

# Philosophy of Medicine

Original Research

## “Doctor Knows Best”: On the Epistemic Authority of the Medical Practitioner

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### Abstract

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We often consider medical practitioners to be epistemic authorities: “Doctor knows best,” as the saying goes. The place of expert judgment in evidence-based medicine hierarchies, and the crucial role of patient preferences and values in medical decision-making, however, pose problems for making sense of such authority. I argue that there is an account of such medical epistemic authority that does justice to the complexities of the doctor–patient relationship, while maintaining that medical practitioners hold an epistemically privileged position. Such a view can better inform medical practice by clearly illuminating the distinct roles of patients and doctors in decision-making processes.

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### 1. Introduction

Is it rational for me to adjust my epistemic behavior on the basis of another’s command? Should I put the full weight of my belief on a crucial medical conclusion or prescription, solely on the say-so of a medical professional? One may resist answering in the affirmative to these questions for fear that countenancing such authority risks leaving us, qua patients, in an all too fragile and dependent position. The literature on epistemic injustice in medical contexts clearly underlines this concern (see Carel and Kidd 2014). Yet, there seems to be something right in the idea that a medical professional has *some kind* of epistemic authority over us, given our lack of medical expertise, or the ability to navigate medical knowledge on our own terms. If there is such a thing as epistemic authority in the doctor–patient relationship, an understanding of what such authority amounts to could play a central role in any prescriptive account of how such a relationship should be structured, established, and examined. Such an account could better aim to avoid epistemic injustice (and injustice of any kind) in medical practice, but also ensure that medical practitioners fulfill their duties (epistemic and otherwise) as ideally as possible.

My task here is to lay the groundwork for articulating such an account. In what follows, I present my own account of epistemic authority, and argue that it, or an account like it, can best make sense of the more subtle and diverse roles that a medical practitioner can play, epistemically speaking, in relation to a patient. In section 2, I provide a brief illustration of



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the kind of role a medical practitioner may enact, emphasizing the possibility of such a role as including the normative power to command us to behave in a certain way. In section 3, I briefly present a variety of accounts of epistemic authority, including my own. Section 4 provides a more in-depth discussion of the range of roles that a medical practitioner may play, epistemically, vis-à-vis a patient, and the kinds of desiderata an account of medical epistemic authority ought to satisfy, including the limitations that evidence-based medicine (EBM) hierarchies place on such authority. I argue that my account, or one sufficiently similar to it, can better accommodate these diverse roles and desiderata. Lastly, in section 5, I suggest how further research on the issue of epistemic authority can help us improve our prescriptive suggestions, and guide policy, in defining the structures and boundaries of the doctor–patient relationship, as well as how we train and educate individuals to adopt either role in that relationship. No such prescriptive suggestion, however, can be effective if it does not also recognize medicine’s ongoing, wrongful treatment of people on the basis of their identities in unjust social hierarchies. The account of medical epistemic authority that I present here remains a distant ideal for such people; the job of making this ideal attainable falls squarely on the shoulders of all medical practitioners.

## **2. An Illustration: Epistemically Muted**

“But I still suspect that it might be an allergic reaction to my new mattress,” I suggested to my dermatologist, trying to resist the urge to scratch the strange, inflamed scales that had been quickly spreading and multiplying on my arms over the course of a month.

On my previous visit, the dermatologist, Dr. G, had asked me the standard series of questions: Have you ever suffered from a skin condition in the past? Are you aware of having any allergies? Are there any new changes in your life? Have you changed detergent? and so forth. He approached me as if he were a detective on the hunt for clues.

From my attempts to gauge Dr. G’s reactions—a task made difficult by his stern, unchanging features—none of my answers suggested a solution to my problem. When I mentioned the fact that I had recently bought a new foam mattress, he paused, adopted the expression of someone entertaining a plausible hypothesis, and said, “Perhaps.” Nothing more was said. I was prescribed an ointment, told to try it for a week, and sent home.

A week later, I was still suffering from the growth of an invasive outbreak of scales, now crawling from my arms up to my lower neck. I feared that my face would soon be caught hostage in the alien takeover. I thought it might be beneficial to ask Dr. G once again about the plausibility of an allergic reaction. At our appointment, I sat in front of him, lacking any sense of confidence under the ridiculous canopy of a hospital gown (designed, one may assume, to manipulate a patient into adopting a position of physical and psychological inferiority), and said: “But I still suspect it might be an allergic reaction to my new mattress.”

His words came to me, ringing firmly and clearly between the walls of the small, white room: “Forget about the mattress.”

With that, I dropped the idea from my mind. Not only did I find myself physically silenced within the confines of the medical space, I also found myself *epistemically muted*, the range of my mental life curtailed and guided in a specific direction: away from considering my mattress purchase as a reason for my current condition. A reason I had once had, a reason that suggested the plausibility of a certain hypothesis, was shut down, and removed from play, seemingly as a result of the power of another. I had experienced the

power of authority. More importantly, I would argue, I had experienced a kind of *epistemic authority*. The task in the following sections is to make sense of what this could involve.

### 3. Epistemic Authority

Following Linda Zagzebski's view (2012), I assume that there is such a thing as epistemic authority, where such authority is understood to entail more than what is usually discussed in the epistemological literature on epistemic expertise, or the expert–novice relationship in general. Broadly speaking, the suggestion is that such an epistemic authority holds a particularly strong sense of normative power over those they have authority over. An epistemic authority is someone that, given their superior epistemic standing (relative to others), has the authority to tell others what to believe, or to how to epistemically behave, more broadly.

Zagzebski famously delineates the core of this notion in terms of what Joseph Raz (1988), in defining political authority, refers to as Preemption. The epistemic version of Preemption, as Zagzebski describes it, stipulates the following thesis: “The fact that the authority has a belief *p* is a reason for me to believe *p* that replaces my other reasons relevant to believing *p* and is not simply added to them” (Zagzebski 2012, 107). The view is basically this: if I recognize someone as an epistemic authority, and I come to know that they hold the belief that *p*, then I ought to believe that *p* too, *solely on the basis of the fact that the authority believes that p*. This is because, argues Zagzebski, I recognize that I will be better able to do what I *should*, epistemically speaking, if I act on authority, rather than if I do not.<sup>1</sup>

At first glance, this seems innocent. The full strength of the thesis comes to light, however, when we consider what it prescribes we do with any “nonauthoritative” reasons we may possess regarding whether to believe or disbelieve that *p*. When I interact with an epistemic authority who believes that *p*, according to Zagzebski, any prior reason I had to believe that *p*, or to believe that *not-p*, ought to be removed from epistemic consideration: I ought to believe that *p* purely on the authoritative reason that the epistemic authority believes that *p*. This is because to put weight on one's own reasons, those not derived from the authority, would be to risk leading oneself astray from the truth: even if one were to give the authoritative reason a very strong weight, relative to one's other reasons, one would nevertheless end up with a different degree of confidence in *p* (or perhaps hold a completely different doxastic state) than the authority. Given that such an authority, by definition, knows better than we do, this would leave us in a less favorable position relative to the truth of the matter.<sup>2</sup> The best course of action is to simply believe that *p* solely on the authority of another's belief. This is a strong normative thesis. Zagzebski suggests that this element is precisely what constitutes an epistemic authority's normative power over a (relative) non-authority.

Zagzebski's view has faced stiff criticism, notably from Katherine Dormandy (2018) and Christoph Jäger (2016). These critics have focused on the counterintuitive results of the Preemption thesis, illuminating the epistemically unsatisfactory consequences of accepting a notion of epistemic authority with it as a component. To put the criticism broadly,

<sup>1</sup> Raz's political equivalent is justified in similar terms: I am better able to do what I *should* do in any case, if I follow a political authority's command, rather than consider my own reasons, and so on (1988).

<sup>2</sup> Note also that counting one's own reason in addition to an authority's reasons suggests that one has reasons that the authority is not aware of. Someone in favor of the preemptivist view of epistemic authority might think that this amounts to a “double-counting” of the relevant evidence or reasons, as the authority, qua authority, should be assumed to have considered all the reasons and evidence in the first place (see Dormandy 2018, 778). As will become clear, my view leaves room for the possibility that an authority does not have all the evidence (as this is a tall order in many circumstances), and that a non-expert can bring evidence to the table.

Preemption threatens to alienate us from our own epistemic attitudes: we could hold certain epistemic attitudes contrary to the full spectrum of evidence and reasons that we possess, solely on the say-so of some supposed authority. In some cases, I could possess a quite large number of reasons that would nevertheless have to be epistemically or rationally inert. I could, for example, have a vast array of my own reasons for thinking that *p* is false but, solely on the basis of an authoritative utterance, believe that *p* instead. Here, the idea that I should have the belief that *p* would seem, at worst, psychologically impossible,<sup>3</sup> and, at best, incoherently related to my reasons and other beliefs.<sup>4</sup>

Though these considerations are relevant, my discussion is primarily focused on a separate issue: namely, the fact that epistemic authorities often provide us with other epistemic goods than merely true beliefs and, perhaps more importantly, that we ourselves *seek* more than mere belief when we engage with them. Jäger (2016), for instance, suggests that an epistemic authority can be a source of *understanding*, and that non-authorities often seek such an epistemic good from the relevant authorities. The problem, then, is that a non-authority who behaves in accordance with the Preemption thesis may fail achieve any such understanding, given that they have forsaken their own (“deeper”) epistemic standing relative to *p/not-p*, instead choosing to adopt whichever doxastic state the authority does. If I, as per Preemption, come to simply believe that *p*, for the sake of being closer to the truth, but cannot make sense of how such a belief relates to other reasons I have, or other evidence I have acquired, then it seems that I am a long way away from understanding that *p*, no matter what view of understanding we adopt.<sup>5</sup> Preemption, as Zagzebski imagines it, seems to be, at least in a wide range of cases, inimical to the possibility of attaining such understanding from an epistemic authority: arguably, reaching a richer epistemic position (such as understanding) would require having the opportunity to engage in a process of inquiry, in which I reason and reflect on a wider range of beliefs, reasons, evidence, and so on.

In light of this, Jäger (2016) defends an account of what he refers to as “Socratic Epistemic Authority.” An epistemic authority of this kind has the appropriate skill set to communicate a certain understanding to a non-authority: they can *guide* us to an understanding of some complex phenomenon. Michel Croce (2017), reacting to both Zagzebski and Jäger, has provided an even more detailed account of epistemic authority related to the transmission of different epistemic goods. The important takeaway from these accounts is the observation that an epistemic authority can provide us with far more than mere true beliefs about a given issue, and that we do in fact engage with them for the purpose of acquiring other epistemic goods. Thus, the conclusion is that an account of epistemic authority ought to make sense of how such engagement is possible. In light of these complexities, the basic Preemption view fails to track the kind of phenomenon it aims to account for—or, as Croce’s (2017) taxonomy of epistemic authority suggests, only identifies *one* particular kind of such authority.

My own view attempts to account for epistemic authority in such a way that we can make better sense of the wide range of epistemic roles such an authority can play, as well as the broader range of epistemic goods that such an authority can provide to the non-authority.

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<sup>3</sup> See, however, Zagzebski’s discussion apropos the plausibility of believing on command (Zagzebski 2012, 99–103).

<sup>4</sup> To make things worse, this fact would be reflectively accessible to me: I could recognize that I have reasons to think otherwise, and even think that the weight of my own personal evidence far outweighs a particular instance of expert testimony, and yet, according to Zagzebski, I ought to continue to believe that *p* nevertheless, because of the Preemption thesis.

<sup>5</sup> See Baumberger, Beisbart, and Brun (2017) for an overview of accounts of understanding in epistemology and philosophy of science.

My suggestion is that we need to focus on the idea of such an authority as grounded in the fact that our epistemic superiors possess the appropriate *know-how* to participate in an epistemic practice that we deem epistemically fruitful, but that we ourselves lack the appropriate know-how, abilities, skills, or resources to directly participate in ourselves. This is in contrast (though not necessarily antithetical) to other accounts that ground epistemic authority more directly in the condition that such authority is the result of an individual possessing more *true beliefs* about a given topic—as Alvin Goldman’s seminal view on intellectual expertise suggests (2011)—or simply being more likely to have true beliefs about a given topic (see Constantin and Grundmann 2020). My aim here is to show how an account like mine can best account for one particular instance of epistemic authority: that of the medical practitioner.<sup>6</sup> Whether readers endorse all the details of my view in particular is a secondary issue—my primary target is to illuminate and elucidate particular epistemic roles in the medical context, and to show that an account of epistemic authority must consider these desiderata.

For the sake of the discussion that follows, my view of epistemic authority assumes the following:

*Epistemic Authority (of Practice)*: An agent (EA) is an epistemic authority relative to another agent (S) if and only if:

1. EA has the requisite skills, abilities, and know-how to successfully partake in a certain kind of epistemic practice (*EP*) relevant to some domain of inquiry (*d*).
2. EA has sufficient access to the evidence and resources required for her to properly partake in the *EP* relevant to *d*.
3. S does not have the skills, abilities, and know-how required to partake in the *EP* relevant to *d*, or at least has them to a (significantly) lesser extent than EA.
4. S recognizes that *d* and the relevant *EP* are epistemically valuable for her/himself; that is, they pertain to questions that would be valuable to have answers to.
5. S recognizes EA as having a sufficient level of the requisite skills, abilities, and know-how to successfully partake in the *EP*.
6. (From 4 and 5:) S recognizes that EA is, by virtue of her ability to partake in the relevant *EP*, a potential source of some kind of epistemic good that S would be epistemically better off in having.

The kicker, however, is the following condition:

7. EA has the power to give S a preemptive reason to behave in a certain epistemic fashion, perhaps by providing higher-order reasons and beliefs about methodological issues relevant to the kind of *EP* that is pertinent to *d*, or alternatively by commanding S to behave in a certain epistemic way. In short, EA is able to authoritatively *tell* S how S *should* epistemically behave in order to partake in the *EP* relevant to *d*.

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<sup>6</sup> I think Croce and Jäger’s own accounts would be similarly fruitful in this context in that they highlight certain intellectual virtues and characteristics that an epistemic authority may need to provide someone with certain epistemic goods (such as understanding). Those familiar with Croce’s recent work on epistemic authority will be aware of his demarcating at least two kinds of such authority, and his enumeration of the kinds of virtues required for either to function correctly: *authority of belief* and *authority of understanding* (Croce 2017). My position is that these two categories fail to recognize a broader, and more important kind of authority, which I call *authority of practice*, as discussed here in the case of medical authority. Furthermore, though I consider the virtues that Croce identifies as being especially beneficial for the social function of such authority, I do not think them *necessary* for such authority. They are discussed briefly in section 5.

The important thing to note here is that I understand an epistemic authority as having such authority over *higher-order* issues, not directly on our first-order beliefs,<sup>7</sup> as Zagzebski suggests. This means, for example, that an epistemic authority can tell me what is and is not a good reason to believe something, what the state of the evidence is in relation to a certain question, or how one should go about answering a question in the relevant domain of inquiry (in which he/she is an authority). This leaves room for a non-authority to consider his/her own (prior) reasons when considering whether to believe that *p* or *not-p*, while also putting him/her in a position to evaluate and properly weigh those reasons by the authority’s guidance—this has the benefit of being a far more intuitive view, while also retaining the authoritative power that I think Zagzebski is right in identifying as being constitutive of such authority. Indirectly, after all, the authority does indeed have the power to tell us whether we should believe that *p*, but this is not because of a preemptive power at the first-order level. Rather, an epistemic authority, from his/her seat of epistemic superiority (relative to us and the domain of inquiry in question), can tell us what to believe by appropriately adjusting the way we consider the evidence, our own reasons, and so on. This leaves room for some considerable variation in how we can engage with epistemic authorities: in some cases, if I only seek true belief, and do not have conflicting reasons or beliefs, I can simply believe that *p* on the authority’s say-so, knowing full well that if I had conflicting reasons, they would have the higher-order authority to bring those in line with *p*; in other cases I can further engage with them, share my reasons and evidence, and make sense of how I should reason about them relative to the relevant epistemic practice, perhaps seeking more robust knowledge, understanding, and so on. Consideration of the particular case of the medical practitioner, I argue, can clearly illustrate that this kind of account of epistemic authority can better capture the reality of such relationships.

## 4. Epistemic Authority in Medicine

### 4.1 Desiderata: EBM Hierarchies, Patient Preferences and Evidence, and Other Complexities

Making sense of epistemic authority in the medical context involves taking into consideration a wide range of complexities that cause issues for basic accounts of expert testimony, and some accounts of epistemic authority in particular. The core issue here is a simple one: the suggestion that we should simply believe what an expert tells us when it comes to our medical diagnoses and treatments, disregarding our other (non-expert-related) reasons, is implausible. This basic tension arises as a consequence of the following element of the medical practitioner–patient relationship: the presence of non-domain-specific reasons and preferences that do not perfectly sit solely within the domain of medical knowledge. I discuss these in more detail shortly.

The issue can be further compounded, however, by considering how medicine itself evaluates the epistemic status of expert opinion within its own domain. Consider what is

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<sup>7</sup> My discussion of first-order and higher-order questions in a domain of inquiry echoes Goldman’s distinction between *primary* and *secondary questions* in a domain of inquiry: primary questions are “the principal questions of interest to researchers or students of the subject-matter” and secondary questions “concern the existing evidence or arguments that bear on the primary questions” (Goldman 2011, 115). I have broadened this distinction as I think there are a wider variety of higher-order issues that may be relevant here, not just about evidence and arguments specifically.

generally referred to as the EBM movement, or paradigm, as introduced by the Evidence-Based Medicine Working Group (1992). EBM is a commitment to deciding medical intervention and treatment on the basis of the best evidence. David Sackett, a member of the Evidence-Based Medicine Working Group, and perhaps the most well-known of EBM proponents, defines the movement in the following terms: “Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett et al. 1996).<sup>8</sup> The best evidence is decided by reference to EBM hierarchies, in which certain kinds of evidence are ranked higher than others. Actual EBM hierarchies in use today vary in detail between institutions, but there are commonalities in their overall structures that are of concern to the present topic. Here I provide a simplified version of such a hierarchical structure, with the best kinds of evidence ranked first:

1. Systematic reviews and meta-analyses
2. Randomized control trials
3. Observational studies
4. Expert judgment and mechanistic reasoning.

The important detail to note here is the relatively low standing of expert opinion in the EBM hierarchy—it should be further noted that such judgment is not even *listed* in some working formulations of the hierarchy. The Evidence-Based Medicine Working Group originally identified such judgment in terms of “intuition [and] unsystematic clinical experience” (Evidence-Based Medicine Working Group 1992, 2420), with EBM being presented as an antidote to a medical practice that had historically placed too much weight on such unsystematic reasoning. The reason for expert judgment’s new low standing is simple: individual medical judgments, on the basis of personal experiences or mechanistic/causal-based reasoning of a medical practitioner, simply do not constitute good evidence in contrast to well-controlled, randomized trials. Individual judgments are too prone to bias and error, and generally fail to properly account for confounding factors (particularly unknown confounders). If, for instance, one wants to know whether medical intervention  $x$  is better than medical intervention  $y$  in treating or preventing illness  $I$ , a doctor’s personal judgment is a far less reliable source of evidence than one or multiple randomized control trials comparing the outcomes of using  $x$  and  $y$  in relation to  $I$ —worse, such judgments can be (and historically have been in quite serious cases) diametrically opposed to what a randomized control trial would suggest is the best course of treatment, or even a safe course of treatment.<sup>9</sup>

The question here is, *prima facie*, quite a troubling one: if EBM does not consider a medical practitioner’s opinion as constituting strong evidence, then why ought we, as patients, to countenance their authority? What is it that I am doing when I ask a doctor what I ought to do to best alleviate a medical condition? It seems to me that when we interact with such experts in the medical field, the questions that our inquiries seek to answer are of the following kind: What is the best course of action for me to take, relative to my condition of health? What is the best medical intervention for my situation? Is the “best” medical

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<sup>8</sup> Sackett is a fascinating case to consider when thinking about medical expertise relative to EBM. He was admirably consistent in his approach to medical practice, given his convictions about EBM. He suggested that anyone who is an expert on some matter should quit their position after ten years because an established expert’s opinions are given too much weight and get in the way of new thought. Following this advice, he gave his last talk on EBM in 1999. Notoriously, he took a dose of his own medicine and even repeated his residency after twenty years of medical practice (Smith 2015).

<sup>9</sup> For a discussion of the problems of expert judgment qua evidence, and a defense of placing such evidence at the bottom of the EBM hierarchy, see Howick (2011, 161–176).

intervention preferable to *me*, rather than another? These are the primary questions that the epistemic practice of medicine is meant to answer.

A few options present themselves. An easy solution, perhaps, would be to simply deny that there is such a thing as an epistemic authority in the doctor–patient relationship: a medical practitioner simply cannot have the kind of normative standing, or epistemic superiority, required to dictate any of our beliefs or epistemic attitudes in relation to medical practice—medical expert judgment is simply bad evidence for decision-making, as per the EBM hierarchy. This solution suggests that I would be altogether wrong in deferring to a doctor on questions pertaining to my medical well-being. My reaction to Dr. G, in the earlier example, for instance, would be epistemically irresponsible—I would have deferred judgment about something that I had no entitlement to defer. I think this would be too rash a conclusion, however. There is certainly a sense in which I, and many others, do defer to a doctor’s judgment, and I do not think that all of these cases are misguided. The complete denial of the possibility of any kind of epistemic superiority in this case would not fit well with facts about how we interact with doctors and would seem peculiar given medicine’s status as a scientific discipline.

Another answer is to strictly delineate the domain of the medical practitioner, such that they retain epistemic authority over only a subset of the kinds of questions they generally deal with. Here, we would consider a doctor, for instance, as merely being able to tell us that the best evidence suggests that *x* has better results, compared to *y*, in preventing *I*. This would reduce the authority of the medical practitioner to merely being a reliable conveyor of medical information about clinical trials and research—they would simply have a better working knowledge of the results of various trials and the information compiled in meta-analyses. On this view, there would not be a significant difference between a doctor and a detailed piece of software that can compile medical evidence. Besides using a doctor as an evidentiary source (and perhaps as a diagnostic tool), I am left to my own judgment to answer the actual questions that motivate my engagement with medical practice.<sup>10</sup>

However, simplified representations of EBM hierarchies aside, it is not clear that this limited role for expertise is even accepted by EBM’s proponents. Prevalent models of EBM seem to suggest an additional, non-evidentiary role for doctors. Sackett et al. argue that expertise in medicine “is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients’ predicaments, rights, and preferences in making clinical decisions about their care” (1996, 71). This position is expanded on by R. Brian Haynes, P.J. Devereaux, and Gordon H. Guyatt (2002) who suggest that doctors are not only responsible for considering the best evidence in relation a patient’s “predicaments, rights, and

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<sup>10</sup> Diminishing a doctor’s authority may seem attractive to some, especially those motivated by a move to a more patient-centered medical practice. Some may also think that this loss of authority is inevitable, as we will one day have artificial intelligence (AI) systems that can more efficiently and efficaciously do all the intellectual work we currently rely on doctors to do. If such systems can fulfill *all* the roles I identify as being relevant to medical practice in this article, then there may not be much need to defer to a doctor. That being said, Konstantin Genin and Thomas Grote (2021) provide us with much reason to think that we are quite far from establishing such a reality, and that there will be much future work for the medical practitioner to do, in tandem with AI systems. Perhaps more crucially for the view of epistemic authority I provide here, such AI systems may conflict with ideals of patient-centered medicine, and the possibility of doctor and patient working in a joint inquiry, if they are not sufficiently transparent enough—see Bjerring and Busch (2020). Marcin Rządęzcka (2020) argues that improvement in medical AI has transformed how we think about expertise, which now emphasizes expertise as involving the ability to delegate well, and to “cooperate in a large group of experts representing various fields of expertise” (222), as well making use of various communication skills. As should become clear below, all of this is in line with what I argue to be the right account of a doctor’s epistemic authority. The view of epistemic authority that I defend is compatible with a doctor working *with* AI and is strongly motivated by the idea that doctors and patients can work together, as suggested by a more patient-centered approach to medicine.

preferences,” but also for what they call “clinical state and circumstances,” explained in the following terms:

Patients’ clinical state, the clinical setting, and the clinical circumstances they find themselves in when they seek medical attention are key, and often dominant, factors in clinical decisions. For example, a patient with an undiagnosed symptom cannot be readily moved from a diagnostic decision to a therapeutic decision. Furthermore, people who find themselves in remote areas when beset by crushing retrosternal chest pain may have to settle for aspirin, whereas those living close to a tertiary care medical centre will probably have many more options—if they recognise the symptoms and act promptly! Similarly, a patient with atrial fibrillation and a high bleeding risk [...] may experience more harm than good from anticoagulation treatment, whereas a patient with a high risk for stroke and a low risk for bleeding may have a substantial net benefit from such treatment. (Haynes, Devereaux, and Guyatt 2002, 37)

The point is that the proven efficacy of any given intervention will “vary from patient to patient according to individual clinical circumstances” (Haynes, Devereaux, and Guyatt 2002, 37).<sup>11</sup>

In line with Haynes, Devereaux, and Guyatt, Jeremy Howick (2011) neatly identifies the various kinds of medical expertise and a diverse range of roles that a doctor can play in the doctor–patient relationship. He considers the role of expertise in the medical field, vis-à-vis a patient, as involving the integration of the results of clinical trials, or the best evidence for a medical intervention, with two other sets of data: circumstances specific to the patient and the patient’s values. As Howick points out, the question of what the *best* therapy is, all things considered, is very different to the question of what a clinician (and patient) ought to do in a particular situation. Conflating the two, he argues, is to make the “perennial error of deriving an *ought* from an *is*” (2011, 177). A doctor’s role is to bring together the different sets of data in order to decide the best possible course of action *given* the specifics of a patient’s situation and their values. In a slogan: “EBM requires clinical expertise to integrate the best research evidence with patient values and circumstances” (177). As Howick argues, such a view of medical expertise will require significant changes to medical training and practice: doctors will need to be able to spend more time with their patients; they will require significant training regarding how to interact with patients, and how to ascertain the details of their situation, preferences, and values, and they will have to learn how to integrate patient values and circumstances and the best clinical evidence (178).<sup>12</sup>

Beyond this, Howick also identifies medical expertise in terms of the role of placebo enhancement and bedside manner (2011, 179–181), and in terms of having the necessary skills to gather, appraise, and implement evidence—for example, “designing and conducting clinical trials, taking blood pressure, eliciting an accurate case study”, and so on (181). The placebo enhancement role, however, is not of primary significance when considering epistemic authority or intellectual expertise. The fact that doctors play such a role is certainly a reason to engage with them, but what we are concerned with when discussing epistemic authority is what they state, claim, or believe about the evidence, best course of action, outcomes, and so on, and what status that has in our own cognition. The fact that they have the skills to generate and make available certain kinds of evidence, however, is relevant. As I will show, such skill is intricately connected to the conditions for authority

<sup>11</sup> For a more detailed review of the models of expertise in EBM, see Wieten (2018).

<sup>12</sup> For further discussion of this integration, see Howick (2011, chapter 11).

that make it possible for doctors to play the role of synthesizing the three sets of data Howick identifies.

The above accounts show that a doctor’s expert judgment has a wider role to play and is not simply reduced to a kind of (relatively bad) evidence. Expert judgment has a non-evidentiary role to play. The question central to this article is how to square such a role with the notion of epistemic authority, as discussed above. As has already been noted, this cannot be a straightforward task. How can a medical practitioner have any epistemically authoritative role over me in deciding what is best for *me*, in *my* life? Questions of autonomy, intellectual and personal, abound.

The central problem for any account of epistemic authority in the medical domain boils down to the fact that medical questions are not strictly domain-specific in the clear-cut way that, say, questions about subatomic particles are relative to the domain of physics.<sup>13</sup> The kinds of medical questions that a patient has to find answers to can overlap with all sorts of other considerations not specific to medicine: practical issues and constraints, cultural norms, religious practices, personal preferences, and moral beliefs. But even outside of these prickly issues, the question of how a doctor can make authoritative statements about my particular circumstances, relative to the body of statistical evidence in favor of a certain kind of medical intervention, is also problematic.

The complexities do not end there, however. Even a medical practitioner’s ability to answer more straightforward questions about diagnosis, and thus treatment options (identifying what is, statistically, the most successful medical treatment, all things being equal), can depend on a large volume of evidence that only the patient has access to. Arguably, first-personal experiences of symptoms, and of illness in general, are deeply relevant to the medical context, and it would seem particularly odd to claim that a medical practitioner has any special access to this kind of medical fact. This suggests another crucial difference between the possibility of there being epistemic authority in a domain such as physics, in which I am trying to ascertain the truth of the matter about some physics-related question, and medicine, in which I am a patient asking a doctor for advice, guidance, solutions, answers, or possibly even a broad understanding of my position relative to all sorts of medical facts: *I*, as the patient, have a much more active role to play in the relevant epistemic inquiry—I cannot simply sit back and let the authority do all the work for me, as I can in other cases where that might seem appropriate.<sup>14</sup> This is made even more startlingly clear by consideration of the fact that when a medical practitioner and patient engage in inquiry, they are jointly working *through* the question at hand, rather than merely discussing established facts (contrast this to simpler cases of epistemic authority, where there is some fact of the matter *p* that has already been discovered as the result of an inquiry, and the authority is simply telling me that *p* is the case). Any satisfying account of epistemic authority has to make sense of such a collaborative inquiry between authority and non-authority.

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<sup>13</sup> In this case, if I want to attain some true belief about the Higgs boson particle, for instance, there seems to be nothing wrong in completely deferring to the judgment of Peter Higgs (assuming that I do not have the relevant expertise myself).

<sup>14</sup> Linda Zagzebski, for instance, argues that the whole point of deferring to an epistemic authority about some matter, or some domain of inquiry, is precisely because I cannot do the relevant epistemic work myself (I do not have enough time, I do not have the right training, and so on), and seems to quite strongly suggest that we are warranted in completely stepping back from the epistemic labor in such deferment—see, for example, Zagzebski (2016, 194). Benjamin McMyler also thinks that we have, as he calls it, “the epistemic right of deferral” in such cases (2011, 62). My argument here shows, in part, that such views cannot be applied to *all* cases of epistemic authority, and in all interactions with such authorities—as I hope to show is particularly true in the medical context.

The above considerations, and glimpses at the non-evidentiary roles that doctors can play, I argue, point toward the epistemic roles that doctors can, do, and *ought* to play. A doctor's authoritative position not only provides me with answers to the kinds of questions included in a very narrowly defined domain of medical knowledge, but also gives me strong, normative reasons to guide me towards answers to certain other (arguably more important) questions, such as "What is the right course of medical action for me, *x* or *y*, all things considered?", and "Will I be happier doing *x* or *y*?" The best doctors, I would argue, can have a role in authoritatively guiding our inquiries when we try to answer some of the most hard-hitting questions that we may have to answer in life, such as "Should I take *x* even though it will lower my quality of life, as it will likely provide me with more time to spend with my family?" This is to say that although a medical practitioner cannot authoritatively answer those questions *for* us, they can nevertheless, by virtue of their epistemic authority qua able performers of an epistemic practice, act as guides in our inquiries, telling us when we are reasoning in a medically unsound way, providing guidelines to properly weigh our evidence and reasons as one would if one were medically trained, proffering evidence to counter our concerns, and so on. It is this kind of role that an account of epistemic authority must make sense of.

Thus, we have a few desiderata to keep in mind when trying to articulate an account of medical epistemic authority:

1. It does not seem conceivable that medical practitioners have complete authority over the final, and most fundamental, first-order questions a non-authority aims at answering when identifying and engaging with them qua authorities, unlike in other more straightforward cases of epistemic authority to non-authority relationships. Any account of such authority should not suggest that I ought to *preemptively* believe that I should commit myself to a course of chemotherapy, for instance: reasons *I* have for and against such treatment must be considered and made part of the relevant inquiry.
2. Epistemic practices in the medical context frequently require—for epistemic reasons, but also for moral reasons—that the non-authority is able to involve themselves in the epistemic practice, by providing evidence, and suggesting counter-evidence as part of the process of seeking answers, whether this is in the form of first-personal reports of symptoms, for instance, or statements of preferences, values, and so on. This is to say that epistemic authorities and non-authorities are able to *jointly* engage in an inquiry.
3. If there is such a thing as epistemic authority in the medical contexts under consideration, then, following the above, it ought to be the case that a medical practitioner can nevertheless *authoritatively* steer my own epistemic behavior, relative to the medical inquiry at hand, while also leaving room for my own preferences and values, whether practical, moral, political, financial, or religious, and a more robust sense of my own epistemic agency.

Accounts of epistemic authority that focus on such authority as being grounded merely in the possession (or potential possession) of more true beliefs concerning first-order issues (in some domain) relative to the non-authority, and articulate the relationship between authority and non-authority purely in terms of strict deferral and belief-acquisition, do injustice to the complexities of the case of the medical practitioner's epistemic authority. Any account of such authority, then, needs to account for the above desiderata in order to properly apply to the broad range of circumstances in which such authority can arise, and to thus properly make sense of the phenomenon in question.

#### 4.2 Epistemic Authority as Normative Guide

On my account, the special normative power that an epistemic authority has in our relationship to them is to be understood specifically in terms of how they can guide us in relation to certain higher-order facts, rather than first-order ones. What I mean by this is that an epistemic authority has the power to command us to epistemically behave a certain way, relative to a domain of inquiry, when it comes to issues concerning higher-order considerations, such as: how to weigh certain evidence for or against *p*, whether something is a good or bad reason for believing that *p*, whether one should consider certain counter-evidence or not, whether a *kind* of evidence is relevant to inquiry, how much credence one should give to certain outcomes, and so on.

To elaborate briefly on why I understand this to be the case, note that the following is entailed by the conditions of epistemic authority outlined above:

- EA is an epistemic authority only in the sense that they are *relatively* epistemically superior to S. By this I mean that such authority can only be understood in relational terms: there is no sense in which someone is absolutely an authority.<sup>15</sup> It is only because someone is relatively better at engaging with the questions pertinent in a certain domain of inquiry that they are considered by others as epistemic authorities.
- For there to be any kind of relationship between S (as an epistemic inferior, relative to a domain of inquiry) and EA, S must *recognize* EA as having the requisite skills, abilities, and know-how to successfully partake in a certain kind of epistemic practice.
- It is thus a constitutive element of the relationship of authority that S recognize that EA is simply better at engaging with a certain epistemic practice, and, in the cases in which a relationship is actually established, it is because S desires to partake in the fruits of that epistemic practice.

One way to summarize the above is to say that EA has the necessary *know-how* to conduct the inquiry and has more such know-how than S.<sup>16</sup> Crucially, S reflectively recognizes that this is the case. The question, then, is to make sense of exactly what this kind of know-how is constituted by in the medical contexts that we are considering.

An approximation of the answer, I would argue, is fairly obvious: in my example above, with Dr. G, I was brought face to face with the reality of this knowledge—Dr. G knew better than I did *how* to answer a pertinent medical question, and that knowledge involved being able to recognize that the evidence that I was bringing to the table was not good evidence in this particular situation. This is an example of an authority dictating that I should not consider some piece of evidence or information as a good reason for making a medical decision.

Recall that in my example case I was suspicious that my new mattress was causing me to have an allergic reaction. I had, after all, just purchased it, and my symptoms had come about shortly after I started sleeping on it. Furthermore, my possible allergic reaction was located on my upper arms, which, as I tend to sleep on my sides, were typically more exposed to the mattress. On the basis of this very simple, albeit naïve, evidence, I could have

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<sup>15</sup> For more on the idea that such authority is relational, see Constantin and Grundmann (2020). The point here is quite simple: it cannot make sense that someone is an epistemic authority in nonrelational terms, *tout court*, as this would suggest that they are also authorities relative to those who are just as knowledgeable in the relevant domain, or, worse, those who are more skilled and knowledgeable.

<sup>16</sup> Note that it makes no difference whether we think that knowledge-how can in any way be reduced to knowledge-that. Whether the knowledge-how that an epistemic authority has is ultimately a species of knowledge-that, stated as rules for conducting one’s behavior, does not change the fact that they are better at applying those rules than their epistemic inferiors.

made the decision to sell the mattress, or at least attempt sleeping elsewhere for a while to see whether the symptoms would subside. I was thus entertaining a (to me) plausible reason, that would suggest a certain diagnosis, and at least one possible course of action to avoid an unwanted medical outcome.

This outcome, of course, was averted by Dr. G's command that I forget about the mattress qua evidence or reason. In this case my final decision as to how to conduct myself medically was modified by his authoritative command with regard to higher-order issues. Though some may balk at the idea that another agent could have such power over my own thoughts, it is difficult to avoid the idea that I have a rational commitment to such behavior as a direct consequence of what is involved in recognizing someone as an epistemic authority, as elaborated above. An epistemic authority in this case is just someone who is better at knowing what counts as good evidence for something in medicine; they are skilled participants in a certain epistemic practice and a certain kind of inquiry: to debate with them the merit of a piece of evidence, and how much weight it ought to have in one's rational deliberations, would be to act in a way contradictory to one's own belief that they are epistemically superior in this case, and one's own identification of them as an epistemic authority. To act in any other way would in fact be incompatible with such recognition. It is true that Dr. G and I are jointly working through a certain kind of inquiry, but the contours of that joint project must be carefully understood: yes, I have a small role to play in providing certain kinds of evidence, and possibly answering questions about my preferences relative to certain kinds of medical procedures, but it is nevertheless the case that Dr. G retains an authoritative standing in that joint venture with regard to certain facts about medical epistemology.<sup>17</sup>

This is a very simple example, and probably not too difficult a case of medical epistemic authority to countenance.<sup>18</sup> Importantly, it illuminates how an account of epistemic authority like mine can make sense of one of the desiderata above: the active epistemic role of non-authorities in providing reasons, evidence, counterevidence, and so on, and, in general, being involved in the inquiry in question, all in a form consistent with EBM views on evidence hierarchies. This is just a consequence of considering such authority as having primary authority over higher-order issues, rather than first-order ones. But what about more difficult cases? The real issue, as mentioned earlier, is that medical decisions are made at the intersection of a variety of data sets, some of which include very personal patient preferences that it does not make sense to suggest that a medical practitioner has any authority over. Some parts of these data fall strictly within the domain of medical inquiry, others do not. What we need to see now is how the kind of epistemic authority I have in mind can be applied to far more complicated cases of medical decision-making.

I do not think, however, that such issues present much more of a challenge for the account of epistemic authority I have provided. The difficulty of accounting for such relationships dissolves once we remove the idea that epistemic authority requires or

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<sup>17</sup> The relationship is somewhat similar to an isolated case of training or teaching: the epistemic authority in this kind of situation guides our activity much as they would, on a far larger scale, when teaching someone to become fluent in the epistemic practice themselves.

<sup>18</sup> It may be objected that this example focuses on a case of diagnosis, rather than any decision on a course of treatment. The point of the example, however, is not to illuminate the medical practitioner's role as a source of first-order evidence (as identified in EBM hierarchies) for treatment decisions, but rather to identify the sort of epistemic role that I argue a doctor plays as a source of information concerning higher-order issues. My view is in agreement with EBM hierarchies concerning clinical expertise as a source of evidence: the view of epistemic authority I am providing is intended to show the kind of authority doctors have in spite of this, where this authority (over higher-order issues) encompasses diagnosis, prognosis, and treatment decisions in the same way. All such higher-order evidence plays a crucial part in a doctor and a patient *jointly* making a final decision on a course of treatment.

involves the strong kind of first-order Preemption that Zagzebski’s view, or any view that identifies such authority purely in terms of first-order issues, suggests. The kinds of medical inquiry we are focused on are ones in which it is transparently obvious that certain issues are a matter of personal value and preference and are not the subject of medical research and inquiry. The fact that I state a belief in a certain quality of life as being preferable to a longer life without such quality is not up for debate, and a medical practitioner cannot override this piece of data in consideration. An epistemic authority is necessarily someone who, as part of their working knowledge of the epistemic practice in question, is aware of what kind of questions and issues both are and are not within the purview of that practice. Medicine does not aim to answer the question “When is a life worth living?” A doctor who for some reason expresses that a patient should *not* hold some preference of this sort has overstepped the bounds of their authority and is thus incompetent in their reflective awareness of medicine as a practice and their role within it.<sup>19</sup> This, in itself, would be good evidence that they are not very good doctors and ought not to be recognized as epistemic authorities.

One may think that this threatens to collapse the view of medical epistemic authority that I have articulated into a much weaker one, suggesting that such authority has no serious role to play in a patient’s decision-making process. But this is to ignore the wealth of alternative ways in which such authority could manifest in these cases. A patient cannot even begin to apply their preferences and values (and their beliefs about future preferences) before they relate them to, and make sense of, the medical facts: such preferences can only motivate a decision when tied to relevant evidence for certain outcomes, something that a medical practitioner is certainly in an authoritative position to speak of. Medical decisions are, or at least should be, the articulated consequence of a generally complicated act of balancing a variety of considerations. A very large number of those considerations are ones that a doctor has a significant role in, adjusting their relative weight and role in consideration. True, a doctor has no authority to tell me that I should not care whether I am disabled by a treatment’s potential side-effect. They do, however, have the authority to tell me whether there is good evidence that this will happen: they can authoritatively guide me to place the right kind of credence in the possibility of this outcome, and thus modify my decision-making on the basis of reasons that are in tune with the medical facts. If I say that I would not want to live with a certain consequence, the doctor has to treat this as a piece of data, but if I say that this consequence is likely to occur (perhaps because I *feel* that it will be so) when the evidence speaks to the contrary, a doctor has the authority to normatively correct my thinking.

In the most pressing cases, due to practical considerations, I, as a patient, may need to be incredibly careful, critical, conscientious, and perhaps even downright skeptical in my dealings with medical practice and knowledge. I am, after all, in a high-stakes scenario: my life, or something just (or almost) as serious, is at stake.<sup>20</sup> For this reason, I may (even if a doctor tells me that *p* is the safest way forward in my continuing treatment), bring counter-evidence to the table, do my own research, and cite various clinical trials and other scientific evidence when articulating a viewpoint to a medical practitioner. I may entertain the

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<sup>19</sup> As I discuss in section 5, this suggests that there is a need for epistemic authorities, particularly in the kinds of cases discussed here, to be appropriately intellectual humble, where such humility is understood as involving an awareness of the limits of one’s expertise, and the kinds of questions one is most capable of answering.

<sup>20</sup> I am leaving aside for now the possibility of a more profound skepticism, one based on an awareness of medicine having historically treated certain minorities in an unjust manner. *This* kind of skepticism, I would argue, actually undermines the possibility of a medical practitioner being treated as an authority: a patient worried about such things is worried *about medicine as an epistemic practice*, and thus does not recognize the practice as authoritative in the first place. I return to this problem in section 5.

possibility of disagreeing with my doctor, as part of the course of inquiry.<sup>21</sup> On my view, unlike others, this is perfectly consistent with my dealing with an epistemic authority. I am being consistent with my belief that a doctor “knows better than me,” in the relevant sense, so long as I accept their judgments about the higher-order issues relevant to medical epistemic practice. Such interactions could go either way: a doctor may, having already considered the evidence I bring to the table, tell me that it ought not to weigh as heavily as other considerations, and may even point me toward other research (in the best situation, toward a meta-analysis of such research); on the other hand, a doctor may not be aware of the particular research I find, and may even suggest that it is brought into consideration when making a final decision, suggesting whether it should be provided much weight in the process.<sup>22</sup> What is important to note is that neither option here undermines the fact that the medical professional remains an epistemic authority—though the kind of relationship I am envisaging is not the most commonly discussed in the epistemology of expertise or authority, it is nevertheless one that I think we would all recognize in real life. It seems to me that it is fundamentally important for any account of epistemic authority that it leave room for the possibility of such engagement, even a critical engagement, while still maintaining that an authority remains an authority.<sup>23</sup>

An epistemic authority can provide a wealth of opportunities for me to better engage with an epistemic practice. Much as when a novice attempts to engage in a nonintellectual kind of practice (for example, playing the violin, riding a bike) such an authority can normatively guide such activity by commanding that the novice do—or does not do—a certain thing. As already noted, a medical authority can tell me which kinds of evidence to take seriously. They can also tell me why a certain kind of evidence is better than another, allowing me to better understand my situation not only in purely practical terms, but also on an epistemic level, providing me with the means to become more intellectually autonomous in my engagement with the authority, and medical practice itself. On the face of it, it may seem counterintuitive to suggest that an authoritative command to think a certain way can provide me with the opportunity to be *autonomous*, but surely this is how we become mature thinkers in the first place: it is just that, in the case of more specialized situations (such as those under consideration in the medical context), those lessons may come about long after we have become adults.

More critically, it does not seem to me that even considerations of preferences, values, and so on, are completely and totally out of the medical practitioner’s authoritative reach.

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<sup>21</sup> This fits comfortably with the view that autonomous inquiry, in this case the patient’s, must include the possibility of the critical interrogation of a doctor’s suggestions, as suggested by Rebecca Kukla—see, for example, Kukla (2007, 31).

<sup>22</sup> This highlights an important point: it would be unrealistic to expect a doctor, particularly a general practitioner, to be up to date on all the relevant research. Any view that grounds their authority on having such knowledge would thus likely fail to be of much use to us in application. On the flip side, it also shows that a medical practitioner must be *sufficiently* up to date, in agreement with Sackett’s attitudes toward medical expertise and the need to retrain, or even retire, at a certain point. Deciding *how* up to date a doctor has to be is a matter far beyond the scope of my expertise.

<sup>23</sup> It may be tempting at times to suggest that a layperson has become “the expert” about a certain medical issue, more so than a medical practitioner, because they have read more relevant studies, and so on. But I think this is a mistake: it grounds the notion of authority in play in the mere possession of basic first-order knowledge, the ability to recite a set of references, evidence, and so on. Intellectual expertise surely requires more than this: it requires a kind of knowledge-how, a superior position relative to higher-order questions I have focused on here. It should be noted that there is nothing particularly original in pointing this out as a necessary condition of expertise—Goldman (2011) has already done so. My point, however, is that we ought to put the proper weight on this condition. Goldman, for example, suggests that such higher-order issues are much less important, and secondary, to an expert possessing relatively more true beliefs about the first-order issues in a domain (2011, 115).

If a doctor and patient are united in a joint investigation into certain matters, it would seem odd to suggest that the experienced physician has to completely recuse themselves on such matters.<sup>24</sup> Indirectly, much can be said and much can be changed on this front, at least in terms of how strong a consideration a patient ought to have for some such preferences. Evidence of a more psychological nature can be alluded to—for example, a doctor could cite the results of observational studies exploring the self-reported psychological outcomes for patients in similar situations, if such research exists. Furthermore, there is room here to consider expert judgment and evidence as playing a relevant role: a doctor with much experience with a certain medical intervention, and its outcomes, can provide some insight into whether that treatment has worked well for someone in circumstances similar to the specific patient’s. If there is evidence that individuals involved in trying to answer a certain question tend to make mistakes in considering which kinds of evidence are most relevant, a medical authority has *some* room to suggest adjustments. One may object that such evidence is quite weak, and could not be considered as having much weight, and certainly not as a totally determining factor in any decision. But this is completely consistent with the EBM hierarchy (which places such observational studies low on the pecking order of evidence): a doctor who shares such information is also in the position to normatively guide a patient in assigning the proper weight to such evidence.<sup>25</sup> Expressions of such judgment, when given their proper weight (and acknowledged as such by the medical practitioner), are an element of the epistemic practice that is constitutive of medical research. A medical practitioner who properly fulfills that role will only be acting consistently with the relevant practice, in accordance with their role as an epistemic authority (as I understand it), and would actually be *improving* a patient’s epistemic situation, making them more aware of the kinds of evidence that exist for or against the decision they are considering. Again, this is a case in which an epistemic authority’s expertise regarding higher-order issues in a certain domain of inquiry plays a fundamentally crucial role in guiding a joint inquiry with the non-authority.

It should also be noted that the view I have presented illuminates a path forward to reconciling views about the role of tacit knowledge in medicine with EBM hierarchies. Stephen G. Henry (2006), for example, argues that a wealth of tacit knowledge is required for medical practitioners to function effectively in medical practice. He argues that tacit knowledge is prevalent and cannot be dismissed: it is necessary for effective data gathering, problem solving, communication, group decision-making, and much more. *Pace* Henry, however, I think such tacit knowledge need not be thought of as antithetical to EBM views on expertise. The non-evidentiary roles of expertise in medicine, which Howick also identifies as tacit knowledge (2011, 160), are consistent with the general structure of the EBM hierarchies, so long as we are sure to identify these roles correctly. The account of epistemic authority I have provided further illuminates why such tacit knowledge is required: the same skills and knowledge that allow a doctor to engage with the epistemic practice of medicine are also partly those that allow a patient, through interaction with a doctor, to engage with it.

Ultimately, I would argue that the strength of my view is that it places the weight of epistemic force not on the opinions of any individual, but in the hands of a particular kind of epistemic practice, in this case in the epistemic methodology constitutive of medical

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<sup>24</sup> For further criticism of the overly simplistic view that medical expertise only concerns the relevant facts, and a patient’s expertise only concerns the values, see Kukla (2007).

<sup>25</sup> It should also be noted that a patient’s own evidence to the contrary—that is, their views about what they *will* feel in the future, given a certain medical outcome—is probably quite weak evidence as well. See Schwartz and Sommers (2013) for a discussion of issues surrounding affective forecasting in general.

practice. The ultimate normative “authority” here is the practice itself: if it truly is a good way of getting to the truth, or the best answers in a certain domain of inquiry, then *it* is what gives any opinion or view an authoritative power. Some opinion is authoritative not because it is expressed or believed by some individual S, but because S’s uttering or believing it is the result of an epistemic practice, which suggests that the opinion is true/evidentially warranted, and so on. The epistemic authority, qua individual, merely adopts a position of normative power as a middle-man to such methodology: they speak for the method itself.<sup>26</sup> I identify someone as an epistemic authority not because they somehow possess an extra-special acquaintance with the truth as an individual, but because they are better accustomed to a certain mode of inquiry—a methodology I identify as an epistemically good one—because they have the tacit and explicit knowledge of how that inquiry is to be done, and how it works. Recognizing this as the grounds for epistemic authority further reveals to us why it is possible for non-authorities to engage with authorities in a joint act of investigation, as I have been arguing is central to the medical context, while still allowing the latter to retain a relevant authoritative stance.

#### 4.3 Significant Problems: Recognition and Disagreement

The discussion above completely ignores two central problems that arise whenever we are discussing the epistemology of expertise or epistemic authority, issues that may be further compounded given the importance of medical decision-making for our well-being. These problems are:

1. The very difficult problem of *how* we can reliably identify experts or epistemic authorities.
2. The related issue of how to adjudicate between *disagreeing* experts.

Both of these problems have been addressed quite extensively in the literature on expertise, especially the latter.<sup>27</sup>

The two problems are deeply related, given that our best measure of expertise is in fact the opinion of other experts. When we identify someone as a relevant expert, we do so on the basis of their having qualifications, certifications, commendations, and so on that are recognized, and given, by others in their field. A medical degree is not just evidence that an individual has spent a sufficient amount training for their position, but also that other medical authorities have evaluated that the training is sufficiently good, and that the individual has sufficiently learned from it. Institutions that provide certification are meant to be recognized by expert consensus. In recognizing experts, we have to rely on there being an appropriate social structure of such expert evaluation.

This is why the possibility of expert disagreement suggests such a deep problem. When experts disagree, we are left to decide whom to endorse, whom to believe, and so on. When we are not sure how to answer such questions, it erodes our faith in our ability to identify experts in the first place.<sup>28</sup>

Much has been written about the problem, without much of a satisfying solution. Goldman (2011) suggests that an expert’s track record offers a layperson the opportunity to

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<sup>26</sup> Depending on one’s view about social groups and practices, one may go so far as to think that the sum of a group of experts’ behaviors, relative to and within a certain domain of inquiry, *constitutes* the epistemic practice in question. The practice, which is authoritative, is thus something above and beyond any of the individuals within that group.

<sup>27</sup> The problem of disagreement is a significant issue for Zagzebski’s view of epistemic authority. See especially Jäger (2016) and Zagzebski’s response (2016).

<sup>28</sup> For a discussion of how such disagreement can undermine public perceptions of medical authority more broadly, see Solomon (2015).

evaluate their credentials. David Matheson (2005) suggests that much can be gleaned from comparing the dialectical skills of disagreeing experts; David Coady (2006), rebutting Goldman, argues that in some cases it is appropriate to decide disagreements by reference to the *number* of experts who agree. Jeryl L. Mumpower and Thomas R. Stewart (1996) provide a detailed analysis of the various ways that expert disagreement can arise, and how to alleviate it. None of these gives a complete answer to the predicament.

My own answer to the problem of disagreement, relative to my account of epistemic authority, is not much more satisfying. I think, however that being clear on the conditions of such authority, as outlined in section 3, gives us a clear sense of our options in the difficult case of disagreement between medical authorities.

First, disagreement about first-order issues is not a particular problem in terms of my view. If a patient sees such disagreement, this will simply be a reason to engage with the higher-order issues, and to ask disagreeing doctors questions about the evidence, reasons, and so on, in play. So far, so good.

If, however, the doctors disagree on higher-order issues, about what counts as good evidence, and so on, things are more difficult. Arguably, the patient’s first recourse would be to ask questions clarifying whether both doctors are in fact aware of the same evidence, and to have them share their own resources, studies informing them, and so on. But what if the problem persists even after sharing their reasons, reading the same meta-analyses and randomized controlled trial results? This would suggest that the disagreement is particularly *deep* and troubling. In this situation, it would be possible to draw some pretty radical conclusions:

1. Hearing of such disagreement, a patient might conclude that, given that both doctors are supposedly partaking in the same epistemic practice, there is something wrong with that practice since it allows for such diverging higher-order claims.
2. Hearing of such disagreement, a patient might conclude that the two doctors are, in fact, not partaking in the same epistemic practice.

To conclude in either way, however, would require that one has other good evidence to question the homogeneity and social order of institutionalized medicine. The fact that there is quite a lot of conformity and agreement weighs against such skepticism.<sup>29</sup> It seems that the only reasonable option is for the patient to conclude that one of the two individuals identified as an authority is significantly less of an authority than the other—that is, that one has less of the know-how required to engage with the epistemic practice of medicine.

Certain pointers can help us pick between doctors at this point: the fact that one doctor can explain the disagreement to me in terms of the relevant epistemic practice, while the other cannot; one doctor may have more accolades, or awards, giving us some evidence that they may have a better grasp of the practice; one doctor may have a more thorough working understanding of the epistemic structure of medical practice, and, again, is better able to communicate this to us; one doctor may have been in medical school more recently, while the other has been working hard dealing with patients, with little time to evaluate current evidence and evidentiary standards; we may notice that one doctor dismisses a randomized controlled trial they have merely glanced over, while the other is more conscientious; and so forth. None of these considerations is as obvious a solution as we may hope for, but they may reasonably lean us one way or the other.

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<sup>29</sup> It is this homogeneity that allows us to dismiss certain antivaccine arguments, Covid skepticism, claims about nutrition and diet, and so on. Those that disregard this consistency in practice and instead identify with outlier opinions are, I would argue, not recognizing an established epistemic practice as I have argued is central to identifying appropriate authorities in the first place.

In the end, however, we may simply not be able to make a choice on any rationally significant basis. In these cases, we are left with the choice of simply accepting the views of a doctor that we trust; seeking a third (fourth, fifth ...) opinion if possible; or, depending on the medical outcomes at stake, withholding judgment about the issue. I imagine that this would not be a very satisfying answer for many, but the reality is that this is simply a consequence of our social-epistemic situation more broadly. We are at the epistemic mercy of certain experts and institutions. The bulk of the responsibility for ensuring that the situation is improved falls on medical institutions and social policy, not on the patient.<sup>30</sup> Being clear on what epistemic authority in medicine consists in can help us to formulate the appropriate policies and training required to avoid such difficulties.

## 5. Going Forward

If there is epistemic authority in the doctor-patient relationship, such authority is constituted by a medical practitioner being able to normatively guide another agent's epistemic behavior relative to a certain kind of practice and methodology. I have argued that there is room for a conception of such authority that both captures the normatively strong component that Zagzebski (2012) argues is constitutive of such authority, whilst also making room for the possibility of a non-authority nevertheless seeking, and gaining, more robust kinds of epistemic states than mere true belief—even as much as understanding, following Jäger (2016) and Croce (2017). Such an account, importantly, illuminates the ways in which such an authority can *guide* our inquiries when we are jointly engaged in answering the first-order questions of a domain of inquiry in which it does not make sense for the non-authority to defer completely to the authority for answers.

My account is only one step in making sense of the kind of social-epistemic relationship that holds between medical practitioners and patients, however. The account I have presented here suggests that there are a wide variety of responsibilities that both patients and doctors have toward one another, as part of a joint effort to ensure that the relevant medical inquiries succeed. Part of this requires that a patient is properly educated with regard to both what constitutes the legitimacy of a doctor's authority and of medical epistemic practice broadly (that is, a basic understanding of medical epistemology, or the kinds of evidential reasoning that support medical interventions).<sup>31</sup> More crucial is that medical practitioners—particularly primary care doctors—must be reflectively aware of their own roles in the relationship. If I am right about how to understand epistemic authority in these cases, I think it is a short argument to the conclusion that doctors ought to be trained to identify themselves as fulfilling the role that I have outlined above, *qua* epistemic authorities working jointly with patients to answer the primary questions of their inquiries. Doctors ought to be aware of—again, echoing Howick (2011)—the various sets of data that such inquiry labors over: the best medical evidence, circumstances specific to a patient, and the patient's preferences and values. Central to this understanding will be an

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<sup>30</sup> Ideally, patients would be aware of their own biases and cognitive limitations. Issues with human reasoning are legion, but of particular interest here are specific issues related to epistemic authority. Recent research, for example, has shown that patients are likely to recognize a doctor as having more epistemic authority when they prescribe some *active* mode of treatment, compared to a doctor that does not—see Stasiuk, Bar-tal, and Maksymiuk (2016).

<sup>31</sup> The responsibility to aid the patient in acquiring this understanding also partly falls on the doctor, given the moral and legal requirements present in the medical context: such responsibility can be, and often is, met by a doctor's simply stating and discussing the nature of EBM with their patients, and transparently presenting the epistemic practice they apply in their daily medical practice.

awareness of where the boundary is between the doctor’s authority over medical epistemology, and the patient’s own authority over his/her own personhood. Importantly, doctors must communicate all this to their patients. As Rebecca Kukla argues, a doctor ought to acknowledge “that patients hear their voices within the context of a larger medical discourse” and reflect the “expectation that patients may be active inquirers” who bring relevant knowledge to their joint inquiry, emphasizing the authority of the practice, rather than the practitioner (2007, 33).

Philosophers have much work to do in articulating what is required of a patient to responsibly engage with a practice they are not fully adept at navigating, the policies that we ought to adopt to better inform them, and, I think most importantly, the kinds of behavior we require of doctors in turn. There is much to be said, for example, for the role of various intellectual virtues in such relationships. Notably, I would argue that a doctor requires a certain level of intellectual humility in recognizing the possibility of a patient having a more active role in the relevant epistemic practice, as well as in recognizing the limits of current medical practice in general, and thus identifying when a patient’s situation is beyond the scope of their own authority (for an account of such humility, see Priest 2017). A doctor who fails to recognize these boundaries, and behaves in an epistemically arrogant fashion, commanding certain kinds of epistemic behavior when not appropriate, can do damage to a patient’s ability to make decisions autonomously. This damage may be most obviously recognized in the undermining of a patient’s role in the present decision-making process but will also have long-term consequences for the patient’s future behavior. A doctor who dismisses a woman’s statements concerning her symptoms, for example, informing her that her experiences are irrelevant to certain medical decisions, may completely undermine her confidence in ever sharing such information in the future, thus ensuring that she is unable to play her proper role in their joint inquiry. In failing to recognize their own specific roles, and the limitations of these roles, such doctors would diminish the legitimacy of medical authority and practice.

There is also something to be said for the idea that a patient is required to achieve a level of epistemic autonomy vis-à-vis the relevant epistemic practice and authority. A patient must be able to reflectively endorse the epistemic practice that she is engaging with, and appropriately recognize a medical practitioner’s authority, the roles such authority can play, and its limitations, in at least some minimal sense. Given that we cannot expect all patients to be sufficiently educated on such issues, and assuming a doctor’s moral responsibility toward their patients, much of this falls on properly training medical practitioners to adopt the proper epistemic roles.

Much more needs to be said about how the doctor–patient relationship ought to be formed, regulated, and protected. The model of medical epistemic authority I have provided glosses over serious issues that I have only briefly discussed. For such relationships to work, patients have to have reason to trust both medical practitioners in general and the practice of medicine itself. They have to be able to *recognize* the practice as an epistemically fruitful one (that it is a reliable source of the epistemic goods they seek), and to recognize individuals as skilled experts in that practice. Many oppressed people have a plethora of good reasons to be skeptical about recognizing either of these things. The history of the forced sterilization of women of color and the non-consensual experimentation on people of color is a horrific reminder of the legitimacy of such skepticism. The ongoing delegitimization of patients’ voices, on the basis of race, gender, sexuality, age, ability, and education, to name but a few areas, only underscores how much more work has to be done before medical practice can live up to its noble ambitions, and before it can be recognized as a legitimate, and authoritative, branch of knowledge for members of such oppressed

groups. For these individuals, the account of medical authority I have provided may represent an idealization far removed from their lived experiences: in reality, it is reserved for the privileged who have been better treated by the medical profession.

My model, however, provides a clear picture of exactly why the relationship of epistemic authority fails in such cases, and how we can go about rectifying the situation, by giving proper weight to the conditions for such authority: namely, that there is an epistemically good practice in play, one that is good for all patients, and that there are individuals who have the proper know-how to make use of it, regardless of a patient's social identity. If I am right about what medical practice, and the doctor–patient relationship, *should* look like, then we can better identify ways to improve our prescriptive suggestions for medicine's future, particularly in its social interactions, as a discipline, with the broader public. My account suggests that this work falls squarely on the shoulders of all medical practitioners and requires that they are transparent and honest in recognizing medicine's shortcomings, in interrogating their own roles in its practice, and taking steps to communicate a process of change and improvement to members of historically marginalized and oppressed groups.

Medicine as a practice has a long way to go to rectify its own ingrained biases and structural issues, and to convincingly communicate this change to its patients. There can be no place for the kind of authority I have illuminated if patients can only, at best, recognize medical methodology as epistemically good for some people, but not for them. Deep skepticism about medical epistemic practice leaves no room for such authority. But even if we are not skeptical about the practice itself (perhaps we trust the results of most randomized control trials and the general evidence that regulates medical decisions) we must have reason to think that doctors are, in general, actually adept at applying that medical knowledge to us, and having the intellectual honesty and humility to recognize their own personal biases (and the possibility of such biases). Given the vital role that I have argued that doctors can play in medical practice, there is much to be done in ensuring that they are trained specifically for this kind of role.<sup>32</sup>

Closely related to this discussion is the even more difficult case of psychiatry. Articulating and assessing the role of experts in medical and psychiatric fields strikes me as a significantly consequential project. The psychiatric case has many of the same pitfalls as the medical one but I think is made all the more difficult by the fact that psychiatry is directly interested in answering questions that pertain to a patient's mental life. Not only does this mean that experts in such a field are probing into parts that we typically like to think ourselves as authoritative over (our own mental states), they are actually claiming authority over them, in a certain sense, in interpreting mental states and conditions as pathological, irrational, removed from reality, and so on. Much resistance to the idea of authority is grounded in our appreciation of our own autonomy, intellectual and personal—the question of epistemic authority in psychiatry clearly illustrates the difficulties of balancing the two ideas in one consistent account.

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<sup>32</sup> Howick has argued that much has to be changed in how we train medical experts, given that their expertise (as per EBM) is not evidentially authoritative, but rather involves their ability to work with patients to integrate the best medical evidence with a patient's circumstances and values. He argues, "EBM proponents are correct that more time must be spent learning how to search for and appraise the best evidence," but if doctors are "to integrate patient values and circumstances with the best evidence, [they] must be allowed to place greater emphasis on listening attentively and empathetically to their patients" (Howick 2011, 183).

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### References

- Baumberger, Christoph, Claus Beisbart, and Georg Brun. 2017. “What Is Understanding? An Overview of Recent Debates in Epistemology and Philosophy of Science.” In *Explaining Understanding: New Perspectives from Epistemology and Philosophy of Science*, edited by Stephen Grimm, Christoph Baumberger, and Sabine Ammon, 1–34. New York: Routledge.
- Bjerring, Jens Christian and Jacob Busch. 2020. “Artificial Intelligence and Patient-Centered Decision-Making.” *Philosophy and Technology* 34: 349–71. <https://doi.org/10.1007/s13347-019-00391-6>.
- Carel, Havi and Ian James Kidd. 2014. “Epistemic Injustice in Healthcare: A Philosophical Analysis.” *Medicine, Health Care and Philosophy* 17: 529–40. <https://doi.org/10.1007/s11019-014-9560-2>.
- Coady, David. 2006. “When Experts Disagree.” *Episteme* 3, no. 1–2: 68–79. <https://doi.org/10.3366/epi.2006.3.1-2.68>.
- Constantin, Jan and Thomas Grundmann. 2020. “Epistemic Authority: Preemption through Source Sensitive Defeat.” *Synthese* 197, no. 9: 4109–30. <https://doi.org/10.1007/s11229-018-01923-x>.
- Croce, Michel. 2017. “Expert-Oriented Abilities vs. Novice-Oriented Abilities: An Alternative Account of Epistemic Authority.” *Episteme* 15, no. 4: 476–98. <https://doi.org/10.1017/epi.2017.16>.
- Dormandy, Katherine. 2018. “Epistemic Authority: Preemption or Proper Basing?” *Erkenntnis* 83, no. 4: 773–91. <https://doi.org/10.1007/s10670-017-9913-3>.
- Evidence-Based Medicine Working Group. 1992. “Evidence-Based Medicine: A New Approach to Teaching the Practice of Medicine.” *JAMA* 268, no. 17: 2420–25. <https://doi.org/10.1001/jama.1992.03490170092032>.
- Genin, Konstantin and Thomas Grote. 2021. “Randomized Control Trials in Medical AI: A Methodological Critique.” *Philosophy of Medicine* 2, no. 1: 1–15. <https://doi.org/10.5195/philmed.2021.27>.
- Goldman, Alvin I. 2011. “Experts: Which Ones Should You Trust?” In *Social Epistemology: Essential Readings*, edited by Alvin I. Goldman and Dennis Whitcomb, 109–33. New York: Oxford University Press.
- Haynes, R. Brian, P.J. Devereaux, and Gordon H. Guyatt. 2002. “Clinical Expertise in the Era of Evidence-Based Medicine and Patient Choice.” *BMJ Evidence-Based Medicine* 7, no. 2: 36–38. <http://dx.doi.org/10.1136/ebm.7.2.36>.
- Henry, Stephen G. 2006. “Recognizing Tacit Knowledge in Medical Epistemology.” *Theoretical Medicine and Bioethics* 27: 187–213. <https://doi.org/10.1007/s11017-006-9005-x>.

- Howick, Jeremy. 2011. *The Philosophy of Evidence-Based Medicine*. Chichester: Wiley-Blackwell, BMJ Books.
- Jäger, Christoph. 2016. “Epistemic Authority, Preemptive Reasons, and Understanding.” *Episteme* 13, no. 2: 167–85. <https://doi.org/10.1017/epi.2015.38>.
- Kukla, Rebecca. 2007. “How Do Patients Know?” *Hastings Center Report* 37, no. 5: 27–35. <https://doi.org/10.1353/hcr.2007.0074>.
- Matheson, David. 2005. “Conflicting Experts and Dialectical Performance: Adjudicating Heuristics for the Layperson.” *Argumentation* 19: 145–58. <https://doi.org/10.1007/s10503-004-7041-0>.
- McMyler, Benjamin. 2011. *Testimony, Trust, and Authority*. New York: Oxford University Press.
- Mumpower, Jeryl L. and Thomas R. Stewart. 1996. “Expert Judgement and Expert Disagreement.” *Thinking and Reasoning* 2, no. 2–3: 191–212. <https://doi.org/10.1080/135467896394500>.
- Priest, Maura. 2017. “Intellectual Humility: An Interpersonal Account.” *Ergo* 4, no. 16. <https://doi.org/10.3998/ergo.12405314.0004.016>.
- Raz, Joseph. 1988. *The Morality of Freedom*. Oxford: Clarendon Press.
- Rządezcka, Marcin. 2020. “The Philosophy of Expertise in the Age of Medical Informatics: How Healthcare Technology Is Transforming Our Understanding of Expertise and Expert Knowledge.” *Studies in Logic, Grammar, and Rhetoric* 63, no. 76: 209–25. <https://doi.org/10.2478/slgr-2020-0035>.
- Sackett, David L., William M.C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, and W. Scott Richardson. 1996. “Evidence Based Medicine: What It Is and What It Isn’t.” *BMJ* 312: 71–72. <https://doi.org/10.1136/bmj.312.7023.71>.
- Schwartz, Barry and Roseanna Sommers. 2013. “Affective Forecasting and Well-Being.” In *The Oxford Handbook of Cognitive Psychology*, edited by Daniel Reisberg, 704–17. New York: Oxford University Press.
- Smith, Richard. 2015. “David Sackett.” *BMJ* 305. <https://doi.org/10.1136/bmj.h2639>.
- Solomon, Miriam. 2015. “Expert Disagreement and Medical Authority.” In *Philosophical Issues in Psychiatry III*, edited by Kenneth S. Kendler and Josef Parnas, 60–72. Oxford: Oxford University Press.
- Stasiuk, Katarzyna, Yoram Bar-tal, and Renata Maksymiuk. 2016. “The Effect of Physicians’ Treatment Recommendations on Their Epistemic Authority: The Medical Expertise Bias.” *Journal of Health Communication* 21, no. 1: 92–99. <https://doi.org/10.1080/10810730.2015.1049308>.
- Wieten, Sarah. 2018. “Expertise in Evidence-Based Medicine: A Tale of Three Models.” *Philosophy, Ethics, and Humanities in Medicine* 13, no. 2. <https://doi.org/10.1186/s13010-018-0055-2>.
- Zagzebski, Linda. 2012. *Epistemic Authority: A Theory of Trust, Authority, and Autonomy in Belief*. New York: Oxford University Press.
- . 2016. “Replies to Christoph Jäger and Elizabeth Fricker.” *Episteme* 13, no. 2: 187–94. <https://doi.org/10.1017/epi.2015.39>.