustice. One might object that the idea of conceptual and conception-mediated epistemic injustices risks inflating the original concept of epistemic injustice. Granted, our theory adds another conception to an already sprawling landscape of different forms of epistemic injustices, but we believe that the upshots of our distinction outweigh the risk of conceptual inflation for several reasons. First, if our analysis is correct, the epistemically problematic role of conceptions does not solely lead to hermeneutical injustices but to testimonial ones as well, when disposing individual epistemic agents to act in a testimonially unjust fashion. Notably, this is not due to the inherent but relative properties of the conceptions, which constitutes the second upshot. CMEI conceptualizes how the embeddedness and use of conceptions within certain practices enable or systematically promote various epistemic injustices. Third, the account captures how certain conceptions need not necessarily be epistemically problematic but may even be beneficial or productive under the right circumstances. Neither naturalism nor dualism are inherently epistemically unjust, but in certain contexts and under the right circumstances, such conceptions may still facilitate epistemic harms, even without the implicated agents harboring epistemic vices. This is the fourth upshot of the concept, for it allows us to theorize how healthcare practitioners who mean well inadvertently may cause epistemic harm; namely, because certain concepts structure the hermeneutical space in such a way that epistemic injustices become more likely. The ability to operate with such nuances is important, especially given the growing resistance to the widespread analyses of healthcare practices as epistemically unjust (Kious et al. 2023; Nielsen et al. 2025), as amelioration requires the active participation of all involved parties.

All of these points are on display in the case of dualism, we believe. Dualism, as understood in medical theory, may prove highly problematic in certain cases like complex or controversial conditions, causing immense epistemic and follow-on harms. Yet, the conception as such is not epistemically unjust and may even prove beneficial in certain cases. Wholesale rejections of dualism in medicine are therefore unwarranted. Rather, we must attend to the cases where dualism is ill-fitting, when it influences clinical reasoning in an unproductive manner, and so on. As we hope to have shown, philosophy and medical theory must move beyond blanket statements about the inherently harmful nature of dualism, instead attending to the practical dimensions of such concepts. Hopefully, a more nuanced and complete understanding of epistemic injustices allows for more targeted countermeasures.

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