who is socially isolated. Despite his lack of social support, this hypothetical candidate seems a suitable candidate, given that there is a reasonable expectation for an increase in life expectancy, and no identified threat to the ability to adhere to the post-transplant plan. Few would argue that someone who meets these criteria is not a suitable steward of a donated organ. At the other extreme is an individual wholly dependent on their social capital, perhaps a child with an intellectual disability who relies on their parents and other caretakers for most or all of their needs. While some may argue that this individual would not enjoy sufficient quality of life to defend transplantation, the subjective measures are inappropriate for judging fitness for transplantation and, in life or death situations, even relatively low quality of life is acceptable (Faden and Leplege 1992). This patient can also be seen, amongst other reasons, by virtue of their ability to contribute to the organ pool and relationships to their loved ones, worthy organ recipients (Wightman, Goldberg, and Diekema 2018).

While these extremes are perhaps not best for practical applications, they illustrate the incoherence of this unstated goal of the transplantation process—the paradox inherent in these unrealistic and idealized patients, creating unnecessary burden on candidates to try to fit these molds. Populations that are already as risk for healthcare marginalization—minorities, those with intellectual disability, social nonconformists—are further disadvantaged based on the inability to meet these contradictory goals. Berry, Daniels, and Ladin and others correctly conclude that, in the absence of substantial evidence given the weight of what is at stake, these subjective and biased criteria, explicit or not, should not factor into transplantation eligibility (Cahn-Fuller and Parent 2017). Research is needed to direct the goals of selection committees and, in its absence, the objective and documented must be favored over the subjective and speculatory lest we further put at risk those most at need for the equity and justice of the transplantation system.

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Credibility Excess and Social Support Criterion

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Berry, Daniels, and Ladin (2019) undermine putative empirical support for and raise substantial moral objections against the claim that social support is a tenable criterion for evaluating whether relevant patients are to be included on organ transplant lists. We agree with the authors' criticisms and conclusion that—to be

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empirically tractable and morally defensible—the social support criterion must be substantially revised. In support, we elaborate one of the authors' moral criticisms through the lens of testimonial injustice, using that lens to reveal a further moral criticism of the social support criterion, as well as to address morally problematic use of the criterion.

An epistemic injustice is a moral harm done to an agent in her capacity to engage in epistemic practices, e.g. testifying to others, interpreting experiences, questioning, etc. (Fricker 2007). A paradigmatic case of epistemic injustice is testimonial,[1] where a hearer discounts the credibility of a speaker owing to the hearer's unwarranted implicit or explicit judgments about a group to which the speaker belongs, e.g. a hearer discounting the credibility of a black woman owing to racism and/or sexism (Medina 2017a; 2017b). Testimonial injustice provides a framework in which to elaborate Berry, Daniels, and Ladin's suggestion that individuals with low socioeconomic status may experience difficulties when presenting evidence of social support to members of review committees who determine whether patients are to be added to organ transplant lists. Specifically: Being a member of a marginalized[2] community is correlated with low socioeconomic status (Williams, Priest, and Anderson 2016). Clinicians discount the credibility of low socioeconomic status individuals when those individuals are, say, reporting the extent and persistence of symptoms, reports of pain, etc. (van Ryn and Burke 2000; Williams, Priest, and Anderson 2016). Communication between marginalized individuals and clinicians may thus be sharply undermined, leading to misunderstanding of patient illnesses, misdiagnosis, and ineffective treatment options. Similarly, members of review committees – composed of medical practitioners and clinicians – may discount the credibility of members of marginalized communities and, say, ignore relevant evidence offered to establish adequate social support or weigh offered evidence too lightly.[3]

Framing the authors' criticism of the use of the social support criterion in terms of credibility discounting reveals, moreover, a further moral criticism. For often where one finds instances of prejudicial credibility discounting one also finds instances of unwarranted credibility excess (Medina 2017a). In particular, members of non-marginalized communities offering evidence of social support to review committees are likely given credibility excess resulting in, say, review committee members weighing evidence offered to establish adequate social support too heavily. In support of this point, note being a member of a non-marginalized community is correlated with high socioeconomic status, and high socioeconomic status individuals are perceived to exhibit qualities highly correlated with trustworthiness (Horowitz and Dovidio 2017; Oosterhof and Todorov 2008). Hence, evidence of adequate social support offered by members of non-marginalized communities to review committees is likely scrutinized to a lesser extent and deemed more supportive than comparable evidence offered by members of marginalized communities. Altogether, the interplay of credibility deficits with respect to marginalized individuals and credibility excesses with respect to non-marginalized individuals magnifies the extent to which equal access to treatment for those with equal need is likely undermined.

A more positive consequence of framing Berry, Daniels, and Ladin's moral criticism in terms of varieties of testimonial injustice is that doing so reveals avenues for improving the use of the social support criterion by review committee members. For example, review committee members might cultivate testimonial justice capacities—those needed to recognize and compensate for instances of testimonial injustices—to remedy unwarranted credibility deficits and excesses (Fricker 2007; 2010). With respect to members of marginalized communities, review committee members who have cultivated capacities of testimonial justice will be aware of how implicit bias influences judgments of testimony, will exhibit a disposition to initially suspend credibility judgments when presented with testimony, and a willingness to revisit and revise such judgments on reflection. Importantly, review committee members will be aware perceived inadequacy or even unintelligibility of evidence offered to establish adequate social support might be a function not of the testifier's lack of sufficient evidence, but instead of the reviewer's own prejudice, warranting adjustment or suspension of credibility assessments of the speaker accordingly (Fricker 2007, 7). With respect to members of non-marginalized communities, review committee members who have cultivated habits of testimonial justice will similarly be sensitive to the possibility that the perceived adequacy and intelligibility of evidence for social support may owe to unwarranted credibility excess. Testimonial justice in this context may be exhibited by review committee member dispositions to compare past evaluations of evidence of social support offered by members of marginalized communities with evaluation of evidence by members of

1. This description of testimonial injustice follows that of Jose Medina rather than the more narrowly circumscribed description offered in Miranda Fricker's initial characterization.

2. Marginalization comes in many forms and involves many intersections, e.g. ethnic minority groups and women in the U.S., those with low socioeconomic status (van Rye and Burke 2000), patients in healthcare settings (Carel and Kidd 2017).

3. These points are independent of Berry, Daniels, and Ladin's observation that since individuals from marginalized communities—due to economic marginalization and mass incarceration—often rely on social support codified as "less robust" than social support found among members of non-marginalized communities they are disadvantaged when providing evidence of social support (Berry, Daniels, Ladin 2019, 12). Credibility discounting and excess described here are independent of the type of evidence offered, though they may exacerbate disadvantages experienced by marginalized individuals and advantages by non-marginalized individuals.

non-marginalized communities, compare time spent evaluating evidence from both sources, and examine varieties of evidence deemed relevant or irrelevant.

Lastly, explicating Berry, Daniels, and Ladin's moral criticism through the lens of testimonial (in)justice fits well with the authors' concluding suggestion that the social support criterion should be used to determine individuals who need institutional assistance rather than as a sieve for eliminating care (Berry, Daniels, and Ladin 2019, 18). Review committee members sensitive to testimonial injustice who have cultivated capacities of testimonial justice will be equipped to assess presented evidence of social support more accurately, as they will be more aware of how prejudice and biases may influence credibility judgments. These epistemically responsible committee members will be in a position to better identify marginalized and non-marginalized individuals who lack adequate social support, in the interest of providing institutional assistance. ■

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