Unjust silence: Therapeutic privilege, ethical issues and epistemic exclusion

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Communication between healthcare professionals and patients typically concerns diagnoses, treatment options, and prognoses. In certain situations, however, not all relevant information is disclosed in order to prevent harm or to protect patient well-being. This practice is commonly referred to as therapeutic privilege. While therapeutic privilege has been widely discussed in relation to autonomy, beneficence, and non-maleficence, its implications for justice remain insufficiently explored. This article addresses this gap by examining therapeutic privilege through the lens of epistemic injustice. It argues that the selective withholding of information may undermine patients' status as epistemic agents and thereby give rise to both hermeneutical and testimonial forms of injustice. The analysis focuses on three contexts in which such injustices arise: (1) the relationship between healthcare professionals and patients, (2) age-based differences in treatment, and (3) the role of family caregivers. Across these cases, the analysis argues that practices of information control can lead to forms of exclusion and unequal recognition. The article concludes that prevailing justifications of therapeutic privilege remain incomplete as long as they neglect considerations of epistemic injustice. The article therefore calls for greater attention to the conditions under which patients are recognized as epistemic participants within healthcare communication.

Keywords: Therapeutic privilege; epistemic injustice; family caregivers; doctor-patient relationship; ageism

Introduction

Interactions between healthcare professionals and patients frequently involve discussions about diagnoses, treatment options, prognoses, and other medically relevant information. Against this background, this article focuses on an ethical analysis of therapeutic privilege. While contemporary clinical and nursing practice strongly emphasizes respect for patient autonomy (Beauchamp & Childress, 2019, pp. 106–107), there are seemingly justifiable exceptions where the full truth is not communicated. Information disclosure is therefore selective. However, such withholding of information also limits patient autonomy, even if it is intended to prevent harm (Wölfel, 2021, pp. 1068–1069). In addition, such practices are often associated with concern for the patient's well-being and may therefore be

understood as expressions of care. This creates a tension between autonomy, truth-telling, informed consent, and potentially justified deception. Discussions surrounding the disclosure or withholding of medical information have long been associated with critiques of medical paternalism.[1] Particularly since the second half of the twentieth century, ethical debates in medicine increasingly emphasized respect for patient autonomy and informed consent, thereby challenging traditional paternalistic models of physician authority (Dworkin, 1981; Husak, 1981; Katz, 2002). Therapeutic privilege emerged within this broader debate as one of the few remaining situations in which the withholding of information could still appear ethically justifiable. While these discussions have predominantly focused on autonomy, beneficence, and non-maleficence, considerably less attention has been paid to the justice-related implications of therapeutic privilege – especially regarding patients' status as epistemic agents.

Despite these developments, therapeutic privilege remains ethically controversial precisely because it reintroduces limited forms of paternalistic decision-making into contemporary healthcare practice. This paper contributes to these debates by examining therapeutic privilege through the lens of epistemic injustice. Thereby, the aim is not to provide a comprehensive historical or cross-cultural analysis of disclosure practices in medicine. First, different conceptions of therapeutic privilege are examined and a working definition proposed. The paper then examines how therapeutic privilege may give rise to forms of epistemic injustice. The analysis then focuses on three domains: (1) the relationship between healthcare professionals and patients, (2) age-based discrimination, and (3) the extension of therapeutic privilege to family caregivers. This investigation suggests that therapeutic privilege systematically raises concerns of epistemic injustice and therefore requires explicit ethical evaluation in these terms. This article makes three contributions to current debates on therapeutic privilege. *First*, it establishes a conceptual connection between therapeutic privilege and epistemic injustice. *Second*, the paper identifies three domains in which therapeutic privilege may give rise to epistemic injustice: the doctor–patient relationship, age-related treatment differences, and the role of family caregivers. *Third,* it highlights the normative implications of these findings for ethically reflective communication practices in healthcare. It argues that prevailing justifications of therapeutic privilege remain incomplete as long as they fail to account for epistemic injustice, and that greater attention must be paid to the conditions under which patients are included – or excluded – as contributors to knowledge in healthcare contexts.

Therapeutic privilege

Contemporary medical ethics largely rejects strong paternalistic models of care.[2] Therapeutic privilege therefore occupies a controversial position, insofar as it permits limited forms of information withholding despite the centrality of patient autonomy and informed consent (Beauchamp, 1989; Groll, 2012). However, therapeutic privilege remained ethically relevant because some clinicians and ethicists continued to argue that exceptional situations may justify temporary or partial information withholding in order to prevent serious harm. It is not only ethically controversial but also legally restricted in many healthcare systems.[3] Contemporary patient-rights frameworks often establish strong disclosure obligations and corresponding rights to information, while permitting only narrow

exceptions in cases of serious and imminent harm. Therapeutic privilege allows a physician, for example, to deliberately withhold certain health-related information during a conversation. Such situations typically concern medical interventions, diagnoses, prognoses, or other information relevant to the patient's condition (Elger, 2002, pp. 533–534; Fritzsche, 2020, p. 55). Withholding important information may not meet the requirements of full informed consent (Krones & Richter, 2008, pp. 818–819), but is also used to avoid harm (Salter & Eberl, 2021, pp. 15–16). In biomedical ethics, informed consent is usually based on certain criteria, including, for example, *intentionality*, *noncontrol*, and *understanding* (Bazzano et al., 2021, pp. 81–82; Beauchamp & Childress, 2019, p. 102). Regarding the latter aspect, it is clear that complete understanding is not possible if the available information is not fully disclosed. However, full disclosure is deliberately avoided in order to prevent harmful consequences. This potential harm can be both physical and psychological in nature and should (in principle) be prevented by the healthcare professional's actions (Finnerty, 2021, pp. 644–646). Whether disclosure would in fact result in serious harm, however, often depends on context-sensitive professional judgment. Such practices are typically justified by reference to patient welfare and harm prevention. The following working definition is proposed to examine therapeutic privilege and the arguments that follow:

> Therapeutic privilege refers to the conscious withholding of medically relevant information from a patient. Such information may concern therapeutic interventions, diagnoses, prognoses, or the patient's current and future state of health. The withholding of information is typically justified by reference to the prevention of serious physical or psychological harm. It is commonly associated with professional assessments regarding the patient's well-being and ability to cope with disclosure.[4]

This raises the question of whether this deliberate deception – or the prevention of full autonomy, for which meaningful explanations on the state of health are crucial – can be justified. In Edwin's opinion, this seems impossible because a competent person or their autonomy is disregarded (Edwin, 2008, pp. 156–157). Even if the delivery of bad news is often perceived as an unpleasant task (Brouwer et al., 2021, pp. 280–281; Fujimori & Uchitomi, 2009, pp. 213–214; Hack et al., 2005, 836–837), an ethical justification cannot be based on this without taking the interests of the persons addressed seriously. Wölfel (2021, pp. 1072–1073) also makes it clear that the justification can only be implemented by referring to a patient. Hodkinson's (2013, pp. 109–110) claim that the physician must take ethical points of reference into account when deciding on therapeutic privilege goes in a similar direction. Brummett und Salter (2023, p. 18) speak comparatively of a "[…] prima facie moral obligation to truth telling […]". Some authors therefore consider it possible to justify the therapeutic privilege. Engels and Wiesing (2023, pp. 694–695) recognize therapeutic privilege as legitimate, particularly in emergency situations or in the case of persons incapable of giving consent. One could also say "[…] the reasons for and against deception need to be balanced" (Sokol, 2007, p. 985). According to the above definition, such a consideration cannot be justified without taking into account the relationship with the patient, moral values, and reflective behavior.

Nevertheless, there are many difficulties associated with therapeutic privilege. These include assessing the perceived risk associated with full disclosure of information (Sokol, 2007, p. 986). Furthermore, it is not entirely clear whether

these procedures are reserved exclusively for medical professionals or whether nursing staff may also be able to avoid certain topics of conversation for the *benefit* of the person concerned. Moreover, it must be discussed whether the justification can be based solely on the avoidance of risks or whether diagnostic and prognostic considerations are also conceivable (Hodkinson, 2013, pp. 117–119). Regardless of the specific case, following Edwin's (2008, pp. 159–160) perspective would mean that the healthcare professional is obliged to tell the truth. This obligation may be grounded in respect for autonomy, the preservation of trust, or the avoidance of harm (Cole & Kodish, 2013, pp. 640–641). However, one must be aware that a complete truth cannot be communicated (Lund, 1947, pp. 344–345).

Sokol (2006, pp. 458–459) also draws attention to the problem associated with truth-telling, or how it is communicated, with his comments on intentional deceptions. In many cases, it will not only be difficult to convey *the* truth due to the difficulty of defining truth[5] as something objectively comprehensible. Rather, deception can occur, regardless of whether a medical professional wants to tell the truth or not. A physician can inform an affected person of their cancer diagnosis with complete conviction, but in doing so deliver the wrong findings from the laboratory. The exclusive focus on the truth value of a statement can therefore also lead to false conclusions in the context of therapeutic privilege. One can therefore already speak of deception if the person in question either knows or at least believes that they want another person to believe something false (Brummett & Salter, 2023, pp. 17–18). Besides that, it should be noted that limited or temporary forms of information withholding may, under exceptional circumstances, be considered ethically justifiable.

In this context, Sokol's (2006, p. 460) consideration that intentional deceptions depend on (1) the intention of the person acting, (2) the reasonable and situation-related expectations of the deceived person, and (3) the success of the deception, is useful. Regarding the example just mentioned, this would mean that the healthcare professional did not deceive the person concerned due to lack of intention, even if something false was conveyed. In ethical terms, this reference to intentionality (1) seems crucial, which also appears to be compatible with a criterion for autonomous decision-making by Beauchamp and Childress (2019, pp. 102–104). This personal intention and the legitimate expectation of the respective counterpart to make an *approximately truthful* statement are morally significant (Clem, 2023, pp. 28–29), especially with regard to the interests of others. The other two criteria would nevertheless be fulfilled because at least the patient was deceived (3) about their own state of health and it can reasonably be assumed (2) that medical professionals tell the truth when diagnosing cancer. Due to different conceptions and definitions of deception, a universal solution seems unrealistic, as the focus must rather be on the moral assessment of individual cases. Additionally, it needs to be kept in mind that not every form of selective disclosure necessarily constitutes deception in the strict sense. Withholding of information and deception are not identical.

Therapeutic privilege and epistemic injustice

Apart from the general problem of therapeutic privilege and the associated questions of when and how certain information should be provided, it is necessary to consider the current practice of therapeutic privilege in terms of justice. The concept of epistemic injustice does not replace autonomy-based critiques of

paternalism. Rather, it complements them by drawing attention to forms of exclusion and credibility deficits that remain insufficiently visible within standard autonomy-centered analyses. The presentation so far should not give the impression that the use of therapeutic privilege is generally morally wrong or morally required. What is essential is an assessment of the relevant situation (Brummett & Salter, 2023, pp. 20–21; Sokol, 2007, p. 985). The following analysis therefore examines therapeutic privilege through the lens of epistemic injustice, focusing specifically on questions of exclusion, credibility, and participation in healthcare-related knowledge practices. *First*, this approach seems plausible because the selective disclosure of information – through therapeutic privilege – is necessarily associated with knowledge, or rather, with knowledge that has not been made available. *Second*, therapeutic privilege has so far been discussed in the scientific literature, quite understandably, in the context of the principles of autonomy, non-maleficence, or even beneficence. The justice-related dimension of therapeutic privilege remains insufficiently addressed and therefore constitutes a significant gap in current ethical analyses.

The types proposed by Fricker serve as a starting point for the following sections. Broadly speaking, epistemic injustice can be divided into (1) hermeneutical and (2) testimonial injustice, although further subcategories are possible (Byskov, 2021; Medina, 2018; Nikolaidis, 2021; Origgi, 2012; Pohlhaus, 2017). Hermeneutical injustice occurs, for example, when a person (Jamie) does not have sufficient hermeneutic opportunities to belong to a knowledge community (Fricker, 2017, pp. 54–55). The people in the community have a common basis of knowledge and therefore also information that Jamie and comparable individuals do not have. As a result of this positioning, Jamie and comparable individuals are also unable to understand certain content associated with this knowledge and therefore cannot make an epistemic contribution (Carel & Kidd, 2014, p. 533). What is unjust about this is that access to this knowledge or specific concepts is based on prejudice and usually corresponds to a structural exclusion of groups. One could imagine a book club in which the readers exchange ideas only on books available there. Jamie is subject to hermeneutical injustice if, for example, access is fundamentally denied on the basis of age or gender.

Testimonial injustice occurs when, for example, another person (Peter) and their opinion are not taken seriously. Prejudices on the part of a listening person or group lead to Peter not being perceived as an epistemic subject (Fricker, 2017, pp. 53–54; Nikolaidis, 2021, p. 386). This means that Peter's contribution is not recognized as epistemically credible or relevant, often independently of its actual quality. The injustice is based on an unfounded assumption. It is not about evaluating a specific statement by Peter and its quality as a contribution to knowledge, but rather that the subject itself is not considered epistemically relevant (McKinnon, 2016, pp. 442–443). To put it more strongly, one could imagine a medical congress at which medical professionals discuss complicated operations. A cleaning employee present (Peter) could provide the perfect answer but would most likely not be taken seriously. Such a non-consideration would be unjust because the solution can apparently only be provided by a physician.

The following three sections apply these two forms of epistemic injustice to therapeutic privilege in different healthcare contexts. This will, *first*, establish a link to therapeutic privilege and, *second*, draw attention to ethically relevant challenges

that have not yet been addressed in this way in the scholarly literature. The assessment of whether information should be withheld is always made by particular individuals within specific relationships of care. The following sections therefore examine how such decisions may give rise to epistemic injustice in three contexts: (1) the doctor–patient relationship, (2) age-related discrimination, and (3) the role of family caregivers.

Doctor-patient relationship

The previous considerations show that the relationship between a healthcare professional and the person being treated has a significant impact on therapeutic privilege. A physician will base their assessment of the potential risk associated with providing full information specifically on the person in question (Brown, 2008, pp. 332–333). The information that one has only a few months to live can be a mental overload for Jamie, a relief for Peter, and no more than a basis for clarifying further steps for Aaron. An understanding of person-specific concerns and fears therefore seems to be a plausible premise for selectively disclosing or withholding information. However, this requires a relationship. Otherwise, a physician would always disclose or withhold information about an incurable disease, for example, regardless of who the patient is. Such a practice seems neither realistic nor acceptable. Therapeutic privilege is frequently grounded in assumptions about the patient that emerge through interpersonal interaction. Certain fears, anxieties, or even resulting actions, of the person concerned are anticipated to a certain extent, which without a functioning relationship structure could only be done based on a hypothetical patient. Such an approach would completely exclude the individual and therefore cannot be understood in terms of patient-specific care and support (de Raeve, 2002, pp. 155–156). If the decision for or against the use of therapeutic privilege depends on this relationship, which seems plausible given what has been said so far, then a form of epistemic injustice arises.

Without some degree of interpersonal engagement, physicians may lack sufficient insight into a patient's specific fears, needs, or coping capacities. Furthermore, it is conceivable that closer and more established relationships influence the use of therapeutic privilege more than short-term acquaintances, to put it simply. However, these thoughts also make it clear that it can be challenging for a physician to respond to the individual person with their specific concerns on the one hand and not be seduced by them on the other. This *seduction* means that the existing relationship structure can establish a tendency for or against the use of therapeutic privilege, and consequently objective aspects lose relevance. In order to treat all people as fairly as possible, objective aspects such as diagnostic information, therapeutic options, and alternative courses of action must (in principle) be provided, regardless of the relationship. This can also be understood as equal access to health care, or appropriate medical support (Österle, 2018, pp. 41–42). Based on the above, forms of hermeneutical injustice may arise when certain individuals do not have an intimate relationship with a physician, are unable to establish one over a longer period of time, or the relationship is characterized by lack of openness, intimacy, and trust. However, if the relationship is an indicator of the use of therapeutic privilege, then the decision for or against is based on the information and knowledge that arises from that relationship.

In this case, the injustice may be due to certain prejudices (no sympathy), structural challenges (little time), or even unjustified assumptions (no valuable

patient-knowledge) on the part of a physician (Kidd & Carel, 2017, p. 178). Even if there is already a relationship between physicians and patients, the kind of interaction determines both the exchange of knowledge and the use of therapeutic privilege. Apart from the fact that the mere existence of medical measures (respectively, knowledge about them) says nothing about whether they will be utilized, one deals with a different constellation in the case of therapeutic privilege. Equal access to medical options, specific information or generally the prerequisite for future planning may be prevented by therapeutic privilege and therefore also a form of fair access could be disregarded (Zink, 2010, pp. 492–493). The more a physician engages with and potentially identifies subject-related concerns, the more likely they are to act for the (perceived) benefit of the person concerned – i.e., to use therapeutic privilege. At the same time, however, the previous remarks suggest that a harmonious relationship, which has been established through experience and interaction over a longer period, can contribute to unfair treatment for different patients.

Those who have not yet had interpersonal interactions with a physician are also very unlikely to benefit from therapeutic privilege, because a trusting relationship often develops over time (Menon et al., 2021, p. 49). This form of hermeneutical injustice is initially decisive, regardless of whether the use of therapeutic privilege itself is considered good or bad. This is because patient-related considerations – namely, knowledge contributions regarding testimonial (in)justice – are insufficiently considered (Carel & Kidd, 2014, p. 533). The doctor-patient relationship therefore determines not only whether patients are able to contribute epistemically at all, but also how their contributions are subsequently received and evaluated. However, the nature of this relationship can vary greatly, and influences therapeutic privilege in this context. Schaupp's (2018, pp. 99–100) descriptions in the context of equitable resource allocation can be usefully applied here, insofar as medical professionals also have the responsibility to organize their time and general interaction with patients. This does not mean that a relationship is determined exclusively by the amount of time spent interacting, but it does mean that time needs to be invested to establish a relationship (Kropf & Schmidhuber, 2024, p. 4). Here the concern is a patient-centered approach that considers individual needs, but only to the extent that a certain degree of equal treatment becomes crucial for further courses of action. However, physicians have a specific responsibility to try to prevent ethically problematic effects on general patient care within such a relationship (Schaupp, 2018, pp. 101–102).

According to Zink (2010, p. 494), an egalitarian approach with an indispensable degree of compassion seems crucial for the care of people in a medical context. This fundamental stance can bring a specific person and at the same time all persons – at least in theory – into focus. However, Rhodes (2005, p. 22) warns against using one principle of justice for all possible cases because in some circumstances, some reasons may be more defensible and more broadly accepted than others. Rather, different conceptions of justice and their corresponding application (or non-application) should be considered in the concrete situation. The described hermeneutical injustice may arise in the course of the doctor-patient relationship, in particular from the way in which this interaction is characterized. The quality and accessibility of the doctor–patient relationship therefore influence both whether patients can participate meaningfully in epistemic exchange and how their

contributions are subsequently received and evaluated. An overly close and unreflective relationship structure can lead to an unfair prioritization of certain people and consequently undermines equal access to healthcare for all. Such selections ought to be avoided, as they introduce unjustified disparities between patients. Based on the *fair procedures* (Daniels, 1996, p. 10), the following conclusion can be drawn: Medical professionals should avoid allowing therapeutic privilege to depend primarily on personal affinity, relational closeness, or subjective sympathies. Otherwise, comparable patients may receive unequal access to medically relevant information, thereby creating forms of epistemic and hermeneutical injustice.

Treatment of elderly people

In addition to the relationship just described, the age of patients can pose a particular challenge, insofar as this may be a decisive factor in the *use* of therapeutic privilege. This assumption can at least be implicitly derived from what has been described so far and is supported by scholarly work (Banerjee et al., 2021; Brandberg et al., 2013; Guidet et al., 2018; Hamel et al., 1999; Hosseini et al., 2020; Saif-Ur-Rahman et al., 2021). Certain information regarding therapeutic intervention options and/or the illness-related condition could be withheld from older people, more often than from younger people. One conceivable reason for this is that the chances of survival of older people with the same disease symptoms are often assessed as lower in clinical contexts (Ehni & Wahl, 2021, p. 253). In comparable contexts, QALYs (quality-adjusted life years) are used to determine both qualitatively and quantitatively what quality of life a person can expect (Österle, 2018, pp. 58–59). However, this is done on the basis of utilitarian considerations and corresponds to an external assessment. In broader healthcare debates, age-related evaluations sometimes appear in allocation frameworks such as QALYs. While such frameworks primarily operate at the systemic level of resource allocation rather than individual disclosure practices, they nevertheless illustrate how age-based assumptions may shape perceptions of whose future, preferences, or treatment outcomes are considered more valuable. What appears to be particularly problematic is ignoring the perspective of those affected, which constitutes a form of testimonial injustice. An exclusive focus on QALYs may contribute to discriminatory assumptions regarding older patients compared to younger people and, regarding the provision of information by a physician, may contribute to broader assumptions about the relative value, resilience, or future prospects of patients of different ages.

Testimonial injustice may arise, for example, when there is an exclusive focus on the age of a patient (Aaron), if this is associated with the conviction that Aaron is no longer able to make rational decisions. It could also depend on the described and generally lower life expectancy to ascribe less weight to the explicitly expressed wishes of Aaron, not to take them into account at all, or to rank them lower than those of younger patients. It is also conceivable that patient's statements are heard but considered irrelevant for medical treatment (Carel & Kidd, 2014, p. 532). In these and similar cases, Aaron is, due to his age, not considered as an epistemic subject, or at least he is less valued as a source of relevant knowledge. According to Lund (1947, p. 348), however, therapeutic privilege loses its relevance in seriously ill and hopeless cases because many of these people are aware of their situation even without the explicit provision of information. These considerations lead to the

conclusion that older people may be subject to discrimination, which should be prevented (Dinges, 2020, pp. 77–78). The fact that they are at a later stage of life and therefore (potentially) have fewer years of life ahead of them than younger people does not justify withholding essential information about their state of health. This view is similarly supported by Dabrock, who deals with limited medical resources and their withholding from people in old age. In his opinion, the waste of resources is morally reprehensible, specifically in times of scarce resources (Dabrock, 2006, p. 250).

Regarding therapeutic privilege, the conviction could arise that doctors' time is currently a limited resource that must be preserved (Krones & Richter, 2008, p. 824). However, when medical professionals provide excessive information on the state of health, therapeutic options or even prognosis, they give up valuable time. At first glance, it would seem appropriate to always make use of therapeutic privilege. However, this approach proves to be deficient, because patients are insufficiently recognized and the efficiency saved is gained at the expense of personal care. In addition to the described *testimonial* injustice regarding older patients, a failure to disclose information in principle could also give rise to a *hermeneutical* injustice if, for the sake of saving time, older patients are denied important information and thus have reduced opportunities for epistemic participation. Even if efficient working methods and ethical guidelines do not necessarily have to be mutually exclusive, this approach seems to lead precisely in this direction. This problem is also illustrated by Höffe (2015, p. 26), as many tasks of justice arise from the limited nature of natural resources. In short, resource constraints may encourage reduced disclosure practices toward older patients.

Age-based prioritization sometimes appears in contexts such as organ transplantation, where benefit assessments and survival probabilities may influence distributive decisions (Kostka, 2014, pp. 250–251). However, such allocation-based considerations cannot simply be transferred to therapeutic privilege. In the context of therapeutic privilege, the central issue is not the distribution of scarce medical goods, but rather patients' epistemic access to medically relevant information and the conditions for autonomous decision-making. Even though Fricker (2017, pp. 53–54) makes it clear that a form of distributive justice is also linked to epistemic justice, it is plausible that therapeutic privilege and the preceding considerations regarding testimonial injustice pertain to knowledge. On the one hand, this concerns the provision of knowledge (by a physician) and, on the other, the consideration of knowledge (by Aaron). Regarding therapeutic privilege, the preceding analysis shows that the selective disclosure of information by medical professionals, for example, also depends on the age of the patient. *Firstly,* the necessary knowledge or information may not be passed on because it apparently no longer pays off for older people. *Secondly,* certain information may be kept to oneself because people at this stage of life are no longer competent to process it adequately (Kidd & Carel, 2017, pp. 184–185). And *thirdly,* it may be the case that, for example, Aaron is listened to, but his needs are not considered due to other (younger) patients.

Based on the above, it can be concluded both that the statements (testimonial injustice) of older people may be ignored and that forms of exclusion from epistemic participation (hermeneutical injustice) is possible (Carel & Kidd, 2014, pp. 534–535). In the first case, the use – or non-use – of therapeutic privilege does

not include the knowledge of Aaron. In the second case, no effort is made at all to recognize the wishes and needs of older people as knowledge. Using a single criterion – age, in this case – as the sole basis for life-and-death decisions does not appear to be justified. This is not only fundamentally discriminatory but also fails to recognize that not all people belonging to a specific group have or bring with them the same problems. Dabrock's (2006, pp. 259–260) consideration seems particularly fruitful in this regard, according to which, for reasons of justice, the respective physical prerequisites for specific support are co-decisive, which vary depending on age and are described by him as a physical lifestyle. This makes it clear that the illnesses and accompanying symptoms that occur with age are not simply part of being human but should not be used as a benchmark in comparison with younger people, for example, who are prevented from experiencing these problems simply because they are not older (Dinges, 2020, pp. 78–79). Nevertheless, years of life are often decisive when it comes to medical treatment or a waiver (Beauchamp & Childress, 2019, pp. 255–256). Applied to the problem of conceivable discrimination through therapeutic privilege, it becomes obvious that a patient's age alone must by no means be misused as a yardstick for conducting discussions for the apparent benefit of the person concerned. What matters is preserving autonomy and respecting an epistemic agent – regardless of age-related conditions.

Family caregivers

The previous remarks suggest that therapeutic privilege is mostly exercised by trained medical professionals. Through years of education and their experience in the medical context as well as in the care and treatment of patients, these people have a special authorization to decide – somewhat dramatically expressed but in many cases according to reality – about the life of another person (Lund, 1947, pp. 344–345). In certain situations of particular vulnerability, physicians thus decide in favor of the person concerned by deliberately refraining from disclosing details about their state of health. However, the question now arises as to whether this privileged position with the right to select information belongs exclusively to medical professionals or not also to *family caregivers,*[6] for example. These people care for another individual in a similar way, probably have an even stronger emotional bond with the person concerned and usually know more precisely about the resilience of the person in question (Hemberg & Hemberg, 2020; Knausz, 2021).

It seems fair to assume that most family caregivers lack the medical skills to be able to communicate therapeutic measures in an appropriate manner. Nevertheless, this consideration can be taken further. If, for example, the prognosis for possible consequences of an operation is not to be communicated exclusively by a medical professional, but this information has been passed on to the family caregiver, a scenario of therapeutic privilege can arise. Situations of this kind often emerge when people requiring care live at home, in the case of people with dementia, and when people are afraid of medical facilities and professionals or generally trust their family more (Bohnet-Joschko & Bidenko, 2022). Family caregivers thus find themselves in a comparable constellation in which it is a matter of honestly passing on information or *obscuring* the truth for the benefit of the patient. Such a scenario is similar to the orientation towards joint decision-making processes mentioned by Menon et al. (2021, p. 49), in which all people are involved as much as possible.

However, the joint aspect only integrates the perspective of the person to be cared for insofar as certain interests are assumed. Thus, epistemic justice comes into play.

From what has been said so far, there is no convincing reason why family caregivers may not also, under certain conditions, contribute relevant contextual and relational knowledge to ethically reflective decisions concerning communication and disclosure. The result might be a reduction of epistemic injustice. What privileges do (or should) people caring for a loved one have? Both in the classical understanding of therapeutic privilege and for family caregivers, justification is conceivable based on the principles of nonmaleficence, beneficence (Beauchamp & Childress, 2019, pp. 126–127), or respect for autonomy (Brummett & Salter, 2023, pp. 19–20). However, unlike medical professionals, family caregivers do not usually have the medical expertise that, at least partially, serves as the basis for the principles described. For this reason, a different justification could prove to be comprehensible and justifiable. This would be feasible if the basic knowledge did not have to come from family caregivers, but rather if these caregivers took on a role as mediators. Described in a similar manner, non-medical experts can also make decisions within the framework of therapeutic privilege (Abigail, 2011, pp. 2–3).

These individuals are assigned as mediators between patients and physicians, with their main purpose of relaying information that physicians do not share to the appropriate parties (Abigail, 2011, pp. 3–4). They are available for clarifying discussions and a communicative exchange. While family caregivers do not usually have the training, they have a special role insofar as they are responsible for the care of a loved one. For de Raeve (2002, pp. 154–155), the difference to professional activity lies above all in the scope and nature of any justification strategies for specific actions. In this context, the justification of therapeutic privilege can also be related to the knowledge advantage, but not in the sense of facts or medical know-how. An emotional dimension of knowledge about the wishes, interests, and states of mind of the person being cared for is crucial. Here, family caregivers can generally – other things being equal – be said to have more insight compared to medical professionals (Kropf, 2024, p. 160). They may not be able to explain the principles of nonmaleficence and beneficence in a scientific sense, but they may possess significant insight into the wishes, concerns, and coping capacities of the person being cared for. Through specific beneficence (Beauchamp & Childress, 2019, pp. 219–220) they may contribute meaningfully to ethically reflective decisions concerning communication and disclosure, depending on what they know about the person being cared for. Their personal connection with the patient gives family caregivers a special insight into their feelings.

Taking family caregivers into consideration when providing knowledge can help reducing testimonial injustice if the wishes and fears of the person concerned are taken seriously. This may be easier to implement in the type of close relationships just described than in the doctor-patient encounter. In addition, the hermeneutical injustice previously mentioned regarding older people seems at least theoretically avoidable because here the mediator and recipient of information (or knowledge) are on a similar level. In contrast, one can agree that "[…] health professionals are considered to be epistemically privileged […]" (Carel & Kidd, 2014, p. 530). As described above, the close relationship not only has a potentially problematic connotation of hermeneutical injustice but also justifies the use of therapeutic

privilege in the first place. If physicians do not address the needs of a specific person and even refrain from disclosing important information, neither nonmaleficence nor beneficence can serve as a justification, and, so: "Negligence falls short of due care" (Beauchamp & Childress, 2019, p. 160). Here harm is done in two ways: *first*, by claiming therapeutic privilege and, *second*, by disregarding personal wishes, considerations, and ideas about life.

It can be argued that the potential extension of therapeutic privilege to family caregivers may also result in epistemic injustice. This is not denied here. Family caregivers can equally disregard the patient's statements or exclude them from any discussion. Thus, the patient remains the primary epistemic and moral subject of disclosure practices. However, if these limitations are considered, family caregivers can make contributions for the persons concerned that medical professionals (mostly) cannot. Furthermore, it seems reasonable to claim that the systematic exclusion of this group of people for the disclosure of information described here can be understood as (1) a hermeneutical injustice and (2) a testimonial injustice. A testimonial injustice exists if these additional perspectives are not considered. This may also contribute to forms of hermeneutical marginalization, for instance, when family caregivers are in principle considered unsuitable for this *privilege* and experience forms of exclusion from epistemic participation. Accordingly, there is a case for involving family caregivers, under appropriate ethical conditions – and in a similar way to that of medical professionals – in communicative processes concerning the disclosure or withholding of information. This is because family caregivers generally do have knowledge of and efforts concerning the interests of affected people.

Conclusion

The preceding analysis has shown that therapeutic privilege can give rise to distinct forms of epistemic injustice – specifically hermeneutical and testimonial injustice. Ethically significant challenges arise in particular from (1) the structure of relationships between medical professionals and patients, (2) age-based assumptions about patients, and (3) the exclusion of family caregivers, for example. While the primary aim of this article has been to draw attention to the justice-related dimensions of therapeutic privilege, the analysis also identifies ethical strategies for addressing these challenges. Moreover, it suggests that decisions concerning the disclosure or withholding of information can only be justified with reference to the specific circumstances of individual patients. Existing frameworks proposed by authors such as Brummett, Salter, and Sokol may help to guide ethically reflective decision-making in such cases. However, this paper does not aim to replace practical decision-making frameworks, but rather to raise awareness of epistemic (in)justice in the context of therapeutic privilege and to direct the focus toward specific groups of people. The argument above further suggests that truth-telling in healthcare should not be understood as a simple all-or-nothing requirement. Rather, considerations of epistemic injustice highlight the relational and social dimensions of healthcare communication and underscore the importance of recognizing patients not merely as recipients of care, but as epistemic agents. The article therefore argues that ethical evaluations of therapeutic privilege remain incomplete unless questions of epistemic injustice are explicitly taken into account.

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Notes

[1] In the medical context and the healthcare system, paternalism is a concept that is often regarded as outdated and therefore unjustifiable due to past abuses, ethically questionable experiments, or the excessive exercise of power by medical professionals (especially in the 20th century). Nevertheless, there are certain exceptions in which paternalistic action is justifiable, and proponents also emphasize specific situations in which paternalistic action is legitimate (e.g., emergency situations, lack of capacity to consent, unconsciousness, minors). These debates are relevant to the significance of the therapeutic privilege emphasized here, but the dimension of justice is usually neglected. For a more in-depth discussion, see, for example, Düber et al. (2015), Dworkin (2014), Faden and Beauchamp (1986).

[2] Practices of truth-telling in medicine have also changed considerably over time and continue to vary across healthcare systems and cultural contexts. While contemporary Northern European healthcare ethics often strongly emphasizes informed consent and full disclosure, more family-centered or protective communication practices continue to exist in other settings. See Beauchamp (2011), Buchanan (2019), Hartlev (2020), Newton-Howes et al. (1998).

[3] For example, Norwegian healthcare law strongly emphasizes patients' rights to information and limits non-disclosure to exceptional situations involving serious harm. The fact that many legal systems narrowly restrict therapeutic privilege itself demonstrates how ethically and politically sensitive these practices are. However, the present article does not aim to provide a comparative legal analysis, but rather an ethical examination of therapeutic privilege and epistemic injustice. See also Hartlev (2020), Lindén and Ervik (2022), Lov om helsepersonell m.v. (helsepersonelloven) (1999), Norway Relocation Group (2025).

[4] It seems reasonable to assume that such a decision is made deliberately, as healthcare professionals aim to prevent suffering and pain. Withholding this information appears justified, as suffering and pain are generally viewed as negative, and healthcare professionals are capable of making such an assessment. This ability is based primarily on medical expertise, personal experience, and an existing relationship with the person concerned. Such a relationship seems necessary because, otherwise, the assessment would be arbitrary and would have no connection to the person in question. More on this below.

[5] In a common theory (correspondence theory), truth refers to the correspondence between reality and what is said about this reality. In this context, we can speak of truth, for example, when a medical professional diagnoses a malignant tumor, and a biopsy confirms it. In this sense, there is a correspondence between the undesired accumulation of cells and what is said about the cells. However, it is important to bear in mind that this is just one theory among many others. See Tarski (1969, pp. 63–64).

[6] Historically, disclosure practices in some healthcare contexts have prioritized communication with family members rather than patients themselves. Such approaches have been criticized for undermining patient autonomy and potentially

reinforcing paternalistic forms of decision-making. The present argument should therefore not be understood as a defense of excluding patients from decision-making, but rather as an argument for considering family caregivers as additional epistemic contributors within ethically reflective communication practices. See, for example, Christman (2014), Dworkin (2014), Kropf (2025), and van Oosten (1991).

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