When Evidence Cannot Be Heard: Epistemic Injustice and the Institutional Failure of Evidence Uptake

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Abstract

Miranda Fricker's account of epistemic injustice identifies two distinct wrongs done to knowers: testimonial injustice, in which a speaker receives less credibility than their evidence warrants, and hermeneutical injustice, in which a gap in collective interpretive resources disadvantages those whose experience falls outside the available conceptual vocabulary. Both forms of injustice have received extensive philosophical treatment at the level of individual interpersonal exchange. This paper argues that testimonial and hermeneutical injustice acquire a distinctive institutional form when they operate through the authority structures of scientific and classificatory practice. Two cases anchor the analysis. The first is the institutional reception of Ignaz Semmelweis's evidence that physician hand hygiene reduces childbed fever mortality: a case in which the uptake of strong evidence was shaped by professional hierarchy, theoretical conservatism, and institutional authority. The second is the politics of

disease classification in the International Classification of Diseases (ICD), in which classification systems help determine which forms of suffering become institutionally legible, clinically actionable, and researchable. Together, the cases demonstrate that epistemic injustice in science is not primarily a matter of individual prejudice but of institutional authority structures that produce and reproduce credibility deficits and hermeneutical gaps at scale. The present work is the second in a compendium of three independent publications; it develops the concept of structural epistemic injustice as a specification of Fricker's framework at the level of institutional authority, building on the structural framework established in the companion paper (Rolfes, 2026).

Keywords: epistemic injustice; testimonial injustice; hermeneutical injustice; Semmelweis; ICD; disease classification; structural injustice; science and power

Contents

1 Introduction: The Institutional Dimension of Epistemic Injustice

Fricker's *Epistemic Injustice* (Fricker, 2007) identified a class of wrongs that had been largely invisible in prior epistemology: wrongs done to persons specifically in their capacity as knowers. Testimonial injustice occurs when a hearer assigns a speaker a lower degree of credibility than their evidence and reasoning warrant, typically because of prejudice tracking a social identity. Hermeneutical injustice occurs when a gap in collective interpretive resources prevents someone from making intelligible, to themselves or others, a significant area of their experience. Both forms of injustice are, in Fricker's original account, primarily wrongs of individual interaction: a hearer misjudges a speaker; a conceptual gap leaves an experience unnamed.

The structural dimension of epistemic injustice has not been absent from the literature. Anderson (2012) treats epistemic justice as a virtue of social institutions; Dotson (2014) analyses persistent epistemic exclusion under the heading of epistemic oppression; Pohlhaus (2012) develops the concept of willful hermeneutical ignorance; and Medina (2013) foregrounds resistant imagination and collective epistemic responsibility. This paper builds on that structural turn but gives it a narrower focus. Unlike Dotson's account of epistemic oppression, which locates the primary site of injustice in persistent exclusion from knowledge production, and unlike Anderson's virtue-theoretic approach, the present framework identifies institutional authority structures, specifically the power to set credibility standards and to maintain classificatory systems, as the generative mechanism, and treats their opacity and self-reproduction as definitive rather than incidental features. It analyses scientific and classificatory authority structures as institutional mechanisms through which credibility and interpretive recognition are allocated. A researcher whose findings are desk-rejected because they challenge a dominant paradigm does not merely suffer a random act of intellectual exclusion; she encounters an institutional structure. A patient whose symptoms fall outside the current edition of a disease classification manual

does not merely lack the right words; she confronts an institution whose authority to name suffering is itself unevenly distributed.

This paper develops the concept of structural epistemic injustice to capture these institutional-level dynamics. The concept is best understood as a specification of Fricker's framework at the level of institutional authority. It foregrounds a feature of institutional epistemic injustice that the interpersonal account does not address sufficiently: structural epistemic injustice is largely invisible to those who administer it, is self-reproducing through the mechanisms of cognitive conservatism and structural feedback analysed in the companion paper to this work (Rolfes, 2026), and is resistant to individual correction precisely because it is not produced by individual prejudice.

Two cases anchor the analysis. Section 2 examines the institutional reception of Semmelweis's evidence on childbed fever: a case in which strong evidence failed to receive appropriate uptake because professional hierarchy, theoretical conservatism, and institutional authority shaped the standards by which the evidence was assessed. Section 3 examines the politics of the International Classification of Diseases, in which hermeneutical injustice can operate through the bureaucratic authority to determine which forms of suffering become medically legible. Section 4 develops the concept of structural epistemic injustice as a specification of Fricker's framework at the level of institutional authority. Section 5 identifies the conditions under which structural epistemic injustice can be addressed.

The central normative question is therefore not whether scientific institutions may require evidential caution, but when the distribution and application of such caution becomes systematically miscalibrated by institutional authority, status, or classificatory power.

2 Semmelweis and Institutional Testimonial Injustice

The first case concerns the rejection of evidence rather than the absence of concepts. Semmelweis is useful here because the evidential situation was unusually strong, while the institutional conditions for uptake were unusually hostile. The case therefore allows the testimonial dimension of structural epistemic injustice to be isolated with some precision: the problem was not simply that an individual claim was doubted, but that the authority to determine what counted as acceptable medical evidence was distributed through professional hierarchy.

2.1 The Evidential Situation

Ignaz Semmelweis began collecting systematic data on childbed fever mortality at the Vienna General Hospital in 1846. By 1847, he had identified a striking natural experiment: mortality in the First Obstetric Clinic, staffed by medical students and physicians who moved between autopsies and deliveries, was consistently and substantially higher than in the Second Clinic, staffed by midwives who did not perform post-mortem examinations (K. C. Carter and B. R. Carter, 2005; Nuland, 2003). After his colleague Jakob Kolletschka died from a wound infection acquired during an autopsy, Semmelweis recognised a structural similarity between Kolletschka's illness and childbed fever. He introduced mandatory hand washing with a chlorinated lime solution, after which mortality in the First Clinic fell dramatically: from rates of approximately 10–18% in prior years to below 2% (Semmelweis, 1861; K. C. Carter and B. R. Carter, 2005).

The evidential quality of Semmelweis's finding was unusually strong by the standards available at the time. He had identified a stable mortality differential between two clinics, formulated a causal hypothesis, introduced a simple and replicable intervention, and observed a dramatic reduction in mortality after the intervention. Yet the evidential situation was not epistemically simple. Semmelweis lacked a germ theory of disease, and his hypothesis had to compete with dominant nineteenth-century explanatory frameworks,

including miasmatic and constitutional accounts of disease. Tulodziecki (2013) has argued that the standard narrative overstates the strength of Semmelweis's reasoning and underestimates the epistemic legitimacy of his contemporaries' hesitation. This objection is well-taken as a corrective to hagiography, but it does not dissolve the institutional-level question this paper addresses. Even granting that individual actors had some epistemic warrant for hesitation, the point here is that professional hierarchy, reputational stakes, and the allocation of review authority, constituting the institutional mechanisms through which hesitation became authoritative, were systematically skewed in ways that cannot be explained by the evidential situation alone. The injustice lies not in irrational individual judgments but in a structure that reliably amplified and reproduced those judgments regardless of individual intent.

The philosophical significance of the case lies in the relation between evidence, explanation, and institutional uptake. Semmelweis had evidence that was practically compelling but theoretically under-integrated: it supported an effective intervention before the relevant causal mechanism could be fully articulated within the dominant medical ontology. This made his evidence vulnerable to dismissal by actors whose professional authority was tied to existing explanatory standards. The case therefore illustrates how standards of causal explanation and mechanism can shape whether evidence becomes acceptable within a scientific community (Hempel, 1966; Gillies, 2005; Scholl, 2013). Longino's account of the social norms that govern uptake in scientific communities, particularly the requirement of responsiveness to criticism (Longino, 1990), provides a useful framework for identifying exactly which norms were violated in the Semmelweis case.

This is where the epistemic-injustice analysis begins. The relevant injustice was not that Semmelweis's critics lacked any epistemic reason for hesitation, but that the standards through which hesitation became authoritative were themselves structured by professional status, institutional hierarchy, and the social cost of accepting his conclusion. A comparison with later medical discoveries helps clarify the point. Cases such as the eventual acceptance

of bacterial causation in peptic ulcer disease show that medical evidence often becomes institutionally actionable only when it can be integrated with acceptable mechanisms, background theories, and professional norms (Thagard, 1998). In the Semmelweis case, this dependence of evidential uptake on institutional and theoretical background conditions was especially consequential: those who possessed the evidence lacked the authority to make it binding, while those who possessed the authority had strong professional and institutional reasons to treat the explanatory gap as decisive.

2.2 The Structure of Rejection

The institutional reception of Semmelweis's evidence cannot be understood as scientific disagreement alone. The most prominent objector, Johann Klein, directed the obstetric clinic in which Semmelweis worked and had professional and reputational interests in not accepting a finding that implicated physician hygiene practices in patient deaths (K. C. Carter and B. R. Carter, 2005). The claim that physicians were transmitting lethal material to patients they were supposed to be treating was not merely intellectually challenging; it was a direct threat to the social and institutional standing of the medical profession at a moment when that profession was actively constructing its authority against the competing claims of midwifery and lay healing (Loudon, 1992; Wootton, 2006).

A critical objection must be addressed here: if institutional standards requiring mechanistic explanation before adoption of a finding are themselves epistemically defensible, is the credibility deficit Semmelweis suffered a wrong or merely an unfortunate but justified outcome of rational norm-following? The answer depends on whether those standards were applied uniformly and on the basis of epistemic criteria alone. The evidence suggests they were not: credibility assignment appears to have been shaped not only by the evidential merits of Semmelweis's intervention data, but also by his institutional rank, outsider status within Viennese medicine, and the professional cost of accepting his conclusion (Nuland, 2003). A credibility deficit is a testimonial injustice in Fricker's sense when it is

systematically deflated relative to what the evidence warrants, and when that deflation is explicable by non-epistemic factors. Both conditions are met here.

The rejection was therefore shaped by institutional factors that affected epistemic evaluation itself. The credibility assigned to Semmelweis's claims appears to have been systematically below what the evidence warranted, and that deficit was plausibly reinforced by his institutional position, relative seniority, outsider status within Viennese medicine, and the professional threat his claims posed to those who evaluated them (Nuland, 2003). This can be understood as testimonial injustice in Fricker's sense, but operating at institutional scale and with consequences measured in deaths. Maternal mortality in European obstetric clinics remained elevated for decades after Semmelweis's evidence became available; the institutional structures through which medical knowledge was evaluated and transmitted contributed to this delay by protecting the authority of those who controlled them rather than facilitating uptake of evidence that threatened that authority (K. C. Carter and B. R. Carter, 2005; Wootton, 2006).

2.3 What the Case Shows

Three features of the Semmelweis case are analytically important for the framework developed in Section 4.

First, the testimonial injustice was not primarily a matter of individual prejudice. Johann Klein was not simply a bigoted man making an isolated personal judgment. He was acting through institutional structures, professional hierarchies, and review processes that were systematically configured to produce this kind of outcome. Individual actors changed, but the outcome remained stable; this is the signature of structural rather than individual injustice (Young, 2011).

Second, the injustice was self-concealing. Those who rejected Semmelweis's evidence

did not experience themselves as suppressing knowledge; they experienced themselves as maintaining professional standards and protecting medicine's hard-won scientific credibility against an inadequately theorised claim. The mechanisms of cognitive conservatism and system justification analysed in the companion paper to this work (Rolfes, 2026; Jost et al., 2004) operated here to render the injustice invisible to its perpetrators. The analysis of performative force and discursive injustice by Kukla (2014) illuminates the same mechanism from a speech-act perspective: uptake failures are not merely communicative misfires but enactments of social authority that determine whose findings can be made to count.

Third, the case illustrates what might be called the *authority asymmetry problem*: Semmelweis possessed the evidence but lacked the institutional authority to enforce its acceptance, while those who possessed institutional authority lacked the epistemic motivation to act on evidence that threatened the foundations of that authority. This asymmetry is structural and predictable; it is not a contingent feature of this particular case but a general property of institutions in which credibility is allocated by mechanisms other than evidential quality.

3 Disease Classification and Institutional Hermeneutical Injustice

The second case shifts from credibility to intelligibility. Disease classification does not merely record already settled medical knowledge; it helps organise the institutional conditions under which suffering becomes nameable, researchable, treatable, and reimbursable. The dominant medical classification systems are therefore a useful site for examining structural hermeneutical injustice: not because classification is avoidable, but because classificatory authority determines which interpretive resources become official and actionable.

3.1 Classification as Epistemic Authority

The World Health Organization (WHO) describes the International Classification of Diseases (ICD), currently in its eleventh revision (ICD-11), as the international standard for systematic recording, reporting, analysis, interpretation, and comparison of mortality and morbidity data (WHO, 2022). Its authority is not merely administrative. ICD categories help determine which conditions become reportable, countable, clinically visible, and administratively actionable. Classification therefore has epistemic consequences: it affects research agendas, clinical training, insurance and reimbursement systems, and the degree to which sufferers can make their experience intelligible to medical institutions (Bowker and Star, 1999; Jutel, 2011). Non-recognition does not mean that the suffering does not exist; it means that institutional resources for naming, treating, researching, and reimbursing it may be unavailable, unstable, or unevenly distributed (Bowker and Star, 1999; Conrad, 2007).

This is the point at which hermeneutical injustice becomes institutional rather than merely interpersonal. The gap is not simply a missing word in shared social understanding; it is a deficit in an authorised classificatory system through which suffering becomes visible to medical institutions (Fricker, 2007; Bowker and Star, 1999; Jutel, 2011). This distinction matters because a hermeneutical gap in dominant institutional resources need not imply that affected communities lack interpretive resources of their own; the injustice may instead lie in the failure of dominant institutions to recognise and uptake those resources (Mason, 2011). The relevant epistemic risk is not that experts classify disease, which is unavoidable, but that the authority to decide which experiences become medically legible is unevenly distributed. In cases of contested illness, affected communities often have to struggle not only for treatment but for recognition of the categories through which their suffering can be understood at all (Brown, 2007).

3.2 Contested Conditions and the Politics of Recognition

The politics of medical classification are most visible in cases of contested illness: conditions whose status, explanation, or appropriate treatment remains disputed. In such cases, classification is not a neutral administrative afterthought. It can affect whether symptoms are treated as medically significant, whether patients are regarded as credible reporters of their own experience, and whether research programmes are organised around biological, psychological, social, or environmental explanations (Brown, 2007; Jutel, 2011).

A parallel psychiatric classification case makes the normative dimension of classificatory authority especially visible: The American Psychiatric Association's (APA) removal of homosexuality from their seventh printing of the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1973 did not follow from a simple empirical discovery alone; it reflected a shift in the normative framework through which psychiatric evidence was interpreted, under conditions of sustained activist and professional contestation (Bayer, 1981). The relevant change was not a simple change in the evidence base alone, but a change in the normative framework within which evidence was evaluated: activist epistemic pressure played a decisive role in forcing psychiatric classification to confront assumptions that had previously been treated as clinically neutral. That the category ego-dystonic homosexuality was retained in DSM-III (APA, 1980) until DSM-III-R (APA, 1987) further illustrates the structural lag: institutional authority structures can partially absorb correction while preserving the underlying mechanisms that produced the original classification. This case instantiates the normative axis of structural hermeneutical injustice: evidence was not methodologically unintelligible, but normatively inadmissible within the dominant framework. The later ICD-11 revision process similarly treated sexual-orientation-related diagnostic categories as a site where classification, clinical evidence, and normative assumptions had to be disentangled (Cochran et al., 2014).

ME/CFS is another useful case because it sits at the intersection of contested diagnosis, patient credibility, and classificatory authority. In ICD-11 for Mortality and Morbidity

Statistics, chronic fatigue syndrome appears under code 8E49, Postviral fatigue syndrome (WHO, 2025). The epistemic-injustice dimension of the case is best located not in ICD coding alone, but in clinical and research uptake. Patients with ME/CFS have been vulnerable to credibility deficits because their symptoms are often difficult to verify through routine clinical tests and have historically been interpreted through psychosomatic or behavioural frames. Blease, Carel, and Geraghty argue explicitly that healthcare encounters involving CFS/ME can make patients particularly vulnerable to epistemic injustice (Blease et al., 2017).

The controversy over behavioural and exercise-based treatment models shows how clinical authority, classification, and patient testimony can interact. The 2021 revision of the National Institute for Health and Care Excellence (NICE) guideline for ME/CFS substantially revised the earlier behavioural-management framework: it rejected graded exercise therapy understood as fixed incremental increases in physical activity, and reframed cognitive behavioural therapy as optional supportive care rather than a curative treatment, exemplifying a decision that represents a partial but significant institutional correction of an earlier hermeneutical gap (NICE, 2021; Geraghty and Esmail, 2016). This revision is itself evidence for the paper's thesis: the classificatory and clinical framework had been sustained not by its evidential quality but by the authority of those who administered it, and correction required organised patient advocacy and external pressure, not merely the internal operation of scientific norms.

ME/CFS is not offered here as an isolated anomaly, but as an illustrative instance of a broader feature of medical classification. In cases of contested illness, the boundary between recognised and insufficiently recognised suffering is often negotiated through interactions among clinical evidence, classificatory authority, patient testimony, and social mobilisation (Brown, 2007; Jutel, 2011). The philosophical point is not that classification is merely political, but that classificatory uptake is an institutional process through which some forms of suffering become more intelligible, credible, and actionable than others.

3.3 The Structural Mechanism

The structural mechanism producing hermeneutical injustice in disease classification is the same authority asymmetry problem identified in the Semmelweis case. Those with the authority to name conditions are not those who bear the cost of non-naming. The authority to revise classification systems is ordinarily allocated through expert credentialing and institutional appointment. Such procedures are epistemically necessary, but they also risk reproducing existing hierarchies of discipline, geography, prestige, and professional recognition (Jutel, 2011; Brown, 2007; Rolfes, 2026).

The hermeneutical gap need not be maintained through deliberate suppression. It can persist because those with classificatory authority are institutionally distant from those who bear the costs of non-recognition. This is an institutional analogue of the hermeneutical injustice Fricker identifies at the interpersonal level. In the institutional case, the relevant gap is not only a deficit in shared interpretive resources, but a deficit in the distribution of authority over which interpretive resources become official, actionable, and durable (Fricker, 2007; Medina, 2013).

4 Structural Epistemic Injustice as Institutional Specification

The two cases identify parallel institutional mechanisms. In the Semmelweis case, evidence failed to receive uptake because credibility was mediated by professional authority. In the ICD case, suffering risks remaining insufficiently legible because interpretive recognition is mediated by classificatory authority. This section draws the conceptual lesson from those cases: epistemic injustice becomes structural when the mechanisms that allocate credibility and intelligibility are built into durable institutional procedures.

4.1 From Interpersonal Injustice to Institutional Authority

Fricker's framework is a significant contribution to social epistemology, and the cases analysed above are in important respects continuous with the phenomena she describes. The institutional cases analysed above foreground three features that are less visible in the interpersonal examples with which Fricker begins: scale, opacity, and authority.

The first is scale. Individual testimonial injustice wrongs one speaker in one encounter; institutional testimonial injustice wrongs a class of speakers systematically and continuously, and its effects compound across the population of those who are not believed. The difference is not merely quantitative; it is structural. Individual injustice admits of individual correction: a prejudiced hearer might learn, develop epistemic virtue, and revise their credibility assignments. Structural injustice is not corrected by the development of individual virtue because it is not produced by individual vice (Young, 2011; Anderson, 2012).

The second is invisibility. Fricker's account of testimonial injustice assumes an evaluative structure in which the injustice is at least in principle recognisable as such by a sufficiently reflective hearer. Institutional epistemic injustice is characterised by its opacity to those who administer it. Johann Klein did not experience himself as suppressing evidence; he experienced himself as maintaining standards. ICD working group members do not experience their credibility judgments as tracking social position; they experience them as tracking evidence. The injustice is reproduced precisely because its mechanisms are invisible to the agents through whom it operates (Jost et al., 2004; Medina, 2013; Rolfes, 2026). The mechanism is not merely psychological but structural: an institution reproduces its credibility assignments through hiring, promotion, and peer review processes that select for those who already accept its norms. This showcases a dynamic Longino (1990) identifies as a failure of the norm of uptake of criticism, and which Young (2011) analyses as the structural seriality of institutions.

The third is authority. Fricker's analysis of hermeneutical injustice focuses on gaps in

collective interpretive resources. In institutional contexts, however, the crucial issue is not only that such gaps exist, but that some institutions possess the authority to stabilise, distribute, and enforce interpretive resources. The ICD does not merely reflect available medical vocabulary; it helps determine which categories become administratively actionable, clinically recognisable, and researchable. The injustice, where it occurs, is therefore not simply a failure of shared understanding but a failure in the distribution of authority over the production of shared understanding (Fricker, 2007; Bowker and Star, 1999; Jutel, 2011).

4.2 Structural Epistemic Injustice

Structural epistemic injustice, as developed here, is the systematic and institutionally produced disadvantage suffered by persons or groups in their capacity as knowers, arising from the structural organisation of knowledge-producing and knowledge-evaluating institutions rather than from the individual prejudices of the agents who operate within them. It encompasses both a testimonial and a hermeneutical dimension.

Structural testimonial injustice occurs when the credibility-assigning mechanisms of an institution are systematically miscalibrated in ways that track social and institutional position rather than evidential quality, such that a class of speakers reliably receives less credibility than their evidence warrants, and this miscalibration is reproduced across changes in individual personnel.

Structural hermeneutical injustice occurs when the authority to produce and maintain collective interpretive resources, including the classificatory systems by which experience is named and made legible to institutions, is distributed in ways that systematically disadvantage those who bear the costs of interpretive gaps. In such cases, experiences falling outside dominant paradigms may remain difficult to name, recognise, research, or treat, even when those experiences are significant for the persons who undergo them.

The concept adds to Fricker's framework in three respects. It locates the primary locus of injustice in institutional structure rather than individual disposition, which implies different corrective conditions (Young, 2011). It foregrounds the opacity of structural injustice to its administrators, which is a feature of the phenomenon rather than an epistemic obstacle external to it. And it connects the epistemic-injustice analysis to the structural framework developed in the companion paper (Rolfes, 2026), such that both can be read as complementary diagnoses of the same institutional condition: how formally truth-seeking institutions systematically produce and reproduce the conditions inhospitable to truth-seeking.

4.3 The Relation to Existing Extensions

The concept developed here overlaps with several existing extensions of Fricker's framework. Anderson (2012) treats epistemic justice as a virtue of social institutions, shifting attention from individual hearers to institutional arrangements. Dotson's account of epistemic oppression identifies persistent epistemic exclusion from knowledge production (Dotson, 2014). Pohlhaus's account of willful hermeneutical ignorance shows how dominantly situated knowers can fail to recognise interpretive resources developed from marginalised experience (Pohlhaus, 2012). Medina's account of epistemic arrogance, insensitivity, and resistance develops the collective and political dimensions of epistemic injustice (Medina, 2013). The present account is continuous with these approaches, but it focuses more narrowly on scientific and classificatory authority: the institutional power to decide which evidence receives uptake and which experiences become officially legible. Its distinctive target is not exclusion from epistemic life as such, but the institutional authority to convert some credibility assignments and interpretive categories into binding standards for research, classification, treatment, and recognition.

The concept of structural epistemic injustice developed here is distinct from each of these extensions in two respects. First, it locates the primary generative mechanism

specifically in institutional authority structures, the power to assign credibility and to maintain classificatory systems, rather than in the dispositions of dominantly situated individuals (Pohlhaus, 2012) or in exclusion from knowledge production per se (Dotson, 2014). A researcher can be included in an institution and still have their evidence systematically miscredited through that institution's authority structure; a patient's experience can be documented in the literature and still fail to achieve hermeneutical recognition through an authoritative classification system. Second, the present account foregrounds self-reproduction as a structural feature: the same authority structures that produce the injustice also evaluate proposals for correcting it, creating a feedback mechanism that Dotson (2014) and Pohlhaus (2012) identify in social terms but which here operates specifically through the gatekeeping functions of scientific peer review and disease classification bodies.

5 The Conditions for Correction

If structural epistemic injustice is produced by institutional structures rather than individual dispositions, its correction requires structural intervention rather than individual reform. This has three practical implications.

The first is the restructuring of credibility-assigning mechanisms to reduce their dependence on markers of institutional position. Double-blind review is one possible mechanism for reducing some prestige and identity cues, although its effects are limited and context-dependent (Budden et al., 2008; Webb et al., 2008; Tomkins et al., 2017). The effects of double-blind review are limited because credibility cues extend beyond author name and institutional affiliation to writing style, citation network, methodological choices, and the research questions themselves, all of which carry social information invisible to nominal blinding. More substantially, the composition of bodies that make authoritative credibility judgments, including grant review panels, editorial boards, and disease classification working groups, must be diversified along multiple dimensions: geographic, demographic,

disciplinary, and experiential. The authority asymmetry problem cannot be addressed without addressing the structural conditions that produce it. Longino (1990) described four norms for epistemically responsible communities that provide a useful structural benchmark: recognised avenues for criticism, public responsiveness to criticism, publicly shared standards, and tempered equality of intellectual authority. Each norm identifies a specific institutional failure point. Semmelweis's Vienna was deficient primarily on the third and fourth norms; the ICD process on the fourth.

The second is the institutionalisation of systematic auditing of credibility patterns. Where testimonial injustice operates at institutional scale it leaves a detectable statistical signature: systematically lower funding rates, higher rejection rates, and lower recognition rates for claims originating from structurally disadvantaged positions, as documented in the case of NIH funding (Hoppe et al., 2019) and faculty placement (Clauset et al., 2015). Making this signature visible and subjecting it to independent audit is a necessary, though not sufficient, condition for correction. The point of such auditing is not to infer injustice from disparity alone, but to identify recurring credibility patterns that require institutional explanation.

The third is the democratisation of the authority to produce interpretive resources. This is the most structurally demanding condition and the most resistant to incremental reform. The ICD case suggests that affected-community participation can be epistemically relevant, not merely procedurally desirable, because patients and community researchers may possess interpretive resources unavailable within dominant clinical paradigms (Brown, 2007; Pohlhaus, 2012; Blease et al., 2017). Structural hermeneutical injustice cannot be adequately corrected by individuals within the existing structure becoming more epistemically virtuous; it requires institutional changes that distribute the authority to name experience more broadly.

6 Conclusion

The analysis developed here leaves three questions open for future work. First, the threshold problem: a precise account is needed of when an institutional credibility deficit crosses from defensible epistemic conservatism into injustice, a question that requires criteria for distinguishing legitimate from illegitimate institutional stability. Second, the authority asymmetry problem identified in both cases points toward a broader question about classification governance: if the power to name conditions and set credibility standards is itself the locus of structural injustice, what accountability mechanisms can constrain that power without eliminating the epistemic specialisation that makes classification valuable? The politics of scientific category governance, including the procedural conditions under which classificatory authority can be legitimately exercised and retroactively revised, will be examined in the third paper of this series. Third, the relationship between structural epistemic injustice and the social epistemology of consensus formation (Longino, 1990; Medina, 2013) requires development: not all consensus is epistemically illegitimate, and the framework must provide criteria for distinguishing justified from unjustified institutional stability.

The concept of structural epistemic injustice developed here specifies Fricker's framework at the level of institutional authority. It locates the locus of injustice in institutional structure rather than individual disposition, foregrounds its opacity to its own administrators, and identifies self-reproduction as the mechanism that makes correction structurally paradoxical. These features (opacity, self-reproduction, authority asymmetry) recur across the cases examined here and in the companion paper, and they appear again, in a different register, in the governance of scientific classification more broadly. How classificatory authority is exercised, on what procedural terms it can be legitimately revised, and when its exercise crosses from epistemically necessary gatekeeping into governance failure: these are the questions that the third paper of this series takes up directly.

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