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REVIEW ARTICLE

A critical and systematic literature review of epistemic justice applied to healthcare: recommendations for a patient partnership approach

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Abstract
Invalidation from healthcare practitioners is an experience shared by many patients, especially those marginalized or living with contested conditions (e.g., chronic pain, fibromyalgia, etc.). Invalidation can include not taking someone's testimony seriously, imposing one's thoughts, discrediting someone's emotions, or not perceiving someone's testimony as equal and competent. Epistemic injustices, that is, the disqualification of a person as a knower, are a form of invalidation. Epistemic injustices have been used as a theoretical framework to understand invalidation that occurs in the patient-healthcare provider relationship. However, to date, the different recommendations to achieve epistemic justice have not been listed, analyzed, nor compared yet. This paper aims at better understanding the state of the literature and to critically review possible avenues to achieve epistemic justice in healthcare. A systematic and critical review of the existing literature on epistemic justice was conducted. The search in four databases identified 629 articles, from which 35 were included in the review. Strategies to promote epistemic justice that can be applied to healthcare are mapped in the literature and sorted in six different approaches to epistemic justice, including virtuous, structural, narrative, cognitive, and partnership approaches, as well as resistance strategies. These strategies are critically appraised. A patient partnership approach based on the Montreal Model, implemented at all levels of healthcare systems, seems promising to promote epistemic justice in healthcare.

Keywords Epistemic justice · Medical invalidation · Patient-provider relationship · Patient partnership · Critical review · Systematic review

Introduction

Medical invalidation is frequently reported by patients in the patient-healthcare provider relationship. Invalidation is defined as non-acceptance and lack of understanding from healthcare practitioners, including not taking seriously what patients communicate, imposing their own thoughts, or discrediting patients' emotions (Greville-Harris et al. 2015). This leads patients to feel stigmatized, misunderstood, rejected, ignored, and blamed for their health condition by healthcare professionals (Greville-Harris et al. 2015). According to some authors, invalidation has an active component, meaning it is not merely a lack of social support, but rather openly rejecting a person and their testimony, not believing them, or not understanding them (Wernicke et al. 2017).

Epistemic injustices

In medical settings, some studies have mobilized epistemic injustices as a theoretical framework to discuss invalidation experienced by patients (e.g., Blease et al. 2017; Buchman et al. 2017; Byrne 2020; Heggen and Berg 2021; Carel and Kidd 2014; Tosas 2021). Miranda Fricker introduced the concept of epistemic injustice in her 2007 book *Epistemic Injustice: Power and the ethics of knowing*. She identifies two types of epistemic injustices: testimonial and hermeneutical injustices. Testimonial injustice is a form of epistemic injustice that affects the credibility given to a person's testimony due to prejudices, based on stereotypes, that are held against them (Fricker 2007). The speaker's credibility is therefore called into question. Hermeneutical injustice is defined as a form of epistemic injustice that affects a person's ability to make sense of their experience

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within a dominant framework that denies it, and in which shared resources for the interpretation of this experience are incomplete or lacking (Fricker 2007; Tosas 2021). The intelligibility of the speaker's testimony is therefore questioned. In this sense, epistemic injustices are a form of invalidation and a lack of recognition of a speaker's knowledge, either regarding their credibility or intelligibility (Fricker 2007). Chronically ill people are, according to Carel (2023), 'epistemically vulnerable'. This means that their knowledge, opinions, and preferences are often excluded from the conversation, and therefore, from decision-making, for a variety of reasons, such as pathophobic biases, but also organizational constraints such as workload and time pressures.

Several authors have discussed epistemic injustices specifically in the context of healthcare, including Carel and Kidd in their foundational text of 2014, *Epistemic Injustice in Healthcare: A Philosophical Analysis*. In this article, the authors argue that sick individuals are particularly vulnerable to epistemic injustices due to characteristics frequently attributed to patients (e.g., emotional instability, cognitive unreliability, etc.), which affect their credibility and their ability to grasp and communicate different aspects of illness, thus affecting their intelligibility. According to Carel and Kidd (2014), healthcare practitioners benefit from an epistemic privilege due to their training, which can lead them to marginalize ill individuals in epistemic exchanges. Kidd and Carel (2018) further theorize certain concepts to specifically describe and understand epistemic injustices in the medical context, which they term 'pathocentric epistemic injustices'. Pathocentric epistemic injustices target individuals living with an illness or chronic condition, or those perceived as such, specifically because they are patients (Kidd and Carel 2018). In their testimonial form, they occur when patients' testimonies are devalued due to stereotypes and pathophobic prejudices against them (Kidd and Carel 2018). These stereotypes may include beliefs that sick individuals are weak, confused, irrational, 'dominated by their illness', and incompetent, that they are not reliable cognitively, or that they are not autonomous and cannot make informed decisions for themselves. For these reasons, they may be considered not sincere nor credible by clinicians. In their hermeneutical form, they occur when patients' testimonies are devalued or misunderstood due to their use of non-dominant hermeneutical resources in the medical context (i.e., resources other than biomedical vocabulary) or when they fail to understand their own experience in light of these interpretive frameworks (Kidd and Carel 2018). Patients thus find themselves not only in a power relationship on a social level, with healthcare providers generally benefitting from a higher social status, but also on an epistemic level, with greater authority being accorded to healthcare providers in this regard.

Several consequences of epistemic injustices have been reported for patients, including the absence of diagnosis, feelings of humiliation, the challenge of repairing the damages that the condition has caused to the person's identity without diagnosis or treatment, the denial of adequate assistance or medical leave, and the lengthy journey needed to find a healthcare professional who believes them (Tosas 2021).

Epistemic injustices contravene the ethical principle of non-maleficence (Freeman and Stewart 2019; Della Croce 2023), often known by Latin expression "Primum non nocere", in English: "First, do no harm". Della Croce (2023) argues that harm to patients in the context of testimonial injustices has "serious clinical implications and represent a failure of the process of due care on the part of the physician." (1), which makes it a harmful practice, even when unintentional. The author thus explains, based on the example of fibromyalgia, how prejudices based on sexist and pathophobic biases have concrete effects on patients, and mainly on women.

Epistemic justice

In addition to being an ethical and moral responsibility in healthcare and to avoid the negative consequences reported by patients, striving for epistemic justice is essential in healthcare for several reasons, including the need for an attenuation of power relationships between patients and healthcare providers. The patient-healthcare provider relationship is inherently unequal, as a power relationship is fed by the trust patients place in healthcare providers, thus accentuating patient's vulnerability (Ho 2017). Patients often find themselves in a position of dependence on healthcare professionals to obtain the care they need (Clarke and Iphofen 2005), as they act as gatekeepers to services and resources in most healthcare systems. Being recognized as a knower is therefore essential to be listened to and believed, to subsequently access the care needed. The power relationship between healthcare providers and patients is also epistemic in nature. Healthcare providers' knowledge is almost unequivocally granted a superior value because of their status in society, while patients' knowledge is usually seen as inferior, regardless of its importance or quality, for instance to report physical sensations related to illness and essential for diagnosis that only patients experience, and therefore, can name with precision in their experiential aspects. Patients are experts of their own body but may also be experts of their medical condition to some extent, as it is often the case for rare illness patients who become highly knowledgeable due to healthcare providers' lack of medical expertise on their condition (Budych et al. 2012). Patients' and healthcare providers' knowledge are consequently complementary, and this should be acknowledged in epistemically just healthcare systems. According to Drożdżowicz (2021), clinicians thus have an epistemic duty toward epistemic justice because of the epistemic privilege (or authority) they hold and from which they benefit.

Epistemic justice is also a question of social justice. Indeed, prejudice and oppression systems, such as sexism, racism, transphobia, classism, pathophobia, etc. enable epistemic injustices. Social health inequities are rooted in these oppression systems (Hankivsky and Christoffersen 2008). Chung (2021) defines the notion of 'structural health vulnerability' to describe how people who experience the effects of different oppression systems are more likely to experience epistemic injustices, and therefore, to suffer harmful effects on their health. Combatting epistemic injustices therefore implies a larger fight against social inequalities globally, but achieving epistemic justice is also a path to achieving greater social justice. The fight against epistemic injustice is therefore both an objective and a means of moving towards social justice. For this reason, it is essential, in any attempt to reduce injustice, whether social or epistemic, including health inequities, to adopt an intersectional approach that considers how several oppression systems intertwine and influence each other (Crenshaw 1991; Hankivsky and Christoffersen 2008). However, concretely, what strategies can be implemented to promote epistemic justice in the healthcare provider-patient relationship and within the healthcare system?

Literature on epistemic in/justice, although relatively recent, offers several avenues to achieve epistemic justice that could be applied to the context of healthcare. However, they never seem to have been identified, analyzed, evaluated, nor compared, which does not allow to reflect on their strengths and weaknesses, as well as their concrete application, for example, in the context of healthcare. If the literature on epistemic injustices in healthcare is constantly growing, the lack of an integrated review on the solutions and alternatives to promote epistemic justice impedes to act upon epistemic injustices raised in the literature. This gap in the literature on epistemic justice applied to specific contexts such as healthcare therefore hinders concrete and practical actions to prevent epistemic injustices in the first place. This article aims at reviewing the existing literature on epistemic justice in general, to identify, evaluate, and compare concrete strategies and recommendations that could be implemented to promote just and ethical relationships between healthcare providers and patients in the context of healthcare specifically.

To fill this gap in the literature, a critical review of the literature was therefore conducted systematically, based on PRISMA guidelines (Page et al. 2021a, b) to identify possible ways to promote epistemic justice and prevent epistemic injustices in healthcare, which allowed to identify 20 strategies that were organized in six categories. Unlike a traditional literature review, which summarizes the state of research on a concept or in a field, a critical review analyzes the existing literature on a subject to highlight strengths and weaknesses (Paré and Kitsiou 2017). This type of review can help guiding future research in a given area and seems particularly relevant in the context of healthcare, where more research is needed, but also, where practical changes are needed.

Methods

Search strategy

Literature on epistemic justice was identified using different databases as of January 25th, 2024, namely PubMed, PsychInfo, Embase, and Web of Science, using the expression "epistemic justice". The review was limited to these keywords and did not include other formulations or synonyms, as it aimed to identify only articles that explicitly addressed epistemic justice. Among the articles identified, only those suggesting concrete and practical avenues or clear theoretical principles to promote epistemic justice, transposable into the healthcare system or the medical relationship, were selected. Additional articles were then added by reviewing lists of references of the selected articles and by completing the search using Google Scholar. The exclusion criteria for articles in the screening process of the author were the following:

1. Commentaries or letters to the editor;
2. Articles not addressing epistemic justice or addressing it in contexts that are not transposable to the healthcare system or patient-healthcare provider relationship;
3. Articles not proposing theoretical or practical avenues to promote epistemic justice;
4. Articles not available in a language that can be understood by the researcher (either French, English, Spanish, Portuguese, or Italian).

Table 1 lists the selected articles and Fig. 1 shows a flowchart of the selection process.

The search strategy allowed to identify a total of 629 records and resulted in the inclusion of 35 articles. All the strategies identified are described in the following sections and are summarized in Table 2.

Critical appraisal

Twenty different avenues to promote epistemic justice were listed and analyzed through different factors, all central in discussions and debates about epistemic in/justice literature, including the type of epistemic injustice

Table 1 List of articles included in the review

Author & date	Title	Journal or book	Approaches illustrated
Anderson 2012	Epistemic Justice as a Virtue of Social Institutions	Social Epistemology	Structural; Virtuous
Bourgault 2023	Attention, injustices épistémiques et humilité	Politique et Sociétés	Structural; Virtuous
Buchman et al. 2017	Investigating Trust, Expertise, and Epistemic Injustice in Chronic Pain	Bioethical Inquiry	Virtous
Campelia and Feinsinger 2020	Creating Space for Feminist Ethics in Medical School	HEC Forum	Structural
Carel 2012	Phenomenology as a Resource for Patients	Journal of Medicine and Philosophy	Resistance strategies
Carel 2021	Pathology as a phenomenological tool	Continental Philosophy Review	Resistance strategies
Carel and Kidd 2014	Epistemic injustice in healthcare: a philosophial analysis	Medicine, Health Care and Philosophy	Resistance strategies
Carel and Kidd 2021	Institutional Opacity, Epistemic Vulnerability, and Institutional Testimonial Justice	International Journal of Philosophical Studies	Structural
Dutta et al. 2022	Counterstorytelling as Epistemic Justice: Decolonial Community-based Praxis from the Global South	American Journal of Community Psychology	Narrative
Faucher 2022	Setting Mental Health Priorities: An Essay in Comparative Social Epistemology	Philosophiques	Partnership
Galasiński et al. 2023	Epistemic justice is the basis of shared decision making	Patient Education and Counseling	Partnership
Gilson 2011	Vulnerability, Ignorance, and Oppression	Hypatia	Virtuous
Gosselin 2019	Philosophizing from Experience: First-Person Accounts and Epistemic Justice	Journal of Social Philosophy	Virtuous
Groenevelt and de Boer 2023	Contesting misrecognition online: Experiences of epistemic in/justice by vloggers with contested illnesses	Social Science & Medicine	Resistance strategies
Groot et al. 2022	What Patients Prioritize for Research to Improve Their Lives and How Their Priorities Get Dismissed again	International Journal of Environmental Research and Public Health	Partnership
Hull 2022	Epistemic redress	Synthese	Cognitive
Johnstone 2021	Centering Social Justice in Mental Health Practice: Epistemic Justice and Social Work Practice	Research on Social Work Practice	Structural; Narrative
Kidd 2016	Inevitability, contingency, and epistemic humility	Studies in History and Philosophy of Science	Virtuous
LeBlanc-Omstead 2021	Troubling Service User Involvement in Health Professional Education: Toward Epistemic Justice	Thèse de doctorat	Narrative; Partnership
LeBlanc-Omstead et Kinsella 2023	Come and share your story and make everyone cry": complicating service user educator storytelling in mental health professional education	Advances in Health Sciences Education	Narrative; Partnership
Lee et al. 2022	Developing a Model of Broaching and Bridging in Cross-Cultural Psychotherapy: Toward Fostering Epistemic and Social Justice	American Journal of Orthopsychiatry	Structural
Narayanan 2023	Epistemic justice and experiential self	Mind & Society	Cognitive
Newbigging and Ridley 2018	Epistemic struggles: The role of advocacy in promoting epistemic justice and rights in mental health	Social Science & Medicine	Partnership

Table 1 (continued)

Author & date	Title	Journal or book	Approaches illustrated
Peled 2018	Language barriers and epistemic injustice in healthcare settings	Bioethics	Virtuous
Pot 2022	Epistemic solidarity in medicine and healthcare	Medicine, Health Care and Philosophy	Virtuous; Structural
Potter 2022	The Virtue of Epistemic Humility	Philosophy, Psychiatry, & Psychology	Virtuous
Rosen 2021	Mapping out epistemic justice in the clinical space: using narrative techniques to affirm patients as knowers	Philosophy, Ethics, and Humanities in Medicine	Narrative
Samarzija and Cerovac 2021	The Institutional Preconditions of Epistemic Justice	Social Epistemology	Structural
Saulnier 2020	Telling, Hearing, and Believing: A Critical Analysis of Narrative Bioethics	Bioethical Inquiry	Narrative
Schwab 2012	Epistemic Humility and Medical Practice: Translating Epistemic Categories into Ethical Obligations	Journal of Medicine and Philosophy	Virtuous
Schlüter 2021	Resisting Epistemic Injustices: Beyond Anderson's "Imperative of Integration"	Las Torres de Lucca. Revista internacional de filosofía política	Structural
Thomas et al. 2020	What is "shared" in shared decision-making? Philosophical perspectives, epistemic justice, and implications for health professions education	Journal of Evaluation in Clinical Practice	Partnership
Valkenburg 2022	Temporality in epistemic justice	Time & Society	Structural
Wardrope 2015	Medicalization and epistemic injustice	Medicine, Health Care and Philosophy	Virtuous
White 2021	Re-writing the master narrative: A Prerequisite for Mad Liberation	The Routledge International Handbook of Mad Studies	Narrative

addressed (i.e., testimonial, hermeneutical or both) and the level of action (i.e., individual, structural, relational). This analysis aimed at identifying the scope of each strategy (e.g., large, addressing structural aspects of both testimonial and hermeneutical epistemic injustices, vs focused, at the individual level addressing only one type of epistemic injustice), as criticisms on epistemic justice frequently include these parameters (e.g., Anderson 2012). Six different categories were formed to sort all strategies based on similar characteristics in their way of achieving epistemic justice. They include virtuous, cognitive, structural, narrative and partnership approaches, in addition to other resistance strategies. Strengths and weaknesses of each strategy were also identified both within the limitations already highlighted by the different authors presenting these strategies or in comparison to one another. Focusing attention to strengths and weaknesses is particularly important in a critical review of the literature, both to allow for future research to develop new strategies and to target which strategies may be used in complementarity for a given situation of epistemic injustice. Table 2 summarizes the different strategies to promote epistemic justice for each category identified, as well as their level of action, their strengths, and their weaknesses.

Results

Virtuous approaches

In her first theorization of epistemic injustices, Fricker (2007) emphasizes the importance of developing epistemic virtue to promote epistemic justice. For Fricker (2007), rectifying prejudicial judgments in testimonial injustices involves compensating by increasing the credibility and sincerity granted. Biases related to the limitations in shared hermeneutical resources, at the root of hermeneutical injustices, can be compensated by adopting a patient and vigilant attitude regarding someone's difficulties in making their testimony intelligible. However, this perspective is limited and has been criticized in the literature. Several authors have sought to enhance the understanding of virtue in epistemic exchanges as proposed by Fricker (2007). Gosselin (2019) thus suggests a set of virtues that should be embodied by both the person sharing a testimony and the person receiving it, including charity, open-mindedness, respect, and epistemic humility. Gosselin develops these virtues in the context of philosophical exchanges involving the sharing of lived experiences, which can potentially be applied in the context

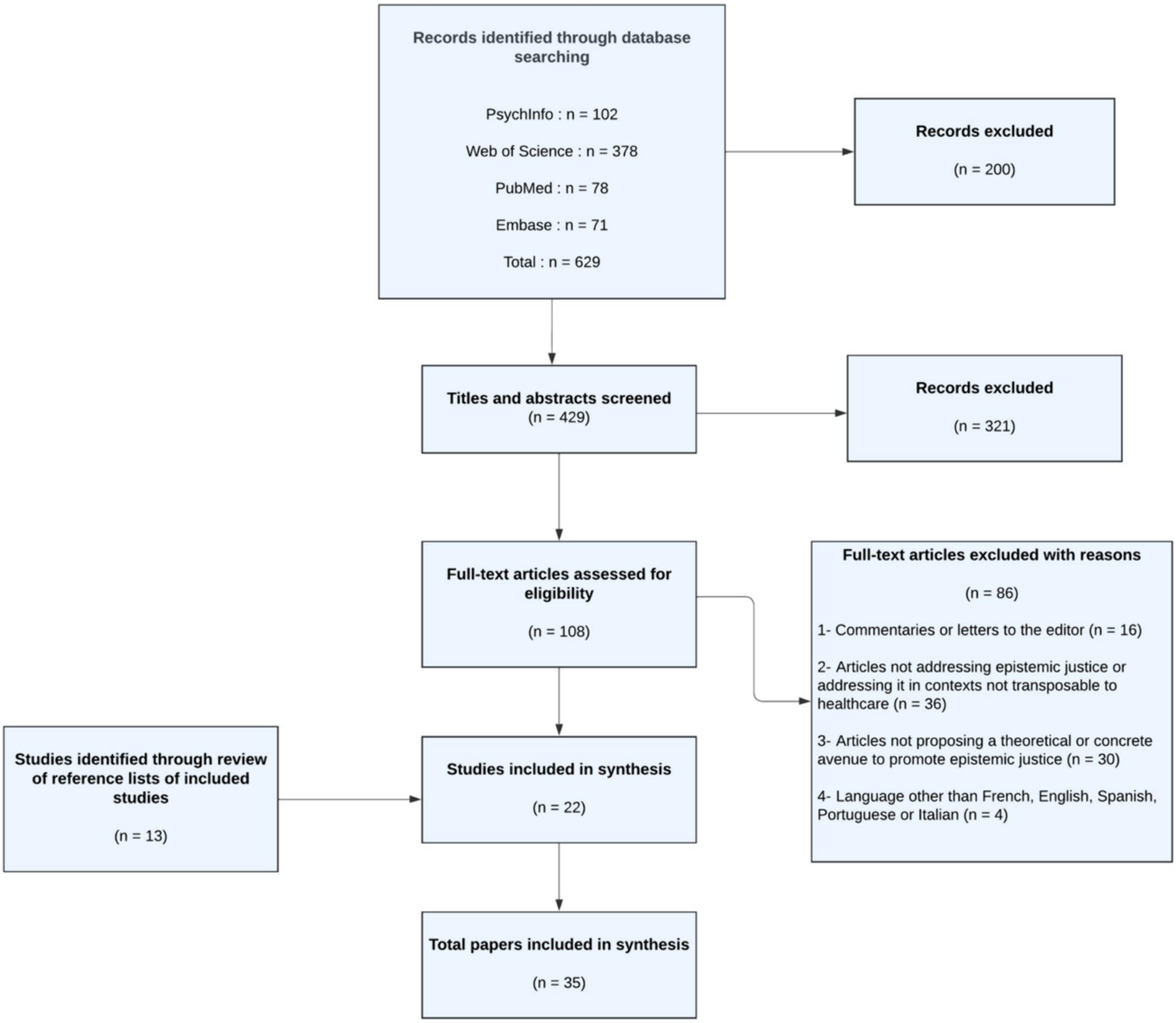

Fig. 1 Flow chart

of medical consultations. Several virtuous approaches have been suggested following Fricker's work, including epistemic vulnerability (Gilson 2011), epistemic humility (e.g., Buchman et al. 2017; Wardrope 2015; etc.), and epistemic solidarity (Pot 2022). Virtuous approaches can target testimonial injustices, hermeneutical injustices, or both. They place the responsibility of not perpetrating epistemic injustices mostly on healthcare practitioners. However, patients should not be considered as passive and can contribute to epistemic justice. Virtuous approaches do not usually consider structural aspects of epistemic injustices.

Epistemic vulnerability

Epistemic vulnerability is proposed by Gilson (2011) as an ethical response and a political resistance strategy to deliberate ignorance (McKinnon 2017), which is frequently present in the context of hermeneutical injustices, where hearers may deliberately choose not to understand the hermeneutical resources mobilized by the speaker. Gilson (2011) suggests promoting epistemic vulnerability, which allows for learning and thus reduction of ignorance, to overcome this difficulty. She proposes five attitudes to cultivate epistemic vulnerability: openness to not knowing; openness to making mistakes by taking the risk of communicating one's ideas, beliefs, and feelings; ability to put oneself in unfamiliar or uncomfortable situations and to learn from them; attention to the affective and bodily dimensions of knowledge; and finally, openness to modifying, in this process, not only one's ideas and beliefs but also one's own person and one's perceptions of oneself. In summary, according to Gilson (2011), "To be epistemically vulnerable, therefore,

Table 2 Recension, classification, and evaluation of strategies to promote epistemic justice in healthcare

Strategy	Injustice type & level of action	Description	Strengths	Limitations	Reference(s)
Virutous approaches					
Virtuous listening, epistemic charity and generosity	Testimonial & hermeneutical; Individual & relational	Critical self-reflection on the influence of one's social positioning on judgments of others' credibility and intelligibility Adjustment of judgments upward to counterbalance Adopting a patient attitude towards the speaker and helping them by sharing our own hermeneutical resources	Aims to cultivate virtue in individuals	Relies on the goodwill of those responsible for injustice Little consideration of structural aspects Does not consider the individuals who experience injustice as contributing to the solution Does not consider the importance of time for its implementation Does not consider credibility surpluses	Fricker (2007)
Epistemic vulnerability	Testimonial & hermeneutical; Individual & relational	The openness to not knowing, to being wrong, to the ambivalence of our emotional and physical responses to new ideas, and to changing one's ideas, beliefs, or perceptions	Conceives epistemic justice as a shared responsibility	Relies on the goodwill of those responsible for injustice Little consideration of structural aspects	Gilson (2011)
Epistemic humility	Testimonial & hermeneutical; Individual & relational	Correcting prejudicial judgments regarding the credibility of patients by acknowledging and communicating the uncertainty surrounding medical decisions	Clear, concrete, and realistic applicability in the current conditions of the healthcare system Promotes a rebalancing of epistemic authority Conceives the responsibility of epistemic justice as shared	Relies on the goodwill of those responsible for injustice Little consideration of structural aspects	Schwab (2012), Wardrope (2015), Kidd (2016), Buchman et al. (2017), Peled (2018), Potter (2022), Bourgault (2023), Gosselin (2019), etc
Epistemic solidarity	Testimonial; Relational & structural	An active commitment to bear "costs" to help a person with a relevant similarity on a given point	Can be institutionalized so that costs are shared between HCP and the system Paves the way for collective action Allows for a revision of knowledge development in healthcare	Relies on the goodwill of those responsible for injustice, who may not always have an interest in helping Involves necessarily costs (e.g., time, money)	Pot (2022)
Structural approaches					

Table 2 (continued)

Strategy	Injustice type & level of action	Description	Strengths	Limitations	Reference(s)
Institutionalized epistemic solidarity	Testimonial; Relational & structural	An active commitment to collectively bear "costs" to help a person with a relevant similarity on a given point	The associated costs are shared collectively Allows for a revision of knowledge development in healthcare	Relies on the goodwill of administrations Involves necessarily costs (e.g., time, money) Requires a cultural shift to consider listening as a form of care	Pot (2022)
Institutional virtue	Testimonial & hermeneutical; Structural	Integration, as opposed to segregation, of social groups at all levels of society to promote contacts	Promotes deep changes	Relies on deep political, and even socio-cultural and economic changes Requires a lot of time (several years, even decades) for the effects to be observed	Anderson (2010, 2012)
Countering institutional opacity	Testimonial; Structural	Application of institutional norms and values in a flexible manner, fostering an appreciation of diversity to combat the challenging understanding of the epistemic stance to adopt within the institution	Attention to the specific needs and non-homogeneity of the institution's users by adapting to individuals' needs and supporting their development	Relies on the goodwill of those responsible for injustice, including healthcare professionals and administration, who may not always have an interest in helping Does not consider the relational aspect Gives little consideration to the role of patients in epistemic justice	Carel and Kidd (2021)
Rethinking temporalities	Testimonial & hermeneutical; Structural	Revision of a healthcare model where medical consultations are short and quick to adapt to the needs and temporalities of each individual	Attention to the non-homogeneity of the institution's users by adapting to the pace of each person	Relies on the goodwill of those responsible for injustice, including healthcare professionals and administration	Bourgault (2020, 2023), Valkenburg (2022)
Education to epistemic injustices	Testimonial & hermeneutical; Structural	Inclusion of training on epistemic injustices for future and current healthcare professionals	Can enable deep changes Can allow addressing epistemic injustices even before they occur	Requires a lot of time (several years, even decades) for the effects to be observed	Campelia and Feinsinger (2020), White (2021)
Anti-oppressive strategies	Testimonial & hermeneutical; Structural & relational	Recognizing power dynamics and oppression system in the therapeutic relationship and centering care around patients' knowledge and experiences	Considers power dynamics in care relationships Promotes recognition of epistemic injustices when they occur	Requires substantial training for healthcare professionals Relies on the goodwill of healthcare professionals and administrations	Johnstone (2021), Lee et al. (2022)

Table 2 (continued)

Strategy	Injustice type & level of action	Description	Strengths	Limitations	Reference(s)
Narrative approaches					
Narrative ethics (coupled with critical analysis)	Testimonial; Relational	Resolving morally problematic situations by placing the individual at the center of the ethical decision and considering power dynamics	Allows for a better understanding and mitigation of injustices and power dynamics in storytelling Increases the ability to provide effective healthcare	Underdeveloped and not very concrete Requires a lot of time Relies on the goodwill of those responsible for the injustice	Saulnier (2020)
Narrative therapy	Testimonial; Relational	Reflexive questions for clinicians and patients and questions to ask each other in order to establish the foundations of the relationship	Allows clinicians to reframe their relationships with their patients by considering them as important sources of knowledge	Requires a lot of time Applies mostly to therapeutic relationships likely to last over time Does not consider structural aspects	Rosen (2021)
Counter-narratives	Hermeneutical; Individual, potentially structural	Reappropriation by a marginalized group of its narrative and knowledge	Promotes patients' empowerment Can be a strategy of resistance and resilience Decolonial potential	Considers little the role that can be played by professionals or politicians Relies mainly on the patients	Dutta et al. (2022), White (2021)
Narration in medical education	Testimonial, hermeneutical; Individual, relational, structural	Including patient in future and current healthcare professionals' training	Can foster a sense of empowerment Encourages contact between professionals and patients outside the clinical context Raises awareness among professionals about patients' experiences	Requires sometimes difficult and emotional work from patients Carries risks of instrumentalizing patientsé	LeBlanc-Omstead (2021), LeBlanc-Omstead and Kinsella (2023)
Cognitive approaches					
Mindfulness	Testimonial; Individual	Addressing cognitive biases by deliberately bringing them to consciousness	Promotes introspection for healthcare professionals Allows recognizing one's own biases in order to address them	Does not consider structural aspects Relies on the goodwill of those responsible for injustice May not make all biases conscious, e.g., those that would threaten self-conception (i.e., racism, sexism, etc.) Difficult to implement in the context of short and quick medical consultations	Narayanan (2023)

Table 2 (continued)

Strategy	Injustice type & level of action	Description	Strengths	Limitations	Reference(s)
Epistemic redress	Testimonial & hermeneutical; Individual & relational	Deliberately forming or not forming a thought to address an epistemic injustice	Promotes self-reflection Allows for rectifying an already committed epistemic injustice Has the potential to prevent further epistemic injustices	Does not consider structural aspects Relies on the goodwill of those responsible for injustice May not make all biases conscious, e.g., those that would threaten self-conception (i.e., racism, sexism, etc.)	Hull (2022)
Partnership approaches					
Patient partnership (Montreal Model)	Testimonial & hermeneutical; Relational & structural	Engagement of patients at all levels of the healthcare system by considering them as full members of care, governance, research, and education teams	Focuses on collaboration Promotes a rebalancing of epistemic authority Transformative potential Integrative model of various strategies	Requires a cultural shift Initially requires time and resources Does not directly address underlying social inequalities	Pomey et al. (2015), Karazivan et al. (2015)
Patient advocates	Testimonial & potentially hermeneutical; Relational	Support in medical appointments by a patient advocate	Promotes epistemic justice both in the relationship with the patient advocate and with healthcare providers Allows for having an ally in the medical consultation Helps rebalance power dynamics in medical consultations	Can be challenging for health-care professionals Requires a cultural shift	Newbigging and Ridley (2018)
Resistance strategies					
Phenomenological toolkit	Hermeneutical; Relational	Empowering patients to reconceptualize illness by shifting focus from biological processes to existential aspects in order to change their relationship with the illness, the world, and themselves	Active role of patients Regaining power and agency Direct empowerment of patients	Does not reduce perpetuated hermeneutical injustices, rather empowers patients to confront them Relies solely on patients and does not engage professionals	Carel (2012), Carel and Kidd (2014), Carel (2021)

Table 2 (continued)

Strategy	Injustice type & level of action	Description	Strengths	Limitations	Reference(s)
Online activism	Testimonial & hermeneutical; Individual	Using social media to share one's testimony of the illness	Active role of patients Regaining power and agency	Renders ill individuals vulnerable to experiencing further epistemic injustices due to the public nature of activism Does not involve healthcare professionals Does not reduce perpetrated injustices	Groenevelt and Boer (2023)

is not just to be open to new ideas, but to be open to the ambivalence of our emotional and bodily responses and to reflecting on those responses in nuanced ways." (325).

In medical settings, epistemic vulnerability could therefore involve healthcare practitioners being open to patient's knowledge, despite the discomfort it may represent to consider new ideas or temporarily suspending their medical expertise, while observing the effects (physical, emotional, etc.) of this attitude; being able to question their own conception of medicine when relevant (e.g., the dominance of the biomedical model, established methods and protocols, etc.); and re-evaluating their epistemic authority as needed. For patients, adopting a posture of epistemic vulnerability may involve risking communicating their concerns, sensations, or hypotheses to healthcare professionals while accepting the possibility of being wrong; paying attention to the ways in which the illness appears in the body both on a physical and affective level; and being open to professionals' recommendations. Epistemic vulnerability addresses certain criticisms raised against Fricker's (2007) conception of epistemic justice, notably by placing the responsibility for such justice both in the hands of those perpetuating epistemic injustices and those suffering from them. In this regard, Gilson (2011) mentions, drawing on feminist theories of situated knowledge, that "epistemic vulnerability is indispensable, albeit in different ways, not only on the part of those who are relatively privileged but also on the part of those who are relatively oppressed or who do not stand to benefit from the status quo" (325). However, epistemic vulnerability has certain limitations, as it remains a voluntary attitude on the part of both patients and healthcare professionals and seems more difficult to transpose structurally.

Epistemic humility

The epistemically humble approach is widely discussed in the literature on epistemic justice in healthcare (e.g., Bourgault 2023; Buchman et al. 2017; Ho 2011; 2017; Kidd 2016; Kishor et al. 2023; Medina 2011; Peled 2018; Potter 2022; Schwab 2012; Wardrope 2015). It aims to correct prejudicial judgments regarding the credibility of patients by acknowledging medical decisions are almost always accompanied by uncertainty (Schwab 2012; Wardrope 2015) and that medical knowledge is constantly evolving (Buchman et al. 2017; Kishor et al. 2023). This approach also involves seeking other sources of knowledge to fill one's own gaps (Wardrope 2015). In medical settings, it is expressed notably by recognizing that patients' testimonies are essential for clinicians to properly understand the clinical picture (Wardrope 2015; Buchman et al. 2017). According to Schwab (2012), the uncertainty that accompanies medical decisions ethically engages healthcare professionals to adopt an epistemically humble approach in their practice. In this context, he recommends physicians to (1) acknowledge the uncertainty they face; (2) communicate this uncertainty; and (3) refrain from relying solely on their intuition or proposing quick experimental solutions, as this requires deeper conversations with patients (e.g., to obtain informed consent). An epistemically humble agent is also capable of recognizing that the epistemic authority bestowed upon them may be disproportionate in some contexts (Wardrope 2015). In the context of healthcare, this involves acknowledging that patients' testimonies are epistemically privileged on certain aspects to choose the best options for clinical management for them. An epistemically humble physician recognizes the limits of their expertise and their fallibility (Wardrope 2015; Ho 2017) and publicly acknowledges them (Wardrope 2015). This approach thus allows for a rebalancing of epistemic authority by granting each individual authority over their skills, knowledge, and expertise, and not only depending on status. It is a balance between the trust placed in science, sometimes uncertain, and the ideas and perceptions of individuals, also imperfect (Bleicher 2021). Several authors thus emphasize the importance, for healthcare practitioners, of considering patients as epistemic peers, and recognizing the privileged perspective of patients regarding their lived experience with the illness and their feelings (Freeman 2015; Freeman and Stewart 2018, 2019; Giladi 2020; Spear 2023). It is not for healthcare professionals to systematically do everything patients wish or to reject their own clinical expertise and that of their colleagues, but rather to recognize the value of patients' knowledge as complementary to their own and to consider them in a shared decision-making approach. Potter (2022) emphasizes that epistemic humility should not eradicate frictions, criticisms, and epistemic resistances, which are necessary for knowledge development. Adopting an excessively humble approach can, according to her, lead to epistemic vice, to the same extent as a lack of humility (Potter 2022). It is therefore a question of balance. Several authors offer similar definitions of epistemic humility. However, Bourgault (2023) adds an interesting element, namely that epistemic humility requires a degree of sacrifice on the part of the hearer. Indeed, increasing the credibility granted to someone, as proposed by Fricker (2007), simultaneously requires, for the hearer, to temporarily suspend the credibility accorded to their own knowledge. This notion of relinquishment or "cost" will be further explored in the following section on epistemic solidarity.

Potter (2022), however, highlights certain limitations of epistemic humility, notably its largely interpersonal aspect, as it requires an attitude that must be practiced by physicians to take effect and does not really offer a structural remedy. Epistemic humility heavily relies on clinicians' willingness to cultivate this virtue. To address these shortcomings, Pot (2022) suggests another approach, which bears similarities to epistemic humility, namely epistemic solidarity.

Epistemic solidarity

Epistemic solidarity is conceptualized by Pot (2022) as a political practice that challenges the distribution of epistemic power. The author grounds her reflection in the idea that solidarity, upon which collective action is based, has historically enabled the assertion of patients' rights, and improved the consideration of patients' testimony, particularly through patient groups and associations. Pot (2022) seeks to push this concept further by establishing the parameters of an epistemically solidary approach, which can be conceptualized as a commitment to bear "costs", whether they are financial, social, emotional, etc., to assist a person with whom a similarity is shared on a given point. Only practices deemed "normatively desirable and transformative" (684), or political, can be qualified as solidary. An undesirable practice (e.g., white individuals, therefore sharing a similarity, choosing to promote racist behavior, even though it entails a cost, such as affecting their reputation) cannot be considered as solidarity. In other words, to be considered epistemically solidary, physicians must recognize a similarity with patients, such as the vulnerability and inherent interdependence of the human nature, and act to improve their situation, assuming the costs involved. According to Pot (2022), epistemic solidarity both promotes epistemic justice and revisits knowledge production more broadly in the medical field. She provides two examples: voluntary sharing by patients of their medical data to contribute to research, as well as healthcare professionals' engagement with patients to better understand their afflictions.

Several authors argue, however, that professionals do not necessarily always have interest in "helping" (Bourgault 2023; Carel 2023; Doan 2018; Fricker 2016; Kidd and Carel 2018; Pohlhaus 2017). As mentioned by Kidd and Carel (2018), healthcare professionals "often have an interest in *not* understanding the experiences of the underprivileged" (219) in order to preserve their position of power and the privileges they derive from it. Bourgault (2023) also echoes this statement by emphasizing this problem as the heart of epistemic injustice, namely that "the ignorance of the privileged—the little attention they pay to more marginalized knowledges—often stems from the fact that they do not need to know or do not want to know (especially if the knowledge in question could disrupt existing socio-economic arrangements)" (152, my translation). It may therefore be counterproductive to leave the responsibility for epistemic justice, such as cultivating epistemic virtue, in the hands of those in position of power (Doan 2018). As mentioned, implementing epistemic solidarity has tangible costs for clinicians, including time and income, but this practice also has epistemic costs, as it means a reduction in their epistemic authority, which would be shared with patients, should this practice be put into practice. According to Pot

(2022), solidarity therefore relies essentially on the idea that healthcare professionals should not act out of self-interest, but rather from a position to "taking care". Like other approaches, such as epistemic humility or Fricker's (2007) vision of epistemic justice, Pot's (2022) proposal seems so far to remain dependent on the ability and willingness of physicians to develop certain virtues. This is why Pot (2022) goes further by putting forward a structural conception of epistemic solidarity, which is described in the section on structural approaches.

Cognitive approaches

Epistemic injustices can be conceptualized as cognitive biases. Indeed, testimonial injustices stem from biases based on stereotypes, which are often unconscious. Similarly, hermeneutical injustices may involve disregarding information or making judgments about someone's testimony without making the effort to understand it because we lack the conceptual resources to interpret it properly. In this regard, two cognitive approaches are identified in the literature to promote epistemic justice. They include mindfulness (Narayanan 2023) and epistemic redress (Hull 2022). These approaches aim to bring biases to consciousness.

Mindfulness

Narayanan (2023) argues that, to promote epistemic justice, it is necessary to implement strategies to limit automatic judgments. According to the author, this involves grounding oneself in the present moment, consciously focusing our attention on it, and acting with introspection. Anchoring in the present helps counteract automatic thinking, which tends to maintain an illusion of validity over one's own beliefs and protect them, thereby contributing to cognitive biases such as epistemic injustices. The author suggests that the practice of mindfulness is a promising way to bring automatic thoughts to awareness for deliberate evaluation. Like several other strategies described, including virtuous listening, mindfulness has the potential to address epistemic injustices directly among those who perpetrate them. However, in the medical context, this strategy once again relies on the individual willingness of healthcare professionals to adopt it.

Epistemic redress

Another cognitive approach, epistemic redress (Hull 2022), focuses not on future actions to promote epistemic justice, as most approaches do, or present actions like mindfulness, but rather on past actions. According to Hull (2022), a cognitive approach is necessary to repair the harm caused by epistemic injustices, as they stem from cognitive processes, including beliefs, thoughts, attitudes, etc. The individual committing epistemic injustices has the power to repair it.

Epistemic redress can be achieved specifically by forming or not forming beliefs or attitudes in a given situation. This form of repair can be (1) refraining from forming a specific belief; (2) actively choosing to remain neutral, or (3) assuming or presuming something voluntarily. These strategies seem particularly relevant in the medical setting. Indeed, refraining from forming a specific belief can imply for a healthcare practitioner to consciously refraining from believing that a patient's pain is psychological, or "in their head" before evaluating all options. Similarly, assuming or presuming something voluntarily can be expressed by assuming that a patient is genuinely experiencing symptoms as described if there are no signs they are lying or exaggerating. These attitudes must be intentional; otherwise, it is not epistemic redress.

While these cognitive strategies for belief modulation described by Hull (2022) seem relevant for repairing epistemic harm already caused, they could potentially be applied more broadly in medical appointment to prevent epistemic injustices, particularly by always assuming, in the first instance, that patients' descriptions of their experiences and symptoms are sincere. Healthcare professionals' attitudes could then be adjusted as needed, for example, in a case where a person's credibility may be legitimately questioned. Beyond their effect on testimonial injustices, these strategies may also be effective in suspending one's judgment over the hermeneutical resources employed by a patient, to allow for openness and time to pay attention, listen, and try to understand patient's testimony. These cognitive strategies are however applied individually and seem to offer little support for structural changes to promote epistemic justice on a large scale. Cognitive approaches are limited in their ability to bring all biases to consciousness and are individual approaches relying on individuals to include them in their practice.

Structural approaches

A vision of epistemic justice based solely on virtuous approaches has been widely criticized in the literature for presenting a perspective overly focused on relational or individual factors, whereas epistemic injustices are largely structural (Anderson 2012; Doan 2018; Bourgault 2020, 2023; Samaržija and Cerovac 2021). Anderson (2012) compares the development of epistemic virtue at the relational level "to the practice of individual charity in the context of massive structural poverty" (171). According to her, to address such a problem, it is necessary to rethink economic institutions. She therefore proposes to reconfigure epistemic institutions to prevent epistemic injustice from occurring in the first place. Mechanisms allowing the emergence of epistemic injustices, in health and in other domains, are largely structural, including structural health vulnerabilities (Chung 2021), largely dependent on social determinants of health (Braveman and Gottlieb 2014). Structural solutions are therefore essential. This section highlights various ways to address epistemic injustices from a structural perspective. Structural approaches include the institutionalization of epistemic solidarity, the development of institutional virtue, the countering of institutional opacity, rethinking temporalities, and anti-oppressive clinical approaches.

Institutionalization of epistemic solidarity

Building on the approach of epistemic solidarity outlined earlier, Pot (2022) suggests institutionalizing epistemic solidarity. Indeed, according to her, epistemic solidarity can—and ideally should—be institutionalized, meaning that the costs—necessary for this approach to be qualified as solidarity—can be supported collectively and not solely borne by healthcare professionals. To this end, Pot (2022) argues that institutionalizing epistemic solidarity could be established to the extent that listening to and engaging with patients were considered healthcare services, akin to other biomedical interventions or diagnostic tests. To achieve this, enough doctors would need to work without (or with less) time constraints and have adequate discussions with patients. This argument aligns with that of Bourgault (2023), who emphasizes the need to consider listening as an act of care.

Institutional virtue

As mentioned earlier, Anderson (2010, 2012) argues that a structural remedy is necessary to promote epistemic justice. She thus proposes social integration, (i.e., the mix of different social groups) as imperative. The author bases her argument on research supporting that increased contact between different groups reduces prejudices and contributes to improving relationships between members of different groups, particularly when these contacts occur in contexts without hierarchical relations (e.g., when children from different social groups are educated together within the same institution). Anderson's (2012) proposal is not further developed, as she admits that a comprehensive response to the question of institutions embodying epistemic justice would require several books. Thus, it is a direction rather than a fully developed proposal. Schlüter (2021), however, urges caution with such an integration approach, as it remains necessary to preserve safe spaces where individuals from marginalized groups can meet and develop hermeneutical resources, particularly since these spaces may be sites of epistemic resistance.

Countering of institutional opacity

Another strategy proposed in the literature to move towards epistemic justice is to counter institutional opacity (Carel and Kidd 2021) as a mechanism underlying epistemic injustices. Institutional opacity occurs when the structure, procedures, and culture of an organization, such as the healthcare system, are not clear, and it becomes difficult for individuals, such as patients, to navigate it, but also to understand the codes that should govern the epistemic exchanges to foster their credibility among these institutions (Carel and Kidd 2021). Understanding the healthcare system and its mechanisms allows patients to know what to say, how to say it, to whom to say it, and in what context to say it in order to achieve what they desire (i.e., receive the care needed). According to Carel and Kidd (2021), it is obvious that our social institutions, such as the healthcare system, should have the ethos of cultivating epistemic justice. The authors argue that an institutional ethos is defined by the institution's values (e.g., transparency and sincerity), its procedures, and its outcomes. A problem can arise with each of these components, their interrelation, or both with one or more components and their interrelation. In the healthcare system, an ethos of epistemic justice would first require that epistemic justice be a value of the institution. According to Carel and Kidd (2021), most healthcare systems have an ethos of epistemic justice, with values and principles such as respect, recognition of rights and freedoms, equity, understanding, and respect for the dignity and autonomy of patients. Epistemic justice should therefore be at the core of procedures in the healthcare system (Aftab 2023). However, healthcare organizations often favor speed and volume, sometimes at the expense of the quality of care and interactions with patients. Due to the complexity of these institutions, Carel and Kidd (2021) argue that it is necessary to develop a "collective intentionality" to move from words to actions. It is thus necessary for individuals to collectively commit to maintaining the institutional ethos by cultivating a certain trust in the institution that motivates action in this direction (Carel and Kidd 2021).

Carel and Kidd (2021) also put forward two strategies to counter epistemic opacity. They first argue that institutional norms and values should be applied flexibly to meet the needs and vulnerabilities of individuals. Additionally, they suggest cultivating an institutional appreciation of human diversity, meaning developing norms, values, and practices that take into account individual needs instead of offering standardized services intended for everyone but suitable for only some (a *one size fits most*). This approach aligns with the importance of paying attention to the differences in patients, as described by Bourgault (2020) and Giladi (2020), among others.

Rethinking temporalities

Paying attention to the differences in patients and considering individual needs inevitably requires time (Bourgault 2020, 2023). According to Bourgault (2020, 2023), developing virtuous listening as described by Fricker practically requires more time. Bourgault (2020, 2023) presents time as an essential condition for epistemic justice, but also for care. Caring or paying attention to others are actions and concerns that are difficult to quantify, requiring an indefinite amount of time, varying from one particular situation to another. Furthermore, Bourgault (2020; 2023) criticizes Fricker for only considering credibility deficits. She argues that in a world where attention and listening are limited resources—which is particularly true in the medical context due to the time constraints—judgments of over credibility or sincerity are also problematic. This issue also extends beyond the medical institution and is rooted in a neoliberal, capitalist system focused on production (Bourgault 2020). Indeed, according to Valkenburg (2022), attention is essentially a temporal practice, as giving attention to someone requires giving them time. This time must also be of a certain quality, without which attention and listening are not optimal. The notions of time and attention are particularly relevant in the context of epistemic injustices, as to be able to give testimony, one must attract the attention of their audience, which in turn requires being granted time (Valkenburg 2022).

Epistemic injustices can therefore occur when a speech act—such as a medical encounter—is timed and the temporality of the speaker is not in line with the time allocated by the hearer (Valkenburg 2022). This is exacerbated by the market value assigned to time in capitalist systems, which implies that time also has a negative value, meaning it is a cost to be minimized and speed should therefore be sought (Valkenburg 2022). This also appears to be consistent with fee-for-service medical reimbursement affecting the time allocated to medical consultations in some public healthcare systems, such as in Quebec, Canada. According to Valkenburg (2022), time is also subject to different constructions. Since different individuals and groups respond to different temporalities, there are power asymmetries towards a hegemonic (fast) conception of time (Valkenburg 2022). The flexibility to navigate between different temporalities stems from a certain form of privilege. This privilege can be understood through the concept of *crip time*, which suggests that people with disabilities, including those with neurodiversity or living with chronic illnesses, experience different temporalities (Baril 2016; Samuels 2017; Ljuslinder et al. 2020). Various obstacles in the daily lives of these individuals, such as symptoms or physical difficulties, energy levels, medical consultations, adapted transportation schedules, mobility barriers, the need for breaks, etc., mean that these individuals need more time to accomplish the same tasks as someone without these challenges and this physical and mental burden. Other groups may also face certain obstacles that modulate their temporality, such as age or culture. According to a theorist of critical disability studies, Kafer (2013), "[r]ather than bend disabled bodies and minds to meet the clock, crip time bends the clock to meet disabled bodies and minds." (27). People living with a chronic illness may also need reassurance and time to address their concerns.

Epistemic justice thus implies that it is fundamental to rethink our relationship to time (Valkenburg 2022) in medical consultations, taking into account both the different temporalities of individuals, the situations of privilege and oppression that may result from them, as well as the specific needs of patients. The shaping of time by political, social and cultural factors, notably capitalism, must also be considered. Restructuring our relationship to time is not an easy task. Other strategies developed in this review, such as epistemic solidarity, can help institutionalize new temporal norms (Pot 2022).

Education on epistemic injustices

Another possible structural approach to epistemic justice is to reconsider certain aspects of healthcare providers' education and training. A feminist perspective on medical ethics presented by Campelia and Feinsinger (2020) argues that to promote epistemic justice, the concepts of epistemic in/justice should be integral to the curriculum of medical students. According to the authors, medical students and healthcare professionals may also encounter epistemic injustices as patients themselves, or in discussions with colleagues as medical professionals. Furthermore, since their professional title confers a certain degree of epistemic authority and the power to regulate epistemic exchanges, formal education on epistemic in/justice could help shape their understanding of their ethical responsibilities towards patients. According to White (2021), patients would also benefit from theoretically understanding the concept of epistemic injustice, as achieving epistemic justice requires first being aware of its existence.

Medical education on epistemic injustices has the potential to promote epistemic justice by addressing epistemic injustices before they even occur and by fostering reflection among future healthcare professionals on their potential epistemically authoritative status in relation to patients. However, this approach still depends on the willingness of professionals for its implementation.

Anti-oppressive strategies

In the field of counseling and social work, certain anti-oppressive strategies are suggested to promote epistemic justice, particularly in the context of intercultural therapy. Like virtuous listening proposed by Fricker (2007), anti-oppressive approaches require critical self-reflection on the part of clinicians. However, these approaches have a more structural perspective, as power dynamics and social inequalities are openly acknowledged and addressed in therapy (Johnstone 2021; Lee et al. 2022). Epistemic justice is also promoted by respecting clients/patients as good informants and by centering the therapeutic relationship around their knowledge and experiences (Johnstone 2021). Considering its application in social work, it may be relevant to consider its applicability in medical settings.

Narrative approaches

Several approaches centered on patients' storytelling can be identified as promoting epistemic justice. Being able to testify and to be listened to are essential needs for patients. In this regard, Carel (2023) states: "This is not merely a psychological need to be heard, although this is certainly important. It is the critical need for patients to be able to put forth views and preferences for these to be an integral part of any decision-making process about their care" (462). This need to tell and to be listened to is not new and has been put into practice by some clinicians for about 20 years in narrative medicine (Charon 2001a, b). Charon defines narrative medicine "as medicine practiced with the narrative competencies necessary to recognize, absorb, interpret, and be moved by the stories of illness" (Charon 2005, p. 262). This approach considers that people living with chronic illnesses naturally become storytellers, while those who care necessarily become listeners (2005). According to Charon (2008), narrative medicine is an approach that has the power to change medical practice, especially "its impersonality, its fragmentation, its coldness, its self-interestedness, its lack of social conscience" (10).

Doan (2018) also highlights how the practice of sharing stories in public spaces, in the context of issues related to access to clean water in Michigan (USA), has helped promoting epistemic justice. Sharing and listening to stories related to water has allowed for the expansion of solidarity networks, identification and treatment of shared traumas, forging a sense of collective identity, collaborating for political transformation, etc. (Doan 2018). In the context of healthcare, several authors directly propose the use of narrative approaches with the aim of promoting epistemic justice, including narrative ethics, narrative therapy, the generation of counter-narratives, and the integration of storytelling into medical education.

Narrative ethics

Narrative ethics is an approach aimed at resolving morally problematic situations by placing the person's story, experience, emotions, wishes, etc., at the center of ethical decision-making (Dion-Labrie and Doucet 2011). This approach can be applied in the context of epistemic injustices, which are morally problematic situations. According to Saulnier (2020), who analyzes the narrative ethics approach from the perspective of critical theories, three elements, seemingly straightforward, must be put in place to enable narrative ethics: stories must be told, heard, and believed. However, this is challenging in a paternalistic approach to medicine. Saulnier (2020) argues that "entrenched patterns of narrative neglect in medicine are harming not only our capacity to make use of narrative ethics but also our capacity to deliver effective healthcare." (297). According to Saulnier (2020), when associated with critical analysis, narrative ethics can be a powerful tool to better understand and mitigate injustices and power dynamics in storytelling in the medical field, particularly testimonial injustices. However, this approach is not extensively described in the literature, and its implementation remains somewhat abstract. Moreover, it seems to largely rely on the willingness of healthcare professionals to put it into practice.

Narrative therapy

Regarding narrative therapy, Rosen (2021) sees this approach as a way to enable clinicians to reframe their relationships with their patients and to view them as important sources of knowledge. She envisions a conversation of approximately 10 min, intended as a reflective moment between clinicians and patients, with reflective questions for each, as well as questions for clinicians to ask patients and vice versa. Examples of questions and reflections include, "What do you wish your clinicians had done better in the past?" and "I have the following fears about the clinical context. How, as a clinician, will you address these fears?" This approach is an interesting avenue that directly applies the concept of self-reflection advocated by Fricker (2007) as essential for cultivating the virtue of epistemic justice. This approach also suggests engaging both patients and clinicians in epistemic justice by inviting them to engage in self-reflection and dialogue. However, it remains limited as it tends to apply only in clinical relationships that are likely to last over time (e.g., between a patient and their general practitioner). Moreover, it does not really consider structural aspects associated with epistemic injustices.

Counter-narratives

Counter-narration can also be a way to reclaim a certain agency, promoting a form of epistemic justice. Counter-narratives involve a marginalized group (or individual) taking back control of a message conveyed by a dominant group about them. This strategy, developed by Dutta et al. (2022) in the context of knowledge reappropriation by the Miya community, a marginalized Muslim group in India, seems applicable to the medical relationship. According to the authors, counter-narratives are a powerful way to recenter marginalized knowledge of the community (in this case, the Miya people) in a context where knowledge about this community is predominantly disseminated by a dominant group (in this context, institutions and universities, considered as centers of knowledge production), with the aim of promoting epistemic justice. While acknowledging that Dutta and colleagues' research was conducted from a decolonial perspective, counter-narratives seem applicable to other contexts where a group's knowledge is marginalized, such as patients' knowledge. In the context of their research, Dutta and colleagues advocate for narratives that humanize the Miya people by creating and reclaiming cultural knowledge and political spaces that place the struggles and resistance of peoples at their center. Similar strategies can potentially be useful for patients. In the medical context, for example, White (2021) suggests that it is essential for patients to contribute to the construction of a powerful counter-narrative. In this regard, the author mentions:

> We must strive to create theories, concepts, meanings, interpretations, beliefs and knowledge that combine our lived experience with thought, reason, and creativity. And we must disseminate this new knowledge through mainstream media, including social media. [...] We must not allow our challenges to be reduced simply to recovery from illness. [...] For true liberation, Mad scholars and activists must re-write the Master Narrative in its entirety, and that narrative must be grounded in difference not sameness, humanity not sanity, and the inherent value of people not the transactional value of money (87).

Such an approach can promote empowerment, but it requires significant engagement, possibly over a long period, on the part of patients to bring about lasting changes. These counter-narratives must also extend beyond patient communities to reach healthcare professionals and society more broadly. This strategy could thus be effectively coupled with others, such as mobilizing patient narratives in medical education, which will be described in the next section. It also seems particularly relevant for the revaluation of traditional medical knowledge to promote epistemic pluralism, such as the healing knowledge of indigenous peoples, which is particularly relevant in the Canadian context or other colonial contexts (Cohen-Fournier et al. 2021).

Narration in medical education

The involvement of patients in narrating their experiences to future healthcare professionals is also presented as an avenue to promote epistemic justice by giving patients the opportunity to reclaim their own stories and embodying them, making a concrete difference in the training of future healthcare practitioners (LeBlanc-Omstead 2021; LeBlanc-Omstead and Kinsella 2023). Although promoting empowerment, narration in an educational setting also carries several risks, including a significant risk of instrumentalization of patients and their stories, pressure on patients to embody their stories in certain expected ways, emotional burden associated with the shared content, underestimation of the work required by patients (emotional work, preparation, etc.), as well as the reproduction of epistemic injustices regarding which narratives are appropriate or not to share in the context of medical education (LeBlanc-Omstead 2021; LeBlanc-Omstead and Kinsella 2023). According to the authors, certain conditions must be in place for narration in the context of medical education to indeed be conducive to epistemic justice. These conditions include fair compensation for the work done by patients as well as a genuine partnership with teachers who invite them to share their experiences, in order to go beyond instrumentalization (tokenism) or involvement and to embrace practices of partnership with patients that are truly transformative.

Narrative approaches, whether it be narrative ethics, narrative therapy, counter-narrative, or narration in medical education, therefore highlight the importance for epistemic justice that patients have the possibility to tell their experiences from their own point of view, but also that they receive attention from hearers.

Patient partnership: an integrative avenue

Two approaches promoting partnership in healthcare were identified in the literature. They include patient advocates (Newbigging and Ridley 2018), and the Montreal Model (Pomey et al. 2015), including partnership in care (Galasiński et al. 2023; Thomas et al. 2020), in medical education (LeBlanc-Omstead and Kinsella 2023; Thomas et al. 2020), in governance (Faucher 2022), and in health research (Faucher 2022; Groot et al. 2022). These approaches are supported by the literature as pathways to promote epistemic justice.

Patient advocates

Patient advocates are a resource proposed in the literature to promote epistemic justice in medical consultations, particularly in mental health (Newbigging and Ridley 2018), but which can be applied in other care contexts. The authors report that being accompanied by a patient advocate, knowledgeable about services and with lived experience, is a means to protect or restore the epistemic agency of patients. Patients who benefit from patient advocates' accompaniment feel listened to and understood by patient advocates (Newbigging and Ridley 2018). They report that it legitimizes their voice and alters the interaction with professionals, who are described as showing more respect and listening (Newbigging and Ridley 2018). Patient advocates also serve as witnesses to the consultation, which promotes respect for the rights and decisions of the person in the psychiatric context and, consequently, a regaining of trust, as well as a sense of epistemic agency and epistemic justice (Newbigging and Ridley 2018). Such an approach potentially allows for rebalancing power dynamics, including inequal epistemic authority, in medical consultations. However, it must be particularly careful to ensure that the voice of the patient advocate does not override the patient's voice.

The Montreal model: toward an integrative partnership at all levels

Several articles cited in the present work emphasize the importance of a patient- and family-centered approach in healthcare and the need to combat epistemic injustices to better embody this approach (e.g., Charon 2008; Ho 2011; Freeman and Stewart 2018; 2019; Saulnier 2020; Bourgault 2023; Carel 2023). The patient-centered approach emerged in opposition to a paternalistic approach to medicine, based on a biomedical and compartmentalized view of medicine and care, dominant at least since the 1950s. Rooted in the social sciences and humanities, the patient-centered approach forefronts an interdisciplinary and humanistic vision by recognizing patients' overall situation and the importance of involving family members in their care (Dumez and Pomey 2019). However, this approach has significant limitations. Indeed, it focuses on collaboration among healthcare professionals to meet patients' needs, quality of care, and efficiency, rather than on the concrete involvement of patients in their own care by recognizing the quality of the knowledge they hold (Dumez and Pomey 2019).

Patient partnership, as defined by the Montreal Model, goes a step further than the patient-centered approach by considering patients as full-fledged team members, on an equal footing with any other professional, not only in their care team but also in governance, research, and education teams (Pomey et al. 2015; Karazivan et al. 2015; Dumez and Pomey 2019). This approach is based on the belief that patients hold important knowledge, including about their bodies and symptoms, as well as cultural, healthcare system navigation, and scientific knowledge. The patient partnership approach is founded on the premise that without patients' testimony, healthcare providers lack fundamental information. Thus, there is an interdependent relationship between patients and healthcare professionals.

The Montreal Model of patient partnership draws from three existing approaches in healthcare, namely shared decision-making, self-management of illness, and therapeutic education (Dumez and Pomey 2019). It is also based on recognizing the knowledge and skills of each member of the care team, including patients, their caregivers, and various healthcare professionals, and their complementarity. Partnership also aims to support the development of patients' autonomy and knowledge and to consider the biopsychosocial aspects of illness in care, particularly patients' life projects (Pomey et al. 2015; Spear 2023). Thus, care and services are offered based on patients' overall life projects rather than on a specific curative goal that may be reductive and often unrealistic in the context of a chronic condition (Karazivan et al. 2015).

This approach seems aligned with the aims of epistemic justice and echoes in many ways different arguments presented in the previously cited articles, although it has been little explored directly in research on epistemic in/justice. For example, several texts on epistemic injustices in healthcare discuss the importance of shared decision-making (e.g., Kidd 2016; Ho 2017; Bourgault 2023; Galasiński et al. 2023; Thomas et al. 2020). Leadership in care team (Galasiński et al. 2023 and Thomas et al. 2020), as well as in research (Faucher 2022; Groot et al. 2022), governance (Faucher 2022), and professional education (LeBlanc-Omstead and Kinsella 2023; Thomas et al. 2020), is also a shared responsibility (Karazivan et al. 2015; Pomey et al. 2015), which can be seen as a democratic exercise aimed at restoring some political agency to patients (Liveriero 2020; Radoilska 2020). The patient partnership approach also seems aligned with the definition of transformative epistemic justice as outlined by Doan (2018) and fundamental for epistemic justice. In this regard, she states:

> a strategy is "transformative" insofar as it aims to resist the reproduction of the social structures in question while also contributing to a process of radical restructuring. In cases of epistemic injustice, a transformative strategy is one that seeks to create new terms, values, and conditions by which people are to recognize one another as thinkers, knowers, and collaborators, contributing thereby to broader processes of social, economic, and political restructuring (Doan 2018).

Patient partnership, as defined by the Montreal Model, has the potential to be classified as a transformative approach since it aims to resist the reproduction of an unjust structure for patients through radical restructuring (at the root, c.f., Wong 2017) of the healthcare system broadly, ranging from professional education to research, care, and governance. In this process, physicians, other professionals, patients, their relatives, researchers, and managers are brought to consider each other as knowers, thinkers, and collaborators working toward a common mission within the same team and shared power over decisions. This vision of patient partnership also resonates with the statements of Kidd and Carel (2018) and Durbhakula and Fortin (2023), who conceive epistemic justice as requiring a cultural shift globally. The multilevel aspect of patient partnership, which seeks to impregnate different layers of the medical institution, supports its transformative potential by fostering a progressive cultural change at all levels. It also allows healthcare professionals to have contacts with patients outside the care context (e.g., in committees, in training, etc.), emphasized by several authors interested in epistemic justice as crucial to reducing epistemic injustices (Anderson 2012; Bourgault 2023). A mutual recognition as knowers as conceptualized by Giladi (2020) gradually occurs with contact, especially in situations where epistemic authority is reversed, for example, in training where professionals are in a learner position and patients in a teacher position.

It is this trickle-down effect from one layer to another of the medical institution that has the potential to promote epistemic justice, by a common objective with patient partnership: the recognition of different types of knowledge complementarity. Patient partnership is also different from epistemic objectification: it does not consider patients as a mere source of information but rather as knowers who can contribute to knowledge development (Calder 2021).

Resistance strategies

Different strategies are also identified to regain a sense of justice and agency once epistemic injustices have already been perpetrated. Several strategies of resistance can be directly implemented by patients in a context of slow institutional changes, where they are confronted with epistemic injustices in healthcare. Various empowerment strategies mobilized by patients in the context of epistemic injustices have been discussed throughout this article, such as counter-narratives, narratives in medical education, and patient partnership. Other resistance and resilience strategies can be deployed by patients once epistemic injustices have been committed, such as online activism (Groenevelt and Boer 2023) or the phenomenological toolkit suggested by Carel (2012) to give meaning to one's experience of the illness outside the dominant biomedical framework. The literature specifically on these strategies could be better investigated using other research terms, such as "empowerment" or "agency" in the context of invalidation in healthcare more largely. In the context of epistemic justice specifically, the literature on such strategies was scarce, but further research should expand outside the literature explicitly using the theoretical framework of epistemic in/justice to target other resistance strategies deployed by patients and other marginalized groups that could be applied to epistemic justice understanding.

Discussion

This article offers a first literature review on epistemic justice applied to healthcare by systematically and critically reviewing theoretical literature regarding the avenues to achieve epistemic justice in healthcare and evaluating their strengths and weaknesses. All the approaches identified in the literature and presented in this article have significant strengths, but also some weaknesses when considered individually. However, it is possible to think epistemic justice by considering that it can unfold in multiple ways, so that the shortcomings of one approach are complemented by the strengths of another. For example, to develop and implement the virtues outlined, healthcare professionals must first have a certain level of availability, both emotionally and in terms of their ability to pay attention to their patients, which requires time. Since it is not possible to question one's biases and beliefs without actually taking the time to listen first, and then continuously questioning one's prejudices and preconceived ideas, organizational and structural factors, such as the time allocated to each patient, play a major role in epistemic justice. It requires a certain dose of epistemic humility and vulnerability for a clinician to embrace self-awareness and criticism as suggested by cognitive approaches. Epistemic solidarity or structural changes in relation to time in healthcare are also required to implement narrative approaches in the clinical practice.

The Montreal Model, which aims for patient partnership and patient engagement at all levels of the healthcare system (Pomey et al. 2015), appears as a promising avenue to promote epistemic justice, as suggested by Thomas et al. (2020). The principles at the core of this model also intersect with several of the approaches presented in this article. By impacting all levels of healthcare, the Montreal Model of patient partnership appears to be the best available tool at the moment, acting both at the level of the care relationship and structurally. However, it has certain flaws. Indeed, while patient partnership directly addresses pathocentric injustices by relying on patient engagement, contact at various organizational levels, and the complementarity of different types of knowledges, it does not address other oppression systems that permeate our institutions and infiltrate our unconscious biases, such as racism, sexism, fatphobia, classism, etc. For this reason, a partnership approach should be articulated considering other approaches that promote critical self-reflection, as advocated by Fricker (2007) or by cognitive approaches, to avoid neglecting other biases. Furthermore, while transformation of systems may begin with patient partnership and engagement at all levels, other means can also significantly contribute to epistemic justice, such as the epistemic solidarity of professionals to facilitate restructuring certain aspects of the healthcare system, including the conditions under which they provide care (e.g., the time allocated to each consultation, recognition of listening as an act of care, etc.).

Is epistemic justice sufficient?

Although a patient partnership approach seems to integrate several avenues identified in the literature to promote epistemic justice, an important question remains: is epistemic justice sufficient? According to Giladi (2020), epistemic justice is difficult to envisage in a society crossed by different oppression systems such as racism, sexism, fatphobia, ableism, etc. Several authors therefore suggest changes at the social and political level more broadly. As an example, Chung (2021) proposes including people most likely to experience health inequalities in the development of policies to tackle these inequalities, which has the effect of both valuing their knowledge and acting on epistemic injustices, but also, on structural health vulnerability. A patient partnership approach, for example, should therefore also include a diversity of people in order to go beyond pathocentric injustices and take an interest in other oppression systems. People from different backgrounds in terms of body, sexual and gender diversity, race, age, ability, socio-economic condition, etc. should be able to act as partners at all levels, from research and care to governance and education.

At a more structural level, Samaržija and Cerovac (2021) suggest four ways to foster epistemic justice to protect vulnerable people from epistemic injustices and promote an epistemically healthy environment. These include ensuring that all groups have equal access to opportunities to acquire socially valued markers of credibility, including education, access to public platforms to communicate their social perspectives (including the media), and access to important positions (e.g., within the civil service, in politics, etc.) to publicly assert their epistemic resources. These are changes to be implemented in the long term and which require significant social and institutional reforms. The authors also suggest developing institutional mechanisms to remove identity markers from formal epistemic exchanges. This last suggestion seems difficult to apply to healthcare, which requires individual attention and direct contact. This point has been discussed in detail by Bourgault (2020).

Although broader social justice is desirable to sustainably promote epistemic justice, this article highlights how structural changes at several organizational levels could be deployed in the healthcare system by promoting a patient partnership approach, in combination with other strategies. Those who would want to put these reflections into practice should consider how oppression systems are deeply intricated in our social institutions, including not only healthcare, but also education, justice, social services, etc. all contributing to structural health vulnerability (Chung 2021). Initiatives aiming at epistemic justice must be led in partnership with those primarily concerned by epistemic injustices, including not only patients, but also patients at the intersection of different marginalized identities. Partnership goes further than the mere implication or consultation (or tokenism) by truly engaging patients in all steps of the processes and in valuing their knowledge, in an approach where structural epistemic justice could only be reached at the term of epistemically just processes. Because of structural conditions (e.g., poverty, lower level of formal education, heavy workload, family obligations, etc.), these individuals might not be the first to volunteer to participate in these changes. Their participation in such initiatives must therefore by supported (e.g., with a financial compensation, reimbursement for transportation or childcare, etc.).

This first attempt to integrate the literature on epistemic justice provides some concrete ways to promote epistemic justice in healthcare, such as implementing a patient partnership approach at all levels of the healthcare system. The review also provides a base for further work on epistemic justice in other contexts, such as racial justice, or education. However, this work also has some limitations. Indeed, the literature review could have been even more robust by including at least one other person in the review, screening, evaluation, and analysis of the articles. Stepping outside the literature with explicit reference to epistemic in/justice could also provide an array of strategies to promote justice in the consideration of knowledge. The literature itself on epistemic justice (in healthcare and in other spheres) is mostly theoretical. Further research should aim at evaluating the strategies highlighted in practice.

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