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Epistemic injustice and medical diagnosis

Vera Tripodi

Abstract: In this contribution, I will be focusing on a particular aspect of epistemic injustice in the sense articulated by Miranda Fricker: the fact that ill women are more exposed than ill men to the experience of not being heard from doctors or health professionals. My aim is to show that epistemic injustice in medical diagnosis constitutes a form of silencing that prevents women from being able to efficiently communicate knowledge to others, and it is related to mechanisms that make doctors fail to recognize female patients as trustworthy and competent with respect to their illness conditions or to readily incorporate their knowledge into decision-making. More precisely, the paper is divided in two parts. In the first part, I present Fricker's notion of epistemic injustice. In the second, I discus some patient reports of cardiovascular disease as example of testimonial and hermeneutical injustice.

Keywords: Epistemic Injustice, Medical Diagnosis, Pain Description

Running head: Can an inaccurate medical diagnosis be a case of epistemic injustice?

Introduction

In *Epistemic injustice. Power and the ethics of knowing*[1], Miranda Fricker argues that women are particularly vulnerable to the phenomenon of epistemic injustice: they are not recognized as trustworthy experts more often than men. In this contribution, I will be focusing on a particular aspect of this kind of injustice: the fact that the ill women are more exposed than ill men to the experience of not being heard by doctors or health professionals. More precisely, I attempt to show that epistemic injustice in medical diagnosis might be linked to mechanisms (sometimes unconscious) that make doctors fail to recognize female patients as trustworthy

[1] Miranda Fricker, *Epistemic Injustice. Power and the Ethics of Knowing*, Oxford University Press, Oxford 2007.

and competent with respect to their illness conditions and to readily incorporate their knowledge into decision-making. The paper is divided in two parts. In the first part, I present Fricker's notion of epistemic injustice. In my analysis, I pay particular attention to the women' common reports that they feel "silenced", not listened to, not taken seriously. In the second part, I discuss some cases of cardiovascular disease as cases of testimonial and hermeneutical injustice and I suggest a way to mitigate this phenomenon. Here is a more detailed layout of my argument.

As narrative analysis has shown, female and male patients may share and describe their illness experience very differently. There are, for example, gender-specific differences in the description of chest pain and – according to some research studies – women are more likely than men to be under-diagnosed and under-treated. This happens – I suggest – mostly because female patients' reports are often ignored, sometimes heard but not considered; taken as irrelevant, not sufficiently articulated, or are less understood from health professionals and seen as not corresponding to their expectations. In the next paragraph, let us first see more in detail how epistemic injustice may arise in the context of knowledge and be perpetuated.

Fricker's Notion of Epistemic Injustice

The concept of epistemic injustice denotes specifically epistemic forms of injustice. According to Fricker, such an injustice arises when a hearer expresses unfair judgments about the credibility of a speaker (or a group of individuals) as knower. More precisely, it is a kind of injustice that occurs when someone is unfairly judged specifically in her or his capacity as expert and as giver of knowledge. Fricker identifies two forms of epistemic injustice[2]: *testimonial* and *hermeneutical*. The testimonial epistemic injustice is "caused by prejudice in the economy of the credibility" and it arises "when prejudice causes a hearer to give a deflated level of credibility to a speaker's word"; while the *hermeneutical* one is "caused by structural prejudice in the economy of collective hermeneutical resources"[3] and "occurs at an unfair disadvantage when it comes to making sense of their social experiences"[4]. Let us consider first the testimonial form.

[2] Ivi, p. 1.
[3] *Ibidem*.
[4] *Ibidem*.

Usually, we assign a certain credibility to the social agents we interact with and it is legitimate to consider some of them more credible than others. As a consequence, not all holders of knowledge are acknowledged by others as an authority: some people are, for instance Cynthia Townley has argued[5], members of the community we trust and recognize as epistemic agents. Accordingly, we do not treat all people as individuals from whom we can get more and better information and, when we trust someone, we commit ourselves not to seek independent verification.

It may be, however, that we regard one person (or group of individuals) as more reliable because we place her (or them) in a category to which we assign a meaning (positive or negative) or that evokes in us certain associations and interpretations (positive or negative). Thus, because of some stereotypical representations and prejudices, we may unfairly give our interlocutor less or more credibility (credibility deficit or excess) than (s)he would otherwise deserve[6]. This injustice occurs when an interlocutor gives a speaker less credibility than (s)he deserves because of a prejudice (about gender, sex, race, and so on) that the listener holds about the speaker's identity. This happens, for example, when a woman is not taken seriously by a listener who has prejudices against women or when the police does not believe the testimony of an African-American simply because (s)he is African-American. This, Fricker says, plays a crucial role in the social dimension of our everyday lives. In fact, attributing a credibility deficit can hinder and limit a person: a person's capacity for knowledge is, as some authors maintain, essential to human value. As a consequence, when this capacity is unfairly undermined, the victim of this kind of injustice is deprived of a fundamental element of respect. Generally, women are not treated as trustworthy experts and suffer from a testimonial deficit: it is common to argue that what they say (or think) is mistaken, false or too vague. The same goes for members of marginalised social groups.

The second form of epistemic injustice is, as outlined above, hermeneutical[7]. Fricker specifies that this form of injustice is caused by a gap in collective interpretive resources of a community; for instance, when a community cannot recognize a wrong suffered by its members because it does not have the means of interpretation to understand or see something as unfair. Consider, for instance, the experience of a woman who

[5] Cynthia Townley, *A Defense of Ignorance: Its Value for Knowers and Roles in Feminist and Social Epistemologies*, Lexington Books, Lanham (Md) 2011.

[6] M. Fricker, *Epistemic Injustice. Power and the Ethics of Knowing*, pp. 4, 17, 18-29, 43-59.

[7] Ivi, pp. 153-161.

suffers from what we call today "sexual harassment" in a historical period or cultural context in which the concept of sexual harassment does not exist. Before this concept was introduced and socially recognized, a community lacked interpretative instruments to see certain acts or behaviours as offensive to personal dignity and freedom and thus such wrongs were tolerated.

The question of epistemic marginalisation seems then to be connected, I guess, to the issue of unconscious bias because epistemic injustice often results from prejudices or stereotypes. According to some research studies, people are affected by implicit bias (some of which relates to gender and sex). Gender bias shapes the manner we judge the quality of a person's work, speech, testimony and views. Moreover, it affects our expectations about men's and women's performance. As this research shows, we are induced to believe that originality, excellence, leadership, intellectual ability are masculine traits and we accordingly associate these traits more with men than women. Certainly, a woman may herself be implicitly biased and persuaded that some traits are more characteristic of males, and even those who embrace egalitarian beliefs may also hold implicit bias[8]. This not only causes social or political harm, but also produces – as Fricker underlines – a form of epistemic harm and disadvantage.

Can we remedy these forms of injustice? What needs to change in our social practices and what should we do to help? Fricker says that is possible to prevent or mitigate epistemic harm and disadvantage by training in a particular virtue or sensibility, namely the *virtue of testimonial justice*. According to her, this virtue can detect and correct the influence of prejudice on the hearer's assessment of a speaker's credibility[9]. It requires the development of critical awareness (social and reflective), which then allows us to consider the impact a prejudice has on the way we perceive our interlocutors, and to correct it[10].

Let us see in what follows in which sense inaccurate (incomplete or wrong) medical diagnosis or treatment can be linked to the phenomenon of the epistemic injustice. In the next paragraph, I will be focusing on the study conducted by Vodopiutz et al. at the KA Rudolfstiftung Hospital in

[8] Jennifer Saul, *Implicit Bias, Stereotype Threat and Women in Philosophy*, in Fiona Jenkins and Katrina Hutchison (eds.), *Women in Philosophy: What Needs to Change?*, Oxford University Press, Oxford 2014, p. 55.

[9] M. Fricker, *Epistemic injustice*, cit., pp. 82-94.

[10] Elizabeth Anderson, *Epistemic Justice as a Virtue of Social Institutions*, "Social Epistemology", Vol. 26, Issue 2, 2012, pp. 163-173.

Vienna, from February to September 2000, and supported by the Austrian Cardiologic Society[11].

Gender Differences in Pain Description

Vodopiutz et al. have conducted a cardiological-linguistic study on chest pain in hospitalized patients with the aim of assessing cause-specific and gender-specific differences in the way patients report and describe their symptoms. As the result of this study has revealed, there are strong gender differences in the symptoms reported among female and male patients. While men tend to present themselves as interested to know the cause of the pain, well informed about their illness and able to describe their pain concretely; women tend to present themselves as pain enduring and to talk about their pain diffusely. According to Vodopiutz et al., since in a case of coronary heart disease patient's description plays an important role in prompting medical diagnosis, under-diagnosis and under-treatment of female patients with heart disease might be a consequence of gender differences in self-presentation and description of the symptoms. More precisely, if it is true that women and men tend to describe their pain very differently, these gender differences in chest pain might help clarify why coronary heart disease in women is often under-diagnosed and why men are more likely to be hospitalized than women when they came to the emergency room with such pain. Let us concentrate on the details of this study.

The data were gathered during an eight-month period between February and September 2000 in the major hospital in Vienna. Instead of taking medical interviews as a data basis, Vodopiutz et al preferred to conduct specific interviews: within 48 hours after hospital admission and having obtained informed consent, the patients were invited to take part in the research and in face-to-face interviews with the same investigator. Their goal was to stimulate a conversation as close as possible to ordinary interaction. In these semi-standardized interviews, the topics were established in advance and the

[11] Julia Vodopiutz, Sabine Poller, Barbara Schneider, Johanna Lalouschek, Florian Menz, Claudia Stöllberger, *Chest Pain in Hospitalized Patient: Cause-Specific and Gender-Specific Differences*, "Journal of Women's Health", Vol. 11, 8, 2002, pp. 719-727; Florian Menz, *Differenze fra i due sessi nella descrizione dei disturbi cardiaci. Risultati di uno studio interdisciplinare medico-linguistico*, in Silvia Luraghi e Anna Olita (a cura di), *Linguaggio e genere*, Carocci, Roma 2006, pp. 170-185; Florian Menz and Johanna Lalouscher, *I just can't tell you how much it hurts. Gender-relevant differences in the description of the chest pain*, in Mauricio Gotti and Françoise Salager-Meyer (eds.), *Advances in Medical Discourse Analysis: Oral and Written Contexts*, Peter Lang, Bern 2004, pp. 133-154.

length of the interviews ranged approximately between 15 to 50 minutes. Then, the interviews were anonymized, transcribed, and then analysed using linguistic analysis. More precisely, 101 interviews were processed and subsequently transcribed but only 23 of them were selected for a deeper analysis. The selection criteria used by the investigators were gender (female\male), cause (coronary\non coronary) and age. During the linguistic analysis, five main subjects and general foci in relation to the research questions were discussed: self-presentation as being well informed; psycho-social strain; illness as a threat to life and fear; downgrading or upgrading of illness; cooperativity or passivity with doctors.

During the interviews, male patients generally presented themselves as well aware about their illness, the course of treatment and the illness prognosis; able to observe their pain extensively and take their pain seriously. The following transcript extracts are examples of pain management linguistic behaviour common among male patients:

(1)
I: Well, you didn't think it was your heart.
P: I knew it instantly.
I: You knew it.
P: I knew it at once – because I felt the first pains at one o' clock.
I: hm
P: I got up and the last 3, 4 weeks I've had a, well, some rattling that I woke up, I really felt how it worked, well, I I was I
I: hm
P: I knew I had to go and well[12].

(2)
P.: Then I talked to my doctor, practically, well but having eased by heavy antibiotics.
I: Yes
P: Let's say, isn't it. The cold sweat, it can't have to do with the bronchial tubes anyway, what one is reading around in the course of many years.
I: yes.
P: One simply says it's a heart attack, all right? but of course, a heart attack, it would have to be there uhm continuously and not, let's say, once. Let's say come once….for five minutes and then disappear again, right? Well, we've made an *ECG*, it didn't show anything, right? Next time I went to him again, I said: Doctor, it is, it doesn't stop, he made an ECG again[13].

[12] J. Vodopiutz et al., *Chest Pain in Hospitalized Patient: Cause-Specific and Gender-Specific Differences*, p. 723.
[13] *Ibidem*.

Conversely, as the results of the linguistic analysis have shown, female patients expressed the pain they experienced differently: they favoured an emotional self-description and provided an imagine of themselves as able to endure *passively* the pain. Moreover, female patients tended to delegate the medical treatment to experts, seemed to be not interested in knowing the cause of the pain, did not describe the pain as serious, often said that their admission to hospital was recommended by relatives, and expressed worries for their family and relatives at home.

In what follows, some examples of transcript extracts may illustrate this linguistic behaviour:

(3)
I: Have you ever experienced such a pain from somewhere else?
P.: Rather not.
I.: No. Occurred for the first time? hm
P.: You know, I am among the ones who say: what appears by itself that has to disappear by itself as well.
I.: aha
P.: Yeah, therefore I haven't gone to the doctor's[14].

(4)
I: And were exactly did you feel the pain?
P: Here.
I: Here.
P: Here. It wasn't, it was endurable, it was just unpleasant somehow[15].

(5)
P: Yes, but as I already said, I'm among the people who – when one has a little bit of pain – who think, "Well, it will stop again…and when it then actually stops, then – well then I forget about it again, don't I?
I: hm
P: So, in that way, you see.
I: Yes.
P: Others may run to the doctor'S at once, but I myself…don't go immediately[16].

Vodopiutz et al. classified the patients' pain description into three categories: very concrete, concrete, and diffuse[17]. According to this classification, by "very concrete" they mean a long and detailed description of

[14] *Ibidem*.
[15] *Ibidem*.
[16] Ivi, p. 724.
[17] *Ibidem.*

the pain symptoms; by "concrete", a short symptomatic description of pain with a quick change of the topic toward a general pain experience; by "diffuse", non-symptomatic pain descriptions and meta-communicative remarks on the impossibility of pain description. The linguistic analysis has revealed that while all male patients interviewed have offered very concrete pain descriptions, all female patients (with just one exception) have offered diffuse pain descriptions.

The transcript extracts below may explain the differences in linguistic behaviour among female and male patients:

Examples of very concrete description

(6):
I: What about this pain, what is it like?
P: Well, it stars suddenly, pressure here, in the chest area, upper chest area, which leads a little bit to dyspnoea [difficulty in breathing].
I: Yes.
P: And besides that causes cold sweating, and a certain feeling of activity, doesn't is? and this, let's say makes me immediately lie down this way.
I: Yes.
P: Yes, and after some deep breaths, well. Let's say, after five, or ten minutes, if you like this has stopped.
I: Yes.
P.: Everything was back to normal[18].

(7)
I: What was it like with the pain?
P: Started – actually – completely surprisingly.
I: Yes?
P: In the night of Sunday till Monday – as I said – point of time – around one twenty. In the morning – with suddenly appearing cold sweating, head ache – vomiting – diarrhoea – dizzy feeling – and pressure in the chest which tuned into a real feeling of anxiety[19].

Example of diffuse descriptions

(8)
I: And when did the pain start?
P: Well, I think around Thursday evening, yeah.
I: The cramp as well? The little one, the twinge as well?

[18] *Ibidem*.
[19] *Ibidem*.

P: uh the twinge….no about 8 days ago or something like that. Eight ten days ago one would have to say.
I: Eight ten days.
P.: That I really don't know anymore. Because in the beginning I really didn't pay attention to it[20].

(9)
P: It's not a cramp – one couldn't actually say that
I: Is it inside?
P: It's inside.
I: It's inside…and it hurts.
P: It hurts.
P: It hurts.
I: How does it hurt?
P: How shall I explain that to you – you can't even say HOW much it hurts. It…it comes, hurts so much, this, this here is contracting and hurting. But I can't really describe to you the WAY it hurts. It's just hurting.
I: hm. Is it piercing or burning?
P: No just pangs.
I: Pressing pain, neither?
P: No[21].

The scenario that Vodopiutz et al. describe is quite similar to that analysed by Kidd and Carel[22] in a different medical context and their results seems to be in accordance with those obtained in the literature on gender differences in linguistic behaviour within contexts of social relevance[23]. It seems correct to argue that epistemic injustice in medical diagnosis constitutes a form of silencing that prevents some individuals (in particular women) from being able to efficiently communicate information to others. From a linguistic point of view, this phenomenon might be also analysed in terms of pragmatic failure. According to Thomas[24], pragmatic failures are those misunderstandings which arise as a consequence of "the inability to understand what is meant by what is said". Briefly stated, this phenomenon alludes to those misunderstandings resulting from the speakers' selection of inappropriate communicative strategies or abidance

[20] Ivi, p. 725.
[21] Ivi, p. 725.
[22] Havi Carel, Ian James Kidd, *Epistemic Injustice in Healthcare: a Philosophical Analysis*, "Medicine, Health Care and Philosophy", Volume 17, 4, 2014, pp. 529-540.
[23] Ruth Wodak (ed.), *Gender and Discourse*, Sage, London 1997; Helga Kotthoff and Ruth Wodak (eds.), *Communicating Gender in Context*, John Benjamins, Amsterdam 1997.
[24] Jenny Thomas, *Cross-Cultural Pragmatic Failure*, "Applied Linguistics", 4, 2, 1983, pp. 93.

by differing socio-cultural principles. Pragmatic failure could be thought to evidence a low level of pragmatic competence[25] (Kasper, 1997) in the individual who commits them. However, pragmatic failures may be at the root of unfair and unjustified attribution of beliefs, intentions, personality traits, feelings and attitudes. This also seems to match what female patients frequently report, viz. that *doctors don't listen to* them.

Conclusion

As noted above, patients' pain description plays a crucial role in medical diagnosis. As research study has shown, medical diagnosis can be affected by the patient's presenting symptoms. More precisely, the physician's diagnosis can be affected by the manner and the style in which a patient describes symptoms[26].

In line with the healthcare practice, doctors privilege a certain style of articulating testimonies and certain forms of impersonal third-person reports. Considered as epistemically privileged by virtue of their expertise, doctors may assign less or more credibility (credibility deficit or excess) than their patients would otherwise deserve. There are, as we saw, gender-specific differences in the description of chest pain and – according to the study scrutinized above – women are more likely than men to be underdiagnosed and under-treated. Mostly this happens – it seems plausible to suggest – also because female patients' reports are often ignored, sometimes heard but not considered; taken as irrelevant, not sufficiently articulated, or less understood by health professionals and seen as not corresponding to their expectations.

If this is right, is there a way to mitigate this phenomenon and effectively end these forms of injustice? What needs to change in the medical

[25] Gabriele Kasper, *Beyond reference*, in G. Kasper & E. Kellerman (eds.), *Communication strategies: Psycholinguistic and sociolinguistic perspectives*, Longman, London 1997, pp. 345-360; Gabriele Kasper, *The role of pragmatics in language teacher education*, in K. Bardovi Harlig & B. Hartford (eds.), *Beyond Methods*, McGraw-Hill, New York 1997, pp. 113-136.

[26] K.A. Milner, M. Funk, S. Richards, R.M. Wilmes, V. Vaccarino, H.M. Krumholz, *Gender Differences in Symptom Presentation Associated with Coronary Heart Disease*, "American Journal of Cardiology", 84, 4, 1999, pp. 396-9; H. Richards, A. McConnachie, C. Morrison, K. Murray, G. Watt, *Social and Gender Variation in the Prevalence, Presentation and General Practitioner Provisional Diagnosis of Chest Pain*, "The Journal of Epidemiology and Community Health", 54, 9, 2000, pp. 714-8; B.G. Birdwell, J.E. Herbers, K. Kroenke, *Evaluating Chest Pain. The Patient's Presentation Style Alters the Physician's Diagnostic Approach*, "Archives of Internal Medicine", 153, 1993, pp. 1991-1995.

practices and what should physicians do to help? This could be done, Vodopiutz et al. suggest, in different ways. First, we should review the clinical routine: when taking the clinical history of patients with chest pain, in particular of female patients, "pain description should be supported by enhancing the patients' ability to describe the kind and course of the symptoms"[27]. Second, if patients do not take their symptoms seriously, physicians should encourage them to take their illness and pain seriously. Moreover, if a patient offers only a diffuse pain description, physician should help her or him offer a more concrete description "by making them aware that, in this setting, the patients rather than the physicians are experts in describing their pain"[28].

[27] J. Vodopiutz et al., *Chest Pain in Hospitalized Patient*, cit., p. 726.
[28] *Idibem*.

Autori di questo numero/Contributors to this issue

Maria Cristina Amoretti, dottore di ricerca in Filosofia, insegna Filosofia della mente presso l'Università degli Studi di Genova. È stata assegnista di ricerca presso l'Università di Genova e l'ICT del CNR, Roma, Visiting Scholar presso l'University of Malta, nonché Visiting Research Fellow presso il King's College, London, la Rurh-Universität, Bochum e la Technische Universität München. Ha fatto parte del comitato direttivo della Società Italiana di Filosofia Analitica, di cui è stata anche vice-presidente nel 2012-14. Le sue principali linee di ricerca riguardano la filosofia della mente, la filosofia della scienza, in particolare la filosofia della medicina e della psichiatria, l'epistemologia. Tra le sue pubblicazioni più recenti: *Filosofia e medicina* (Carocci 2015), *La mente fuori dal corpo* (FrancoAngeli 2011), *Piccolo trattato di epistemologia* (con N. Vassallo, Codice 2010), Il triangolo dell'interpretazione (FrancoAngeli 2008).

Maurizio Balistreri è ricercatore di Filosofia morale presso il Dipartimento di Filosofia e Scienze dell'Educazione dell'Università di Torino. È stato Presidente del Comitato di Bioetica del Policlinico militare del Celio dal 2005 al 2013 ed è attualmente responsabile della segreteria scientifica del Comitato di Bioetica d'Ateneo. È autore di più numerosi articoli, saggi e contributi a volume sui temi di etica e di bioetica, e ha scritto *Etica e clonazione umana* (Guerini & Associati, 2004), *Organismi geneticamente modificati* (2006), *Etica e romanzi* (2010), *Superumani* (2011), *La clonazione umana prima di Dolly* (2015) e *Il futuro della riproduzione umana* (2016). È autore con Arianna Ferrari di *La ricerca sugli embrioni in Europa e nel mondo* (Zadig 2004), ed ha curato con Maurizio Benato e Maurizio Mori, *Etica medica nella vita militare* (Value 2014).

Giulia Borgogni, Dottore in Psicologia, Università degli Studi di Firenze.

Francesca Ervas is a Researcher in Philosophy of Language at the University of Cagliari. After completion of the PhD in Philosophy at Roma Tre University in 2006, she worked as a postdoc at the University College London and the Institut Jean Nicod, Ecole Normale Supérieure in Paris. Her main writings focus on figurative language, translation and interpretation theory. In these

fields, she wrote four monographs: *Uguale ma diverso. Il mito dell'equivalenza nella traduzione* (Quodlibet, Macerata 2008), *Il principio di traducibilità* (Sapere, Padova 2009), *Pensare e parlare* (Editori Riuniti, Rome 2016) and *Che cos'è una metafora* (Carocci, Rome 2016, with E. Gola). Her recent publications on metaphor include *Metaphor and Argumentation* (Isonomia, Urbino 2014, ed. with M. Sangoi) and *Metaphor and Communication* (John Benjamins, Amsterdam 2016, ed. with E. Gola).

Eleonora Fazzini, Dottore in Psicologia, Università degli Studi di Firenze.

Giada Gori, Dottore in Psicologia, Università degli Studi di Firenze.

Rosapia Lauro Grotto, Professore Associato di Psicologia Dinamica, Dipartimento di Scienze della Salute, Università degli Studi di Firenze.

Fiorella Lopiccoli, laureata in Filosofia, è docente di ruolo presso il Liceo Scientifico "Paolo Frisi" di Monza ed ha conseguito il Dottorato in Storia della Scienza presso l'Università di Bari. L'ambito delle sue ricerche è relativo ai secoli XVII e XVIII per quanto riguarda la storia del pensiero scientifico ed epistemologico, in particolare Blaise Pascal, e del pensiero medico, tra pratiche e teoria, attraverso le opere di Francesco Maria Nigrisoli e Francesco Torti. Tra le sue pubblicazioni, oltre ad aver curato la voce *Alessandro Lopiccoli, igiene e pubblica sanità tra i Borboni e i Savoia* in *Scienziati di Puglia* (a cura di F.P. de Ceglia, Bari 2007), ricorda: *Il corpuscolarismo italiano nel "Giornale de' Letterati" di Roma (1668-1681)* in *Scienza, filosofia e religione tra '600 e '700 in Italia* (a cura di M.V. Predaval Magrini, Milano 1990); *Francia 1679-1683: l'uso terapeutico della china-china tra iatrochimica e iatromeccanica,* "Medicina e Storia", VII, 13, 2007; *Francesco Maria Nigrisoli e Antonio Vallisneri: forse un dialogo mancato* in *Antonio Vallisneri. La figura, il contesto, le immagini storiografiche* (a cura di D. Generali, Firenze 2008); *Notizia intorno alle Consultazioni mediche di Francesco Torti (1658-1741)*,"QE - Quaderni Estensi", 4, 2012.

Elisabetta Lalumera è ricercatrice dal 2006 presso il Dipartimento di psicologia dell'università di Milano-Bicocca, dove insegna Filosofia della scienza. Si è occupata di questioni epistemologiche e metodologiche della psicologia e in particolare delle nozioni di regola, concetto e relativismo cognitivo. Più recentemente i suoi interessi di ricerca vertono sulla filosofia della medicina e della psichiatria. Oltre ad articoli in riviste italiane e internazionali ha pubblicato i *volumi Concepts and normativity. A realist approach* (Il Poligrafo, Padova 2004); *Pensare. Leggi ed errori del ragionamento* (con A. Coliva, Carocci, Roma 2006), *Cosa sono i concetti* (Laterza, Roma-Bari 2009) e *Che cos'è il relativismo cognitivo* (Carocci, Roma 2013).

Luciano Mecacci, formerly Full Professor of General Psychology at the University of Florence, has extensively published in the field of cognitive psychophysiology and history of psychology, especially the history of Russian psychology (since his first book *Brain and History*, preface by Aleksandr R. Luria, Brunner-Mazel, New York, 1979). Recently he has devoted his work on the cultural, social and political context in Florence at the end of Fascist period (*La Ghirlanda fiorentina e la morte di Giovanni Gentile*, Adelphi, Milano 2014).

Marcello Montibeller is a post-doc researcher in Philosophy of Language at University of Sassari. He graduated at Scuola Normale Superiore and obtained a PhD in Philosophy at Roma Tre University. He worked at Istituto Italiano per gli Studi Storici – Naples, Brenner Archiv – Innsbruck, Wittgenstein Archive – Cambridge, University of Sassari. His main writings focus on philosophy of social sciences (*Pareto Efficiency, the Coase Theorem and Externalities*, Journal of Economic Issues 2016, with A. Ventura e C. Cafiero), history of epistemology (*The Duty of Clarity: a Persuasion Effort: Continuity and Physics from Boltzmann to Wittgenstein*, Philosophical Investigations 2015), and philosophy (*L'Übersetzungsregel negli scritti di Wittgenstein*, Paradigmi, 2008). He is currently focusing on philosophy of evidence based medicine and medical communication. He is a student at the Faculty of Medicine of University of Rome and clinical trainee at the National Institute for Infectious Diseases of Rome.

Lucia Morra insegna Logica e Filosofia della Scienza nel Corso di Laurea in Tecnica della Riabilitazione Psichiatrica presso la Scuola di Medicina di Torino. Dal 2012 organizza per lo stesso corso di studi un seminario nel quale studiose e studiosi di differenti discipline (psichiatria, genetica, psicologia, psicolinguistica, filosofia del linguaggio, linguistica, neurologia) presentano agli studenti le prospettive attraverso le quali il loro campo di ricerca indaga i disturbi comunicativi e di linguaggio nell'autismo e nella schizofrenia.

Massimo Papini, Professore Ordinario di Neuropsichiatria Infantile, Università degli Studi di Firenze.

Elena Raveggi, Psicologo clinico, Ricercatrice Associazione LAPO ONLUS (Associazione Italiana Famiglie, Enti e Professioni contro le malattie neurologiche e psichiatriche dell'età evolutiva, Firenze), sezione del Pupazzo di Garza.

Maria Grazia Rossi is a post-doc researcher in Linguistics at the Catholic University of the Sacred Heart, Milan. She obtained her PhD in Cognitive Sciences from the University of Messina. After which, she worked as post-doc and adjunct professor at the University of Cagliari. She is currently focusing on the role of reasoning and argumentation in the social and collaborative dimension of human communication. Her writings focus on the role of emotions and

metaphors in medical decision-making, political reasoning, and moral judgment. Her recent publications include a monograph titled *Il giudizio del sentimento. Emozioni, giudizi morali, natura umana* (Editori Riuniti, Rome 2013) and journal articles as *Emozioni e deliberazione razionale* (Sistemi Intelligenti 2014); *Argomenti metaforici* (Rivista italiana di filosofia del linguaggio 2016, with F. Ervas and E. Gola).

Pietro Salis is a post-doc researcher at the University of Cagliari. He obtained a PhD in Philosophy (Cagliari) and a MA in Philosophy of mind (Warwick). His research interests deal with philosophy of language, philosophy of mind, and epistemology. His main writings deal with inferentialist theories of conceptual content, justificationism about meaning, and enactive approaches to mind and cognition. His more recent publications include *Grasp of concepts: common sense and expertise in an inferentialist framework*, (in M. Bianca, P. Piccari (eds.) *Epistemology of Ordinary Knowledge*, Cambridge Scholars, Newcastle 2015), *Counterfactually robust inferences, modally ruled out inferences, and semantic holism* (Al-Mukhatabat Journal 2015), and the book *Pratiche discorsive razionali. Studi sull'inferenzialismo di Robert Brandom* (Mimesis, Milano-Udine 2016). He also edited, together with P.L. Lecis e V. Busacchi, the book *Realtà, Verità, Rappresentazione* (FrancoAngeli, Milano 2015).

Debora Tringali, Dottore in Filosofia, Ricercatrice Associazione LAPO ONLUS (Associazione Italiana Famiglie, Enti e Professioni contro le malattie neurologiche e psichiatriche dell'età evolutiva, Firenze), ccordinatrore della Sezione del Pupazzo di Garza.

Vera Tripodi, membro del Labont (Laboratorio di Ontologia diretto da Maurizio Ferraris) e di APhEx, lavora all'Università degli Studi di Torino. Si è laureata presso l'Università degli Studi di Roma La Sapienza con una tesi su Frege e Dummett e ha conseguito il dottorato di ricerca in Logica ed Epistemologia presso lo stesso ateneo. È stata *Visiting Scholar* alla Columbia University di New York e ha svolto la sua attività di ricerca (in qualità di *Post-Doctoral Research Fellow*) presso il *Centre for Gender Research* dell'Università di Oslo, il centro di ricerca *Logos* dell'Università di Barcellona e il *CAS SEE* dell'Università di Rijeka. Le sue aree di ricerca sono: filosofia femminista, metafisica, filosofia del linguaggio ed epistemologia. Tra i suoi lavori: *Filosofia della sessualità*, Carocci, 2011; *Filosofie di genere. Differenza sessuale e ingiustizie sociali*, Carocci, 2015.

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